Enrolled
House Bill 3321

Sponsored by Representative ROSENBAUM; Representative HUNT

CHAPTER .....

AN ACT

Relating to health insurance; creating new provisions; amending ORS 731.146, 731.484, 731.486, 743.734 and 743.748; and declaring an emergency.

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

SECTION 1. ORS 731.146 is amended to read:

731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or otherwise:

(a) Making or proposing to make an insurance contract.

(b) Taking or receiving any application for insurance.

(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other consideration for any insurance or any part thereof.

(d) Issuing or delivering policies of insurance.

(e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aiding on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof, the dissemination of information as to coverage or rates, the forwarding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation of the policy and arising out of it, or in any other manner representing or assisting a person with respect to insurance.

(f) Advertising locally or circularizing therein without regard for the source of such circularization, whenever such advertising or circularization is for the purpose of solicitation of insurance business.

(g) Doing any other kind of business specifically recognized as constituting the doing of an insurance business within the meaning of the Insurance Code.

(h) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (g) of this subsection in a manner designed to evade the provisions of the Insurance Code.

(2) Subsection (1) of this section does not include, apply to or affect the following:

(a) Making investments within a state by an insurer not admitted or authorized to do business within such state.

(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group life insurance [*or group health insurance, or both,*] or a policy of blanket health insurance, if the master policy was validly issued to cover a group organized primarily for purposes other than the procurement of insurance and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business;

(B) The policyholder is domiciled or otherwise has a bona fide situs; and

(C) With respect to a policy of blanket health insurance, the policy was approved by the director of such state.

(c) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group health insurance, if the master policy was validly issued to cover an employer group other than an association, trust or multiple employer welfare arrangement and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business; and

(B) The policyholder is domiciled or otherwise has a bona fide situs.

[*(c)*] **(d)** Investigating, settling, or litigating claims under policies lawfully written within a state, or liquidating assets and liabilities, all resulting from the insurer's former authorized operations within such state.

[*(d)*] **(e)** Transactions within a state under a policy subsequent to its issuance if the policy was lawfully solicited, written and delivered outside the state and did not cover a subject of insurance resident, located or to be performed in the state when issued.

[*(e)*] **(f)** The continuation and servicing of life or health insurance policies remaining in force on residents of a state if the insurer has withdrawn from such state and is not transacting new insurance therein.

(3) If mail is used, an act shall be deemed to take place at the point where the matter transmitted by mail is delivered and takes effect.

SECTION 2. ORS 731.484 is amended to read:

731.484. (1) No insurer or insurance producer selling a policy of group life insurance or group health insurance subject to [*the*] **an** exemption in ORS 731.146 (2)(b) **or (c)** is authorized to sell membership in a group for the purpose of qualifying an applicant who is an individual for the insurance.

(2) No insurer or insurance producer selling membership in a group is authorized to offer a policy of group life insurance or group health insurance subject to [*the*] **an** exemption in ORS 731.146 (2)(b) **or (c)** for the purpose of selling membership in the group.

SECTION 3. ORS 731.486 is amended to read:

731.486. (1) The exemption in ORS 731.146 (2)(b) does not apply to an insurer that offers coverage under [*a group health insurance policy or*] a group life insurance policy in this state unless the Director of the Department of Consumer and Business Services determines that the exemption applies.

(2) The insurer shall submit evidence to the director that the exemption applies. When a master policy **for a policy of group life insurance** is delivered or issued for delivery outside this state to trustees of a fund for two or more employers, for one or more labor unions, for one or more employers and one or more labor unions or for an association, the insurer shall also submit evidence showing compliance with[*:*]

[*(a) ORS 743.526, for a policy of group health insurance; or*]

[*(b)*] ORS 743.354[*, for a policy of group life insurance*].

(3) The director shall review the evidence submitted and may request additional evidence as needed.

(4) An insurer shall submit to the director any changes in the evidence submitted under subsection (2) of this section.

(5) The director may order an insurer to cease offering a policy or coverage under a policy if the director determines that the exemption under ORS 731.146 (2)(b) is no longer satisfied.

