House Bill 2009

Ordered printed by the Speaker pursuant to House Rule 12.00A (5). Presession filed (at the request of House Interim Committee on Health Care)

SUMMARY

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

Establishes Oregon Health Authority Board and Oregon Health Authority and specifies duties, functions and powers. Transfers health and health insurance functions to authority from Department of Human Services and Department of Consumer and Business Services.

Creates Quality Care Institute and Oregon Health Insurance Exchange in Oregon Health Authority.

Requires authority to implement premium assistance program. Requires authority to streamline application process for medical assistance and premium assistance programs. Requires authority to increase reimbursement rates for health services providers participating in medical assistance programs. Requires authority to conduct outreach for and marketing of medical assistance and premium assistance programs.

Creates tax on health insurance and managed care plans. Sets fixed rate for hospital assessment and removes sunset. Creates new cigarette tax. Establishes Oregon Health Authority Fund. Deposits moneys from taxes and assessments into fund. Continuously appropriates moneys in fund to authority for purpose of carrying out functions of authority.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to health care; creating new provisions; amending ORS 25.323, 65.800, 107.092, 127.646, 192.410, 192.502, 192.519, 192.527, 192.535, 192.547, 192.549, 192.630, 238.410, 243.105, 243.860, 244.050, 291.055, 291.371, 315.604, 315.613, 323.505, 343.499, 343.507, 408.305, 408.310, 408.320, 408.325, 408.380, 408.570, 408.580, 409.720, 414.025, 414.033, 414.034, 414.042, 414.049, 414.051, 414.065, 414.109, 414.115, 414.125, 414.135, 414.145, 414.153, 414.211, 414.221, 414.225, 414.227, 414.312, 414.314, 414.316, 414.318, 414.320, 414.325, 414.327, 414.329, 414.340, 414.342, 414.344, 414.346, 414.348, 414.350, 414.355, 414.360, 414.365, 414.375, 414.380, 414.390, 414.410, 414.426, 414.428, 414.534, 414.536, 414.538, 414.630, 414.640, 414.707, 414.708, 414.709, 414.710, 414.712, 414.720, 414.725, 414.727, 414.728, 414.735, 414.736, 414.737, 414.738, 414.739, 414.740, 414.741, 414.742, 414.743, 414.750, 414.751, 414.805, 414.807, 414.815, 414.839, 431.035, 431.045, 431.110, 431.120, 431.150, 431.155, 431.157, 431.170, 431.175, 431.180, 431.190, 431.195, 431.210, 431.220, 431.230, 431.250, 431.260, 431.262, 431.264, 431.270, 431.290, 431.310, 431.330, 431.335, 431.340, 431.345, 431.350, 431.375, 431.380, 431.385, 431.415, 431.416, 431.418, 431.530, 431.550, 431.607, 431.609, 431.611, 431.613, 431.619, 431.623, 431.627, 431.633, 431.671, 431.705, 431.710, 431.715, 431.720, 431.725, 431.730, 431.735, 431.740, 431.745, 431.750, 431.760, 431.825, 431.827, 431.830, 431.831, 431.832, 431.834, 431.836, 431.853, 431.890, 431.915, 431.920, 431.940, 431.945, 431.950, 431.955, 431.990, 432.500, 442.011, 442.015, 442.700, 442.800, 442.807, 678.730, 731.016, 731.036, 731.042, 731.072, 731.096, 731.142, 731.216, 731.228, 731.232, 731.236, 731.240, 731.244, 731.248, 731.252, 731.256, 731.258, 731.260, 731.264, 731.268, 731.272, 731.276, 731.280, 731.282, 731.288, 731.296, 731.300, 731.302, 731.304, 731.308, 731.312, 731.314, 731.316, 731.324, 731.328, 731.354, 731.356, 731.362, 731.363, 731.364, 731.365, 731.367, 731.369, 731.370, 731.380, 731.385, 731.386, 731.398, 731.402, 731.406, 731.410, 731.414, 731.418, 731.422, 731.426, 731.428, 731.430, 731.434,

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.

731.466, 731.470, 731.486, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.554, 731.570, 731.574, 731.608, 731.616, 731.620, 731.636, 731.640, 731.642, 731.644, 731.648, 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.754, 731.762, 731.764, 731.812, 731.822, 731.836, 731.840, 731.842, 731.854, 731.859, 731.988, 732.521, 732.531, 733.080, 733.630, 733.770, 734.760, 734.770, 734.800, 734.805, 734.810, 734.815, 734.820, 734.825, 734.830, 734.835, 734.850, 734.870, 735.610, 735.612, 735.614, 735.630, 735.700, 735.701, 735.706, 735.722, 735.734, 735.754, 735.756, 742.003, 742.005, 742.041, 742.420, 742.434, 743.013, 743.015, 743.018, 743.028, 743.106, 743.378, 743.405, 743.408, 743.447, 743.459, 743.462, 743.465, 743.472, 743.498, 743.522, 743.524, 743.526, 743.527, 743.529, 743.534, 743.537, 743.546, 743.655, 743.684, 743.685, 743.687, 743.730, 743.731, 743.736, 743.737, 743.745, 743.748, 743.754, 743.758, 743.760, 743.761, 743.766, 743.767, 743.769, 743.790, 743.804, 743.807, 743.814, 743.817, 743.823, 743.827, 743.831, 743.857, 743.858, 743.862, 743.863, 743.874, 743.876, 743.878, 743.911, 743A.144, 743A.168, 744.062, 744.063, 744.067, 744.088, 744.091, 744.338, 744.531, 744.626, 744.702, 744.704, 744.714, 744.718, 746.230, 746.600, 746.608, 746.650, 748.211, 748.403, 750.045, 750.055, 750.085, 750.303, 750.309 and 750.323 and section 5, chapter 318, Oregon Laws 2001, section 2, chapter 76, Oregon Laws 2003, sections 1, 2, 5, 8, 10, 14 and 51, chapter 736, Oregon Laws 2003, section 18, chapter 810, Oregon Laws 2003, section 2, chapter 460, Oregon Laws 2007, and section 2a, chapter 872, Oregon Laws 2007; repealing ORS 414.019, 414.021, 414.022, 414.023, 414.024, 414.031, 414.032, 414.036, 414.038, 414.039, 414.085, 414.107, 414.660, 414.670, 414.744, 414.747, 445.270, 731.076 and 735.706 and sections 4, 9, 12 and 13, chapter 736, Oregon Laws 2003, and sections 10 and 13, chapter 810, Oregon Laws 2003; appropriating money; prescribing an effective date; and providing for revenue raising that requires approval by a three-fifths majority.

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

HEALTH AUTHORITY LAW

ESTABLISHING OREGON HEALTH AUTHORITY BOARD

(Establishment; Appointment; Term; Confirmation; Per Diem)

SECTION 1. (1) There is established the Oregon Health Authority Board, consisting of nine members appointed by the Governor.

(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) The appointment of the board is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(4) A member of the board is entitled to compensation and expenses as provided in ORS 292.495 for their attendance at board meetings and subcommittee meetings.

SECTION 2. Notwithstanding the term of office specified by section 1 of this 2009 Act, of the members first appointed to the Oregon Health Authority Board:

(1) Two shall serve for terms ending December 31, 2011.

(2) Two shall serve for terms ending December 31, 2012.

(3) Two shall serve for terms ending December 31, 2013.

(4) Three shall serve for terms ending December 31, 2014.

SECTION 3. The members of the Oregon Health Authority Board may be appointed before the operative date specified in section 468 of this 2009 Act and may take any action before that date that is necessary to enable the board to exercise, on and after the operative date specified in section 468 of this 2009 Act, the duties, functions and powers of the board pursuant to section 10 of this 2009 Act.

(Qualification of Members)

SECTION 4. (1) The members of the Oregon Health Authority Board must be residents of this state:

(a) Who have demonstrated leadership skills in their professional and civic lives.

(b) A majority of whom have not been gainfully employed in health care delivery or health care finance within 12 months prior to appointment.

(2) The membership of the board shall include a physician licensed to practice medicine in this state.

(Officers of Oregon Health Authority Board; Quorum; Meetings)

SECTION 5. (1) The Governor shall select from the membership of the Oregon Health Authority Board, the chairperson and vice chairperson who are subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(2) A majority of the members of the board constitutes a quorum for the transaction of business.

(3) The board shall meet at least once every month and at least once every two years in each congressional district in this state, at a place, day and hour determined by the board. The board may also meet at other times and places specified by the call of the chairperson or a majority of the members of the board, or as specified in bylaws adopted by the board.

(Employees)

SECTION 6. The Oregon Health Authority Board, subject to any applicable provisions of ORS chapter 240 and within the budgetary authority approved by the Legislative Assembly, shall appoint all subordinate officers and employees of the board, prescribe their duties and fix their compensation.

(Authority to Adopt Rules)

SECTION 7. In accordance with applicable provisions of ORS chapter 183, the Oregon Health Authority Board may adopt rules necessary for the administration of the laws that the board is charged with administering.

(Subcommittees)

SECTION 8. (1) The Oregon Health Authority Board shall establish subcommittees composed of individuals, appointed by the board, who are qualified by experience or training to perform the duties of the subcommittees, and of individuals who are members of the board. The subcommittees shall include, but are not limited to:

(a) The Public Employer Health Coalition that shall include the leadership of the Public Employees' Benefit Board, the Oregon Educators Benefits Board, cities, counties and other local government entities.

(b) The Payment Reform Council to investigate opportunities in both public and private sector programs to develop and implement new methodologies of reimbursing health care providers to reward comprehensive management of diseases, quality outcomes and the efficient use of resources.

(c) The Health Care Workforce Council to ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, system transformations and an increasingly diverse population.

(2) Members of subcommittees who are not members of the board are not entitled to compensation but shall be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them by their attendance at subcommittee meetings, in the manner and amount provided in ORS 292.495.

(Advisory and Technical Committees)

SECTION 9. (1) The Oregon Health Authority Board may establish such advisory and technical committees as it considers necessary to aid and advise the board in the performance of its functions. These committees may be continuing or temporary committees. The board shall determine the representation, membership, terms and organization of the committees and shall appoint their members.

(2) Members of the committees are not entitled to compensation, but at the discretion of the board may be reimbursed from funds available to the board for actual and necessary travel and other expenses incurred by them in the performance of their official duties, in the manner and amount provided in ORS 292.495.

(Duties of Oregon Health Authority Board)

SECTION 10. (1) The duties of the Oregon Health Authority Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in section 11 of this 2009 Act and all of the authority's departmental divisions, including the Quality Care Institute and the Oregon Health Insurance Exchange described in sections 17 and 18 of this 2009 Act.

(b) Implement a program to provide health insurance premium assistance to all low and moderate income families residing in Oregon.

(c) Establish health benefit plans for individuals who are covered under the Public Employees' Benefit Board and the Oregon Educators Benefit Board that will achieve optimal coordination among state agencies that provide health care benefits.

(d) Establish and continuously refine uniform, statewide health care quality standard for use by all purchasers of health care, third party payers and health care providers as quality

performance benchmarks.

(e) Establish clinical standards and guidelines described in section 18 (3)(f)(B) of this 2009 Act.

(f) Approve and monitor community-centered health initiatives described in section 11 of this 2009 Act that are consistent with public health goals, strategies, programs and performance standards adopted by the board to improve the health of all Oregonians and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost control mechanisms to limit increases in health care costs in this state to an amount no greater than the U.S. City Average Consumer Price Index for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor minus one percent, by the year 2015.

(h) Work with the Oregon congressional delegation to advance the adoption of or changes in federal policy to promote Oregon's comprehensive health reform plan.

(i) Establish an essential benefit package for all insurance offered through the Oregon Health Insurance Exchange.

(j) Investigate and report to the Legislative Assembly on the feasibility and advisability of future changes to the health insurance market in Oregon including, but not limited to:

(A) A requirement for every resident to have health insurance coverage;

(B) A state program to subsidize health insurance premiums for all low and moderate income Oregon families;

(C) A payroll tax tied to the provision of health insurance by employers;

(D) Expansion of the Oregon Health Insurance Exchange to administer a program of premium assistance and advance reforms of the insurance market;

(E) The creation of a publicly owned health insurance plan to be offered through the Oregon Health Insurance Exchange;

(F) The development of an essential benefits package for all insurance offered through the Oregon Health Insurance Exchange; and

(G) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

(2) The board is authorized to:

(a) Undertake joint contracting for health care services on behalf of the public entities participating in the Public Health Employer Coalition; and

(b) Subject to the approval of the Governor, organize and reorganize the Oregon Health Authority as the board considers necessary to properly conduct the work of the authority.

(3) If the board or the Oregon Health Authority is unable to perform in whole or in part, any of the duties listed in sections 1 to 25 of this 2009 Act without legislative authority, the board shall submit to the Legislative Counsel, no later than October 1, a measure request which shall be introduced at the next regular session of the Legislative Assembly. The board shall implement any portions of the duties not requiring legislative authority, to the extent practicable.

(4) If the board or the Oregon Health Authority is unable to perform in whole or in part, any of the duties listed in sections 1 to 25 of this 2009 Act without federal approval, the board is authorized to request waivers or other approval necessary to implement this section. The board shall implement any portions of the duties not requiring legislative authority or federal

approval, to the extent practicable.

(5) Except as provided in subsections (3) and (4) of this section, the enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the board by other statutes.

ESTABLISHING OREGON HEALTH AUTHORITY

SECTION 11. (1) The Oregon Health Authority is established. The Oregon Health Authority shall:

(a) Carry out policies adopted by the Oregon Health Authority Board;

(b) Establish the Quality Care Institute and the Oregon Health Insurance Exchange;

(c) Administer the Oregon Prescription Drug Program;

(d) Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance including reports of trends in health services and enrollee satisfaction;

(e) Guide and support with the authorization of the board, community-centered health initiatives designed to address critical behavioral risk factors, especially those that contribute to chronic disease; and

(f) Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414.

(2) The Oregon Health Authority is authorized to:

(a) Create a health care data collection program to work with insurers and other state agencies to access insurer, health plan and health plan network information in order to provide comparative information to consumers; and

(b) Acquire healthcare facilities as a means to provide stability in the health care market and to ensure adequate health care facility coverage in all areas of the state.

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the department by other statutes.

(Director)

SECTION 12. (1) The Oregon Health Authority is under the supervision and control of a director, who is responsible for the performance of the duties, functions and powers of the authority.

(2) The Governor shall appoint the Director of the Oregon Health Authority, who holds office at the pleasure of the Governor. The appointment of the director shall be subject to confirmation by the Senate in the manner provided by ORS 171.562 and 171.565.

SECTION 13. The Director of the Oregon Health Authority may be appointed before the operative date specified in section 468 of this 2009 Act and may take any action before that date that is necessary to enable the director to exercise, on and after the operative date specified in section 468 of this 2009 Act, the duties, functions and powers of the director pursuant to sections 1 to 25 of this 2009 Act.

(Deputy Directors)

SECTION 14. (1) The Director of the Oregon Health Authority may, by written order filed with the Secretary of State, appoint deputy directors. A deputy director serves at the pleasure of the director, has authority to act for the director in the absence of the director and is subject to the control of the director at all times.

(2) The director and any deputy directors shall receive such salary as may be provided by law or as fixed by the Governor. In addition to salaries, the director and deputy directors, subject to the limitations otherwise provided by law, shall be reimbursed for all reasonable expenses necessarily incurred in the performance of official duties.

(3) Subject to any applicable provisions of ORS chapter 240, the director shall appoint all subordinate officers and employees of the Oregon Health Authority, prescribe their duties and fix their compensation.

(General Authority to Adopt Rules)

SECTION 15. In accordance with applicable provisions of ORS chapter 183, the Director of the Oregon Health Authority may adopt rules necessary for the administration of the laws that the authority is charged with administering.

(Oaths, Depositions and Subpoenas)

SECTION 16. The Director of the Oregon Health Authority, each deputy director and authorized representatives of the director may administer oaths, take depositions and issue subpoenas to compel the attendance of witnesses and the production of documents or other written information necessary to carry out the provisions of sections 1 to 25 of this 2009 Act. If any person fails to comply with a subpoena issued under this section or refuses to testify on matters on which the person lawfully may be interrogated, the director, deputy director or authorized representative may follow the procedure set out in ORS 183.440 to compel obedience.

ESTABLISHING DEPARTMENTAL ENTITIES WITHIN THE OREGON HEALTH AUTHORITY

(Quality Care Institute)

SECTION 17. (1) The Quality Care Institute is created within the Oregon Health Authority.

(2) The institute shall develop for the Oregon Health Authority Board, uniform statewide health care quality standards to be used by all purchases, third-party payers and health care providers as the quality performance benchmarks in Oregon.

(Oregon Health Insurance Exchange)

SECTION 18. (1) The Oregon Health Insurance Exchange is created in the Oregon Health Authority.

(2) The exchange shall regulate the sale and transaction of all policies of health insurance

in this state including but not limited to:

(a) Approval of rates;

(b) Enforcement of rating rules; and

(c) Enforcement of market conduct rules.

(3) Under the guidance of the Oregon Health Authority Board, the exchange shall develop a plan for the exchange to serve as the conduit for the purchase of all individual and small employer group health insurance in Oregon. The plan shall also describe how all insurance purchased by the state will be administered through the exchange. The plan must contain all of the following elements:

(a) All individual and small employer group health insurance must be purchased through the exchange.

(b) Participating insurers shall be selected based upon requests for proposals that ensure:

(A) A range of plan options specified by the exchange;

(B) Community rating;

(C) No denial of enrollment based on pre-existing medical conditions;

(D) Adequate provider networks as prescribed by the exchange;

(E) Adherence to standardized contract requirements prescribed by the Oregon Health Authority by rule;

(F) Adherence to cost transparency rules prescribed by the exchange;

(G) The use of a medical screening tool and common rejection rules;

(H) Adherence to standards prescribed by the exchange with respect to administrative costs and rating; and

(I) Other contract standards approved by the board and prescribed by the exchange by rule.

(c) The future expansion of health insurance coverage through premium assistance, tax credits or other means.

(4) The exchange may, with the approval of the board:

(a) Develop and implement a reinsurance program available to all participating insurers.

(b) Evaluate the need for and, if warranted, the development of a publicly-owned health plan option to be administered by the exchange.

(c) Work with insurers and state agencies to obtain insurer, health plan and health plan network information and use the information to provide comparative information to consumers of health care.

(d) Develop methodologies and standards for reviewing the administrative expenses of health insurers and deny rate increases based upon excessive administrative expense portions of premiums.

(e) Establish annual maximum limits on price increases charged by health care providers within established categories of services to amounts no more than:

(A) The U.S. City Average Consumer Price Index for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor minus one percent; or

(B) A multiple, established by the exchange, of the Medicare reimbursement rate for the service.

(f) Develop uniform contracting standards for the purchase of health care services by state agencies including:

(A) Uniform quality performance measures;

(B) Evidence-based guidelines for major chronic diseases, health care services with unexplained variations in frequency or cost; and

(C) Comparative effectiveness guidelines for select new technologies.

(Establishment of Oregon Health Authority Fund)

SECTION 19. The Oregon Health Authority Fund is established in the State Treasury, separate and distinct from the General Fund. Moneys in the fund are continuously appropriated to the Oregon Health Authority for the purposes of sections 1 to 25 of this 2009 Act.

TRANSFER OF FUNCTIONS TO OREGON HEALTH AUTHORITY

SECTION 20. (1) All of the duties, functions and powers of the Department of Human Services with respect to health are imposed upon, transferred to and vested in the Oregon Health Authority, including but not limited to:

(a) Developing the policies for and the provision of medical assistance and premium assistance in this state, except for long-term care, home- and community-based care and residential facility care for seniors.

(b) Ensuring the promotion and protection of public health and the licensing of health care facilities.

(c) Developing the policies for and the provision of mental health treatment and treatment for substance use disorders, but not for health services to individuals with developmental disabilities.

(d) The administration of the Oregon Prescription Drug Program.

(e) Responsibility for the Office for Oregon Health Policy and Research and all of the functions of the office.

(f) Collecting and enforcing the hospital assessment established in section 2, chapter 736, Oregon Laws 2003.

(2) All of the duties, functions and powers of the Department of Consumer and Business Services with respect to health insurance, health benefit plans, health care service contractors and multiple employer welfare arrangements are imposed upon, transferred to and vested in the Oregon Health Authority, including but not limited to:

(a) Licensing and regulation of health insurance offered in this state.

(b) The responsibility for the Office of Private Health Partnerships and the Family Health Insurance Assistance Program.

(c) The responsibility for the Oregon Medical Insurance Pool Board and the operation of the Oregon Medical Insurance Pool.

(d) Collecting and enforcing assessments imposed by law upon health insurers and third party administrators of health benefits, including but not limited to the assessments established in sections 131 and 134 of this 2009 Act.

(3) The Oregon Health Policy Commission is abolished. On the operative date of this section, the tenure of office of the members of the Oregon Health Policy Commission ceases. All the duties, functions and powers of the Oregon Health Policy Commission are imposed upon, transferred to and vested in the Oregon Health Authority.

(Records, Property, Employees)

SECTION 21. (1) The Department of Human Services and the Department of Consumer and Business Services shall:

(a) Deliver to the Oregon Health Authority all records and property within the jurisdiction of the commission that relate to the duties, functions and powers transferred by section 20 of this 2009 Act; and

(b) Transfer to the Oregon Health Authority those employees engaged primarily in the exercise of the duties, functions and powers transferred by section 20 of this 2009 Act.

