House Bill 2491

Sponsored by Representative HOLVEY (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure as introduced.

Requires short term health insurance policies to cover essential health benefits. Prohibits short term health insurance policies with terms of six months or longer from denying coverage based on preexisting condition.

A BILL FOR AN ACT

Relating to insurance; creating new provisions; and amending ORS 743B.011, 743B.105 and 743B.125.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 743B.011 is amended to read:

743B.011. (1) Except as provided in subsection (2) of this section, every health benefit plan shall be subject to the provisions of ORS 743B.010 to 743B.013, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Subsection (1) of this section does not apply to:

(a) An individual health benefit plan for which a portion of the premium is reimbursed through a qualified small employer health reimbursement arrangement as defined in section 9831 of the Internal Revenue Code; or

(b) An individual health benefit plan that is considered to be integrated with a health reimbursement arrangement or other account-based group health plan authorized by federal law.

(3) Except as otherwise provided by ORS 743B.010 to 743B.013 or other law, no health benefit plan offered to a small employer shall:

(a) Inhibit a carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(b) Except as provided in ORS 743B.012 (7), a carrier that offers coverage to a small employer

NOTE: Matter in boldfaced type in an amended section is new; matter in italic and bracketed is existing law to be omitted. New sections are in boldfaced type.

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shall offer coverage to all eligible employees of the small employer.

(c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier shall offer coverage to all dependents of eligible employees.

(5) An insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or a short term health insurance policy with a term of six months or longer or exclude coverage otherwise provided to an individual under a group health benefit plan or a short term health insurance policy with a term of six months or longer based on a preexisting condition of the individual.

SECTION 2. ORS 743B.105 is amended to read:

743B.105. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) A group eligibility waiting period for late enrollees that does not exceed 90 days.

(3) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(4) (a) A carrier shall issue to a group any of the carrier’s group health benefit plans offered by the carrier for which the group is eligible, if the group applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.

(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier’s ability to fulfill the carrier’s contractual obligations or result in financial impairment of the carrier.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The policyholder fails to comply with the contribution requirements under the plan.

(e) The carrier discontinues both offering and renewing, all of the carrier’s group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a
specified service area, except that:

(i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and

(ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.

(f) The carrier discontinues both offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the department and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) The carrier discontinues both offering and renewing a group health benefit plan, other than a grandfathered health plan, for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(h) The carrier discontinues both offering and renewing a grandfathered health plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(j) The director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier’s ability to meet contractual obligations.

(k) In the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(L) In the case of a health benefit plan that is offered in the group market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.
(6) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:
   (A) Performs an act, practice or omission that constitutes fraud; or
   (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days’ advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:
   (A) Performs an act, practice or omission that constitutes fraud; or
   (B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days’ advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) A group health benefit plan and a short term health insurance policy shall provide coverage of essential health benefits.

[9] (10) A group health benefit plan and a short term health insurance policy may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 3. ORS 743B.125 is amended to read:

743B.125. (1) With respect to coverage under an individual health benefit plan or a short term health insurance policy with a term of six months or longer, other than a grandfathered health plan, a carrier may not impose a preexisting condition exclusion or an individual coverage waiting period.

(2) With respect to individual coverage under a grandfathered health plan, a carrier:

(a) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) May not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

   (A) The exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage.

   (B) The exclusion expires no later than six months after the individual's effective date of coverage.

   (c) May not impose a waiting period.

(3) An individual health benefit plan and any short term health insurance policy other than a grandfathered health plan must cover, at a minimum, all essential health benefits.
(4)(a) A carrier shall issue any individual health benefit plan offered by the carrier, other than a grandfathered health plan, to any individual who applies for the health benefit plan, if:
   (A) The individual resides in the geographic area where the plan is offered;
   (B) The individual agrees to make the required premium payments; and
   (C) Issuance of the health benefit plan is not otherwise prohibited by law.

(b) The Department of Consumer and Business Services may allow a carrier to cap the number of individuals enrolled in an individual health benefit plan offered by the carrier if the department finds that issuing the health benefit plan to more individuals than are currently enrolled in the plan would have a material adverse effect upon the carrier's ability to fulfill the carrier's contractual obligations or result in the financial impairment of the carrier.

(c) Except as otherwise provided in this section and ORS 743.022, a carrier offering an individual health benefit plan may not impose different terms or conditions on the coverage provided or the premium charged based on the actual or expected health status of an enrollee or prospective enrollee.

(5) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:
   (a) The policyholder fails to pay the required premiums.
   (b) The policyholder or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.
   (c) The carrier discontinues both offering and renewing all of the carrier's individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:
      (A) Shall give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;
      (B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a specified service area, except that:
         (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if the cancellation is for a specified service area in the circumstances described in subparagraph (C) of this paragraph; and
         (ii) The Director of the Department of Consumer and Business Services may specify a cancellation date other than the cancellation date specified in this subparagraph if the carrier is subject to a delinquency proceeding, as defined in ORS 734.014; and
      (C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area.
   (d) The carrier discontinues both offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:
      (A) Shall give notice of the decision to the department and to all policyholders covered by the plan;
      (B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and
(C) Shall offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) The carrier discontinues both offering and renewing an individual health benefit plan, other than a grandfathered health plan, for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(f) The carrier discontinues both offering and renewing a grandfathered health plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier shall:
   (A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the carrier offers to individuals in the specified service area.
   (B) Offer the plans at least 90 days prior to discontinuation.
   (C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:
   (A) Not be in the best interests of the enrollee; or
   (B) Impair the carrier’s ability to meet the carrier’s contractual obligations.

(i) In the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

(j) In the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(6) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(c), (e) and (f) of this section.

(7) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:
   (a) Performs an act, practice or omission that constitutes fraud; or
   (b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(8) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier’s individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in the carrier’s other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.

(9) An individual health benefit plan or a short term health insurance policy may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(10) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.
(11) This section does not require a carrier to actively market, offer, issue or accept applications for:
(a) A bona fide association health benefit plan from individuals who are not members of the bona fide association; or
(b) A grandfathered health plan from individuals who are not eligible for coverage under the plan.

SECTION 4. The amendments to ORS 743B.011, 743B.105 and 743B.125 by sections 1 to 3 of this 2021 Act apply to short term health insurance policies issued, renewed or extended on or after the effective date of this 2021 Act.