(6) Coverage under a master group life [*or health*] insurance policy delivered or issued for delivery outside this state that does not qualify for the exemption in ORS 731.146 (2)(b) may be offered in this state if the director determines that the state in which the policy was delivered or issued for delivery has requirements that are substantially similar to those established under ORS 743.360 [*or 743.522 (2)*] and that the policy satisfies those requirements.

(7) Coverage under a master group health insurance policy that is delivered or issued for delivery outside this state to an association or trust may be offered in this state if the director determines that the association or trust meets applicable standards under ORS 743.522 (1)(b) or (c) or (2).

[*(7)*] **(8)** This section does not apply to any master policy issued to a multistate employer or labor union.

[*(8)*] **(9)** The director may adopt rules to carry out this section.

SECTION 4. ORS 743.734 is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737, 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 eligible 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 eligible 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) Except as provided in ORS 743.733 to 743.737, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

(3) Except as otherwise provided by law or ORS 743.733 to 743.737, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer 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 small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee, a small employer carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except in the case of a late enrollee and as otherwise provided in this section, a small employer carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee in a small employer group that are based on the actual or expected health status of any eligible employee.

(6) A small employer 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. Except as provided in ORS 743.736 (10):

(a) When a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) If the small employer elects to offer coverage to dependents of eligible employees, the small employer carrier shall offer coverage to all dependents of eligible employees, without regard to the actual or expected health status of any eligible dependent.

(7) A health benefit plan issued to a small employer group through an association health plan is exempt from subsection (1) of this section. For purposes of this subsection, an association health plan is group health insurance described in ORS 743.522 (2) or a health benefit plan that:

(a) Is delivered or issued for delivery to:

(A) An association or trust established in this state, that meets applicable requirements of ORS 743.524 or 743.526, or to a multiple employer welfare arrangement located inside this state, subject to ORS 750.301 to 750.341; or

(B) An association or trust established in another state, that is approved by the director under ORS 731.486 (7), or a multiple employer welfare arrangement located in another state that complies with ORS 750.311; and

(b) Satisfies all of the following:

(A) The initial premium rate for the association health plan does not vary by more than 50 percent across the groups of small employers under the plan.

(B) The association policyholder does not discriminate in membership requirements based on actual or expected health status of individual enrollees or prospective enrollees, in accordance with ORS 743.752 (5).

(C) Small employer groups that have two or more eligible employees and that meet the membership requirements for the association are not excluded from the association health plan.

(D) Except as provided in subsection (8) of this section, the association health plan maintains a 95 percent retention rate.

(8)(a) The 95 percent retention rate in subsection (7) of this section does not include employer groups that:

(A) Go out of business, whether through merger, acquisition or any other reason;

(B) No longer meet eligibility requirements for membership in the association;

(C) No longer meet participation requirements for employers that are set forth in the plan documents; or

(D) Fail to pay premiums.

(b) An association health plan that fails to maintain the 95 percent retention rate during any year may have 12 months to correct the retention level before losing the exemption under subsection (7) of this section.

SECTION 5. ORS 743.748 is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(c) The retention rate and claims experience of employer groups within the plan for the preceding year for association health plans as described in ORS 743.734 (7). This information is not subject to public disclosure under ORS chapter 192.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; [*and*]

(d) Health benefit plans for employers with more than 50 employees[*.*]**; and**

(e) Association health plans described in ORS 743.734 (7).

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 6. ORS 731.146, as amended by section 1 of this 2007 Act, is amended to read:

731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or otherwise:

(a) Making or proposing to make an insurance contract.

(b) Taking or receiving any application for insurance.

(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other consideration for any insurance or any part thereof.

(d) Issuing or delivering policies of insurance.

(e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aiding on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof, the dissemination of information as to coverage or rates, the forwarding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation of the policy and arising out of it, or in any other manner representing or assisting a person with respect to insurance.

(f) Advertising locally or circularizing therein without regard for the source of such circularization, whenever such advertising or circularization is for the purpose of solicitation of insurance business.

(g) Doing any other kind of business specifically recognized as constituting the doing of an insurance business within the meaning of the Insurance Code.

(h) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (g) of this subsection in a manner designed to evade the provisions of the Insurance Code.