(2) The Director of the Oregon Health Authority shall take possession of the records and property, and shall take charge of the employees and employ them in the exercise of the duties, functions and powers transferred by section 20 of this 2009 Act, without reduction of compensation but subject to change or termination of employment or compensation as provided by law.

(3) The Governor shall resolve any dispute between the Department of Human Services or the Department of Consumer and Business Services and the Oregon Health Authority relating to transfers of records, property and employees under this section, and the Governor's decision is final.

(Action, Proceeding, Prosecution)

SECTION 22. The transfer of duties, functions and powers to the Oregon Health Authority by section 20 of this 2009 Act does not affect any action, proceeding or prosecution involving or with respect to such duties, functions and powers begun before and pending at the time of the transfer, except that the Oregon Health Authority is substituted for the Department of Human Services, the Department of Consumer and Business Services or Oregon Health Policy Commission in the action, proceeding or prosecution.

(Liability, Duty, Obligation)

SECTION 23. (1) Nothing in sections 20 to 22 of this 2009 Act relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers transferred by section 20 of this 2009 Act. The Oregon Health Authority may undertake the collection or enforcement of any such liability, duty or obligation.

(2) The rights and obligations of the Department of Human Services and the Department of Consumer and Business Services legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of section 20 of this 2009 Act and with respect to the duties, functions and powers transferred by section 20 of this 2009 Act are transferred to the Oregon Health Authority. For the purpose of succession to these rights and obligations, the Oregon Health Authority is a continuation of the Department of Human Services and the Department of Consumer and Business Services and not a new authority.

SECTION 24. Whenever, in any uncodified law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the Department of Human Services, the Department of Consumer and

Business Services or the Oregon Health Policy Commission or an executive, officer or employee of the departments or commission, with respect to the duties, functions and powers transferred by section 20 of this 2009 Act, the reference is considered to be a reference to the Oregon Health Authority Board or an executive, officer or employee of the Oregon Health Authority.

NO RESTRAINT OF TRADE

SECTION 25. (1) The collaboration of insurers under the direction of the Oregon Health Authority, including the Oregon Health Insurance Exchange, is intended to displace current market forces based on the legislative finding that existing health insurance market forces do not permit the market to operate in a cost-efficient manner or to ensure the availability of health care throughout the state.

(2) Activities carried on under sections 1 to 20 of this 2009 Act do not constitute a conspiracy or a combination in restraint of trade or an illegal monopoly, nor are they carried out for the purposes of lessening competition or fixing prices arbitrarily, as long as the activities carry out sections 1 to 20 of this 2009 Act.

(3) A contract entered into between the Oregon Health Insurance Exchange and an insurer relating to premium rates or provider reimbursement is not an unlawful restraint in trade or part of a conspiracy or combination to accomplish an improper or illegal purpose or act so long as the Oregon Health Insurance Exchange, subject to the approval by the board, establishes the rates and reimbursement.

SECTION 26. Section 27 of this 2009 Act is added to and made a part of the Insurance Code.

SECTION 27. "Regulator" means:

(1) With respect to the regulation of health insurance, health benefit plans, health care service contractors and multiple employer welfare arrangements, the Oregon Health Authority; and

(2) With respect to the regulation all other insurance, the Department of Consumer and Business Services.

CONFORMING AMENDMENTS

SECTION 28. ORS 414.839 is amended to read:

414.839. (1) Subject to funds available, the [*Department of Human Services*] **Oregon Health Authority** may provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to the Family Health Insurance Assistance Program, for currently uninsured individuals [*based on*]**:**

(a) Under 19 years of age with family incomes up to 200 percent of the federal poverty [*level.*] **guidelines; and**

(b) 19 years of age and older with incomes at or below 185 percent of the federal poverty guidelines. [*The objective is to create a transition from dependence on public programs to privately financed health insurance.*]

(2) Public subsidies shall apply only to health benefit plans that meet or exceed the basic benchmark health benefit plan or plans established under ORS 735.733.

(3) Cost sharing shall be permitted and structured in such a manner to encourage appropriate use of preventive care and avoidance of unnecessary services.

(4) Cost sharing shall be based on an individual's ability to pay and may not exceed the cost of purchasing a plan.

(5) The state may pay a portion of the cost of the subsidy, based on the individual's income and other resources.

SECTION 29. ORS 244.050 is amended to read:

244.050. (1) On or before April 15 of each year the following persons shall file with the Oregon Government Ethics Commission a verified statement of economic interest as required under this chapter:

(a) The Governor, Secretary of State, State Treasurer, Attorney General, Commissioner of the Bureau of Labor and Industries, Superintendent of Public Instruction, district attorneys and members of the Legislative Assembly.

(b) Any judicial officer, including justices of the peace and municipal judges, except any pro tem judicial officer who does not otherwise serve as a judicial officer.

(c) Any candidate for a public office designated in paragraph (a) or (b) of this subsection.

(d) The Deputy Attorney General.

(e) The Legislative Administrator, the Legislative Counsel, the Legislative Fiscal Officer, the Secretary of the Senate and the Chief Clerk of the House of Representatives.

(f) The Chancellor and Vice Chancellors of the Oregon University System and the president and vice presidents, or their administrative equivalents, in each institution under the jurisdiction of the State Board of Higher Education.

(g) The following state officers:

(A) Adjutant General.

(B) Director of Agriculture.

(C) Manager of State Accident Insurance Fund Corporation.

(D) Water Resources Director.

(E) Director of Department of Environmental Quality.

(F) Director of Oregon Department of Administrative Services.

(G) State Fish and Wildlife Director.

(H) State Forester.

(I) State Geologist.

(J) Director of Human Services.

(K) Director of the Department of Consumer and Business Services.

(L) Director of the Department of State Lands.

(M) State Librarian.

(N) Administrator of Oregon Liquor Control Commission.

(O) Superintendent of State Police.

(P) Director of the Public Employees Retirement System.

(Q) Director of Department of Revenue.

(R) Director of Transportation.

(S) Public Utility Commissioner.

(T) Director of Veterans' Affairs.

(U) Executive Director of Oregon Government Ethics Commission.

(V) Director of the State Department of Energy.

(W) Director and each assistant director of the Oregon State Lottery.

(X) Director of the Oregon Health Authority.

(h) Any assistant in the Governor's office other than personal secretaries and clerical personnel.

(i) Every elected city or county official.

(j) Every member of a city or county planning, zoning or development commission.

(k) The chief executive officer of a city or county who performs the duties of manager or principal administrator of the city or county.

(L) Members of local government boundary commissions formed under ORS 199.410 to 199.519.

(m) Every member of a governing body of a metropolitan service district and the executive officer thereof.

(n) Each member of the board of directors of the State Accident Insurance Fund Corporation.

(o) The chief administrative officer and the financial officer of each common and union high school district, education service district and community college district.

(p) Every member of the following state boards and commissions:

(A) Board of Geologic and Mineral Industries.

(B) Oregon Economic and Community Development Commission.

(C) State Board of Education.

(D) Environmental Quality Commission.

(E) Fish and Wildlife Commission of the State of Oregon.

(F) State Board of Forestry.

(G) Oregon Government Ethics Commission.

(H) Oregon Health [*Policy Commission*] **Authority Board**.

(I) State Board of Higher Education.

(J) Oregon Investment Council.

(K) Land Conservation and Development Commission.

(L) Oregon Liquor Control Commission.

(M) Oregon Short Term Fund Board.

(N) State Marine Board.

(O) Mass transit district boards.

(P) Energy Facility Siting Council.

(Q) Board of Commissioners of the Port of Portland.

(R) Employment Relations Board.

(S) Public Employees Retirement Board.

(T) Oregon Racing Commission.

(U) Oregon Transportation Commission.

(V) Wage and Hour Commission.

(W) Water Resources Commission.

(X) Workers' Compensation Board.

(Y) Oregon Facilities Authority.

(Z) Oregon State Lottery Commission.

(AA) Pacific Northwest Electric Power and Conservation Planning Council.

(BB) Columbia River Gorge Commission.

(CC) Oregon Health and Science University Board of Directors.

(q) The following officers of the State Treasurer:

(A) Chief Deputy State Treasurer.

(B) Chief of staff for the office of the State Treasurer.

(C) Director of the Investment Division.

(r) Every member of the board of commissioners of a port governed by ORS 777.005 to 777.725 or 777.915 to 777.953.

(s) Every member of the board of directors of an authority created under ORS 441.525 to 441.595.

(2) By April 15 next after the date an appointment takes effect, every appointed public official on a board or commission listed in subsection (1) of this section shall file with the Oregon Government Ethics Commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(3) By April 15 next after the filing deadline for the primary election, each candidate for public office described in subsection (1) of this section shall file with the commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(4) Within 30 days after the filing deadline for the general election, each candidate for public office described in subsection (1) of this section who was not a candidate in the preceding primary election, or who was nominated for public office described in subsection (1) of this section at the preceding primary election by write-in votes, shall file with the commission a statement of economic interest as required under ORS 244.060, 244.070 and 244.090.

(5) Subsections (1) to (4) of this section apply only to persons who are incumbent, elected or appointed public officials as of April 15 and to persons who are candidates for public office on April 15. Subsections (1) to (4) of this section also apply to persons who do not become candidates until 30 days after the filing deadline for the statewide general election.

(6) If a statement required to be filed under this section has not been received by the commission within five days after the date the statement is due, the commission shall notify the public official or candidate and give the public official or candidate not less than 15 days to comply with the requirements of this section. If the public official or candidate fails to comply by the date set by the commission, the commission may impose a civil penalty as provided in ORS 244.350.

SECTION 30. ORS 414.025, as amended by section 18a, chapter 861, Oregon Laws 2007, is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means assistance provided by the Oregon Supplemental Income Program, aid granted under ORS 412.001 to 412.069 and 418.647 or federal Supplemental Security Income payments.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child as defined in ORS 412.001 except for age and regular attendance in school or in a course of professional or technical training.

(e)(A) Is a caretaker relative, as defined in ORS 412.001, who cares for a child who would be a dependent child except for age and regular attendance in school or in a course of professional or technical training; or

(B) Is the spouse of the caretaker relative.

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Department of Human Services to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative as defined in ORS 412.001 who cares for a dependent child receiving aid granted under ORS 412.001 to 412.069 and 418.647 or is the spouse of the caretaker relative.

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for persons with mental retardation; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by the Department of Human Services.

(L) Is a member of a family that received aid in the preceding month under ORS 412.006 or 412.014 and became ineligible for aid due to increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of at least six calendar months beginning with the month in which such family became ineligible for assistance due to increased hours of employment or increased earnings.

(m) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(n) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(o) Is an individual or member of a group who, subject to the rules of the department and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(p) Is a pregnant woman who would be eligible for aid granted under ORS 412.001 to 412.069 and 418.647, whether or not the woman is eligible for cash assistance.

(q) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(r) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act or is not a full-time student in a post-secondary education program as defined by the Department of Human Services by rule, but whose family income is less than the federal poverty level and whose family investments and savings equal less than the investments and savings limit established by the department by rule.

(s) Would be eligible for a category of aid but for the receipt of qualified long term care insurance benefits under a policy or certificate issued on or after January 1, 2008. As used in this paragraph, "qualified long term care insurance" means a policy or certificate of insurance as defined in ORS 743.652 (6).

(3) "Income" has the meaning given that term in ORS 411.704.

(4) "Investments and savings" means cash, securities as defined in ORS 59.015, negotiable in-

struments as defined in ORS 73.0104 and such similar investments or savings as the Department of Human Services may establish by rule that are available to the applicant or recipient to contribute toward meeting the needs of the applicant or recipient.

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the [*Department of Human Services*] **Oregon Health Authority** according to the standards established pursuant to [*ORS 414.065*] **section 10 of this 2009 Act**, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases; and

(s) Hospice services.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" has the meaning given that term in ORS 411.704. For eligibility purposes, "resources" does not include charitable contributions raised by a community to assist with medical expenses.

SECTION 31. ORS 414.033 is amended to read:

414.033. The [*Department of Human Services*] **Oregon Health Authority** may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project which determines the cost of providing medical assistance to the medically needy and evaluates service delivery systems.

SECTION 32. ORS 414.034 is amended to read:

414.034. The [*Department of Human Services*] **Oregon Health Authority** shall accept federal Centers for Medicare and Medicaid Services billing, reimbursement and reporting forms instead of department billing, reimbursement and reporting forms if the federal forms contain substantially the same information as required by the department forms.

SECTION 33. ORS 414.105 and 414.106 are added to and made a part of ORS chapter 416.

SECTION 34. ORS 414.042 is added to and made a part of ORS chapter 411.

SECTION 35. ORS 414.042 is amended to read:

414.042. [*(1) The need for and the amount of medical assistance to be made available for each eligible group of recipients of medical assistance shall be determined, in accordance with the rules of the Department of Human Services, taking into account:*]

[*(a) The requirements and needs of the person, the spouse and other dependents;*]

[*(b) The income, resources and maintenance available to the person but, except as provided in ORS 414.025 (2)(r), resources shall be disregarded for those eligible by reason of having income below the federal poverty level and who are eligible for medical assistance only because of the enactment of chapter 836, Oregon Laws 1989;*]

[*(c) The responsibility of the spouse and, with respect to a person who is blind or is permanently and totally disabled or is under 21 years of age, the responsibility of the parents; and*]

[*(d) The report of the Health Services Commission as funded by the Legislative Assembly and such other programs as the Legislative Assembly may authorize. However, medical assistance, including health services, shall not be provided to persons described in ORS 414.025 (2)(r) unless the Legislative Assembly specifically appropriates funds to provide such assistance.*]

[*(2) Such amounts of income and resources may be disregarded as the department may prescribe by rules, except that*] The Department **of Human Services** may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule of the department inconsistent with this section is to that extent invalid. [*The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.*]

[*(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the department, shall be applied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.*]

SECTION 36. ORS 414.047, 414.049, 414.051, 414.055, 414.057, 414.073, 414.151, 414.420, 414.422

and 414.424 are added to and made a part of ORS chapter 411.

SECTION 37. ORS 414.049 is amended to read:

414.049. For each person applying for [*health services under ORS 414.705 to 414.750*] **medical assistance**, the Department of Human Services shall fully document:

(1) The category of aid as defined in ORS 414.025 that makes the person eligible for medical assistance or the way in which the person qualifies as categorically needy as defined in ORS 414.025;

(2) The status of the person as a resident of this state; and

(3) The financial income and resources of the person.

SECTION 38. ORS 414.051 is amended to read:

414.051. The [*Department of Human Services*] **Oregon Health Authority** shall approve or deny prior authorization requests for dental services not later than 30 days after submission thereof by the provider, and shall make payments to providers of prior authorized dental services not later than 30 days after receipt of the invoice of the provider.

SECTION 39. ORS 414.065 is amended to read:

414.065. (1)(a) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the [*Department of Human Services*] **Oregon Health Authority** shall determine, subject to such revisions as it may make from time to time and with respect to the "health services" defined in ORS 414.705, subject to legislative funding in response to the report of the Health Services Commission and paragraph (b) of this subsection:

(A) The types and extent of medical and remedial care and services to be provided to each eligible group of recipients of medical assistance.

(B) Standards to be observed in the provision of medical and remedial care and services.

(C) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(D) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(E) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(F) The amount and application of any copayment or other similar cost-sharing payment that the [*department*] **authority** may require a recipient to pay toward the cost of medical and remedial care or services.

(b) Notwithstanding ORS 414.720 (8), the [*department*] **authority** shall adopt rules establishing timelines for payment of health services under paragraph (a) of this subsection.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the [*department*] **authority** and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the [*department*] **authority** for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to subsection (1)(a)(A), (B) and (C) of this section for the eligible medically needy, except for persons receiving assistance under

ORS 411.706, may be less than but may not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy.

SECTION 40. ORS 414.109 is amended to read:

414.109. (1) The Oregon Health Plan Fund is established, separate and distinct from the General Fund. Interest earned by the Oregon Health Plan Fund shall be retained by the Oregon Health Plan Fund.

(2) Moneys in the Oregon Health Plan Fund are continuously appropriated to the Department of Human Services for the purposes of funding the maintenance and expansion of the number of persons eligible for medical assistance under the Oregon Health Plan and funding the maintenance of the benefits available under the Oregon Health Plan.

(3) On the effective date of this 2009 Act, all moneys in the Oregon Health Plan Fund shall be transferred to the Oregon Health Authority Fund established in section 19 of this 2009 Act.

SECTION 41. ORS 414.115 is amended to read:

414.115. (1) In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the [*Department of Human Services*] **Oregon Health Authority** shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy [*or the medically needy, or both*]. Notwithstanding other specific provisions, the use of available medical assistance funds to purchase medical or remedial care and services may provide the following insurance or contract options:

(a) Differing services or levels of service among groups of eligibles as defined by rules of the [*department*] **authority**; and

(b) Services and reimbursement for these services may vary among contracts and need not be uniform.

(2) The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the [*department*] **authority** must guarantee:

(a) To provide medical and remedial care and services of the type, within the extent and according to standards prescribed under ORS 414.065;

(b) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts which employ a method of accounting or payment on other than a fee-for-service basis;

(c) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(d) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the [*department*] **authority** as may be required by the [*department*] **authority** for its records, reports and audits.

SECTION 42. ORS 414.125 is amended to read:

414.125. (1) Any payment of available medical assistance funds for policies of insurance or ser-

vice contracts shall be according to such uniform area-wide rates as the [*Department of Human Services*] **Oregon Health Authority** shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstration project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state.

SECTION 43. ORS 414.135 is amended to read:

414.135. The [*Department of Human Services*] **Oregon Health Authority** may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the [*department*] **authority** pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the [*department*] **authority** by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the [*department*] **authority** as may be required by the [*department*] **authority**.

SECTION 44. ORS 414.145 is amended to read:

414.145. (1) The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented whenever it appears to the [*Department of Human Services*] **Oregon Health Authority** that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the [*department*] **authority** to the providers of medical assistance, but in no case greater than the legislatively approved budgeted cost per eligible recipient at the time of contracting.

(2) When determining comparable benefits at equal or less cost as provided in subsection (1) of this section, the [*department*] **authority** must take into consideration the recipients' need for reasonable access to preventive and remedial care, and the contractor's ability to assure continuous quality delivery of both routine and emergency services.

SECTION 45. ORS 414.153 is amended to read:

414.153. In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to insure access to public health services through contract under ORS chapter 414, the state shall:

(1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between prepaid health plans and publicly funded providers for authorization of payment for point of contact services in the following categories:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

(2) Allow enrollees in prepaid health plans to receive from fee-for-service providers:

(a) Family planning services;

(b) Human immunodeficiency virus and acquired immune deficiency syndrome prevention ser-

vices; and

(c) Maternity case management if the [*Department of Human Services*] **Oregon Health Authority** determines that a prepaid plan cannot adequately provide the services;

(3) Encourage and approve agreements between prepaid health plans and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care;

(c) Prenatal care;

(d) School-based clinics;

(e) Health services for children provided through schools and Head Start programs; and

(f) Screening services to provide early detection of health care problems among low income women and children, migrant workers and other special population groups; and

(4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility.

SECTION 46. ORS 414.211 is amended to read:

414.211. (1) There is established a Medicaid Advisory Committee consisting of not more than 15 members appointed by the Governor.

(2) The committee shall be composed of:

(a) A physician licensed under ORS chapter 677;

(b) Two members of health care consumer groups that include Medicaid recipients;

(c) Two Medicaid recipients, one of whom shall be a person with a disability;

(d) The Director of [*Human Services*] **the Oregon Health Authority** or designee;

(e) Health care providers;

(f) Persons associated with health care organizations, including but not limited to managed care plans under contract to the Medicaid program; and

(g) Members of the general public.

(3) In making appointments, the Governor shall consult with appropriate professional and other interested organizations. All members appointed to the committee shall be familiar with the medical needs of low income persons.

(4) The term of office for each member shall be two years, but each member shall serve at the pleasure of the Governor.

(5) Members of the committee shall receive no compensation for their services but, subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the [*Public Welfare Account*] **Oregon Health Authority Fund**.

SECTION 47. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the Director of [*Human Services*] **the Oregon Health Authority** on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 48. ORS 414.225 is amended to read:

414.225. The [*Department of Human Services*] **Oregon Health Authority** shall consult with the

Medicaid Advisory Committee concerning the determinations required under ORS 414.065.

SECTION 49. ORS 414.227 is amended to read:

414.227. (1) ORS 192.610 to 192.690 apply to any meeting of an advisory committee with the authority to make decisions for, conduct policy research for or make recommendations to the [*Department of Human Services*] **Oregon Health Authority or the Oregon Health Authority Board** on administration or policy related to the medical assistance program operated under this chapter.

(2) Subsection (1) of this section applies only to advisory committee meetings attended by two or more advisory committee members who are not employed by a public body.

SECTION 50. ORS 414.312 is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Department of Human Services*] **Oregon Health Authority**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*Human Services*] **the Oregon Health Authority** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities [*may*] **shall** participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020; **and**

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities[*;*]**.**

(5) The following individuals or entities may participate in the program:

[*(f)*] **(a)** Residents of this state who lack or are underinsured for prescription drug coverage;

[*(g)*] **(b)** Private entities; and

[*(h)*] **(c)** Labor organizations.

