

A-Engrossed House Bill 3134

Ordered by the House May 5
Including House Amendments dated May 5

Sponsored by Representative NOSSE, Senator PATTERSON; Representatives CHOTZEN, PHAM H, WALTERS, Senator REYNOLDS (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. The statement includes a measure digest written in compliance with applicable readability standards.

Digest: Tells some insurers to report more data to DCBS and makes rules about prior authorization for some procedures. Tells some insurers to use a program by a set date. (Flesch Readability Score: 60.8).

[Digest: This Act tells insurers, PEBB, OEBB and CCOs to exempt some health care providers from prior authorization in some situations and makes rules about how to do so. Adds reporting rules for these insurers to DCBS and OHA. (Flesch Readability Score: 60.6).]

[Creates a process that exempts certain health care providers from prior authorization requirements under certain circumstances.] Requires additional reporting **about prior authorization** to the Department of Consumer and Business Services **from insurers offering a health benefit plan** and tells the department to make *[certain]* **this** data publicly available. *[Applies these requirements to commercial health insurance, the Public Employees' Benefit Board, the Oregon Educators Benefit Board and coordinated care organizations.]*

[Takes effect on the 91st day following adjournment sine die.]

Creates restrictions for prior authorization requirements during certain surgical procedures for insurers offering a health benefit plan.

Requires certain insurers offering a health benefit plan to implement a prior authorization programming interface by January 1, 2027.

A BILL FOR AN ACT

1
2 Relating to prior authorization; creating new provisions; and amending ORS 743B.001, 743B.250,
3 750.055 and 750.333.

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

5 **SECTION 1.** ORS 743B.250 is amended to read:

6 743B.250. All insurers offering a health benefit plan in this state shall:

7 (1) Provide to all enrollees directly or in the case of a group policy to the employer or other
8 policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon re-
9 quest, the following information:

10 (a) The insurer's written policy on the rights of enrollees, including the right:

11 (A) To participate in decision making regarding the enrollee's health care.

12 (B) To be treated with respect and with recognition of the enrollee's dignity and need for pri-
13 vacy.

14 (C) To have grievances handled in accordance with this section.

15 (D) To be provided with the information described in this section.

16 (b) An explanation of the procedures described in subsection (2) of this section for making cov-
17 erage determinations and resolving grievances. The explanation must be culturally and linguistically
18 appropriate, as prescribed by the Department of Consumer and Business Services by rule, and must
19 include:

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

1 (A) The procedures for requesting an expedited response to an internal appeal under subsection
2 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-
3 nation;

4 (B) A statement that if an insurer does not comply with the decision of an independent review
5 organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

6 (C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-
7 ment of Consumer and Business Services in filing grievances; and

8 (D) A description of the process for filing a complaint with the department.

9 (c) A summary of benefits and an explanation of coverage in a form and manner prescribed by
10 the department by rule.

11 (d) A summary of the insurer's policies on prescription drugs, including:

12 (A) Cost-sharing differentials;

13 (B) Restrictions on coverage;

14 (C) Prescription drug formularies;

15 (D) Procedures by which a provider with prescribing authority may prescribe clinically appro-
16 priate drugs not included on the formulary;

17 (E) Procedures for the coverage of clinically appropriate prescription drugs not included on the
18 formulary; and

19 (F) A summary of the criteria for determining whether a drug is experimental or investigational.

20 (e) A list of network providers and how the enrollee can obtain current information about the
21 availability of providers and how to access and schedule services with providers, including clinic
22 and hospital networks. The list must be available online and upon request in printed format.

23 (f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

24 (g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

25 (h) Restrictions on services obtained outside of the insurer's network or service area.

26 (i) The availability of continuity of care as required by ORS 743B.225.

27 (j) Procedures for accessing after-hours care and emergency services as required by ORS
28 743A.012.

29 (k) Cost-sharing requirements and other charges to enrollees.

30 (L) Procedures, if any, for changing providers.

31 (m) Procedures, if any, by which enrollees may participate in the development of the insurer's
32 corporate policies.

33 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-
34 ment or services, including a general description of any prior authorization and utilization review
35 requirements that affect coverage or payment.

36 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-
37 ers.

38 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records
39 and other enrollee information and the requirement under ORS 743B.555 that a carrier or third
40 party administrator send communications containing protected health information only to the
41 enrollee who is the subject of the protected health information.