(2) Subsection (1) of this section does not include, apply to or affect the following:

(a) Making investments within a state by an insurer not admitted or authorized to do business within such state.

(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group life insurance **or group health insurance, or both,** or a policy of blanket health insurance, if the master policy was validly issued to cover a group organized primarily for purposes other than the procurement of insurance and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business;

(B) The policyholder is domiciled or otherwise has a bona fide situs; and

(C) With respect to a policy of blanket health insurance, the policy was approved by the director of such state.

[*(c) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group health insurance, if the master policy was validly issued to cover an employer group other than an association, trust or multiple employer welfare arrangement and was delivered in and pursuant to the laws of another state in which:*]

[*(A) The insurer was authorized to do an insurance business; and*]

[*(B) The policyholder is domiciled or otherwise has a bona fide situs.*]

[*(d)*] **(c)** Investigating, settling, or litigating claims under policies lawfully written within a state, or liquidating assets and liabilities, all resulting from the insurer's former authorized operations within such state.

[*(e)*] **(d)** Transactions within a state under a policy subsequent to its issuance if the policy was lawfully solicited, written and delivered outside the state and did not cover a subject of insurance resident, located or to be performed in the state when issued.

[*(f)*] **(e)** The continuation and servicing of life or health insurance policies remaining in force on residents of a state if the insurer has withdrawn from such state and is not transacting new insurance therein.

(3) If mail is used, an act shall be deemed to take place at the point where the matter transmitted by mail is delivered and takes effect.

SECTION 7. ORS 731.484, as amended by section 2 of this 2007 Act, is amended to read:

731.484. (1) No insurer or insurance producer selling a policy of group life insurance or group health insurance subject to [*an*] **the** exemption in ORS 731.146 (2)(b) [*or (c)*] is authorized to sell membership in a group for the purpose of qualifying an applicant who is an individual for the insurance.

(2) No insurer or insurance producer selling membership in a group is authorized to offer a policy of group life insurance or group health insurance subject to [*an*] **the** exemption in ORS 731.146 (2)(b) [*or (c)*] for the purpose of selling membership in the group.

SECTION 8. ORS 731.486, as amended by section 3 of this 2007 Act, is amended to read:

731.486. (1) The exemption in ORS 731.146 (2)(b) does not apply to an insurer that offers coverage under **a group health insurance policy or** a group life insurance policy in this state unless the Director of the Department of Consumer and Business Services determines that the exemption applies.

(2) The insurer shall submit evidence to the director that the exemption applies. When a master policy [*for a policy of group life insurance*] is delivered or issued for delivery outside this state to trustees of a fund for two or more employers, for one or more labor unions, for one or more employers and one or more labor unions or for an association, the insurer shall also submit evidence showing compliance with**:**

(a) ORS 743.526, for a policy of group health insurance; or

(b) ORS 743.354**, for a policy of group life insurance**.

(3) The director shall review the evidence submitted and may request additional evidence as needed.

(4) An insurer shall submit to the director any changes in the evidence submitted under subsection (2) of this section.

(5) The director may order an insurer to cease offering a policy or coverage under a policy if the director determines that the exemption under ORS 731.146 (2)(b) is no longer satisfied.

(6) Coverage under a master group life **or health** insurance policy delivered or issued for delivery outside this state that does not qualify for the exemption in ORS 731.146 (2)(b) may be offered in this state if the director determines that the state in which the policy was delivered or issued for delivery has requirements that are substantially similar to those established under ORS 743.360 **or 743.522 (2)** and that the policy satisfies those requirements.

[*(7) Coverage under a master group health insurance policy that is delivered or issued for delivery outside this state to an association or trust may be offered in this state if the director determines that the association or trust meets applicable standards under ORS 743.522 (1)(b) or (c) or (2).*]

[*(8)*] **(7)** This section does not apply to any master policy issued to a multistate employer or labor union.

[*(9)*] **(8)** The director may adopt rules to carry out this section.

SECTION 9. ORS 743.734, as amended by section 4 of this 2007 Act, is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737, 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 eligible 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 eligible 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) Except as provided in ORS 743.733 to 743.737, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

(3) Except as otherwise provided by law or ORS 743.733 to 743.737, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer 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 small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee, a small employer carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except in the case of a late enrollee and as otherwise provided in this section, a small employer carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee in a small employer group that are based on the actual or expected health status of any eligible employee.