[*(5)*] **(6)** The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

[*(6)*] **(7)** The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

[*(7)*] **(8)** The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

[*(8)*] **(9)** Except as provided in subsection [*(9)*] **(10)** of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

[*(9)*] **(10)** The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

[*(10)*] **(11)** Notwithstanding subsection [*(4)(f)*] **(5)(a)** of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 51. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 [*(4)*] **(5)** may apply to participate in the Oregon Prescription Drug Program. Participants shall apply on an application provided by the [*Department of Human Services*] **Oregon Health Authority**. The [*department*] **authority** may charge participants a nominal fee to participate in the program. The [*department*] **authority** shall issue a prescription drug identification card to participants of the program.

(2) The [*department*] **authority** shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the [*department*] **authority**.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 52. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Department of Human Services*] **Oregon Health Authority** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 53. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Department of Human Services*] **Oregon Health Authority** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*department*] **authority** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the [*department*] **authority** for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 54. ORS 414.320 is amended to read:

414.320. The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 55. ORS 414.325 is amended to read:

414.325. (1) As used in this section, "legend drug" means any drug requiring a prescription by a practitioner, as defined in ORS 689.005.

(2) A licensed practitioner may prescribe such drugs under this chapter as the practitioner in the exercise of professional judgment considers appropriate for the diagnosis or treatment of the patient in the practitioner's care and within the scope of practice. Prescriptions shall be dispensed in the generic form pursuant to ORS 689.515 and pursuant to rules of the [*Department of Human Services*] **Oregon Health Authority** unless the practitioner prescribes otherwise and an exception is granted by the [*department*] **authority**.

(3) Except as provided in subsections (4) and (5) of this section, the [*department*] **authority** shall place no limit on the type of legend drug that may be prescribed by a practitioner, but the [*department*] **authority** shall pay only for drugs in the generic form unless an exception has been granted by the [*department*] **authority**.

(4) Notwithstanding subsection (3) of this section, an exception must be applied for and granted before the [*department*] **authority** is required to pay for minor tranquilizers and amphetamines and amphetamine derivatives, as defined by rule of the [*department*] **authority**.

(5)(a) Notwithstanding subsections (1) to (4) of this section and except as provided in paragraph (b) of this subsection, the [*department*] **authority** is authorized to:

(A) Withhold payment for a legend drug when federal financial participation is not available; and

(B) Require prior authorization of payment for drugs that the [*department*] **authority** has determined should be limited to those conditions generally recognized as appropriate by the medical profession.

(b) The [*department*] **authority** may not require prior authorization for therapeutic classes of nonsedating antihistamines and nasal inhalers, as defined by rule by the [*department*] **authority**, when prescribed by an allergist for treatment of any of the following conditions, as described by the Health Services Commission on the funded portion of its prioritized list of services:

(A) Asthma;

(B) Sinusitis;

(C) Rhinitis; or

(D) Allergies.

(6)(a) The [*department*] **authority** shall pay a rural health clinic for a legend drug prescribed and dispensed under this chapter by a licensed practitioner at the rural health clinic for an urgent medical condition if:

(A) There is not a pharmacy within 15 miles of the clinic;

(B) The prescription is dispensed for a patient outside of the normal business hours of any pharmacy within 15 miles of the clinic; or

(C) No pharmacy within 15 miles of the clinic dispenses legend drugs under this chapter.

(b) As used in this subsection, "urgent medical condition" means a medical condition that arises suddenly, is not life-threatening and requires prompt treatment to avoid the development of more serious medical problems.

(7) Notwithstanding ORS 414.334, the [*department*] **authority** may conduct prospective drug utilization review prior to payment for drugs for a patient whose prescription drug use exceeded 15 drugs in the preceding six-month period.

(8) Notwithstanding subsection (3) of this section, the [*department*] **authority** may pay a pharmacy for a particular brand name drug rather than the generic version of the drug after notifying the pharmacy that the cost of the particular brand name drug, after receiving discounted prices and rebates, is equal to or less than the cost of the generic version of the drug.

SECTION 56. ORS 414.327 is amended to read:

414.327. [*(1) The Department of Human Services shall seek a waiver from the federal Centers for Medicare and Medicaid Services to allow the department to communicate prescription drug orders by electronic means from a practitioner authorized to prescribe drugs directly to the dispensing pharmacist.*]

[*(2)*] The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules permitting [*the department*] **a practitioner** to communicate prescription drug orders by electronic means [*from a practitioner authorized to prescribe drugs*] directly to the dispensing pharmacist.

SECTION 57. ORS 414.329 is amended to read:

414.329. (1) Notwithstanding ORS 414.705 to 414.750, the [*Department of Human Services*] **Oregon Health Authority** shall adopt rules modifying the prescription drug benefits for persons who are eligible for Medicare Part D prescription drug coverage and who receive prescription drug benefits under the state medical assistance program or Title XIX of the Social Security Act. The rules shall include but need not be limited to:

(a) Identification of the Part D classes of drugs for which federal financial participation is not available and that are not covered classes of drugs;

(b) Identification of the Part D classes of drugs for which federal financial participation is not available and that are covered classes of drugs;

(c) Identification of the classes of drugs not covered under Medicare Part D prescription drug coverage for which federal financial participation is available and that are covered classes of drugs; and

(d) Cost-sharing obligations related to the provision of Part D classes of drugs for which federal financial participation is not available.

(2) As used in this section, "covered classes of drugs" means classes of prescription drugs pro-

vided to persons eligible for prescription drug coverage under the state medical assistance program or Title XIX of the Social Security Act.

SECTION 58. ORS 414.340 is amended to read:

414.340. As used in this section and ORS 414.342 and 414.348:

(1) "Eligible person" means a resident of this state who:

(a) Is 65 years of age or older;

(b) Has a gross annual income that does not exceed the lesser of the maximum amount established by the [*Department of Human Services*] **Oregon Health Authority** by rule or [*185*] **200** percent of the federal poverty guidelines;

(c) Has not been covered under any public or private prescription drug benefit program for the previous six months; and

(d) Has less than $2,000 in resources.

(2) "Enrollee" means a person who has been found to be eligible for the Senior Prescription Drug Assistance Program, who has paid an enrollment fee of up to $50 and who has a Senior Prescription Drug Assistance Program enrollment card issued by the [*Department of Human Services*] **Oregon Health Authority**.

(3) "Federal poverty guidelines" means the most recent poverty guidelines as published annually in the Federal Register by the United States Department of Health and Human Services.

(4) "Income" has the meaning given that term in ORS 411.704.

(5) "Resources" includes but is not limited to cash, checking and savings accounts, certificates of deposit, money market funds, stocks and bonds. "Resources" does not include the primary residence or car of an eligible person.

(6) "Senior Prescription Drug Assistance Program price" means the price of a prescription drug paid by an enrollee that is equal to or less than the Medicaid price.

SECTION 59. ORS 414.342 is amended to read:

414.342. (1) The Senior Prescription Drug Assistance Program is created in the [*Department of Human Services*] **Oregon Health Authority**. The purpose of the program is to provide financial assistance to eligible persons for the purchase of prescription drugs.

(2) A pharmacy shall charge an enrollee the Senior Prescription Drug Assistance Program price for a prescription drug upon presentation of a Senior Prescription Drug Assistance Program enrollment card.

(3) A pharmacy may charge the enrollee an amount established by the [*Department of Human Services*] **authority** to cover the professional dispensing fee, which may not exceed the fee paid by the state Medicaid program.

(4) This section does not apply to over-the-counter medications.

(5) The [*department*] **authority** shall provide a mechanism to calculate and transmit the Senior Prescription Drug Assistance Program price to the pharmacy.

(6) A person seeking to participate in the Senior Prescription Drug Assistance Program shall apply annually by completing and mailing a one-page application and including payment of an enrollment fee established by the [*department*] **authority**, not to exceed $50. The [*department*] **authority** shall issue an enrollment card annually to enrollees of the program. Each individual's application shall be considered separately, regardless of the number of persons in the individual's household.

(7) The maximum prescription drug assistance available annually to an enrollee is $2,000.

(8) Subject to funds available, the [*Department of Human Services*] **Oregon Health Authority**

may adjust the Senior Prescription Drug Assistance Program price to subsidize up to 50 percent of the Medicaid price of the prescription drug, using a sliding scale based on the income and resources of an enrollee.

(9)(a) The [*department*] **authority** shall adopt rules that:

(A) Identify critical access pharmacies; and

(B) Provide for additional reimbursement to critical access pharmacies that participate in the Senior Prescription Drug Assistance Program.

(b) In addition, a critical access pharmacy may charge an enrollee a fee of not more than $2 per prescription. The $2 charge shall be annually adjusted for inflation using the U.S. City Average Consumer Price Index, as defined in ORS 316.037.

SECTION 60. ORS 414.344 is amended to read:

414.344. The [*Department of Human Services*] **Oregon Health Authority** may contract with a pharmacy provider or a pharmacy benefits manager to provide services under the Senior Prescription Drug Assistance Program established under ORS 414.342.

SECTION 61. ORS 414.346 is amended to read:

414.346. The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules necessary to implement ORS 414.342.

SECTION 62. ORS 414.348 is amended to read:

414.348. The Senior Prescription Drug Assistance Fund is established separate and distinct from the General Fund. The Senior Prescription Drug Assistance Fund may receive any appropriations, allocations, federal moneys or gifts designated for the Senior Prescription Drug Assistance Program. The moneys in the Senior Prescription Drug Assistance Fund are continuously appropriated to the [*Department of Human Services*] **Oregon Health Authority** and shall be used to reimburse retail pharmacies for subsidized prices provided to enrollees and to reimburse the [*department*] **authority** for the costs of administering the program, including contracted services costs, computer costs, professional fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund accrues to the fund.

SECTION 63. ORS 414.350 is amended to read:

414.350. As used in ORS 414.350 to 414.415:

(1) "Appropriate and medically necessary use" means drug prescribing, drug dispensing and patient medication usage in conformity with the criteria and standards developed under ORS 414.350 to 414.415.

(2) "Board" means the Drug Use Review Board created under ORS 414.355.

(3) "Compendia" means those resources widely accepted by the medical profession in the efficacious use of drugs, including the following sources:

(a) The American Hospital Formulary Services drug information.

(b) The United States Pharmacopeia drug information.

(c) The American Medical Association drug evaluations.

(d) The peer-reviewed medical literature.

(e) Drug therapy information provided by manufacturers of drug products consistent with the federal Food and Drug Administration requirements.

(4) "Counseling" means the effective communication of information by a pharmacist, as defined by rules of the State Board of Pharmacy.

(5) "Criteria" means the predetermined and explicitly accepted elements based on the compendia that are used to measure drug use on an ongoing basis to determine if the use is appropriate, med-

ically necessary and not likely to result in adverse medical outcomes.

(6) "Drug-disease contraindication" means the potential for, or the occurrence of, an undesirable alteration of the therapeutic effect of a given prescription because of the presence, in the patient for whom it is prescribed, of a disease condition or the potential for, or the occurrence of, a clinically significant adverse effect of the drug on the patient's disease condition.

(7) "Drug-drug interaction" means the pharmacological or clinical response to the administration of at least two drugs different from that response anticipated from the known effects of the two drugs when given alone, which may manifest clinically as antagonism, synergism or idiosyncrasy. Such interactions have the potential to have an adverse effect on the individual or lead to a clinically significant adverse reaction, or both, that:

(a) Is characteristic of one or any of the drugs present; or

(b) Leads to interference with the absorption, distribution, metabolizing, excretion or therapeutic efficacy of one or any of the drugs.

(8) "Drug use review" means the programs designed to measure and assess on a retrospective and a prospective basis, through an evaluation of claims data, the proper utilization, quantity, appropriateness as therapy and medical necessity of prescribed medication in the medical assistance program.

(9) "Intervention" means an action taken by the [*Department of Human Services*] **Oregon Health Authority** with a prescriber or pharmacist to inform about or to influence prescribing or dispensing practices or utilization of drugs.

(10) "Overutilization" means the use of a drug in quantities or for durations that put the recipient at risk of an adverse medical result.

(11) "Pharmacist" means an individual who is licensed as a pharmacist under ORS chapter 689.

(12) "Prescriber" means any person authorized by law to prescribe drugs.

(13) "Prospective program" means the prospective drug use review program described in ORS 414.375.

(14) "Retrospective program" means the retrospective drug use review program described in ORS 414.380.

(15) "Standards" means the acceptable prescribing and dispensing methods determined by the compendia, in accordance with local standards of medical practice for health care providers.

(16) "Therapeutic appropriateness" means drug prescribing based on scientifically based and clinically relevant drug therapy that is consistent with the criteria and standards developed under ORS 414.350 to 414.415.

(17) "Therapeutic duplication" means the prescribing and dispensing of two or more drugs from the same therapeutic class such that the combined daily dose puts the recipient at risk of an adverse medical result or incurs additional program costs without additional therapeutic benefits.

(18) "Underutilization" means that a drug is used by a recipient in insufficient quantity to achieve a desired therapeutic goal.

SECTION 64. ORS 414.355 is amended to read:

414.355. (1) There is created a 12-member Drug Use Review Board responsible for advising the [*Department of Human Services*] **Oregon Health Authority Board** on the implementation of the retrospective and prospective drug utilization review programs.

(2) The members of the **Drug Use Review** Board shall be appointed by the Director of [*Human Services*] **the Oregon Health Authority** and shall serve a term of two years. An individual appointed to the board may be reappointed upon completion of the individual's term. The membership

of the board shall be composed of the following:

(a) Four persons licensed as physicians and actively engaged in the practice of medicine or osteopathic medicine in Oregon, who may be from among persons recommended by the Oregon Medical Association, the Osteopathic Physicians and Surgeons of Oregon or other organization representing physicians;

(b) One person licensed as a physician in Oregon who is actively engaged in academic medicine;

(c) Three persons licensed and actively practicing pharmacy in Oregon who may be from among persons recommended by the Oregon State Pharmacists Association, the National Association of Chain Drug Stores, the Oregon Society of Hospital Pharmacists, the Oregon Society of Consultant Pharmacists or other organizations representing pharmacists whether affiliated or unaffiliated with any association;

(d) One person licensed as a pharmacist in Oregon who is actively engaged in academic pharmacy;

(e) Two persons who shall represent persons receiving medical assistance; and

(f) One person licensed and actively practicing dentistry in Oregon who may be from among persons recommended by the Oregon Dental Association or other organizations representing dentists.

(3) Board members must have expertise in one or more of the following:

(a) Clinically appropriate prescribing of outpatient drugs covered by the medical assistance program.

(b) Clinically appropriate dispensing and monitoring of outpatient drugs covered by the medical assistance program.

(c) Drug use review, evaluation and intervention.

(d) Medical quality assurance.

(4) The director shall fill a vacancy on the board by appointing a new member to serve the remainder of the unexpired term based upon qualifications described in subsections (2) and (3) of this section.

(5) A board member may be removed only by a vote of eight members of the board and the removal must be approved by the director. The director may remove a member, without board action, if a member fails to attend two consecutive meetings unless such member is prevented from attending by serious illness of the member or in the member's family.

SECTION 65. ORS 414.360 is amended to read:

414.360. (1) The Drug Use Review Board shall advise the [*Department of Human Services*] **Oregon Health Authority Board** on:

(a) Adoption of rules to implement ORS 414.350 to 414.415 in accordance with the provisions of ORS 183.710 to 183.725, 183.745 and 183.750 and ORS chapter 183.

(b) Implementation of the medical assistance program retrospective and prospective programs as described in ORS 414.350 to 414.415, including the type of software programs to be used by the pharmacist for prospective drug use review and the provisions of the contractual agreement between the state and any entity involved in the retrospective drug use review program.

(c) Development of and application of the criteria and standards to be used in retrospective and prospective drug utilization review in a manner that insures that such criteria and standards are based on the compendia, relevant guidelines obtained from professional groups through consensus-driven processes, the experience of practitioners with expertise in drug therapy, data and experience obtained from drug utilization review program operations. The **Drug Use Review** Board shall have

an open professional consensus process for establishing and revising criteria and standards. Criteria and standards shall be available to the public. In developing recommendations for criteria and standards, the board shall establish an explicit ongoing process for soliciting and considering input from interested parties. The board shall make timely revisions to the criteria and standards based upon this input in addition to revisions based upon scheduled review of the criteria and standards. Further, the drug utilization review standards shall reflect the local practices of prescribers in order to monitor:

(A) Therapeutic appropriateness.

(B) Overutilization or underutilization.

(C) Therapeutic duplication.

(D) Drug-disease contraindications.

(E) Drug-drug interactions.

(F) Incorrect drug dosage or drug treatment duration.

(G) Clinical abuse or misuse.

(H) Drug allergies.

(d) Development, selection and application of and assessment for interventions for medical assistance program prescribers, dispensers and patients that are educational and not punitive in nature.

(2) In reviewing retrospective and prospective drug use, the **Drug Use Review** Board may consider only drugs that have received final approval from the federal Food and Drug Administration.

SECTION 66. ORS 414.365 is amended to read:

414.365. In addition to advising the [*Department of Human Services*] **Oregon Health Authority Board**, the Drug Use Review Board shall do the following subject to the approval of the [*Director of Human Services*] **Oregon Health Authority Board**:

(1) Publish an annual report, as described in ORS 414.415.

(2) Publish and disseminate educational information to prescribers and pharmacists regarding the **Drug Use Review** Board and the drug use review programs, including information on the following:

(a) Identifying and reducing the frequency of patterns of fraud, abuse or inappropriate or medically unnecessary care among prescribers, pharmacists and recipients.

(b) Potential or actual severe or adverse reactions to drugs.

(c) Therapeutic appropriateness.

(d) Overutilization or underutilization.

(e) Appropriate use of generic products.

(f) Therapeutic duplication.

(g) Drug-disease contraindications.

(h) Drug-drug interactions.

(i) Drug allergy interactions.

(j) Clinical abuse and misuse.

(3) Adopt and implement procedures designed to insure the confidentiality of any information collected, stored, retrieved, assessed or analyzed by the **Drug Use Review** Board, staff of the board or contractors to the drug use review programs that identifies individual prescribers, pharmacists or recipients.

SECTION 67. ORS 414.375 is amended to read:

414.375. The prospective drug use review program must be based on the guidelines established

by the [*Department of Human Services*] **Oregon Health Authority Board** in consultation with the Drug Use Review Board. The program must provide that prior to the prescription being filled or delivered a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from the following:

(1) Therapeutic duplication.

(2) Drug-drug interactions, including serious interactions with nonprescription or over-the-counter drugs.

(3) Incorrect dosage and duration of treatment.

(4) Drug-allergy interactions.

(5) Clinical abuse and misuse.

(6) Drug-disease contraindications.

SECTION 68. ORS 414.380 is amended to read:

414.380. The retrospective drug use review program must:

(1) Be based on the guidelines established by the [*Department of Human Services in consultation with*] **Oregon Health Authority Board based upon recommendations from** the Drug Use Review Board; and

(2) Use the mechanized drug claims processing and information retrieval system to analyze claims data on drug use against explicit predetermined standards that are based on the compendia and other sources to monitor the following:

(a) Therapeutic appropriateness.

(b) Overutilization or underutilization.

(c) Fraud and abuse.

(d) Therapeutic duplication.

(e) Drug-disease contraindications.

(f) Drug-drug interactions.

(g) Incorrect drug dosage or duration of drug treatment.

(h) Clinical abuse and misuse.

SECTION 69. ORS 414.390 is amended to read:

414.390. (1) Information collected under ORS 414.350 to 414.415 that identifies an individual is confidential and shall not be disclosed by the Drug Use Review Board, the retrospective drug use review program, [*or the Department of Human Services*] **the Oregon Health Authority Board or the Oregon Health Authority** to any person other than a health care provider appearing on a recipient's medication profile.

(2) The staff of the **Drug Use Review** Board may have access to identifying information for purposes of carrying out intervention activities. The identifying information shall not be released to anyone other than a staff member of the board, retrospective drug use review program, [*Department of Human Services*] **Oregon Health Authority Board, Oregon Health Authority**[,] or to any health care provider appearing on a recipient's medication profile or, for purposes of investigating potential fraud in programs administered by the [*Department of Human Services*] **Oregon Health Authority**, to the Department of Justice.

(3) The **Drug Use Review** Board may release cumulative, nonidentifying information for the purposes of legitimate research and for educational purposes.

SECTION 70. ORS 414.410 is amended to read:

414.410. The [*Department of Human Services*] **Oregon Health Authority** shall provide staff to the Drug Use Review Board.

SECTION 71. ORS 414.426 is amended to read:

414.426. The [*Department of Human Services*] **Oregon Health Authority** is hereby authorized to pay the cost of care for patients in institutions operated under ORS 179.321 under the medical assistance program established by ORS chapter 414.

SECTION 72. ORS 414.428 is amended to read:

414.428. (1) An individual described in ORS 414.025 (2)(r) who is eligible for or receiving medical assistance and who is an American Indian and Alaskan Native beneficiary shall receive the benefit package of health care services described in ORS [*414.835*] **414.707 (1)** if:

(a) The [*Department of Human Services*] **Oregon Health Authority** receives 100 percent federal medical assistance percentage for payments made by the [*department*] **authority** for the health care services provided as part of the benefit package described in ORS [*414.835 that are not included in the benefit package described in ORS 414.834*] **414.707 (1)**; or

(b) The [*department*] **authority** receives funding from the Indian tribes for which federal financial participation is available.

