

Enrolled Senate Bill 699

Sponsored by Senator KNOPP; Senator PATTERSON, Representatives DEXTER, DRAZAN,
HAYDEN, LEVY, MOORE-GREEN, MORGAN, NOBLE, REYNOLDS, SCHOUTEN, SMITH DB,
WILDE, ZIKA

CHAPTER

AN ACT

Relating to preexisting condition exclusions; creating new provisions; amending ORS 743B.003,
743B.005, 743B.103 and 743B.125; and prescribing an effective date.

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

SECTION 1. ORS 743B.003 is amended to read:

743B.003. The purposes of ORS 743.004, 743.022, 743.535, 743B.003 to 743B.127 and 743B.800 are:

- (1) To promote the availability of health insurance coverage to groups regardless of their enrollees' health status or claims experience;
- (2) To prevent abusive rating practices;
- (3) To require disclosure of rating practices to purchasers of small employer and individual health benefit plans;
- (4) To prohibit the use of preexisting condition exclusions [*except in individual grandfathered health plans*];
- (5) To encourage the availability of individual health benefit plans for individuals who are not enrolled in group health benefit plans;
- (6) To improve renewability and continuity of coverage for employers and covered individuals;
- (7) To improve the efficiency and fairness of the health insurance marketplace; and
- (8) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152), and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services.

SECTION 2. ORS 743B.005 is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

- (1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer health benefit plans.
- (2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common

control with a specified person. For purposes of this definition, “control” has the meaning given that term in ORS 732.548.

(3) “Affiliation period” means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee’s or late enrollee’s first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) “Bona fide association” means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual’s dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) “Carrier” means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743B.010 to 743B.013; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(7) “Eligible employee” means an employee who is eligible for coverage under a group health benefit plan.

(8) “Employee” means any individual employed by an employer.

(9) “Enrollee” means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(10) “Exchange” means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

(11) “Exclusion period” means a period during which specified treatments or services are excluded from coverage.

(12) “Financial impairment” means that a carrier is not insolvent and is:

(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(13)(a) “Geographic average rate” means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier’s:

- (A) Group health benefit plans offered to small employers; or
- (B) Individual health benefit plans.
- (b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.
- (14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.
- (15) "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.
- (16)(a) "Health benefit plan" means any:
 - (A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
 - (B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or
 - (C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.
- (b) "Health benefit plan" does not include:
 - (A) Coverage for accident only, specific disease or condition only, credit or disability income;
 - (B) Coverage of Medicare services pursuant to contracts with the federal government;
 - (C) Medicare supplement insurance policies;
 - (D) Coverage of TRICARE services pursuant to contracts with the federal government;
 - (E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;
 - (F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;
 - (G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;
 - (H) Short term health insurance policies that are in effect for periods of three months or less, including the term of a renewal of the policy;
 - (I) Dental only coverage;
 - (J) Vision only coverage;
 - (K) Stop-loss coverage that meets the requirements of ORS 742.065;
 - (L) Coverage issued as a supplement to liability insurance;
 - (M) Insurance arising out of a workers' compensation or similar law;
 - (N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or
 - (O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.
- (c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.
- (17) "Individual health benefit plan" means a health benefit plan:
 - (a) That is issued to an individual policyholder; or
 - (b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.
- (18) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.
- (19) "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(20) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(21) "Preexisting condition exclusion" means[.:]

[(a) Except for a grandfathered health plan,] a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

[(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.]

(22) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(23) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(24) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(25) "Small employer" means an employer who employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and who employs at least one full-time equivalent employee on the first day of the plan year, determined in accordance with a methodology prescribed by the Department of Consumer and Business Services by rule.

SECTION 3. ORS 743B.103 is amended to read:

743B.103. (1) *[Except as provided in subsection (2) of this section,]* A carrier may not:

(a) Require an applicant to provide health-related information as a precondition for the issuance of an individual health benefit plan policy; or

(b) Deny coverage under an individual health benefit plan policy based on health-related information provided by the applicant.

[(2) A carrier may require an applicant for an individual grandfathered health plan to complete the standard health statement prescribed by the Department of Consumer and Business Services prior to enrollment for the purpose of:]

[(a) Determining eligibility for coverage; or]

[(b) Imposing a preexisting condition provision.]

[(3)] (2) A carrier may require an enrollee in a health benefit plan to complete the standard health statement prescribed by the department for the purpose of:

(a) Managing the enrollee's health care; or

(b) Administering:

- (A) A program of health promotion or disease prevention, as described in 42 U.S.C. 300gg-4;
- (B) A program to promote healthy behaviors under ORS 743.824; or
- (C) A wellness program defined by the department by rule.

SECTION 4. ORS 743B.125 is amended to read:

743B.125. (1) With respect to coverage under an individual health benefit plan [*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 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 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 5. The amendments to ORS 743B.003, 743B.005, 743B.103 and 743B.125 by sections 1 to 4 of this 2021 Act apply to grandfathered health plans renewed or extended on or after the effective date of this 2021 Act.

SECTION 6. This 2021 Act takes effect on the 91st day after the date on which the 2021 regular session of the Eighty-first Legislative Assembly adjourns sine die.

Passed by Senate April 19, 2021

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Lori L. Brocker, Secretary of Senate

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Peter Courtney, President of Senate

Passed by House June 1, 2021

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Tina Kotek, Speaker of House

Received by Governor:

.....M.,....., 2021

Approved:

.....M.,....., 2021

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Kate Brown, Governor

Filed in Office of Secretary of State:

.....M.,....., 2021

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Shemia Fagan, Secretary of State