42 (q) An explanation of assistance provided to non-English-speaking enrollees.

43 (r) Notice of the information available from the department that is filed by insurers as required
44 under ORS 743B.200, 743B.202 and 743B.423.

45 (2) Establish procedures, in accordance with requirements adopted by the department, for mak-

1 ing coverage determinations and resolving grievances that provide for all of the following:

2 (a) Timely notice of adverse benefit determinations.

3 (b) A method for recording all grievances, including the nature of the grievance and significant
4 action taken.

5 (c) Written decisions.

6 (d) An expedited response to a request for an internal appeal that accommodates the clinical
7 urgency of the situation.

8 (e) At least one but not more than two levels of internal appeal for group health benefit plans
9 and one level of internal appeal for individual health benefit plans and for any denial of an exception
10 to a prescription drug formulary. If an insurer provides:

11 (A) Two levels of internal appeal, a person who was involved in the consideration of the initial
12 denial or the first level of internal appeal may not be involved in the second level of internal appeal;
13 and

14 (B) No more than one level of internal appeal, a person who was involved in the consideration
15 of the initial denial may not be involved in the internal appeal.

16 (f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255,
17 after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have
18 exhausted internal appeals.

19 (B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly
20 comply with this section and federal requirements for internal appeals.

21 (g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing
22 course of treatment under the health benefit plan pending the conclusion of the internal appeal
23 process.

24 (h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

25 (A) Submit for consideration by the insurer any written comments, documents, records and other
26 materials relating to the adverse benefit determination; and

27 (B) Receive from the insurer, upon request and free of charge, reasonable access to and copies
28 of all documents, records and other information relevant to the adverse benefit determination.

29 (3) Establish procedures for notifying affected enrollees of:

30 (a) A change in or termination of any benefit; and

31 (b)(A) The termination of a primary care delivery office or site; and

32 (B) Assistance available to enrollees in selecting a new primary care delivery office or site.

33 (4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each
34 level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an
35 enrollee who files a grievance.

36 (5) Upon the request of an enrollee, applicant or prospective applicant, provide:

37 (a) The insurer's annual report on grievances and internal appeals submitted to the department
38 under subsection (8) of this section.

39 (b) A description of the insurer's efforts, if any, to monitor and improve the quality of health
40 services.

41 (c) Information about the insurer's procedures for credentialing network providers.

42 (6) In addition to the requirements in ORS 743B.423 and 743B.602, provide, upon the request of
43 an enrollee, a written summary of information that the insurer may consider in its utilization review
44 of a particular condition or disease, to the extent the insurer maintains such criteria. This sub-
45 section does not require an insurer to advise an enrollee how the insurer would cover or treat that

1 particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be
2 subject to oral disclosure only.

3 (7) Maintain for a period of at least six years written records that document all grievances de-
4 scribed in ORS 743B.001 (8)(a) and make the written records available for examination by the de-
5 partment or by an enrollee or authorized representative of an enrollee with respect to a grievance
6 made by the enrollee. The written records must include but are not limited to the following:

7 (a) Notices and claims associated with each grievance.

8 (b) A general description of the reason for the grievance.

9 (c) The date the grievance was received by the insurer.

10 (d) The date of the internal appeal or the date of any internal appeal meeting held concerning
11 the appeal.

12 (e) The result of the internal appeal at each level of appeal.

13 (f) The name of the covered person for whom the grievance was submitted.

14 (8) Provide to the department, in the format prescribed by the department, an annual summary
15 of the insurer's aggregate data regarding:

16 (a) Grievances;

17 (b) Internal appeals;

18 (c) Requests for external review; and

19 (d) The following information, **which shall be published by the department, in a format that**
20 **does not identify the insurer, to the department's website no later than March 1 of each**
21 **calendar year**, about requests for prior authorization received by the insurer:

22 *[(A) The number of requests received;]*

23 *[(B) The number of requests that were initially denied and the reasons for the denials, including,*
24 *but not limited to, lack of medical necessity or failure to provide additional clinical information re-*
25 *quested by the insurer;]*

26 *[(C) The number of requests that were initially approved; and]*

27 *[(D) The number of denials that were reversed by internal appeals or external reviews.]*