(2) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose.

SECTION 73. Section 2, chapter 76, Oregon Laws 2003, is amended to read:

Sec. 2. (1) Section 1**, chapter 76, Oregon Laws 2003,** [*of this 2003 Act*] becomes operative on the day after the date the [*Department of Human Services*] **Oregon Health Authority** receives approval from the federal Centers for Medicare and Medicaid Services to amend Oregon's Medicaid waiver.

(2) The [*Department of Human Services*] **authority** shall notify the Legislative Counsel upon receipt of approval or disapproval to amend Oregon's Medicaid waiver.

SECTION 74. ORS 414.534 is amended to read:

414.534. (1) The [*Department of Human Services*] **Oregon Health Authority** shall provide medical assistance to a woman who:

(a) Is screened for breast or cervical cancer through the Oregon Breast and Cervical Cancer Program operated by the [*department*] **authority**;

(b) As a result of a screening in accordance with paragraph (a) of this subsection, is found by a provider to be in need of treatment for breast or cervical cancer;

(c) Does not otherwise have creditable coverage, as defined in 42 U.S.C. 300gg(c); and

(d) Is 64 years of age or younger.

(2) The period of time a woman can receive medical assistance based on the eligibility criteria of subsection (1) of this section:

(a) Begins:

(A) On the date the Department **of Human Services** makes a formal determination that the woman is eligible for medical assistance in accordance with subsection (1) of this section; or

(B) Up to three months prior to the month in which the woman applied for medical assistance if on the earlier date the woman met the eligibility criteria of subsection (1) of this section.

(b) Ends when:

(A) The woman is no longer in need of treatment; or

(B) The department determines the woman no longer meets the eligibility criteria of subsection (1) of this section.

SECTION 75. ORS 414.536 is amended to read:

414.536. (1) **If** the Department of Human Services [*shall provide medical assistance to a woman whom the department determines is presumptively eligible for medical assistance. As used in this section, a woman is "presumptively eligible for medical assistance" if the department determines that the*] **determines that a** woman likely is eligible for medical assistance under ORS 414.534**, the department shall determine her to be presumptively eligible for medical assistance until a formal determination on eligibility is made**.

(2) The period of time a woman may receive medical assistance based on presumptive eligibility is limited. The period of time:

(a) Begins on the date that the department determines the woman likely meets the eligibility criteria under ORS 414.534; and

(b) Ends on the earlier of the following dates:

(A) If the woman applies for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the date on which a formal determination on eligibility is made by the department in accordance with ORS 414.534; or

(B) If the woman does not apply for medical assistance following the determination by the department that the woman is presumptively eligible for medical assistance, the last day of the month following the month in which presumptive eligibility begins.

SECTION 76. ORS 414.538 is amended to read:

414.538. (1) The Department of Human Services [*shall provide medical assistance under ORS 414.534 or 414.536 to a woman who meets general coverage requirements applicable to recipients of medical assistance. The department*] may not impose income or resource limitations or a prior period of uninsurance on a woman who otherwise qualifies for medical assistance under ORS 414.534 or 414.536.

(2) In [*providing*] **determining eligibility for** medical assistance under ORS 414.534 or 414.536, the department [*of Human Services*] shall give priority to low-income women.

SECTION 77. ORS 414.630 is amended to read:

414.630. (1) The [*Department of Human Services*] **Oregon Health Authority** shall execute prepaid capitated health service contracts for at least hospital or physician medical care, or both, with hospital and medical organizations, health maintenance organizations and any other appropriate public or private persons.

(2) For purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.640, instrumentalities and political subdivisions of the state are authorized to enter into prepaid capitated health service contracts with the [*Department of Human Services*] **Oregon Health Authority or the Oregon Health Authority Board** and shall not thereby be considered to be transacting insurance.

(3) In the event that there is an insufficient number of qualified bids for prepaid capitated health services contracts for hospital or physician medical care, or both, in some areas of the state, the [*department*] **Oregon Health Authority** may continue a fee for service payment system.

(4) Payments to providers may be subject to contract provisions requiring the retention of a specified percentage in an incentive fund or to other contract provisions by which adjustments to the payments are made based on utilization efficiency.

SECTION 78. ORS 414.640 is amended to read:

414.640. (1) Eligible persons shall select, to the extent practicable as determined by the [*De-*

partment of Human Services] **Oregon Health Authority**, from among available providers participating in the program.

(2) The [*department*] **authority** by rule shall define the circumstances under which it may choose to reimburse for any medical services not covered under the prepaid capitation or costs of related services provided by or under referral from any physician participating in the program in which the eligible person is enrolled.

(3) The [*department*] **authority** shall establish requirements as to the minimum time period that an eligible person is assigned to specific providers in the system.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this chapter in forming consortiums or in otherwise entering into contracts to provide medical care shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of ORS 279A.025, 279A.140, 414.145 and 414.610 to 414.640.

SECTION 79. ORS 414.707 is amended to read:

414.707. [*(1) Subject to funds available:*]

[*(a)*] **(1)** Persons [*who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706,*] **described in ORS 414.706 (1), (2), (3) and (5)** are eligible to receive all the health services approved and funded by the Legislative Assembly.

[*(b)*] **(2)** Persons described in ORS 414.708 are eligible to receive the health services described in ORS 414.705 (1)(c), (f) and (g).

[*(c) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 are eligible to receive the health services described in ORS 414.705 (1)(b) to (m).*]

[*(2) Persons who are categorically needy as described in ORS 414.025 (2)(n) and (o), and persons under 19 years of age and pregnant women who are eligible to receive health services under ORS 414.706, must be provided, at a minimum, the health services described in ORS 414.705 (1)(a) to (g).*]

[*(3) Persons 19 years of age and older who are eligible to receive health services under ORS 414.706 must be provided, at a minimum, health services described in ORS 414.705 (1)(b) to (h).*]

[*(4) Persons described in ORS 414.708 must be provided, at a minimum, the health services described in ORS 414.705 (1)(c).*]

[*(5) The Department of Human Services shall:*]

[*(a) Develop at least three benefit packages of provider services to be offered under ORS 414.705 (1)(j); and*]

[*(b) Define by rule the services to be offered under ORS 414.705 (1)(k).*]

[*(6) Notwithstanding ORS 414.735, the Legislative Assembly shall adjust health services funded under ORS 414.705 (1) by increasing or reducing benefit packages or health services and, subject to ORS 414.709, by increasing or reducing the population of eligible persons.*]

SECTION 80. ORS 414.708 is amended to read:

414.708. (1) A person is eligible to receive the health services described in ORS 414.707 [*(1)(b)*] **(2)** when the person is a resident of this state who:

(a) Is 65 years of age or older, or is blind or has a disability as those terms are defined in ORS 411.704;

(b) Has a gross annual income that does not exceed the standard established by the [*Department of Human Services*] **Oregon Health Authority Board**; and

(c) Is not covered under any public or private prescription drug benefit program.

(2) A person receiving prescription drug services under ORS 414.707 [*(1)(b)*] **(2)** shall pay up to a percentage of the Medicaid price of the prescription drug established by the [*department*] **authority** by rule and the dispensing fee.

SECTION 81. ORS 414.709 is amended to read:

414.709. (1) Except as provided in subsection (2) of this section, if insufficient resources are available during a biennium, the population of eligible persons receiving health services may not be reduced below the population of eligible persons approved and funded in the legislatively adopted budget for the [*Department of Human Services*] **Oregon Health Authority** for the biennium.

(2) The [*Department of Human Services*] **Oregon Health Authority** may periodically limit enrollment of persons described in ORS 414.708 in order to stay within the legislatively adopted budget for the [*department*] **authority**.

SECTION 82. ORS 414.710 is amended to read:

414.710. The following services [*are available to persons eligible for services under ORS 414.025, 414.036, 414.042, 414.065 and 414.705 to 414.750 but such services*] are not subject to ORS 414.720:

(1) Nursing facilities and home- and community-based waivered services funded through the Department of Human Services; **and**

[*(2) Medical assistance to eligible persons who receive assistance under ORS 411.706 or to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460;*]

[*(3) Institutional, home- and community-based waivered services or community mental health program care for persons with mental retardation, developmental disabilities or severe mental illness and for the treatment of alcohol and drug dependent persons; and*]

[*(4)*] **(2)** Services to children who are wards of the Department of Human Services by order of the juvenile court and services to children and families for health care or mental health care through the department.

SECTION 83. ORS 414.712 is amended to read:

414.712. The [*Department of Human Services*] **Oregon Health Authority** shall provide medical assistance under ORS 414.705 to 414.750 to eligible persons who [*receive assistance under*] **are determined eligible for medical assistance by the Department of Human Services according to** ORS 411.706**.** [*and to children described in ORS 414.025 (2)(f), (i), (j), (k) and (m), 418.001 to 418.034, 418.189 to 418.970 and 657A.020 to 657A.460 and those mental health and chemical dependency services recommended according to standards of medical assistance and according to the schedule of implementation established by the Legislative Assembly. In providing medical assistance services described in ORS 414.018 to 414.024, 414.042, 414.107, 414.710, 414.720 and 735.712, the Department of Human Services*] **The Oregon Health Authority** shall also provide the following:

(1) Ombudsman services for eligible persons who receive assistance under ORS 411.706. With the concurrence of the Governor **and the Oregon Health Authority Board**, the Director of [*Human Services*] **the Oregon Health Authority** shall appoint ombudsmen and may terminate an ombudsman. Ombudsmen are under the supervision and control of the director. An ombudsman shall serve as a patient's advocate whenever the patient or a physician or other medical personnel serving the patient is reasonably concerned about access to, quality of or limitations on the care being provided by a health care provider. Patients shall be informed of the availability of an ombudsman. Ombudsmen shall report to the Governor **and the Oregon Health Authority Board** in writing at least once each quarter. A report shall include a summary of the services that the ombudsman provided during the quarter and the ombudsman's recommendations for improving ombudsman ser-

vices and access to or quality of care provided to eligible persons by health care providers.

(2) Case management services in each health care provider organization for those eligible persons who receive assistance under ORS 411.706. Case managers shall be trained in and shall exhibit skills in communication with and sensitivity to the unique health care needs of people who receive assistance under ORS 411.706. Case managers shall be reasonably available to assist patients served by the organization with the coordination of the patient's health care services at the reasonable request of the patient or a physician or other medical personnel serving the patient. Patients shall be informed of the availability of case managers.

(3) A mechanism, established by rule, for soliciting consumer opinions and concerns regarding accessibility to and quality of the services of each health care provider.

(4) A choice of available medical plans and, within those plans, choice of a primary care provider.

(5) Due process procedures for any individual whose request for medical assistance coverage for any treatment or service is denied or is not acted upon with reasonable promptness. These procedures shall include an expedited process for cases in which a patient's medical needs require swift resolution of a dispute.

SECTION 84. ORS 414.725 is amended to read:

414.725. (1)(a) Pursuant to rules adopted by the [*Department of Human Services*] **Oregon Health Authority**, the [*department*] **authority** shall execute prepaid managed care health services contracts for health services funded by the Legislative Assembly. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the [*department*] **authority** shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the state use, to the greatest extent possible, prepaid managed care health services organizations to provide physical health, dental, mental health and chemical dependency services under ORS 414.705 to 414.750.

(c) The [*department*] **authority** shall solicit qualified providers or plans to be reimbursed for providing the covered services. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private prepaid managed care health services organization. The [*department*] **authority** may not discriminate against any contractors that offer services within their providers' lawful scopes of practice.

(d) The [*department*] **authority** shall establish annual financial reporting requirements for prepaid managed care health services organizations. The [*department*] **authority** shall prescribe a reporting procedure that elicits sufficiently detailed information for the [*department*] **authority** to assess the financial condition of each prepaid managed care health services organization and that includes information on the three highest executive salary and benefit packages of each prepaid managed care health services organization.

(e) The [*department*] **authority** shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with a prepaid managed care health services organization.

(2) The [*department*] **authority** may institute a fee-for-service case management system or a fee-for-service payment system for the same physical health, dental, mental health or chemical de-

pendency services provided under the health services contracts for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state in which a prepaid managed care health services organization is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee. In addition, the [*department*] **authority** may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop-loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the [*department*] **authority** for health services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for health services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting to provide services under ORS 414.705 to 414.750 shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) A prepaid managed care health services organization shall provide information on contacting available providers to an enrollee in writing within 30 days of assignment to the health services organization.

(7) Each prepaid managed care health services organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to enrollees.

(8) A prepaid managed care health services organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

SECTION 85. ORS 414.727 is amended to read:

414.727. (1) A prepaid managed care health services organization, as defined in ORS 414.736, that contracts with the [*Department of Human Services*] **Oregon Health Authority** under ORS 414.725 (1) to provide prepaid managed care health services, including hospital services, shall reimburse Type A and Type B hospitals and rural critical access hospitals, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals, fully for the cost of covered services based on the cost-to-charge ratio used for each hospital in setting the capitation rates paid to the prepaid managed care health services organization for the contract period.

(2) The [*department*] **authority** shall base the capitation rates described in subsection (1) of this section on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

(3) This section may not be construed to prohibit a prepaid managed care health services organization and a hospital from mutually agreeing to reimbursement other than the reimbursement specified in subsection (1) of this section.

(4) Hospitals reimbursed under subsection (1) of this section are not entitled to any additional reimbursement for services provided.

SECTION 86. ORS 414.728 is amended to read:

414.728. For services provided to persons who are entitled to receive medical assistance and whose medical assistance benefits are not administered by a prepaid managed care health services organization, as defined in ORS 414.736, the [*Department of Human Services*] **Oregon Health Authority** shall reimburse Type A and Type B hospitals and rural critical access hospitals, as described in ORS 442.470 and identified by the Office of Rural Health as rural hospitals, fully for the cost of covered services based on the most recent audited Medicare cost report for Oregon hospitals adjusted to reflect the Medicaid mix of services.

SECTION 87. ORS 414.735 is amended to read:

414.735. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important.

(3) The [*Department of Human Services*] **Oregon Health Authority Board** shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under ORS 414.705 to 414.750 must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

SECTION 88. ORS 414.736 is amended to read:

414.736. As used in this section and ORS 414.725, 414.737, 414.738, 414.739, 414.740, 414.741, 414.742[,] **and** 414.743 [*and 414.744*]:

(1) "Designated area" means a geographic area of the state defined by the [*Department of Human Services*] **Oregon Health Authority** by rule that is served by a prepaid managed care health services organization.

(2) "Fully capitated health plan" means an organization that contracts with the [*Department of Human Services*] **Oregon Health Authority or the Oregon Health Authority Board** on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services provided under the contract are reasonably accessible to enrollees.

(3) "Physician care organization" means an organization that contracts with the [*Department of Human Services*] **Oregon Health Authority or the Oregon Health Authority Board** on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that the health services described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j) are reasonably accessible to enrollees. A physician care organization may also contract with the [*department*] **authority or the board** on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L).

(4) "Prepaid managed care health services organization" means a managed physical health, dental, mental health or chemical dependency organization that contracts with the [*Department of Human Services*] **authority or the board** on a prepaid capitated basis under ORS 414.725. A prepaid managed care health services organization may be a dental care organization, fully capitated health plan, physician care organization, mental health organization or chemical dependency organization.

SECTION 89. ORS 414.737 is amended to read:

414.737. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750 must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

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

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the [*department*] **Oregon Health Authority** may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs; and

(E) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.

(4) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose.

SECTION 90. ORS 414.737, as amended by section 8, chapter 751, Oregon Laws 2007, is amended to read:

414.737. (1) Except as provided in subsections (2) and (3) of this section, a person who is eligible for or receiving physical health, dental, mental health or chemical dependency services under ORS 414.705 to 414.750 must be enrolled in the prepaid managed care health services organizations to receive the health services for which the person is eligible.

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

(a) A person who is a noncitizen and who is eligible only for labor and delivery services and emergency treatment services;

(b) A person who is an American Indian and Alaskan Native beneficiary; and

(c) A person whom the [*department*] **Oregon Health Authority** may by rule exempt from the mandatory enrollment requirement of subsection (1) of this section, including but not limited to:

(A) A person who is also eligible for Medicare;

(B) A woman in her third trimester of pregnancy at the time of enrollment;

(C) A person under 19 years of age who has been placed in adoptive or foster care out of state;

(D) A person under 18 years of age who is medically fragile and who has special health care needs;

(E) A person receiving services under the Medically Involved Home-Care Program created by ORS 417.345 (1); and

(F) A person with major medical coverage.

(3) Subsection (1) of this section does not apply to a person who resides in a designated area in which a prepaid managed care health services organization providing physical health, dental, mental health or chemical dependency services is not able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health, dental, mental health or chemical dependency services provided to the enrollee.

(4) As used in this section, "American Indian and Alaskan Native beneficiary" means:

(a) A member of a federally recognized Indian tribe, band or group;

(b) An Eskimo or Aleut or other Alaskan Native enrolled by the United States Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601; or

(c) A person who is considered by the United States Secretary of the Interior to be an Indian for any purpose.

SECTION 91. ORS 414.738 is amended to read:

414.738. (1) If the [*Department of Human Services*] **Oregon Health Authority** has not been able to contract with the fully capitated health plan or plans in a designated area, the [*department*] **authority** may contract with a physician care organization in the designated area.

(2) The Office for Oregon Health Policy and Research shall develop criteria that the [*department*] **authority** shall consider when determining the circumstances under which the [*department*] **authority** may contract with a physician care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The physician care organization must be able to assign an enrollee to a person or entity that is primarily responsible for coordinating the physical health services provided to the enrollee;

(b) The contract with a physician care organization does not threaten the financial viability of other fully capitated health plans in the designated area; and

(c) The contract with a physician care organization must be consistent with the legislative intent of using prepaid managed care health services organizations to provide services under ORS 414.705 to 414.750.

SECTION 92. ORS 414.739 is amended to read:

414.739. (1) A fully capitated health plan may apply to the [*Department of Human Services*] **Oregon Health Authority** to contract with the [*department*] **authority** as a physician care organization rather than as a fully capitated health plan to provide services under ORS 414.705 to 414.750.

(2) The Office for Oregon Health Policy and Research shall develop the criteria that the [*department*] **authority** must use to determine the circumstances under which the [*department*] **authority** may accept an application by a fully capitated health plan to contract as a physician care organization. The criteria developed by the office shall include but not be limited to the following:

(a) The fully capitated health plan must show documented losses due to hospital risk and must show due diligence in managing those risks; and

(b) Contracting as a physician care organization is financially viable for the fully capitated health plan.

SECTION 93. ORS 414.740 is amended to read:

414.740. (1) Notwithstanding ORS 414.738 (1), the [*Department of Human Services*] **Oregon Health Authority** shall contract under ORS 414.725 with a prepaid group practice health plan that serves at least 200,000 members in this state and that has been issued a certificate of authority by

the [*Department of Consumer and Business Services*] **authority** as a health care service contractor to provide health services as described in ORS 414.705 (1)(b), (c), (d), (e), (g) and (j). A health plan may also contract with the [*Department of Human Services*] **authority** on a prepaid capitated basis to provide the health services described in ORS 414.705 (1)(k) and (L). The [*Department of Human Services*] **authority** may accept financial contributions from any public or private entity to help implement and administer the contract. The [*Department of Human Services*] **authority** shall seek federal matching funds for any financial contributions received under this section.

(2) In a designated area, in addition to the contract described in subsection (1) of this section, the [*Department of Human Services*] **authority** shall contract with prepaid managed care health services organizations to provide health services under ORS 414.705 to 414.750.

SECTION 94. ORS 414.741 is amended to read:

414.741. (1) The Health Services Commission shall retain an actuary to determine the benchmark for setting per capita rates necessary to reimburse prepaid managed care health services organizations and fee-for-service providers for the cost of providing health services under ORS 414.705 to 414.750.

(2) The actuary retained by the commission shall use the following information to determine the benchmark for setting per capita rates:

(a) For hospital services, the most recently available Medicare cost reports for Oregon hospitals;

(b) For services of physicians licensed under ORS chapter 677 and other health professionals using procedure codes, the Medicare Resource Based Relative Value system conversion rates for Oregon;

(c) For prescription drugs, the most recent payment methodologies in the fee-for-service payment system for the Oregon Health Plan;

(d) For durable medical equipment and supplies, 80 percent of the Medicare allowable charge for purchases and rentals;

(e) For dental services, the most recent payment rates obtained from dental care organization encounter data; and

(f) For all other services not listed in paragraphs (a) to (e) of this subsection:

(A) The Medicare maximum allowable charge, if available; or

(B) The most recent payment rates obtained from the data available under subsection (3) of this section.

(3) The actuary shall use the most current encounter data and the most current fee-for-service data that is available, reasonable trends for utilization and cost changes to the midpoint of the next biennium, appropriate differences in utilization and cost based on geography, state and federal mandates and other factors that, in the professional judgment of the actuary, are relevant to the fair and reasonable estimation of costs. The Department of Human Services shall provide the actuary with the data and information in the possession of the department or contractors of the department reasonably necessary to develop a benchmark for setting per capita rates.

(4) The commission shall report the benchmark per capita rates developed under this section to the Director of the Oregon Department of Administrative Services, the Director of [*Human Services*] **the Oregon Health Authority** and the Legislative Fiscal Officer no later than August 1 of every even-numbered year.