(6) A small employer 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. Except as provided in ORS 743.736 (10):

(a) When a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) If the small employer elects to offer coverage to dependents of eligible employees, the small employer carrier shall offer coverage to all dependents of eligible employees, without regard to the actual or expected health status of any eligible dependent.

[*(7) A health benefit plan issued to a small employer group through an association health plan is exempt from subsection (1) of this section. For purposes of this subsection, an association health plan is group health insurance described in ORS 743.522 (2) or a health benefit plan that:*]

[*(a) Is delivered or issued for delivery to:*]

[*(A) An association or trust established in this state, that meets applicable requirements of ORS 743.524 or 743.526, or to a multiple employer welfare arrangement located inside this state, subject to ORS 750.301 to 750.341; or*]

[*(B) An association or trust established in another state, that is approved by the director under ORS 731.486 (7), or a multiple employer welfare arrangement located in another state that complies with ORS 750.311; and*]

[*(b) Satisfies all of the following:*]

[*(A) The initial premium rate for the association health plan does not vary by more than 50 percent across the groups of small employers under the plan.*]

[*(B) The association policyholder does not discriminate in membership requirements based on actual or expected health status of individual enrollees or prospective enrollees, in accordance with ORS 743.752 (5).*]

[*(C) Small employer groups that have two or more eligible employees and that meet the membership requirements for the association are not excluded from the association health plan.*]

[*(D) Except as provided in subsection (8) of this section, the association health plan maintains a 95 percent retention rate.*]

[*(8)(a) The 95 percent retention rate in subsection (7) of this section does not include employer groups that:*]

[*(A) Go out of business, whether through merger, acquisition or any other reason;*]

[*(B) No longer meet eligibility requirements for membership in the association;*]

[*(C) No longer meet participation requirements for employers that are set forth in the plan documents; or*]

[*(D) Fail to pay premiums.*]

[*(b) An association health plan that fails to maintain the 95 percent retention rate during any year may have 12 months to correct the retention level before losing the exemption under subsection (7) of this section.*]

SECTION 10. ORS 743.748, as amended by section 5 of this 2007 Act, is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

[*(c) The retention rate and claims experience of employer groups within the plan for the preceding year for association health plans as described in ORS 743.734 (7). This information is not subject to public disclosure under ORS chapter 192.*]

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule after obtaining a recommendation from the Health Insurance Reform Advisory Committee.

(3) The advisory committee shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; **and**

(d) Health benefit plans for employers with more than 50 employees**.** [*; and*]

[*(e) Association health plans described in ORS 743.734 (7).*]

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 11. (1) The Department of Consumer and Business Services shall monitor, on a continuing basis, association health plans to determine the degree to which the claims experience of nonretained association groups exceeds the claims experience of the association's member groups as a whole.

(2) The Director of the Department of Consumer and Business Services shall report to the Legislative Assembly by February 1 of each odd-numbered year on the findings under subsection (1) of this section and may recommend legislative changes based upon the findings.

SECTION 12. (1) ORS 743.734, as amended by section 4 of this 2007 Act, applies to health benefit plans issued or renewed on or after the effective date of this 2007 Act and before January 2, 2014.

(2) An association health plan issued to a group described in ORS 743.522 (2) prior to May 1, 2007, to an association or trust approved prior to May 1, 2007, or to a multiple employer welfare arrangement authorized prior to May 1, 2007, is not subject to the requirements of ORS 743.734 (7)(b)(C) with respect to membership requirements in effect prior to May 1, 2007.

SECTION 13. The amendments to ORS 731.146, 731.484, 731.486, 743.734 and 743.748 by sections 6 to 10 of this 2007 Act become operative on January 2, 2014.

SECTION 14. Sections 11 and 12 of this 2007 Act are repealed on January 2, 2014.

SECTION 15. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect July 1, 2007.

Passed by House May 31, 2007

Repassed by House June 20, 2007

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Chief Clerk of House

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Speaker of House

Passed by Senate June 18, 2007

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President of Senate

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

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Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

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Secretary of State