28 **(A) The percentage and number of standard prior authorization requests that were ap-**
29 **proved;**

30 **(B) The percentage and number of standard prior authorization requests that were de-**
31 **denied;**

32 **(C) The percentage and number of standard prior authorization requests that were ap-**
33 **proved after appeal;**

34 **(D) The percentage and number of all prior authorization requests for which the time**
35 **frame for review was extended and the request was approved;**

36 **(E) The percentage and number of expedited prior authorization requests that were ap-**
37 **proved;**

38 **(F) The percentage and number of expedited prior authorization requests that were de-**
39 **denied;**

40 **(G) The average and median times that elapsed between the submission of a request and**
41 **a determination by the insurer for standard prior authorization; and**

42 **(H) The average and median times that elapsed between the submission of a request and**
43 **a decision by the insurer for expedited prior authorization.**

44 (9) Allow the exercise of any rights described in this section or ORS 743B.252 or 743B.255 by
45 an authorized representative.

1 (10) Procedures adopted under subsection (2) of this section for health benefit plans other than
2 grandfathered health plans must be consistent with 42 U.S.C. 300-gg-19 and rules adopted by the
3 United States Department of Health and Human Services implementing 42 U.S.C. 300-gg-19.

4 (11) An adverse benefit determination under subsection (2)(a) of this section that is provided to
5 an enrollee in a health benefit plan other than a grandfathered health plan must:

6 (a) Be provided in a culturally and linguistically appropriate manner;

7 (b) Be consistent with federal requirements regarding the manner and content for notices of
8 benefit determinations and federal requirements for the full and fair review of adverse benefit de-
9 terminations; and

10 (c) Include the information required by subsection (4) of this section and:

11 (A) Information sufficient to identify the claim involved, the date of services, the health care
12 provider and, if applicable, the claim amount;

13 (B) A statement describing the availability, upon request, of the information described in sub-
14 section (12) of this section;

15 (C) The specific reason for the adverse benefit determination, a reference to the specific plan
16 provisions on which the determination is based, the denial code and the meaning of the denial code
17 and a description of the standard that was used to make the determination, if any;

18 (D) A description of available internal appeals and external reviews, including expedited appeals
19 and reviews, and instructions on how to initiate an appeal or review; and

20 (E) Contact information for the office of consumer assistance within the Department of Con-
21 sumer and Business Services.

22 (12) Upon the request of an enrollee, an insurer that makes an adverse benefit determination
23 with respect to the enrollee under a health benefit plan other than a grandfathered health plan must
24 provide the enrollee with the diagnosis code, the meaning of the diagnosis code, the treatment code
25 and the meaning of the treatment code that are associated with the adverse benefit determination.

26 (13) An adverse benefit determination issued to an enrollee following the final level of internal
27 appeals by an insurer under a health benefit plan other than a grandfathered health plan must, in
28 addition to the requirements under subsection (11) of this section, include:

29 (a) An explanation and discussion of the decision to uphold the initial adverse benefit determi-
30 nation; and

31 (b) An authorization form, or other document that complies with state and federal privacy laws
32 and is approved by the department, with which an enrollee that requests an external review under
33 ORS 743B.255 may authorize the insurer and the enrollee's treating health care provider to disclose
34 medical records or other protected health information pertinent to the external review.

35 (14) **As used in this section:**

36 (a) **"Expedited prior authorization" means a prior authorization that must be expedited**
37 **in order to avoid jeopardizing the enrollee's life, health or ability to maintain or regain**
38 **maximum function.**

39 (b) **"Standard prior authorization" means a prior authorization request that is not an**
40 **expedited prior authorization request.**

41 **SECTION 2. An insurer offering a health benefit plan that requires prior authorization**
42 **for surgical procedures may not require prior authorization for an additional or related**
43 **health care procedure that is identified during the authorized surgical procedure if:**

44 (1) **The provider, while providing an approved surgical procedure, identifies a medical**
45 **condition, disease or ailment that was not identified in the prior authorization request and,**

1 in accordance with generally accepted standards of medical practice, determines that per-
2 forming a related health care procedure, instead of or in addition to the approved surgical
3 procedure, is medically necessary and, in the provider's judgment, to interrupt or delay the
4 provision of care in order to obtain prior authorization for the additional or related health
5 care procedure would not be medically advisable;

6 (2) The additional or related health care procedure is a covered benefit under the
7 enrollee's health benefit plan; and

8 (3) The additional or related health care procedure is not experimental or for investi-
9 gation purposes.