(5) The [*Department of Human Services*] **Oregon Health Authority** shall retain an actuary to determine:

(a) Per capita rates for health services that the [*department*] **authority** shall use to develop the

[*department's*] **authority's** proposed biennial budget; and

(b) Capitation rates to reimburse physician care organizations for the cost of providing health services under ORS 414.705 to 414.750 using the same methodologies used to develop capitation rates for fully capitated health plans. The rates may not advantage or disadvantage fully capitated health plans for similar services.

(6) The [*Department of Human Services*] **Oregon Health Authority** shall submit to the Legislative Assembly no later than February 1 of every odd-numbered year a report comparing the per capita rates for health services on which the proposed budget of the [*department*] **authority** is based with the rates developed by the actuary retained by the Health Services Commission. If the rates differ, the [*department*] **authority** shall disclose, by provider categories described in subsection (2) of this section, the amount of and reason for each variance.

SECTION 95. ORS 414.742 is amended to read:

414.742. The [*Department of Human Services*] **Oregon Health Authority** may not establish capitation rates that include payment for mental health drugs. The [*department*] **authority** shall reimburse pharmacy providers for mental health drugs only on a fee-for-service payment basis.

SECTION 96. ORS 414.743 is amended to read:

414.743. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the [*Department of Human Services*] **Oregon Health Authority** on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services at 80 percent of the Medicare rate for the noncontracting hospital.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full the rates described in subsection (2) of this section.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(5) The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules to implement and administer this section.

SECTION 97. ORS 414.743, as amended by section 2, chapter 886, Oregon Laws 2007, is amended to read:

414.743. (1) As used in this section, "fully capitated health plan" means an organization that contracts with the [*Department of Human Services*] **Oregon Health Authority** on a prepaid capitated basis under ORS 414.725 to provide an adequate network of providers to ensure that all health services described in ORS 414.705 are reasonably accessible to enrollees.

(2) A fully capitated health plan that does not have a contract with a hospital to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must pay for hospital services as follows:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(3) A hospital that does not have a contract with a fully capitated health plan to provide inpatient or outpatient hospital services under ORS 414.705 to 414.750 must accept as payment in full for hospital services, rates:

(a) For inpatient hospital services, based on the capitation rates developed for the budget period, at the level of the statewide average unit cost, multiplied by the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(b) For outpatient hospital services, based on the capitation rates developed for the budget period, at the level of charges multiplied by the statewide average cost-to-charge ratio, the geographic factor, the payment discount factor and an adjustment factor of 0.925.

(4) This section does not apply to type A and type B hospitals, as described in ORS 442.470, and rural critical access hospitals, as defined in ORS 315.613.

(5) The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules to implement and administer this section.

SECTION 98. Section 18, chapter 810, Oregon Laws 2003, is amended to read:

Sec. 18. [*(1)*] Except as provided in section 19 [*of this 2003 Act*], **chapter 810, Oregon Laws 2003,** sections 2, 3, 5, 5a, 11, 12, 12a, 14 and 15 [*of this 2003 Act*], **chapter 810, Oregon Laws 2003,** and the amendments to ORS 414.705 and 414.725 by sections 4 and 7 [*of this 2003 Act*]**, chapter 810, Oregon Laws 2003,** become operative on October 1, 2003.

[*(2) Sections 10 and 13 of this 2003 Act become operative on the day after the date the Department of Human Services receives the necessary waivers from the Centers for Medicare and Medicaid Services.*]

[*(3) The Director of Human Services shall notify the Legislative Counsel upon receipt of the waivers or denial of the waiver request.*]

SECTION 99. ORS 414.750 is amended to read:

414.750. Nothing in ORS [*414.036 and*] 414.705 to 414.750 is intended to limit the authority of the Legislative Assembly to authorize services for persons whose income exceeds 100 percent of the federal poverty level for whom federal medical assistance matching funds are available if state funds are available therefor.

SECTION 100. ORS 414.751 is amended to read:

414.751. (1) There is established in the [*Office for Oregon Health Policy and Research*] **Oregon Health Authority** the Office for Oregon Health Policy and Research Advisory Committee composed of members appointed by the Governor. Members shall include:

(a) Representatives of managed care health services organizations under contract with the [*Department of Human Services*] **Oregon Health Authority** pursuant to ORS 414.725 and serving primarily rural areas of the state;

(b) Representatives of managed care health services organizations under contract with the [*Department of Human Services*] **Oregon Health Authority** pursuant to ORS 414.725 and serving primarily urban areas of the state;

(c) Representatives of medical organizations representing health care providers under contract with managed care health services organizations pursuant to ORS 414.725 who serve patients in both rural and urban areas of the state; **and**

(d) One representative from Type A hospitals and one representative from Type B hospitals.[*; and*]

[*(e) Representatives of the Department of Human Services.*]

(2) Members of the advisory committee shall not be entitled to compensation or per diem.

SECTION 101. ORS 414.805 is amended to read:

414.805. (1) An individual who receives medical services while in the custody of a law enforcement officer is liable:

(a) To the provider of the medical services for the charges and expenses therefor; and

(b) To the [*Department of Human Services*] **Oregon Health Authority** for any charges or expenses paid by the [*Department of Human Services*] **authority** out of the Law Enforcement Medical Liability Account for the medical services.

(2) A person providing medical services to an individual described in subsection (1)(a) of this section shall first make reasonable efforts to collect the charges and expenses thereof from the individual before seeking to collect them from the [*Department of Human Services*] **authority** out of the Law Enforcement Medical Liability Account.

(3)(a) If the provider has not been paid within 45 days of the date of the billing, the provider may bill the [*Department of Human Services*] **authority** who shall pay the account out of the Law Enforcement Medical Liability Account.

(b) A bill submitted to the [*Department of Human Services*] **authority** under this subsection must be accompanied by evidence documenting that:

(A) The provider has billed the individual or the individual's insurer or health care service contractor for the charges or expenses owed to the provider; and

(B) The provider has made a reasonable effort to collect from the individual or the individual's insurer or health care service contractor the charges and expenses owed to the provider.

(c) If the provider receives payment from the individual or the insurer or health care service contractor after receiving payment from the [*Department of Human Services*] **authority**, the provider shall repay the [*department*] **authority** the amount received from the public agency less any difference between payment received from the individual, insurer or contractor and the amount of the billing.

(4) As used in this section:

(a) "Law enforcement officer" means an officer who is commissioned and employed by a public agency as a peace officer to enforce the criminal laws of this state or laws or ordinances of a public agency.

(b) "Public agency" means the state, a city, port, school district, mass transit district or county.

SECTION 102. ORS 414.807 is amended to read:

414.807. (1)(a) When charges and expenses are incurred for medical services provided to an individual for injuries related to law enforcement activity and subject to the availability of funds in the account, the cost of such services shall be paid by the [*Department of Human Services*] **Oregon Health Authority** out of the Law Enforcement Medical Liability Account established in ORS 414.815 if the provider of the medical services has made all reasonable efforts to collect the amount, or any part thereof, from the individual who received the services.

(b) When a law enforcement agency involved with an injury certifies that the injury is related to law enforcement activity, the [*Department of Human Services*] **Oregon Health Authority** shall pay the provider:

(A) If the provider is a hospital, in accordance with current fee schedules established by the Director of the Department of Consumer and Business Services for purposes of workers' compensation under ORS 656.248; or

(B) If the provider is other than a hospital, 75 percent of the customary and usual rates for the services.

(2) After the injured person is incarcerated and throughout the period of incarceration, the [*Department of Human Services*] **Oregon Health Authority** shall continue to pay, out of the Law Enforcement Medical Liability Account, charges and expenses for injuries related to law enforcement activities as provided in subsection (1) of this section. Upon release of the injured person from actual physical custody, the Law Enforcement Medical Liability Account is no longer liable for the payment of medical expenses of the injured person.

(3) If the provider of medical services has filed a medical services lien as provided in ORS 87.555, the [*Department of Human Services*] **Oregon Health Authority** shall be subrogated to the rights of the provider to the extent of payments made by the [*Department of Human Services*] **authority** to the provider for the medical services. The [*Department of Human Services*] **authority** may foreclose the lien as provided in ORS 87.585.

(4) The [*Department of Human Services*] **authority** shall deposit in the Law Enforcement Medical Liability Account all moneys received by the [*department*] **authority** from:

(a) Providers of medical services as repayment;

(b) Individuals whose medical expenses were paid by the [*department*] **authority** under this section; and

(c) Foreclosure of a lien as provided in subsection (3) of this section.

(5) As used in this section:

(a) "Injuries related to law enforcement activity" means injuries sustained prior to booking, citation in lieu of arrest or release instead of booking that occur during and as a result of efforts by a law enforcement officer to restrain or detain, or to take or retain custody of, the individual.

(b) "Law enforcement officer" has the meaning given that term in ORS 414.805.

SECTION 103. ORS 414.815 is amended to read:

414.815. (1) The Law Enforcement Medical Liability Account is established separate and distinct from the General Fund. Interest earned, if any, shall inure to the benefit of the account. The moneys in the Law Enforcement Medical Liability Account are appropriated continuously to the [*Department of Human Services*] **Oregon Health Authority** to pay expenses in administering the account and paying claims out of the account as provided in ORS 414.807.

(2) The liability of the Law Enforcement Medical Liability Account is limited to funds accrued to the account from assessments collected under ORS 137.309 (6), (8) or (9), or collected from individuals under ORS 414.805.

(3) The [*Department of Human Services*] **authority** may contract with persons experienced in medical claims processing to provide claims processing for the account.

(4) The [*Department of Human Services*] **authority** shall adopt rules to implement administration of the Law Enforcement Medical Liability Account including, but not limited to, rules that establish reasonable deadlines for submission of claims.

(5) Each biennium, the [*Department of Human Services*] **Oregon Health Authority** shall submit a report to the Legislative Assembly regarding the status of the Law Enforcement Medical Liability Account. Within 30 days of the convening of each regular legislative session, the [*department*] **authority** shall submit the report to the chair of the Senate Judiciary Committee and the chair of the House Judiciary Committee. The report shall include, but is not limited to, the number of claims submitted and paid during the biennium and the amount of money in the fund at the time of the report.

SECTION 104. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Department of Human Services*] **Oregon Health Authority**

the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission and the Oregon Health Fund Board.

SECTION 105. ORS 442.011, as amended by section 15, chapter 697, Oregon Laws 2007, is amended to read:

442.011. [*(1)*] There is created in the [*Department of Human Services*] **Oregon Health Authority** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

[*(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission.*]

SECTION 106. ORS 442.015 is amended to read:

442.015. As used in ORS chapter 441 and this chapter, unless the context requires otherwise:

(1) "Acquire" or "acquisition" means obtaining equipment, supplies, components or facilities by any means, including purchase, capital or operating lease, rental or donation, with intention of using such equipment, supplies, components or facilities to provide health services in Oregon. When equipment or other materials are obtained outside of this state, acquisition is considered to occur when the equipment or other materials begin to be used in Oregon for the provision of health services or when such services are offered for use in Oregon.

(2) "Adjusted admission" means the sum of all inpatient admissions divided by the ratio of inpatient revenues to total patient revenues.

(3) "Affected persons" has the same meaning as given to "party" in ORS 183.310.

(4) "Ambulatory surgical center" means a facility that performs outpatient surgery not routinely or customarily performed in a physician's or dentist's office, and is able to meet health facility licensure requirements.

(5) "Audited actual experience" means data contained within financial statements examined by an independent, certified public accountant in accordance with generally accepted auditing standards.

(6) "Budget" means the projections by the hospital for a specified future time period of expenditures and revenues with supporting statistical indicators.

(7) "Case mix" means a calculated index for each hospital, based on financial accounting and case mix data collection as set forth in ORS 442.425, reflecting the relative costliness of that hos-

pital's mix of cases compared to a state or national mix of cases.

[*(8) "Commission" means the Oregon Health Policy Commission.*]

[*(9) "Department" means the Department of Human Services of the State of Oregon.*]

[*(10)*] **(8)** "Develop" means to undertake those activities that on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation, as defined under applicable state law, in relation to the offering of such a health service.

[*(11) "Director" means the Director of Human Services.*]

[*(12)*] **(9)** "Expenditure" or "capital expenditure" means the actual expenditure, an obligation to an expenditure, lease or similar arrangement in lieu of an expenditure, and the reasonable value of a donation or grant in lieu of an expenditure but not including any interest thereon.

[*(13)*] **(10)** "Freestanding birthing center" means a facility licensed for the primary purpose of performing low risk deliveries.

[*(14)*] **(11)** "Governmental unit" means the state, or any county, municipality or other political subdivision, or any related department, division, board or other agency.

[*(15)*] **(12)** "Gross revenue" means the sum of daily hospital service charges, ambulatory service charges, ancillary service charges and other operating revenue. "Gross revenue" does not include contributions, donations, legacies or bequests made to a hospital without restriction by the donors.

[*(16)(a)*] **(13)(a)** "Health care facility" means a hospital, a long term care facility, an ambulatory surgical center, a freestanding birthing center or an outpatient renal dialysis facility.

(b) "Health care facility" does not mean:

(A) An establishment furnishing residential care or treatment not meeting federal intermediate care standards, not following a primarily medical model of treatment, prohibited from admitting persons requiring 24-hour nursing care and licensed or approved under the rules of the Department of Human Services or the Department of Corrections; or

(B) An establishment furnishing primarily domiciliary care.

[*(17)*] **(14)** "Health maintenance organization" or "HMO" means a public organization or a private organization organized under the laws of any state that:

(a) Is a qualified HMO under section 1310 (d) of the U.S. Public Health Services Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of the basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis; and

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

[*(18)*] **(15)** "Health services" means clinically related diagnostic, treatment or rehabilitative services, and includes alcohol, drug or controlled substance abuse and mental health services that may be provided either directly or indirectly on an inpatient or ambulatory patient basis.

[*(19)*] **(16)** "Hospital" means a facility with an organized medical staff, with permanent facilities that include inpatient beds and with medical services, including physician services and continuous nursing services under the supervision of registered nurses, to provide diagnosis and medical or surgical treatment primarily for but not limited to acutely ill patients and accident victims, to provide treatment for patients with mental illness or to provide treatment in special inpatient care facilities.

[*(20)*] **(17)** "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which such services are provided.

[*(21)*] **(18)** "Intermediate care facility" means a facility that provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services above the level of room and board that can be made available to them only through institutional facilities.

[*(22)*] **(19)** "Long term care facility" means a facility with permanent facilities that include inpatient beds, providing medical services, including nursing services but excluding surgical procedures except as may be permitted by the rules of the Director **of Human Services**, to provide treatment for two or more unrelated patients. "Long term care facility" includes skilled nursing facilities and intermediate care facilities but may not be construed to include facilities licensed and operated pursuant to ORS 443.400 to 443.455.

[*(23)*] **(20)** "Major medical equipment" means medical equipment that is used to provide medical and other health services and that costs more than $1 million. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under Title XVIII of the Social Security Act to meet the requirements of paragraphs (10) and (11) of section 1861(s) of that Act.

[*(24)*] **(21)** "Net revenue" means gross revenue minus deductions from revenue.

[*(25)*] **(22)** "New hospital" means a facility that did not offer hospital services on a regular basis within its service area within the prior 12-month period and is initiating or proposing to initiate such services. "New hospital" also includes any replacement of an existing hospital that involves a substantial increase or change in the services offered.

[*(26)*] **(23)** "New skilled nursing or intermediate care service or facility" means a service or facility that did not offer long term care services on a regular basis by or through the facility within the prior 12-month period and is initiating or proposing to initiate such services. "New skilled nursing or intermediate care service or facility" also includes the rebuilding of a long term care facility, the relocation of buildings that are a part of a long term care facility, the relocation of long term care beds from one facility to another or an increase in the number of beds of more than 10 or 10 percent of the bed capacity, whichever is the lesser, within a two-year period.

[*(27)*] **(24)** "Offer" means that the health care facility holds itself out as capable of providing, or as having the means for the provision of, specified health services.

[*(28)*] **(25)** "Operating expenses" means the sum of daily hospital service expenses, ambulatory service expenses, ancillary expenses and other operating expenses, excluding income taxes.

[*(29)*] **(26)** "Outpatient renal dialysis facility" means a facility that provides renal dialysis services directly to outpatients.

[*(30)*] **(27)** "Person" means an individual, a trust or estate, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state, or a political subdivision

or instrumentality, including a municipal corporation, of a state.

[*(31)*] **(28)** "Skilled nursing facility" means a facility or a distinct part of a facility, that is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or an institution that provides rehabilitation services for the rehabilitation of individuals who are injured or sick or who have disabilities.

[*(32)*] **(29)** "Special inpatient care facility" means a facility with permanent inpatient beds and other facilities designed and utilized for special health care purposes, including but not limited to a rehabilitation center, a college infirmary, a chiropractic facility, a facility for the treatment of alcoholism or drug abuse, an inpatient care facility meeting the requirements of ORS 441.065, and any other establishment falling within a classification established by the [*Department of Human Services*] **Oregon Health Authority**, after determination of the need for such classification and the level and kind of health care appropriate for such classification.

[*(33)*] **(30)** "Total deductions from gross revenue" or "deductions from revenue" means reductions from gross revenue resulting from inability to collect payment of charges. Such reductions include bad debts, contractual adjustments, uncompensated care, administrative, courtesy and policy discounts and adjustments and other such revenue deductions. The deduction shall be net of the offset of restricted donations and grants for indigent care.

SECTION 107. ORS 735.610 is amended to read:

735.610. (1) There is created in the [*Department of Consumer and Business Services*] **Oregon Health Authority** the Oregon Medical Insurance Pool Board. The board shall establish the Oregon Medical Insurance Pool and otherwise carry out the responsibilities of the board under ORS 735.600 to 735.650.

(2) The board shall consist of nine individuals, eight of whom shall be appointed by the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority**. The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** or the director's designee shall be a member of the board. The chair of the board shall be elected from among the members of the board. The board shall at all times, to the extent possible, include at least one representative of a domestic insurance company licensed to transact health insurance, one representative of a domestic not-for-profit health care service contractor, one representative of a health maintenance organization, one representative of reinsurers and two members of the general public who are not associated with the medical profession, a hospital or an insurer.

(3) The director may fill any vacancy on the board by appointment.

(4) The board shall have the general powers and authority granted under the laws of this state to insurance companies with a certificate of authority to transact health insurance and the specific authority to:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 735.600 to 735.650 including the authority to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Recover any assessments for, on behalf of, or against insurers;

(c) Take such legal action as is necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, insurance producers' referral fees, claim reserves or formulas and perform any other actuarial function appropriate to the operation of the pool. Rates may not be unreasonable in relation to the coverage

provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(e) Issue policies of insurance in accordance with the requirements of ORS 735.600 to 735.650;

(f) Appoint from among insurers appropriate actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the board;

(g) Seek advances to effect the purposes of the pool; and

(h) Establish rules, conditions and procedures for reinsuring risks under ORS 735.600 to 735.650.

(5) Each member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(6) The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt rules, as provided under ORS chapter 183, implementing policies recommended by the board for the purpose of carrying out ORS 735.600 to 735.650.

(7) In consultation with the board, the director shall employ such staff and consultants as may be necessary for the purpose of carrying out responsibilities under ORS 735.600 to 735.650.

SECTION 108. ORS 735.612 is amended to read:

735.612. (1) There is established in the State Treasury, the Oregon Medical Insurance Pool Account, which shall consist of:

(a) Moneys appropriated to the account by the Legislative Assembly to obtain the coverage described in ORS 735.625.

(b) Interest earnings from the investment of moneys in the account.

(c) Assessments and other revenues collected or received by the Oregon Medical Insurance Pool Board.

(2) All moneys in the Oregon Medical Insurance Pool Account are continuously appropriated to the Oregon Medical Insurance Pool Board to carry out the provisions of ORS 735.600 to 735.650.

(3) The Oregon Medical Insurance Pool Board shall transfer to the [*Consumer and Business Services Fund created by ORS 705.145*] **Oregon Health Authority Fund established in section 19 of this 2009 Act** an amount equal to the operating budget authorized by the Legislative Assembly or as that budget may be modified by the Emergency Board or the Oregon Department of Administrative Services, for operation of the Oregon Medical Insurance Pool Board.

SECTION 109. ORS 735.614 is amended to read:

735.614. (1) If the Oregon Medical Insurance Pool Board determines at any time that funds in the Oregon Medical Insurance Pool Account are or will become insufficient for payment of expenses of the pool in a timely manner, the board shall determine the amount of funds needed and shall impose and collect assessments against insurers, as provided in this section, in the amount of the funds determined to be needed.

(2) Each insurer's assessment shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of Oregon insureds and certificate holders insured or reinsured by each insurer, and the denominator of which equals the total of all Oregon insureds and certificate holders insured or reinsured by all insurers, all determined as of March 31 each year.

(3) The board shall ensure that each insured and certificate holder is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains re-

insurance for its insureds and certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or part. The board shall allow an insurer who is a reinsurer to exclude from its number of insureds those that have been counted by the primary insurer or the primary reinsurer for the purpose of determining its assessment under this subsection.

(4) Each insurer shall pay its assessment as required by the board.

(5) If assessments exceed the amounts actually needed, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future net losses or to reduce pool premiums. For purposes of this subsection, "future net losses" includes reserves for claims incurred but not reported.