10 **SECTION 3.** (1) An insurer offering a health benefit plan in this state that provides
11 utilization review or has utilization review provided on the insurer's behalf shall utilize a
12 prior authorization application programming interface as described in 45 C.F.R. 156.223(b),
13 as in effect on February 28, 2024. The application programming interface shall enable a pro-
14 vider to:

15 (a) Determine whether prior authorization is required;

16 (b) Identify the information and documentation necessary to submit the request; and

17 (c) Transfer prior authorization requests and determinations from the provider's elec-
18 tronic health records or practice management system through a secure electronic trans-
19 mission.

20 (2) An insurer shall respond through the application programming interface described in
21 subsection (1) of this section to a request that was submitted by a provider through the ap-
22 plication programming interface.

23 **SECTION 4.** ORS 743B.001, as amended by section 3, chapter 35, Oregon Laws 2024, is amended
24 to read:

25 743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195,
26 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
27 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,
28 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550,
29 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024, **and sections 2 and 3 of this**
30 **2025 Act:**

31 (1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a
32 health care item or service, or an insurer's failure or refusal to provide or to make a payment in
33 whole or in part for a health care item or service, that is based on the insurer's:

34 (a) Denial of eligibility for or termination of enrollment in a health benefit plan;

35 (b) Rescission or cancellation of a policy or certificate;

36 (c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury
37 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
38 services;

39 (d) Determination that a health care item or service is experimental, investigational or not
40 medically necessary, effective or appropriate;

41 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
42 course of treatment for purposes of continuity of care under ORS 743B.225; or

43 (f) Denial, in whole or in part, of a request for prior authorization, a request for an exception
44 to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory
45 test that is subject to other utilization review requirements.

1 (2) "Authorized representative" means an individual who by law or by the consent of a person
2 may act on behalf of the person.

3 (3) "Clinical review criteria" means screening procedures, decision rules, medical protocols and
4 clinical guidance used by an insurer or other entity in conducting utilization review and evaluating:

5 (a) Medical necessity;

6 (b) Appropriateness of an item or health service for which prior authorization is requested or
7 for which an exception to step therapy has been requested as described in ORS 743B.602; or

8 (c) Any other coverage that is subject to utilization review.

9 (4) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

10 (5) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

11 (6) "Enrollee" has the meaning given that term in ORS 743B.005.

12 (7) "Essential community provider" has the meaning given that term in rules adopted by the
13 Department of Consumer and Business Services consistent with the description of the term in 42
14 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,
15 the United States Department of the Treasury or the United States Department of Labor to carry
16 out 42 U.S.C. 18031.

17 (8) "Grievance" means:

18 (a) A communication from an enrollee or an authorized representative of an enrollee expressing
19 dissatisfaction with an adverse benefit determination, without specifically declining any right to
20 appeal or review, that is:

21 (A) In writing, for an internal appeal or an external review; or

22 (B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited
23 external review; or

24 (b) A written complaint submitted by an enrollee or an authorized representative of an enrollee
25 regarding the:

26 (A) Availability, delivery or quality of a health care service;

27 (B) Claims payment, handling or reimbursement for health care services and, unless the enrollee
28 has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit
29 determination; or

30 (C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

31 (9) "Health benefit plan" has the meaning given that term in ORS 743B.005.

32 (10) "Independent practice association" means a corporation wholly owned by providers, or
33 whose membership consists entirely of providers, formed for the sole purpose of contracting with
34 insurers for the provision of health care services to enrollees, or with employers for the provision
35 of health care services to employees, or with a group, as described in ORS 731.098, to provide health
36 care services to group members.

37 (11) "Insurer" includes a health care service contractor as defined in ORS 750.005.

38 (12) "Internal appeal" means a review by an insurer of an adverse benefit determination made
39 by the insurer.

40 (13) "Managed health insurance" means any health benefit plan that:

41 (a) Requires an enrollee to use a specified network or networks of providers managed, owned,
42 under contract with or employed by the insurer in order to receive benefits under the plan, except
43 for emergency or other specified limited service; or

44 (b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service
45 provision that allows an enrollee to use providers outside of the specified network or networks at

1 the option of the enrollee and receive a reduced level of benefits.

2 (14) “Medical services contract” means a contract between an insurer and an independent
3 practice association, between an insurer and a provider, between an independent practice associ-
4 ation and a provider or organization of providers, between medical or mental health clinics, and
5 between a medical or mental health clinic and a provider to provide medical or mental health ser-
6 vices. “Medical services contract” does not include a contract of employment or a contract creating
7 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
8 similar professional organizations permitted by statute.

9 (15)(a) “Preferred provider organization insurance” means any health benefit plan that:

10 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
11 ployed by an insurer;

12 (B) Does not require an enrollee to use the preferred network of providers in order to receive
13 benefits under the plan; and

14 (C) Creates financial incentives for an enrollee to use the preferred network of providers by
15 providing an increased level of benefits.

16 (b) “Preferred provider organization insurance” does not mean a health benefit plan that has
17 as its sole financial incentive a hold harmless provision under which providers in the preferred
18 network agree to accept as payment in full the maximum allowable amounts that are specified in
19 the medical services contracts.

20 (16) “Prior authorization” means a form of utilization review that requires a provider or an
21 enrollee to request a determination by an insurer, prior to the provision of health care that is sub-
22 ject to utilization review, that the insurer will provide reimbursement for the health care requested.
23 “Prior authorization” does not include referral approval for evaluation and management services
24 between providers.

25 (17)(a) “Provider” means a person licensed, certified or otherwise authorized or permitted by
26 laws of this state to administer medical or mental health services in the ordinary course of business
27 or practice of a profession.

28 (b) With respect to the statutes governing the billing for or payment of claims, “provider” also
29 includes an employee or other designee of the provider who has the responsibility for billing claims
30 for reimbursement or receiving payments on claims.

31 (18) “Step therapy” means a utilization review protocol, policy or program in which an insurer
32 requires certain preferred drugs for treatment of a specific medical condition be proven ineffective
33 or contraindicated before a prescribed drug may be reimbursed.

34 (19) “Utilization review” means a set of formal techniques used by an insurer or delegated by
35 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
36 cacy or efficiency of health care items, services, procedures or settings.

37 **SECTION 5.** ORS 750.055, as amended by section 3, chapter 24, Oregon Laws 2024, section 4,
38 chapter 35, Oregon Laws 2024, section 21, chapter 70, Oregon Laws 2024, and section 162, chapter
39 73, Oregon Laws 2024, is amended to read:

40 750.055. (1) The following provisions apply to health care service contractors to the extent not
41 inconsistent with the express provisions of ORS 750.005 to 750.095:

42 (a) ORS 705.137, 705.138 and 705.139.

43 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
44 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
45 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,

1 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

2 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
3 including ORS 732.582, and ORS 732.650 to 732.689.

4 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
5 to 733.780.

6 (e) ORS 734.014 to 734.440.

7 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
8 742.542.

9 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
10 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
11 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
12 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

13 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
14 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
15 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
16 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
17 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
18 and 743A.315 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 70, Oregon Laws
19 2024.

20 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
21 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
22 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
23 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
24 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
25 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
26 [and] section 2, chapter 35, Oregon Laws 2024, **and section 2 of this 2025 Act.**

27 (j) The following provisions of ORS chapter 744:

28 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
29 ers;

30 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

31 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

32 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
33 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

34 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
35 cept in the case of group practice health maintenance organizations that are federally qualified
36 pursuant to Title XIII of the Public Health Service Act:

37 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
38 ates an in-house drug outlet.

39 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
40 practitioner associated with a group practice health maintenance organization.

41 (3) For the purposes of this section, health care service contractors are insurers.

42 (4) Any for-profit health care service contractor organized under the laws of any other state that
43 is not governed by the insurance laws of the other state is subject to all requirements of ORS
44 chapter 732.

45 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-

1 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

2 (b) A health care service contractor's classification as a domestic insurance company under
3 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
4 to 734.710.

5 (6) The Director of the Department of Consumer and Business Services may, after notice and
6 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
7 and 750.045 that are necessary for the proper administration of these provisions.