(6) Each insurer's proportion of participation in the pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the insurer with the board. The board may use any reasonable method of estimating the number of insureds and certificate holders of an insurer if the specific number is unknown. With respect to insurers that are reinsurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer.

(7) The board may abate or defer, in whole or in part, the assessment of an insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations. In the event an assessment against an insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers in a manner consistent with the basis for assessments set forth in this section. The insurer receiving the abatement or deferment shall remain liable to the board for the deficiency for four years.

(8) The board shall abate or defer assessments authorized by this section if a court orders that assessments cannot be made applicable to reinsurers. However, if a court orders that assessments cannot be made applicable to reinsurers, the board may continue to assess insurers to the end of the biennium in which the determination is made.

(9) Subject to the approval of the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority**, the board may develop a program for adjusting the assessment of an insurer in the individual health benefits market based on that insurer's contribution to reducing the enrollment in the Oregon Medical Insurance Pool. When developing the program, the board may consider, but is not limited to, the following factors:

(a) The insurer's level of participation;

(b) Level of health benefit plan coverage offered; and

(c) Assumption of risk in the individual health benefits market.

SECTION 110. ORS 735.630 is amended to read:

735.630. Neither participation in the pool as members, the establishment of rates, forms or procedures, nor any other action taken in the performance of the powers and duties under ORS 735.600 to 735.650 shall be the basis of any legal action, criminal or civil liability or penalty against the Oregon Medical Insurance Pool Board, any members, the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** or any of their agents or employees.

SECTION 111. ORS 735.700 is amended to read:

735.700. As used in ORS 735.700 to 735.714, unless the context requires otherwise:

(1) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the [*Department of Consumer and Business Services*]

Oregon Health Authority, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

(2) "Eligible employee" means an employee of an employer who is employed by the employer for an average of at least 17.5 hours per week who elects to participate in one of the group benefit plans provided through action of the Office of Private Health Partnerships, and sole proprietors, business partners, and limited partners. The term does not include individuals:

(a) Engaged as independent contractors.

(b) Whose periods of employment are on an intermittent or irregular basis.

(c) Who have been employed by the employer for a period of time established by the employer or for fewer than 90 days, whichever is less.

(3) "Family member" means an eligible employee's spouse, any unmarried child or stepchild within age limits and other conditions imposed by the office with regard to unmarried children or stepchildren, or any other dependents eligible under the terms of the health benefit plan selected by the employee's employer.

(4) "Health benefit plan" means a contract for group medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies.

(5) "Premium" means the monthly or other periodic charge for a health benefit plan.

(6) "Small employer" means a person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 50 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bona fide partnership or employer-employee relationship exists. "Small employer" includes corporations that are eligible to file a consolidated tax return pursuant to ORS 317.715.

SECTION 112. ORS 735.701 is amended to read:

735.701. (1) The Office of Private Health Partnerships is established **in the Oregon Health Authority**.

(2) The office shall carry out the duties described under ORS [*414.831,*] 735.700 to 735.714 and 735.720 to 735.740.

SECTION 113. ORS 735.706 is amended to read:

735.706. **(1)** The Office of Private Health Partnerships Account is established separate and distinct from the General Fund. All moneys received by the Office of Private Health Partnerships, other than appropriations from the General Fund and except for moneys in the account established by ORS 735.736, shall be deposited into the account and are continuously appropriated to the office to carry out the duties, functions and powers of the office.

(2) On the effective date of this 2009 Act, all moneys in the Office of Private Health Partnerships Account shall be transferred to the Oregon Health Authority Fund established in section 19 of this 2009 Act.

SECTION 114. ORS 735.722 is amended to read:

735.722. (1) There is established the Family Health Insurance Assistance Program in the Office of Private Health Partnerships. The purpose of the program is to remove economic barriers to health insurance coverage for residents of the State of Oregon with family income less than 200 percent of the federal poverty level, and investment and savings less than the limit established by the office, while encouraging individual responsibility, promoting health benefit plan coverage of children, building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

(2) The Office of Private Health Partnerships shall be responsible for the implementation and operation of the Family Health Insurance Assistance Program. The Administrator of the Office for Oregon Health Policy and Research, in consultation with the Oregon Health [*Policy Commission*] **Authority Board**, shall make recommendations to the Office of Private Health Partnerships regarding program policy, including but not limited to eligibility requirements, assistance levels, benefit criteria and carrier participation.

(3) The Office of Private Health Partnerships may contract with one or more third-party administrators to administer one or more components of the Family Health Insurance Assistance Program. Duties of a third-party administrator may include but are not limited to:

(a) Eligibility determination;

(b) Data collection;

(c) Assistance payments;

(d) Financial tracking and reporting; and

(e) Such other services as the office may deem necessary for the administration of the program.

(4) If the office decides to enter into a contract with a third-party administrator pursuant to subsection (3) of this section, the office shall engage in competitive bidding. The office shall evaluate bids according to criteria established by the office, including but not limited to:

(a) The bidder's proven ability to administer a program of the size of the Family Health Insurance Assistance Program;

(b) The efficiency of the bidder's payment procedures;

(c) The estimate provided of the total charges necessary to administer the program; and

(d) The bidder's ability to operate the program in a cost-effective manner.

SECTION 115. ORS 735.734 is amended to read:

735.734. The Office of Private Health Partnerships, in consultation with the Administrator of the Office for Oregon Health Policy and Research and the [*Department of Human Services*] **Oregon Health Authority**, shall adopt all rules necessary for the implementation and operation of the Family Health Insurance Assistance Program.

SECTION 116. ORS 735.754 is amended to read:

735.754. (1) In order to increase public subsidies for the purchase of health insurance coverage provided by public programs or private insurance described by ORS 414.839, the Office of Private Health Partnerships, the Oregon Medical Insurance Pool Board and the [*Department of Human Services*] **Oregon Health Authority** shall work cooperatively to obtain federal matching dollars. The office, the Oregon Medical Insurance Pool Board and the [*department*] **authority** shall develop a system for payment or reimbursement of other costs and subsidies provided to subsidized members.

(2) For each subsidized member, the Oregon Medical Insurance Pool Board shall determine:

(a) The full cost of administering the benefits plan of the subsidized member; and

(b) The amount of other costs.

(3) The Oregon Medical Insurance Pool Board shall bill the Family Health Insurance Assistance Program for the total amount of the premium received by the Oregon Medical Insurance Pool Board and for the amount of other costs. The program shall forward the bill to the [*department*] **authority**.

(4) The [*department*] **authority** shall pay the program an amount equal to the portion of the premium that is a subsidy and for other costs. The program shall forward the payment to the Oregon Medical Insurance Pool Board.

SECTION 117. ORS 735.756 is amended to read:

735.756. (1) Of payments made to the Family Health Insurance Assistance Program by the [*Department of Human Services*] **Oregon Health Authority** under ORS 735.754 (4), the [*department*] **authority** shall determine:

(a) The portion of a subsidy of a subsidized member that is from the General Fund; and

(b) The portion of other costs that is from the General Fund.

(2) The [*department*] **authority** shall bill the program for the amounts determined under subsection (1) of this section. The program shall forward the bill for the amount determined under subsection (1)(b) of this section to the Oregon Medical Insurance Pool Board.

(3) The board shall:

(a) Determine the amount of funds needed for the payment of other costs under subsection (1)(b) of this section; and

(b) Impose and collect assessments in that amount against insurers, using the methodology described in ORS 735.614 (2), (6) and (9).

(4) The board shall pay the program for the amounts determined under subsection (1)(b) of this section.

(5) The program shall forward to the [*department*] **authority** the amounts determined under subsection (1) of this section.

(6) ORS 735.614 (3), (4), (5), (7) and (8) applies to assessments collected under this section.

SECTION 118. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans shall be subject to the following provisions:

(1) Each carrier must file the geographic average rate for its individual health benefit plans for a rating period with the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** on or before March 15 of each year.

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. For age adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

(3) A carrier may not increase the rates of an individual health benefit plan more than once in a 12-month period except as approved by the director. Annual rate increases shall be effective on the anniversary date of the individual health benefit plan's issuance. The percentage increase in the premium rate charged for an individual health benefit plan for a new rating period may not exceed the sum of the following:

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan measured from the first day of the prior rating period to the first day of the new period; and

(b) Any adjustment attributable to changes in age and differences in benefit design and family composition.

(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge shall be approved by the Director of the [*Department of Consumer and Business Services*] **Oregon**

Health Authority and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting conditions provision.

SECTION 119. Section 2a, chapter 872, Oregon Laws 2007, is amended to read:

Sec. 2a. The Health Resources Commission shall:

(1) Conduct a review of available medical and behavioral health evidence on the treatment of pervasive developmental disorders.

(2) In conducting its review, work with the Public Employees' Benefit Board, the Health Services Commission, the [*Department of Human Services*] **Oregon Health Authority** and the Department of Education.

(3) Report its findings and recommendations to the Seventy-fifth Legislative Assembly in the manner provided in ORS 192.245.

REPEALS

SECTION 120. (1) ORS 414.019, 414.021, 414.022, 414.023, 414.024, 414.031, 414.032, 414.036, 414.038, 414.039, 414.085, 414.107, 414.660, 414.670, 414.744, 414.747, 445.270 and 731.076 and sections 10 and 13, chapter 810, Oregon Laws 2003, are repealed.

(2) ORS 735.706 is repealed on January 2, 2011.

NOTE: Sections 121 through 123 were deleted. Subsequent sections were not renumbered.

EXPANSION OF MEDICAL ASSISTANCE

SECTION 124. (1) The Oregon Health Authority is responsible for statewide outreach and marketing of the medical assistance and premium assistance programs administered by the authority with the goal of enrolling in those programs all eligible individuals residing in this state.

(2) To maximize the enrollment and retention of eligible children in the medical assistance and premium assistance programs, the authority shall develop and administer a grant program to provide funding to organizations and community-based groups to deliver culturally-specific and targeted outreach and direct application assistance to:

(a) Members of racial, ethnic and language minority communities;

(b) Individuals living in geographic isolation; and

(c) Individuals with additional barriers to accessing health care such as individuals with cognitive, mental health or sensory disorders, physical disabilities, chemical dependency or individuals experiencing homelessness.

SECTION 125. The Oregon Health Authority shall implement a streamlined and simple application process for the medical assistance and premium assistance programs administered by the authority. The process shall include, but not be limited to:

(1) An online application that may be submitted via the internet;

(2) Application forms that are readable at a 6th grade level and request the minimum amount of information necessary to begin processing the application; and

(3) Application assistance from qualified staff to aid individuals who have language, cognitive, physical or geographic barriers to applying for medical assistance.

SECTION 126. (1) The Oregon Health Authority shall implement a premium assistance program to provide subsidies, on a sliding scale basis, to individuals with incomes at or below

300 percent of the federal poverty guidelines to enable them to purchase employer sponsored health insurance or private market health insurance products that offer the essential benefits package established by the Oregon Health Authority Board for insurance offered through the Oregon Health Insurance Exchange.

(2) The authority shall offer for purchase, without subsidy, the products described in subsection (1) of this section for the enrollment of children in families with incomes above 300 percent of the federal poverty guidelines.

SECTION 127. The Oregon Health Authority is authorized to apply for approval from the Centers for Medicaid and Medicare Services to obtain federal financial participation in the provision of medical assistance and premium assistance to children with family incomes at or below 300 percent of the federal poverty guidelines.

SECTION 128. Of the moneys in the Oregon Health Authority Fund established in section 19 of this 2009 Act, the authority shall use $100 million to increase the reimbursement rates paid to health services providers participating in the medical assistance program, to levels above the reimbursement rates existing on the effective date of this 2009 Act.

HEALTH CARE ASSESSMENTS

SECTION 129. Sections 130 to 132 of this 2009 Act are added to and made a part of the Insurance Code.

SECTION 130. As used in this section and sections 131 and 132 of this 2009 Act:

(1) "Gross amount of premiums" has the meaning given that term in ORS 731.808.

(2) "Health benefit plan" has the meaning given that term in ORS 743.730.

(3) "Insurer" means an authorized insurer that issues or renews a health benefit plan in this state.

SECTION 131. (1) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of _____ percent of the gross amount of premiums that were derived from health benefit plans covering direct domestic risks during that calendar quarter.

(2) The assessment shall be paid to the Oregon Health Authority and shall be accompanied by a verified report, on a form prescribed by the authority, of:

(a) All health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and

(b) The gross amount of premiums by line of insurance, derived by the insurer from all health benefit plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.

(3) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.

(4) An insurer may not offset the assessment under this section against corporate excise taxes imposed under ORS chapter 317.

(5) Assessments under this section may not be considered in the gross amount of premiums for any purpose.

(6) If the authority determines that the assessment paid by the insurer under this section is incorrect, the authority shall charge or credit to the insurer the difference between the correct amount of the assessment and the amount paid by the insurer.

SECTION 132. **(1) An insurer that fails to timely file a verified report or to pay an assessment under section 131 of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.**

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 131 of this 2009 Act.

SECTION 133. **Sections 131 and 132 of this 2009 Act apply to premiums received by an insurer on or after the calendar quarter ending December 31, 2009.**

SECTION 134. **(1) As used in this section, "managed care plan" includes a prepaid capitated health service contractor described in ORS 414.630, a prepaid managed care health services organization described in ORS 414.725 and a health care service contractor as defined in ORS 750.005.**

(2) No later than 45 days following the end of a calendar quarter, a managed care plan shall pay an assessment at a rate of _____ percent of the gross amount of capitation payments received by the managed care plan during that calendar quarter for providing coverage of health services under ORS 414.705 to 414.750.

(3) The assessment shall be paid to the Oregon Health Authority in a manner and form prescribed by the authority.

(4) Assessments received by the authority under this section shall be deposited in the Oregon Health Authority Fund established in section 19 of this 2009 Act.

SECTION 135. **(1) A managed care plan that fails to timely pay an assessment under section 134 of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.**

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 134 of this 2009 Act.

SECTION 136. **Sections 134 and 135 of this 2009 Act apply to capitation payments received by a managed care plan on or after October 1, 2009.**

SECTION 136a. **Sections 136b to 136d of this 2009 Act are added to and made a part of the Insurance Code.**

SECTION 136b. **As used in this section and sections 136c and 136d of this 2009 Act, "third party administrator" means any person required to obtain a license pursuant to ORS 744.702 or any person required to register with the Oregon Health Authority pursuant to ORS 744.714.**

SECTION 136c. **(1) No later than 45 days following the end of a calendar quarter, a third party administrator shall pay an assessment at the rate of _____ percent of the gross amount of premiums and charges collected by the administrator during that calendar quarter.**

(2) The assessment shall be paid to the Oregon Health Authority in the form and manner prescribed by the authority.

(3) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on a third party administrator.

(4) A third party administrator may not offset the assessment under this section against corporate excise taxes imposed under ORS chapter 317.

(5) If the authority determines that the assessment paid by the third party administrator

under this section is incorrect, the authority shall charge or credit to the third party administrator the difference between the correct amount of the assessment and the amount paid by the third party administrator.

SECTION 136d. (1) A third party administrator that fails to timely report or to pay an assessment under section 136c of this 2009 Act shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under section 136c of this 2009 Act.

SECTION 136e. Sections 136c and 136d of this 2009 Act apply to premiums and charges collected by a third party administrator on or after the calendar quarter ending December 31, 2009.

SECTION 136f. Assessments collected by the Oregon Health Authority under sections 131, 134 and 136c of this 2009 Act shall be paid into the Oregon Health Authority Fund established in section 19 of this 2009 Act.

SECTION 136g. Penalties collected by the Oregon Health Authority under sections 132, 135 and 136d of this 2009 Act shall be paid to the State Treasurer to be deposited in the General Fund for general governmental expenses.

SECTION 137. Section 1, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 1. As used in sections 1 to 9**, chapter 736, Oregon Laws 2003** [*of this 2003 Act*]:

(1) "Charity care" means costs for providing inpatient or outpatient care services free of charge or at a reduced charge because of the indigence or lack of health insurance of the patient receiving the care services.

(2) "Contractual adjustments" means the difference between the amounts charged based on the hospital's full established charges and the amount received or due from the payor.

(3) "Hospital" has the meaning given that term in ORS 442.015 but does not include special inpatient care facilities.

(4) "Net revenue":

(a) Means the total amount of charges for inpatient or outpatient care provided by the hospital to patients, less **the cost to the hospital of** charity care[*, bad debts*] and contractual adjustments;

(b) Does not include revenue derived from sources other than inpatient or outpatient operations, including but not limited to interest and guest meals; and

(c) Does not include any revenue that is taken into account in computing a long term care facility assessment under sections 15 to 22**, chapter 736, Oregon Laws 2003** [*of this 2003 Act*].

[*(5) "Waivered hospital" means a type A or type B hospital, as described in ORS 442.470, a hospital that provides only psychiatric care or a hospital identified by the Department of Human Services as appropriate for inclusion in the application described in section 4 of this 2003 Act.*]

SECTION 138. Section 2, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 2. (1) An assessment is imposed on the net revenue of each hospital in this state [*that is not a waivered hospital*]. The assessment shall be imposed at **the rate of _____ percent.** [*a rate determined by the Director of Human Services by rule that is the director's best estimate of the rate needed to fund the services and costs identified in section 9, chapter 736, Oregon Laws 2003. The rate of assessment shall be imposed on the net revenue of each hospital subject to assessment. The director shall consult with representatives of hospitals before setting the assessment.*]

[*(2) Notwithstanding subsection (1) of this section, the rate of assessment may not exceed 1.5 percent.*]

[*(3)*] **(2)** The assessment shall be reported on a form prescribed by the [*Department of Human Services*] **Oregon Health Authority** and shall contain the information required to be reported by the [*department*] **authority**. The assessment form shall be filed with the [*department*] **authority** on or before the 75th day following the end of the calendar quarter for which the assessment is being reported. Except as provided in subsection [*(7)*] **(5)** of this section, the hospital shall pay the assessment at the time the hospital files the assessment report. The payment shall accompany the report.

[*(4) To the extent permitted by federal law, aggregate taxes levied under this section may not exceed payments under section 9 (2), chapter 736, Oregon Laws 2003.*]

[*(5)*] **(3)** [*Notwithstanding subsection (4) of this section,*] A hospital is not guaranteed that any additional moneys paid to the hospital in the form of payments for services shall equal or exceed the amount of the assessment paid by the hospital.

[*(6)*] **(4)** Hospitals operated by the United States Department of Veterans Affairs**,** [*and*] pediatric specialty hospitals providing care to children at no charge **and hospitals designated by the Office of Rural Health as type A or type B hospitals** are exempt from the assessment imposed under this section.

[*(7)(a) The Department of Human Services shall develop a schedule for collection of the assessment for the calendar quarter ending September 30, 2009, that will result in the collection occurring between December 15, 2009, and the time all Medicaid cost settlements are finalized for that calendar quarter.*]

[*(b)*] **(5)** The [*Department of Human Resources*] **Oregon Health Authority** shall prescribe by rule criteria for late payment of assessments.

SECTION 139. Section 5, chapter 736, Oregon Laws 2003, is amended to read:

Sec. 5. (1) A hospital that fails to file a report or pay an assessment under section 2**, chapter 736, Oregon Laws 2003,** [*of this 2003 Act*] by the date the report or payment is due shall be subject to a penalty of **up to** $500 per day of delinquency. The total amount of penalties imposed under this section for each reporting period may not exceed five percent of the assessment for the reporting period for which penalties are being imposed.

(2) Penalties imposed under this section shall be collected by the [*Department of Human Services*] **Oregon Health Authority** and deposited in the [*Department of Human Services Account established under ORS 409.060.*] **Oregon Health Authority Fund established in section 19 of this 2009 Act.**

(3) Penalties paid under this section are in addition to and not in lieu of the assessment imposed under section 2**, chapter 736, Oregon Laws 2003** [*of this 2003 Act*].

SECTION 140. Section 8, chapter 736, Oregon Laws 2003, as amended by section 1, chapter 757, Oregon Laws 2005, is amended to read:

Sec. 8. Amounts collected by the [*Department of Human Services*] **Oregon Health Authority** from the assessments imposed under section 2, chapter 736, Oregon Laws 2003, shall be deposited in the [*Hospital Quality Assurance Fund established under section 9, chapter 736, Oregon Laws 2003.*] **Oregon Health Authority Fund established in section 19 of this 2009 Act.**

SECTION 141. Section 10, chapter 736, Oregon Laws 2003, as amended by section 3, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 10. Sections 1 to 9, chapter 736, Oregon Laws 2003, apply to net revenues earned by hospitals on or after [*January 1, 2004, and before the earlier of October 1, 2009, or when the assessment*

described in sections 37 to 44, chapter 736, Oregon Laws 2003, no longer qualifies for federal matching funds under Title XIX of the Social Security Act.] **October 1, 2009.**

SECTION 142. Section 14, chapter 736, Oregon Laws 2003, as amended by section 6, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 14. Any moneys remaining in the Hospital Quality Assurance Fund on [*December 31, 2013*] **October 1, 2009**, are transferred to the [*General Fund.*] **Oregon Health Authority Fund established in section 19 of this 2009 Act.**

SECTION 143. Section 51, chapter 736, Oregon Laws 2003, as amended by section 20, chapter 780, Oregon Laws 2007, is amended to read:

Sec. 51. Any moneys [*remaining*] **deposited** in the Medical Care Quality Assurance Fund [*on December 31, 2011, are*] **shall be** transferred to the [*General Fund*] **Oregon Health Authority Fund established in section 19 of this 2009 Act**.