8 **SECTION 6.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
9 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
10 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
11 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
12 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
13 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
14 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,
15 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
16 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
17 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
18 2024, section 22, chapter 70, Oregon Laws 2024, and section 163, chapter 73, Oregon Laws 2024, is
19 amended to read:

20 750.055. (1) The following provisions apply to health care service contractors to the extent not
21 inconsistent with the express provisions of ORS 750.005 to 750.095:

22 (a) ORS 705.137, 705.138 and 705.139.

23 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
24 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
25 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
26 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

27 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
28 including ORS 732.582, and ORS 732.650 to 732.689.

29 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
30 to 733.780.

31 (e) ORS 734.014 to 734.440.

32 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
33 742.542.

34 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
35 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
36 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
37 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

38 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
39 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
40 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
41 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
42 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
43 and 743A.315 and section 2, chapter 70, Oregon Laws 2024.

44 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
45 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,

1 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
2 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
3 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
4 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
5 [and] section 2, chapter 35, Oregon Laws 2024, **and section 2 of this 2025 Act.**

6 (j) The following provisions of ORS chapter 744:

7 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
8 ers;

9 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

10 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

11 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
12 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

13 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
14 cept in the case of group practice health maintenance organizations that are federally qualified
15 pursuant to Title XIII of the Public Health Service Act:

16 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
17 ates an in-house drug outlet.

18 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
19 practitioner associated with a group practice health maintenance organization.

20 (3) For the purposes of this section, health care service contractors are insurers.

21 (4) Any for-profit health care service contractor organized under the laws of any other state that
22 is not governed by the insurance laws of the other state is subject to all requirements of ORS
23 chapter 732.

24 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
25 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

26 (b) A health care service contractor's classification as a domestic insurance company under
27 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
28 to 734.710.

29 (6) The Director of the Department of Consumer and Business Services may, after notice and
30 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
31 and 750.045 that are necessary for the proper administration of these provisions.

32 **SECTION 7.** ORS 750.055, as amended by section 3, chapter 24, Oregon Laws 2024, section 4,
33 chapter 35, Oregon Laws 2024, section 21, chapter 70, Oregon Laws 2024, and section 162, chapter
34 73, Oregon Laws 2024, and section 5 of this 2025 Act, is amended to read:

35 750.055. (1) The following provisions apply to health care service contractors to the extent not
36 inconsistent with the express provisions of ORS 750.005 to 750.095:

37 (a) ORS 705.137, 705.138 and 705.139.

38 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
39 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
40 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
41 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

42 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
43 including ORS 732.582, and ORS 732.650 to 732.689.

44 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
45 to 733.780.

1 (e) ORS 734.014 to 734.440.

2 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
3 742.542.

4 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
5 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
6 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
7 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

8 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
9 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
10 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
11 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
12 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
13 and 743A.315 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 70, Oregon Laws
14 2024.

15 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
16 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
17 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
18 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
19 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
20 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
21 section 2, chapter 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

22 (j) The following provisions of ORS chapter 744:

23 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
24 ers;

25 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

26 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

27 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
28 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

29 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
30 cept in the case of group practice health maintenance organizations that are federally qualified
31 pursuant to Title XIII of the Public Health Service Act:

32 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
33 ates an in-house drug outlet.

34 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
35 practitioner associated with a group practice health maintenance organization.

36 (3) For the purposes of this section, health care service contractors are insurers.

37 (4) Any for-profit health care service contractor organized under the laws of any other state that
38 is not governed by the insurance laws of the other state is subject to all requirements of ORS
39 chapter 732.

40 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
41 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

42 (b) A health care service contractor's classification as a domestic insurance company under
43 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
44 to 734.710.

45 (6) The Director of the Department of Consumer and Business Services may, after notice and

1 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
2 and 750.045 that are necessary for the proper administration of these provisions.

3 **SECTION 8.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
4 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
5 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
6 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
7 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
8 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
9 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,
10 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
11 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
12 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
13 2024, section 22, chapter 70, Oregon Laws 2024, and section 163, chapter 73, Oregon Laws 2024, and
14 section 6 of this 2025 Act, is amended to read:

15 750.055. (1) The following provisions apply to health care service contractors to the extent not
16 inconsistent with the express provisions of ORS 750.005 to 750.095:

17 (a) ORS 705.137, 705.138 and 705.139.

18 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
19 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
20 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
21 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

22 (c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
23 including ORS 732.582, and ORS 732.650 to 732.689.