SECTION 144. ORS 731.840 is amended to read:

731.840. (1) The retaliatory tax imposed upon a foreign or alien insurer under ORS 731.854 and 731.859, or the corporate excise tax imposed upon a foreign or alien insurer under ORS chapter 317, is in lieu of all other state taxes upon premiums, taxes upon income, franchise or other taxes measured by income that might otherwise be imposed upon the foreign or alien insurer except the fire insurance premiums tax imposed under ORS 731.820**,** [*and*] the tax imposed upon wet marine and transportation insurers under ORS 731.824 and 731.828**, and the assessment imposed under section 131 of this 2009 Act**. However, all real and personal property, if any, of the insurer shall be listed, assessed and taxed the same as real and personal property of like character of noninsurers. Nothing in this subsection shall be construed to preclude the imposition of the assessments imposed under ORS 656.612 upon a foreign or alien insurer.

(2) Subsection (1) of this section applies to a reciprocal insurer and its attorney in its capacity as such.

(3) Subsection (1) of this section applies to foreign or alien title insurers and to foreign or alien wet marine and transportation insurers issuing policies and subject to taxes referred to in ORS 731.824 and 731.828.

(4) The State of Oregon hereby preempts the field of regulating or of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses and fees upon insurers and their insurance producers and other representatives as such, and:

(a) No county, city, district, or other political subdivision or agency in this state shall so regulate, or shall levy upon insurers, or upon their insurance producers and representatives as such, any such tax, license or fee; except that whenever a county, city, district or other political subdivision levies or imposes generally on a nondiscriminatory basis throughout the jurisdiction of the taxing authority a payroll, excise or income tax, as otherwise provided by law, such tax may be levied or imposed upon domestic insurers; and

(b) No county, city, district, political subdivision or agency in this state shall require of any insurer, insurance producer or representative, duly authorized or licensed as such under the Insurance Code, any additional authorization, license, or permit of any kind for conducting therein transactions otherwise lawful under the authority or license granted under this code.

SECTION 145. (1) Section 4, chapter 736, Oregon Laws 2003, is repealed.

(2) Section 9, chapter 736, Oregon Laws 2003, as amended by section 2, chapter 757, Oregon Laws 2005, and section 2, chapter 780, Oregon Laws 2007, is repealed.

(3) Section 12, chapter 736, Oregon Laws 2003, as amended by section 4, chapter 780,

Oregon Laws 2007, is repealed.

(4) Section 13, chapter 736, Oregon Laws 2003, as amended by section 5, chapter 780, Oregon Laws 2007, is repealed.

SECTION 146. Sections 129 to 136 of this 2009 Act, the amendments to ORS 731.840 and sections 1, 2, 5, 8, 10, 14 and 51, chapter 736, Oregon Laws 2003, by sections 137 to 144 of this 2009 Act and the repeal of sections 4, 9, 12 and 13, chapter 736, Oregon Laws 2003, by section 145 of this 2009 Act become operative on October 1, 2009.

TOBACCO TAX

SECTION 147. Sections 148, 149, 151 and 152 of this 2009 Act are added to and made a part of ORS 323.005 to 323.482.

SECTION 148. (1) Notwithstanding ORS 323.030 (2) and in addition to and not in lieu of any other tax, every distributor shall pay a tax upon distributions of cigarettes at the rate of _____ mills for the distribution of each cigarette in this state.

(2) Any cigarette for which a tax has once been imposed under ORS 323.005 to 323.482 may not be subject upon a subsequent distribution to the taxes imposed by ORS 323.005 to 323.482.

SECTION 149. All moneys received by the Department of Revenue from the tax imposed under section 148 of this 2009 Act shall be paid over to the State Treasurer to be held in a suspense account established under ORS 293.445. After the payment of refunds, the moneys shall be transferred to the Oregon Health Authority Fund established in section 19 of this 2009 Act and are continuously appropriated to the Oregon Health Authority for the purpose of supporting public health system transformation and funding public health programs as follows:

(1) Fifty percent shall be allocated to counties on a per capita basis after a minimum payment to each county of $_____.

(2) Fifty percent of the moneys shall be distributed in the form of grants to counties meeting criteria established by the authority by rule.

SECTION 150. Sections 148 and 149 of this 2009 Act apply to cigarette distributions occurring on or after the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act.

SECTION 151. (1) Notwithstanding ORS 323.030 (3) and in addition to and not in lieu of any other tax, for the privilege of holding or storing cigarettes for sale, use or consumption, a floor tax is imposed upon every dealer at the rate of 30 mills for each cigarette in the possession of or under the control of the dealer in this state at 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act.

(2) The tax imposed by this section is due and payable on or before 20 days after the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act. Any amount of tax that is not paid within the time required shall bear interest at the rate established under ORS 305.220 per month, or fraction of a month, from the date on which the tax is due to be paid, until paid.

(3) On or before 20 days after the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act, every dealer must file a report with the

Department of Revenue in such form as the department may prescribe. The report must state the number of cigarettes in the possession of or under the control of the dealer in this state at 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act and the amount of tax due. Each report must be accompanied by a remittance payable to the department for the amount of tax due.

SECTION 152. Notwithstanding ORS 323.030 (3) and in addition to and not in lieu of any other tax, for the privilege of distributing cigarettes as a distributor and for holding or storing cigarettes for sale, use or consumption, a floor tax and cigarette adjustment indicia tax is imposed upon every distributor in the amount of 75 cents for each Oregon cigarette tax stamp bearing the designation "25," in the amount of 60 cents for each Oregon cigarette tax stamp bearing the designation "20," in the amount of 30 cents for each Oregon cigarette tax stamp bearing the designation "10" and in the amount of 3 cents for each Oregon cigarette tax stamp bearing the designation "1" that is affixed to any package of cigarettes in the possession of or under the control of the distributor at 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act.

SECTION 153. (1) Every distributor must take an inventory as of 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act of all packages of cigarettes to which are affixed Oregon cigarette tax stamps and of all unaffixed Oregon cigarette tax stamps in the possession of or under the control of the distributor.

(2) Every distributor must file a report with the Department of Revenue on or before 20 days after the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act in such form as the department may prescribe, showing:

(a) The number of Oregon cigarette tax stamps, with the designations of the stamps, that were affixed to packages of cigarettes in the possession of or under the control of the distributor at 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act; and

(b) The number of unaffixed Oregon cigarette tax stamps, with the designations of the stamps, that were in the possession of or under the control of the distributor at 12:01 a.m. on the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act.

(3) The amount of tax required to be paid with respect to the affixed Oregon cigarette tax stamps shall be computed pursuant to section 151 of this 2009 Act and remitted with the distributor's report. Any amount of tax not paid within the time specified for the filing of the report shall bear interest at the rate established under ORS 305.220 per month, or fraction of a month, from the due date of the report until paid.

(4) Notwithstanding ORS 323.320, the department may establish a date after which the value of stamps sold prior to the effective date of this 2009 Act will not be refunded or credited to a distributor.

SECTION 154. All moneys received by the Department of Revenue from the taxes imposed by sections 151 and 152 of this 2009 Act shall be paid over to the State Treasurer to be held in a suspense account established under ORS 293.445. After the payment of refunds, the net amount of revenues remaining shall be distributed as prescribed in section 149 of this 2009 Act.

SECTION 155. ORS 323.505 is amended to read:

323.505. (1) A tax is hereby imposed upon the distribution of all tobacco products in this state. The tax imposed by this section is intended to be a direct tax on the consumer, for which payment upon distribution is required to achieve convenience and facility in the collection and administration of the tax. The tax shall be imposed on a distributor at the time the distributor distributes tobacco products.

(2) The tax imposed under this section shall be imposed at the rate of:

(a) [*Sixty-five*] _____ percent of the wholesale sales price of cigars, but not to exceed 50 cents per cigar; or

(b) [*Sixty-five*] _____ percent of the wholesale sales price of all tobacco products that are not cigars.

(3) If the tax imposed under this section does not equal an amount calculable to a whole cent, the tax shall be equal to the next higher whole cent. However, the amount remitted to the Department of Revenue by the taxpayer for each quarter shall be equal only to 98.5 percent of the total taxes due and payable by the taxpayer for the quarter.

(4) No tobacco product shall be subject to the tax if the base product or other intermediate form thereof has previously been taxed under this section.

SECTION 156. The Department of Revenue may take administrative actions it considers necessary to implement sections 148, 149, 151, 152 and 153 of this 2009 Act and the amendments to ORS 323.505 by section 155 of this 2009 Act, including but not limited to:

(1) Limiting sales of stamps prior to the effective date of this 2009 Act;

(2) Selling stamps at the increased rate prior to the effective date of this 2009 Act; or

(3) Establishing a date after which stamps sold prior to the effective date of this 2009 Act will not be redeemed.

SECTION 157. The amendments to ORS 323.505 by section 155 of this 2009 Act apply to tobacco products tax reporting periods beginning on or after the later of January 1, 2010, or the first day of the calendar month following the effective date of this 2009 Act.

CONFORMING AMENDMENTS

SECTION 158. ORS 408.305 is amended to read:

408.305. As used in ORS 408.305 to 408.340, unless the context requires otherwise:

(1) "Agent Blue" means the herbicide composed primarily of cacodylic acid (organic arsenic) and inorganic arsenic.

(2) "Agent Orange" means the herbicide composed primarily of trichlorophenoxyacetic acid and dichlorophenoxyacetic acid.

(3) "Agent White" means any herbicide composed primarily of 2, 4, D and picloram.

(4) "Causative agent" includes Agent Blue, Agent Orange, Agent White and any other combination of chemicals consisting primarily of 2, 4, D or 2, 4, 5, T or any other chemical or biological agent used by any government involved in the Vietnam Conflict, or diseases endemic to Southeast Asia, including, but not limited to, the disease known as melioidosis.

[*(5) "Department" means the Department of Human Services.*]

[*(6)*] **(5)** "Veteran" means any individual who resides in this state, who served on active duty in the Armed Forces of the United States for a period of not less than 180 days any part of which occurred between January 1, 1962, and May 7, 1975, within the borders of Vietnam, Cambodia, Laos or Thailand, and who was either a resident of this state at the time of enlistment, induction or other

entry into the Armed Forces or became a bona fide resident of Oregon prior to April 1, 1981.

SECTION 159. ORS 408.310 is amended to read:

408.310. (1) A physician who has primary responsibility for the treatment of a veteran who may have been exposed to causative agents while serving in the Armed Forces of the United States or for the treatment of a veteran's spouse, surviving spouse or minor child who may be exhibiting symptoms or conditions that may be attributable to the veteran's exposure to causative agents shall, at the request and direction of the veteran, veteran's spouse or surviving spouse or the parent or guardian of such minor child, submit a report to the [*Department of Human Services*] **Oregon Health Authority**. The report shall be made on a form adopted by the department and made available to physicians and hospitals in this state.

(2) If there is no physician having primary responsibility for the treatment of a veteran, veteran's spouse, surviving spouse or minor child, then the senior medical supervisor of the hospital or clinic treating the veteran, veteran's spouse, surviving spouse or minor child shall submit the report described in this section to the [*department*] **authority** at the request and direction of the veteran, veteran's spouse or surviving spouse or the parent or legal guardian of a veteran's minor child.

(3) The form adopted by the [*department*] **authority** under this section shall list the symptoms commonly attributed to exposure to causative agents, and shall require the following information:

(a) Symptoms of the patient which may be related to exposure to causative agents.

(b) A diagnosis of the patient's condition.

(c) Methods of treatment prescribed.

(d) Any other information required by the department.

(4) The [*department*] **authority**, after receiving a report from a physician, hospital or clinic under this section, may require the veteran, veteran's spouse, surviving spouse or minor child to provide such other information as may be required by the [*department*] **authority**.

SECTION 160. ORS 408.320 is amended to read:

408.320. The Oregon Public Health Advisory Board created under ORS 431.195 shall:

(1) Order the compilation of statistical data from information obtained under ORS 408.310 and determine the use and dissemination of that data.

(2) Make recommendations to the Director of [*Human Services*] **the Oregon Health Authority** or the Director of Veterans' Affairs concerning the implementation and operation of programs authorized by ORS 408.300 to 408.340.

(3) Assess programs of federal agencies operating for the benefit of veterans exposed to causative agents and their families, and make recommendations to the appropriate agencies for the improvement of those programs.

(4) Suspend or terminate specific programs or duties required under ORS 408.300 to 408.340 when necessary to prevent duplication of those programs or duties by other governmental agencies.

(5) Apply for, receive and accept any grants or contributions available from the United States or any of its agencies for the purpose of carrying out ORS 408.300 to 408.340.

(6) When the advisory board considers it necessary for the health and welfare of veterans and the spouses, surviving spouses and minor children of veterans, ask the Attorney General to initiate proceedings as provided under ORS 408.335.

(7) Report biennially to the Legislative Assembly or to the Emergency Board, as appropriate, as necessary to accomplish the objectives of ORS 408.300 to 408.340 concerning the programs instituted under ORS 408.300 to 408.340.

SECTION 161. ORS 408.325 is amended to read:

408.325. (1) The [*Department of Human Services*] **Oregon Health Authority** and the Oregon Public Health Advisory Board shall institute a cooperative program to refer veterans to appropriate state and federal agencies for the purpose of filing claims to remedy medical and financial problems caused by exposure to causative agents.

(2) The Director of [*Human Services*] **the Oregon Health Authority**, after receiving the recommendations of the advisory board, shall adopt rules to provide for the administration and operation of programs authorized by ORS 408.300 to 408.340. The director [*of Human Services*] shall cooperate with appropriate state and federal agencies in providing services under ORS 408.300 to 408.340.

SECTION 162. ORS 408.380 is amended to read:

408.380. (1) The Oregon Veterans' Home authorized by section 1, chapter 591, Oregon Laws 1995, is subject to all state laws and administrative rules and all federal laws and administrative regulations to which long term care facilities operated by nongovernmental entities are subject, except for the requirement to obtain a certificate of need under ORS 442.315 from the [*Department of Human Services*] **Oregon Health Authority**.

(2) As used in this section, "long term care facility" has the meaning given that term in ORS 442.015.

SECTION 163. ORS 408.570 is amended to read:

408.570. When a veteran who has been adjudged mentally ill is eligible for treatment in a United States veterans facility and commitment is necessary for the proper care and treatment of such veteran, the [*Department of Human Services*] **Oregon Health Authority** or community mental health and developmental disabilities program director, as provided under ORS 426.060, may, upon receipt of a certificate of eligibility from the United States Department of Veterans Affairs, assign the person to the United States Department of Veterans Affairs for care, custody and treatment in a United States veterans facility. Upon admission to any such facility, the veteran shall be subject to the rules and regulations of the United States Department of Veterans Affairs and provisions of ORS 426.060 to 426.395 and related rules and regulations of the [*Department of Human Services*] **Oregon Health Authority**. The chief officer of such facility shall be vested with the same powers exercised by superintendents of state hospitals for persons with mental illness within this state with reference to the retention, transfer, trial visit or discharge of the veteran so assigned. The commitment of a veteran to a veterans facility within this state by a court of another state under a similar provision of law has the same force and effect as if the veteran was committed to a veterans facility within that other state.

SECTION 164. ORS 408.580 is amended to read:

408.580. Upon receipt of a certificate of eligibility and available facilities, the [*Department of Human Services*] **Oregon Health Authority** may cause to be transferred any veteran from any facility to which the veteran has been assigned to a United States veterans facility. No veteran under sentence by any court, or committed by any court after having been charged with any crime and acquitted on the ground of mental disease or defect, may be transferred without an order of such court authorizing the transfer. Whenever any veteran, not a convict, has been committed by order of a court and is transferred as provided in this section, the order of commitment shall be held to apply to the facility to which the veteran is transferred as to any other facility to which the veteran could be assigned or transferred under ORS 426.060.

SECTION 165. ORS 431.035 is amended to read:

431.035. (1) The Director of [*Human Services*] **the Oregon Health Authority** may delegate to

any of the officers and employees of the [*Department of Human Services*] **Oregon Health Authority** the exercise or discharge in the director's name of any power, duty or function of whatever character vested in or imposed upon the director by the laws of Oregon. However, the power to administer oaths and affirmations, subpoena witnesses, take evidence and require the production of books, papers, correspondence, memoranda, agreements or other documents or records may be exercised by an officer or employee of the [*department*] **authority** only when specifically delegated in writing by the director.

(2) The official act of any such person so acting in the director's name and by the authority of the director shall be deemed to be an official act of the director.

(3)(a) The Director of [*Human Services*] **the Oregon Health Authority** shall appoint a Public Health Director to perform the duties and exercise authority over public health emergency matters in the state and other duties as assigned by the director [*of Human Services*]. The director [*of Human Services*] may appoint the same person to serve as both the Public Health Director and the Public Health Officer appointed under ORS 431.045.

(b) The Public Health Director shall be an assistant director appointed by the Director of [*Human Services*] **the Oregon Health Authority** in accordance with ORS 409.130.

(c) The Public Health Director shall delegate to an employee of the [*department*] **authority** the duties, powers and functions granted to the Public Health Director by ORS 431.264 and 433.443 in the event of the absence from the state or the unavailability of the director. The delegation must be in writing.

SECTION 166. ORS 431.045 is amended to read:

431.045. The Director of [*Human Services*] **the Oregon Health Authority** shall appoint a physician licensed by the Oregon Medical Board and certified by the American Board of Preventive Medicine who shall serve as the Public Health Officer and be responsible for the medical and paramedical aspects of the health programs within the [*Department of Human Services*] **Oregon Health Authority**.

SECTION 167. ORS 431.110 is amended to read:

431.110. Subject to ORS 417.300 and 417.305, the [*Department of Human Services*] **Oregon Health Authority** shall:

(1) Have direct supervision of all matters relating to the preservation of life and health of the people of the state.

(2) Keep the vital statistics and other health related statistics of the state.

(3) Make sanitary surveys and investigations and inquiries respecting the causes and prevention of diseases, especially of epidemics.

(4) Investigate, conduct hearings and issue findings in connection with annexations proposed by cities as provided in ORS 222.840 to 222.915.

(5) Have full power in the control of all communicable diseases.

(6) Have authority to send a representative of the [*department*] **authority** to any part of the state when deemed necessary.

(7) From time to time, publish and distribute to the public in such form as the [*department*] **authority** determines, such information as in its judgment may be useful in carrying on the work or purposes for which the [*department*] **authority** was established.

(8) Carry out the duties imposed on the [*department*] under ORS chapter 690.

SECTION 168. ORS 431.120 is amended to read:

431.120. The [*Department of Human Services*] **Oregon Health Authority** shall:

(1) Enforce state health policies and rules.

(2) Have the custody of all books, papers, documents and other property belonging to the State Health Commission, which may be deposited in the [*department's*] **authority's** office.

(3) Give any instructions that may be necessary, and forward them to the various local public health administrators throughout the state.

(4) Routinely conduct epidemiological investigations for each case of sudden infant death syndrome including, but not limited to, the identification of risk factors such as birth weight, maternal age, prenatal care, history of apnea and socioeconomic characteristics. The [*department*] **authority** may conduct the investigations through local health departments only upon adoption by rule of a uniform epidemiological data collection method.

(5) Adopt rules related to loans and grants awarded under ORS 285B.560 to 285B.599 or 541.700 to 541.855 for the improvement of drinking water systems for the purpose of maintaining compliance with applicable state and federal drinking water quality standards. In adopting rules under this subsection, the [*Department of Human Services*] **authority** shall coordinate the [*department's*] **authority's** rulemaking process with the Water Resources Department and the Economic and Community Development Department in order to ensure that rules adopted under this subsection are consistent with rules adopted under ORS 285B.563 and 541.845.

(6) Control health care capital expenditures by administering the state certificate of need program pursuant to ORS 442.325 to 442.344.

SECTION 169. ORS 431.150 is amended to read:

431.150. (1) The local public health administrators are charged with the strict and thorough enforcement of the public health laws of this state in their districts, under the supervision and direction of the [*Department of Human Services*] **Oregon Health Authority**. They shall make an immediate report to the [*department*] **authority** of any violation of such laws coming to their notice by observation, or upon the complaint of any person, or otherwise.

(2) The [*department*] **authority** is charged with the thorough and efficient execution of the public health laws of this state in every part of the state, and with supervisory powers over all local public health administrators, to the end that all the requirements are complied with.

(3) The [*department*] **authority** may investigate cases of irregularity or violation of law. All local public health administrators shall aid the [*department*] **authority**, upon request, in such investigation.

(4) When any case of violation of the public health laws of this state is reported to any district attorney or official acting in said capacity, such official shall forthwith initiate and promptly follow up the necessary proceedings against the parties responsible for the alleged violations of law.

(5) Upon request of the [*department*] **authority**, the Attorney General shall likewise assist in the enforcement of the public health laws of this state.

SECTION 170. ORS 431.155 is amended to read:

431.155. (1) Whenever it appears to the [*Department of Human Services*] **Oregon Health Authority** that any person is engaged or about to engage in any acts or practices that constitute a violation of any statute relating to public health administered by the [*department*] **authority**, or any rule or order issued thereunder, the [*department*] **authority** may institute proceedings in the circuit courts to enforce obedience thereto by injunction, or by other processes, mandatory or otherwise, restraining such person, or its officers, agents, employees and representatives from further violation of such statute, rule or order, and enjoining upon them obedience thereto.