24 (d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
25 to 733.780.

26 (e) ORS 734.014 to 734.440.

27 (f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
28 742.542.

29 (g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
30 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
31 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
32 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

33 (h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
34 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
35 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
36 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
37 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
38 and 743A.315 and section 2, chapter 70, Oregon Laws 2024.

39 (i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
40 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
41 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
42 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
43 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
44 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
45 section 2, chapter 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

1 (j) The following provisions of ORS chapter 744:

2 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
3 ers;

4 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

5 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

6 (k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610,
7 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

8 (2) The following provisions of the Insurance Code apply to health care service contractors ex-
9 cept in the case of group practice health maintenance organizations that are federally qualified
10 pursuant to Title XIII of the Public Health Service Act:

11 (a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
12 ates an in-house drug outlet.

13 (b) ORS 743A.024, unless the patient is referred by a physician, physician associate or nurse
14 practitioner associated with a group practice health maintenance organization.

15 (3) For the purposes of this section, health care service contractors are insurers.

16 (4) Any for-profit health care service contractor organized under the laws of any other state that
17 is not governed by the insurance laws of the other state is subject to all requirements of ORS
18 chapter 732.

19 (5)(a) A health care service contractor is a domestic insurance company for the purpose of de-
20 termining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

21 (b) A health care service contractor's classification as a domestic insurance company under
22 paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510
23 to 734.710.

24 (6) The Director of the Department of Consumer and Business Services may, after notice and
25 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
26 and 750.045 that are necessary for the proper administration of these provisions.

27 **SECTION 9.** ORS 750.333, as amended by section 5, chapter 24, Oregon Laws 2024, and section
28 23, chapter 70, Oregon Laws 2024, is amended to read:

29 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
30 arrangement:

31 (a) ORS 705.137, 705.138 and 705.139.

32 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
33 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
34 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
35 731.992.

36 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

37 (d) ORS 734.014 to 734.440.

38 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

39 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
40 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and 743B.221.

41 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
42 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
43 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
44 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
45 743A.170, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260

1 and 743A.310 and section 2, chapter 70, Oregon Laws 2024.

2 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
3 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
4 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
5 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
6 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 and section 2,
7 chapter 24, Oregon Laws 2024, **and section 2 of this 2025 Act.**

8 (i) The following provisions of ORS chapter 744:

9 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
10 ers;

11 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

12 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

13 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

14 (2) For the purposes of this section:

15 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

16 (b) References to certificates of authority are references to certificates of multiple employer
17 welfare arrangement.

18 (c) Contributions are premiums.

19 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
20 insurance.

21 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
22 implement the provisions of ORS 750.301 to 750.341.

23 **SECTION 10.** ORS 750.333, as amended by section 5, chapter 24, Oregon Laws 2024, and section
24 23, chapter 70, Oregon Laws 2024, and section 9 of this 2025 Act, is amended to read:

25 750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
26 arrangement:

27 (a) ORS 705.137, 705.138 and 705.139.

28 (b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
29 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
30 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
31 731.992.

32 (c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

33 (d) ORS 734.014 to 734.440.

34 (e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

35 (f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
36 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and 743B.221.

37 (g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
38 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
39 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
40 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
41 743A.170, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260
42 and 743A.310 and section 2, chapter 70, Oregon Laws 2024.

43 (h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
44 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
45 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,

1 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
2 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 and section 2,
3 chapter 24, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

4 (i) The following provisions of ORS chapter 744:

5 (A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance produc-
6 ers;

7 (B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

8 (C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

9 (j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

10 (2) For the purposes of this section:

11 (a) A trust carrying out a multiple employer welfare arrangement is an insurer.

12 (b) References to certificates of authority are references to certificates of multiple employer
13 welfare arrangement.

14 (c) Contributions are premiums.

15 (3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
16 insurance.

17 (4) The Department of Consumer and Business Services may adopt rules that are necessary to
18 implement the provisions of ORS 750.301 to 750.341.

19 **SECTION 11. Sections 2 and 3 of this 2025 Act are added to and made a part of the In-**
20 **insurance Code.**

21 **SECTION 12. Section 3 of this 2025 Act and the amendments to ORS 750.055 and 750.333**
22 **by sections 7, 8 and 10 of this 2025 Act become operative on January 1, 2027.**

23