(2) The provisions of this section are in addition to and not in substitution of any other

enforcement provisions contained in any statute administered by the [*department*] **authority**.

SECTION 171. ORS 431.157 is amended to read:

431.157. Pursuant to ORS 448.100 (1) and 446.425 (1), the county is delegated the authority granted to the Director of [*Human Services*] **the Oregon Health Authority** in ORS 431.155.

SECTION 172. ORS 431.170 is amended to read:

431.170. (1) The Director of [*Human Services*] **the Oregon Health Authority** shall take direct charge of the functions that are necessary to preserve the public health in any county or district whenever any county or district official fails or refuses to administer or enforce the public health laws or rules that the director or board is charged to enforce.

(2) The director may call to the aid of the director such assistance as is necessary for the enforcement of such statutes and rules, the expense of which shall be borne by the county or district making the use of this procedure necessary, to be paid out of the respective county or district treasury upon vouchers properly certified by the director.

SECTION 173. ORS 431.175 is amended to read:

431.175. If necessary, the Director of [*Human Services*] **the Oregon Health Authority** or a designee thereof, the State Fire Marshal or a designee thereof or an officer of a law enforcement agency may appear before any magistrate empowered to issue warrants in criminal cases, and require such magistrate to issue a warrant, directing it to any sheriff or deputy or any constable or police officer, to enter the described property or to remove any person or obstacle, or to defend any threatened violence to the director or a designee thereof, the State Fire Marshal or a designee thereof or an officer, upon entering private property, or to assist the director in any way.

SECTION 174. ORS 431.180 is amended to read:

431.180. Nothing in the public health laws shall be construed to empower or authorize the [*Department of Human Services*] **Oregon Health Authority** or its representatives, or any county or district board of health or its representatives to interfere in any manner with the individual's right to select the physician or mode of treatment of the choice of the individual, nor interfere with the practice of any person whose religion treats or administers to people who are sick or suffering by purely spiritual means. However, sanitary laws and rules must be complied with.

SECTION 175. ORS 431.190 is amended to read:

431.190. The Director of [*Human Services*] **the Oregon Health Authority** shall appoint, not later than 60 days after October 4, 1977, an advisory board to study the practices and procedures of the health care professions in this state and to recommend rules relating to the auditing of health care practices in hospitals which will:

(1) Promote standard record keeping by hospitals and persons practicing any of the healing arts in hospitals;

(2) Establish those criteria most appropriate for determining the proper objects of such auditing; and

(3) Insure auditing of those practices and procedures most relevant to the causes and occurrence of professional negligence in hospitals.

SECTION 176. ORS 431.195 is amended to read:

431.195. (1) There is established the Oregon Public Health Advisory Board to serve as an advisory body to the [*Director of Human Services*] **Oregon Health Authority Board**.

(2) The members of the [*board*] **Oregon Public Health Advisory Board** shall be residents of this state and shall be appointed by the Governor. The [*board*] **Oregon Public Health Advisory Board** shall consist of 15 members at least one-half of whom shall be public members broadly representing

the state as a whole and the others to include representatives of local government and public and private health providers.

(3) The Oregon Public Health Advisory Board shall:

(a) Advise the [*director*] **Oregon Health Authority Board** on policy matters related to the operation of the [*Department of Human Services*] **Oregon Health Authority**.

(b) Provide a review of statewide public health issues and make recommendations to the [*director*] **Oregon Health Authority Board**.

(c) Participate in public health policy development.

(4) Members shall be appointed for four-year terms. No person shall serve more than two consecutive terms.

(5) The [*board*] **Oregon Public Health Advisory Board** shall meet at least quarterly.

(6) Members of the [*board*] **Oregon Public Health Advisory Board** shall be entitled to compensation and expenses as provided in ORS 292.495.

(7) Vacancies on the [*board*] **Oregon Public Health Advisory Board** shall be filled by appointments of the Governor for the unexpired term.

SECTION 177. ORS 431.210 is amended to read:

431.210. (1) There is established in the General Fund the Public Health Account, classified separately as to federal and other moneys.

(2) All fines, fees, penalties, federal apportionments or contributions and other moneys received by the [*Department of Human Services*] **Oregon Health Authority** relating to public health shall be turned over to the State Treasurer not later than the 10th day of the calendar month next succeeding their receipt by the department and shall be credited to the Public Health Account.

(3) All moneys credited to the Public Health Account are continuously appropriated to the [*department*] **authority** for the payment of expenses of the [*department*] **authority**.

SECTION 178. ORS 431.220 is amended to read:

431.220. The [*Department of Human Services*] **Oregon Health Authority** shall keep a record of all moneys deposited in the Public Health Account. This record shall indicate by separate cumulative accounts the source from which the moneys are derived and the individual activity or program against which each withdrawal is charged.

SECTION 179. ORS 431.230 is amended to read:

431.230. (1) The [*Director of Human Services*] **Oregon Health Authority** may request the Oregon Department of Administrative Services to, and when so requested, the Oregon Department of Administrative Services shall, draw a payment on the Public Health Account in favor of the Director of [*Human Services*] **the Oregon Health Authority** in a sum not exceeding $25,000, which sum shall be used by the director as an emergency or revolving fund.

(2) The emergency or revolving fund shall be deposited with the State Treasurer, and shall be at the disposal of the director [*of Human Services*]. It may be used to pay advances for salaries, travel expenses or any other proper claim against, or expense of, the [*Department of Human Services*] **authority** or the health-related licensing boards for whom the [*department*] **authority** provides accounting services.

(3) Claims for reimbursement of advances paid from the emergency or revolving fund shall be submitted to the [*department*] **authority** for approval. When such claims are so approved, payments covering them shall be drawn in favor of the director [*of Human Services*] and charged against the appropriate fund or account, and shall be used to reimburse the emergency or revolving fund.

(4) The [*department*] **authority** may establish petty cash funds within the emergency or revolv-

ing fund by drawing checks upon the emergency or revolving fund payable to the custodians of the petty cash funds.

SECTION 180. ORS 431.250 is amended to read:

431.250. (1) The [*Department of Human Services*] **Oregon Health Authority** hereby is designated as the state agency to apply to and receive from the federal government or any agency thereof such grants for promoting public health and the prevention of disease, including grants for cancer control and industrial hygiene programs, as may be available to this state or any of its political subdivisions or agencies.

(2) For the purposes of subsection (1) of this section, the [*department*] **authority** shall:

(a) Disburse or supervise the disbursement of all funds made available at any time by the federal government or this state for those purposes.

(b) Adopt, carry out and administer plans for those purposes. Plans so adopted shall be made statewide in application insofar as reasonably feasible, possible or permissible, and shall be so devised as to meet the approval of the federal government or any of its agencies, not inconsistent with the laws of the state.

SECTION 181. ORS 431.260 is amended to read:

431.260. As used in ORS 431.035 to 431.530:

(1) "Children's facility" has the meaning given that term in ORS 433.235.

(2) "Communicable disease" means a disease or condition, the infectious agent of which may be transmitted by any means from one person or from an animal to another person, that may result in illness, death or severe disability.

(3) "Condition of public health importance" means a disease, syndrome, symptom, injury or other threat to public health that is identifiable on an individual or community level.

(4) "Disease outbreak" means a significant or notable increase in the number of cases of a disease or other condition of public health importance.

(5) "Epidemic" means the occurrence in a community or region of a group of similar conditions of public health importance that are in excess of normal expectancy and derived from a common or propagated source.

(6) "Local public health administrator" means the public health administrator of a county or health district appointed under ORS 431.418 or the authorized representative of that public health administrator.

(7) "Local public health authority" means a county government, or a health district created under ORS 431.414 or a person or agency a county or health district has contracted with to act as the local public health authority.

(8) "Public health law" means any statute, rule or local ordinance that has the purpose of promoting or protecting the public health and that establishes the authority of the [*Department of Human Services*] **Oregon Health Authority**, the Public Health Director, the Public Health Officer, a local public health authority or local public health administrator to enforce the statute, rule or local ordinance.

(9) "Public health measure" means a test, medical examination, treatment, isolation, quarantine or other measure imposed on an individual or group of individuals in order to prevent the spread of or exposure to a communicable disease, toxic substance or transmissible agent.

(10) "Reportable disease" means a disease or condition, the reporting of which enables a public health authority to take action to protect or to benefit the public health.

(11) "School" has the meaning given that term in ORS 433.235.

(12) "Specimen" means blood, sputum, urine, stool or other bodily fluids and wastes, tissues, and cultures necessary to perform required tests.

(13) "Test" means any diagnostic or investigative analyses or medical procedures that determine the presence or absence of, or exposure to, a condition of potential public health importance, or its precursor in an individual.

(14) "Toxic substance" means a substance that may cause illness, disability or death to persons who are exposed to it.

SECTION 182. ORS 431.262 is amended to read:

431.262. (1) The [*Department of Human Services*] **Oregon Health Authority** and local public health administrators shall have the power to enforce public health laws. The enforcement powers authorized by this section include, but are not limited to, the authority to:

(a) Investigate possible violations of public health laws;

(b) Issue subpoenas requiring testimony or the production of physical or other evidence;

(c) Issue administrative orders to enforce compliance with public health laws;

(d) Issue a notice of violation of a public health law and impose a civil penalty as established by rule not to exceed $500 a day per violation;

(e) Enter private property at any reasonable time with consent of the owner or custodian of the property to inspect, investigate, evaluate or conduct tests, or take specimens or samples for testing, as may be reasonably necessary to determine compliance with any public health law;

(f) Enter a public place to inspect, investigate, evaluate, conduct tests, or take specimens or samples for testing as may be reasonably necessary to determine compliance with the provisions of any public health law;

(g) Seek an administrative warrant from an appropriate court authorizing the inspection, investigation, evaluation or testing, or taking of specimens or samples for testing, if denied entry to property;

(h) Restrict access to contaminated property;

(i) Require removal or abatement of a toxic substance on any property and prescribe the proper measures for the removal or abatement;

(j) Maintain a civil action to enforce compliance with public health laws, including a petition to a court for an order imposing a public health measure appropriate to the public health threat presented;

(k) Refer any possible criminal violations of public health laws to a district attorney or other appropriate law enforcement official; and

(L) Request the Attorney General to assist in the enforcement of the public health laws.

(2) Any administrative actions undertaken by the state under this section shall comply with the provisions of ORS chapter 183.

(3) State and local law enforcement officials, to the extent resources are available, must assist the [*Department of Human Services*] **Oregon Health Authority** and local public health administrators in ensuring compliance with administrative or judicial orders issued pursuant to this section.

(4) Nothing in this section shall be construed to limit any other enforcement authority granted by law to a local public health authority or to the state.

SECTION 183. ORS 431.264 is amended to read:

431.264. (1) Unless the Governor has declared a public health emergency under ORS 433.441, the Public Health Director may, upon approval of the Governor or the designee of the Governor, take the public health actions described in subsection (2) of this section if the Public Health Director

determines that:

(a)(A) A communicable disease, reportable disease, disease outbreak, epidemic or other condition of public health importance has affected more than one county;

(B) There is an immediate need for a consistent response from the state in order to adequately protect the public health;

(C) The resources of the local public health authority or authorities are likely to be quickly overwhelmed or unable to effectively manage the required response; and

(D) There is a significant risk to the public health; or

(b) A communicable disease, reportable disease, disease outbreak, epidemic or other condition of public health importance is reported in Oregon and is an issue of significant regional or national concern or is an issue for which there is significant involvement from federal authorities requiring state-federal coordination.

(2) The Public Health Director, after making the determinations required under subsection (1) of this section, may take the following public health actions:

(a) Coordinate the public health response across jurisdictions.

(b) Prescribe measures for the:

(A) Identification, assessment and control of the communicable disease or reportable disease, disease outbreak, epidemic or other condition of public health importance; and

(B) Allocation and distribution of antitoxins, serums, vaccines, immunizing agents, antibiotics, antidotes and other pharmaceutical agents, medical supplies or personal protective equipment.

(c) After consultation with appropriate medical experts, create and require the use of diagnostic and treatment guidelines and provide notice of those guidelines to health care providers, institutions and facilities.

(d) Require a person to obtain treatment and use appropriate prophylactic measures to prevent the introduction or spread of a communicable disease or reportable disease, unless:

(A) The person has a medical diagnosis for which a vaccination is contraindicated; or

(B) The person has a religious or conscientious objection to the required treatments or prophylactic measures.

(e) Notwithstanding ORS 332.075, direct a district school board to close a children's facility or school under the jurisdiction of the board. The authority granted to the Public Health Director under this paragraph supersedes the authority granted to the district school board under ORS 332.075 to the extent the authority granted to the board is inconsistent with the authority granted to the director.

(f) Issue guidelines for private businesses regarding appropriate work restrictions.

(g) Organize public information activities regarding the public health response to circumstances described in subsection (1) of this section.

(h) Adopt reporting requirements for, and provide notice of those reporting requirements to, health care providers, institutions and facilities for the purpose of obtaining information directly related to the public health threat presented.

(i) Take control of antitoxins, serums, vaccines, immunizing agents, antibiotics, antidotes and other pharmaceutical agents, medical supplies or personal protective equipment.

(3) The authority granted to the Public Health Director under this section is not intended to override the general authority provided to a local public health authority except as already permitted by law, or under the circumstances described in subsection (1) of this section.

(4) If the [*Department of Human Services*] **Oregon Health Authority** adopts temporary rules to

implement subsection (2) of this section, the rules adopted are not subject to the provisions of ORS 183.335 (6)(a). The [*department*] **authority** may amend the temporary rules adopted under this subsection as often as is necessary to respond to the public health threat.

(5) If it is necessary for the [*department*] **authority** to purchase antitoxins, serums, vaccines, immunizing agents, antibiotics, antidotes or other pharmaceutical agents, medical supplies or personal protective equipment, the purchases are not subject to the provisions of ORS chapter 279A, 279B or 279C.

(6) If property is taken under the authority granted to the Public Health Director under subsection (2) of this section, the owner of the property is entitled to reasonable compensation from the state.

SECTION 184. ORS 431.270 is amended to read:

431.270. (1) The [*Department of Human Services*] **Oregon Health Authority** shall educate residents of this state about:

(a) The need for bone marrow donors;

(b) The procedures required to become registered as a potential bone marrow donor, including procedures for determining a person's tissue type; and

(c) The medical procedures a donor must undergo to donate bone marrow or other sources of blood stem cells.

(2) The [*Department of Human Services*] **Oregon Health Authority** shall make special efforts to educate and recruit citizens of Oregon with a special emphasis on minority populations to volunteer as potential bone marrow donors. Means of communication may include use of press, radio and television, and placement of educational materials in appropriate health care facilities, blood banks and state and local agencies. The [*Department of Human Services*] **Oregon Health Authority** in conjunction with the Department of Transportation shall make educational materials available at all places where driver licenses are issued or renewed.

SECTION 185. ORS 431.290 is amended to read:

431.290. (1) There is established a Spinal Cord Injury Research Board consisting of 11 members appointed by the Governor.

(2) The term of office of each member is four years, but a member serves at the pleasure of the Governor. A member is eligible for reappointment. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term.

(3) The appointment of a member to the board is subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565.

(4) The members of the Spinal Cord Injury Research Board shall be citizens of this state who are well informed on the issues relating to spinal cord injuries and related disabilities. Members may include, but are not limited to:

(a) A minimum of five health professionals with clinical practice experience in each of the practice fields of neuroscience, neurology, neurosurgery, neuropharmacology and spinal cord rehabilitative medicine;

(b) A representative of the Oregon Disabilities Commission;

(c) A representative of a disabilities advocacy organization or an individual who advocates on behalf of persons with spinal cord injuries;

(d) A representative of the [*Department of Human Services*] **Oregon Health Authority**;

(e) Members of the Legislative Assembly; and

(f) A person with a spinal cord injury.

(5) The board shall elect one of its members as chairperson and another as vice chairperson, for such terms and with such duties and powers necessary for the performance of the functions of such offices as the board determines.

(6) The board shall meet at least once every three months at a place, day and hour determined by the chairperson. The board also shall meet at other times and places specified by the call of the chairperson or of a majority of the members of the board.

(7) In accordance with applicable provisions of ORS chapter 183, the board may adopt rules necessary for the administration of the grant program and fund described in ORS 431.292 and 431.294.

SECTION 186. ORS 431.310 is amended to read:

431.310. (1) For the better protection of the public health the laboratory of the [*Department of Human Services*] **Oregon Health Authority** shall make bacteriological and other examinations of water, milk, blood, secretions or tissues required by any state, county or city institution, or officer, and may make such examinations for any licensed physician in accordance with the rules of the [*department*] **authority**.

(2) The [*department*] **authority** shall establish by rule and collect fees for tests performed in the state public health laboratory, not to exceed:

(a) $50 per test for tests other than newborn screening tests; and

(b) $30 per specimen for newborn screening tests.

(3) All money received for such tests shall be deposited in the Public Health Account to be used for expenses of the state public health laboratory.

SECTION 187. ORS 431.330 is amended to read:

431.330. (1) The Conference of Local Health Officials is created. The conference shall consist of all local health officers and public health administrators, appointed pursuant to ORS 431.418 and such other local health personnel as may be included by the rules of the conference.

(2) The Conference of Local Health Officials shall select one of its members as chairperson, another as vice chairperson and another as secretary with such powers and duties necessary to the performance of the functions of such offices as the conference shall determine. The chairperson, after consultation with the Director of [*Human Services*] **the Oregon Health Authority**, shall appoint from the conference membership an executive committee. The executive committee with the chairperson shall advise the director in the administration of ORS 431.330 to 431.350.

SECTION 188. ORS 431.335 is amended to read:

431.335. (1) The Conference of Local Health Officials shall meet at least annually at a place, day and hour determined by the executive committee and the Director of [*Human Services*] **the Oregon Health Authority**. The conference may meet specially at such other times as the director or the executive committee considers necessary.

(2) The director shall cause at least 10 days′ notice of each meeting date to be given to the members. The chairperson or an authorized representative of the chairperson shall preside at all meetings of the conference.

(3) Each conference member shall receive from the local board which the conference member represents from funds available under ORS 431.510, the actual and necessary travel and other expenses incurred by the conference member in attendance at no more than two meetings of the conference per year. Additionally, subject to applicable law regulating travel and other expenses for state officers, a local health official who is a member of the executive committee of the conference or who is the chairperson shall receive from funds available to the [*Department of Human Services*]

Oregon Health Authority, actual and necessary travel and other expenses for attendance at no more than six meetings per year of the executive committee called by the [*department*] **authority**.

SECTION 189. ORS 431.340 is amended to read:

431.340. The Conference of Local Health Officials may submit to the [*Department of Human Services*] **Oregon Health Authority** such recommendations on the rules and standards specified in ORS 431.345 and 431.350.

SECTION 190. ORS 431.345 is amended to read:

431.345. In order to establish criteria for local boards of health to qualify for such financial assistance as may be made available, the [*Department of Human Services*] **Oregon Health Authority**, upon receipt of written approval from the Conference of Local Health Officials shall adopt minimum standards governing:

(1) Education and experience for professional and technical personnel employed in local health departments, such standards to be consistent with any applicable merit system.

(2) Organization, operation and extent of activities which are required or expected of local health departments to carry out their responsibilities in implementing the public health laws of this state and the rules of the [*Department of Human Services*] **Oregon Health Authority**.

SECTION 191. ORS 431.350 is amended to read:

431.350. Upon receipt of written approval from the Conference of Local Health Officials the [*Department of Human Services*] **Oregon Health Authority** shall adopt rules necessary for the administration of ORS 431.330 to 431.350.

SECTION 192. ORS 431.375 is amended to read:

431.375. (1) The Legislative Assembly of the State of Oregon finds that each citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon. To provide for basic public health services the state, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs.

(2) County governments or health districts established under ORS 431.414 are the local public health authority responsible for management of local public health services unless the county contracts with private persons or an agency to act as the local public health authority or the county relinquishes authority to the state. If authority is relinquished, the state may then contract with private persons or an agency or perform the services.

(3) All expenditure of public funds utilized to provide public health services on the local level must be approved by the local public health authority unless the county has relinquished authority to the state or an exception has been approved by the [*Department of Human Services*] **Oregon Health Authority** with the concurrence of the Conference of Local Health Officials.

(4) The [*Department of Human Services*] **Oregon Health Authority**:

(a) Shall contract for the provision of maternal and child public health services with any tribal governing council of a federally recognized Indian tribe that requests to receive funding and to deliver services under the federal Title V Maternal and Child Health Services Block Grant Program.

(b) May contract directly with any tribal governing council of a federally recognized Indian tribe for provision of public health services and programs not required under paragraph (a) of this subsection.

(5) Contracts authorized by subsection (4) of this section must specify that:

(a) Payments will be made to the tribe on a per capita or other equitable formula basis;

(b) The tribe must provide services that are comparable to the services provided by a local

public health authority; and

(c) The tribe must comply with any state or federal requirements with which a local public health authority providing the same services must comply.

SECTION 193. ORS 431.380 is amended to read:

431.380. (1) From funds available to the [*Department of Human Services*] **Oregon Health Authority** for local public health purposes, regardless of the source, the [*department*] **authority** shall provide payments to the local public health authority on a per capita or other equitable formula basis to be used for public health services. Funding formulas shall be determined by the [*department*] **authority** with the concurrence of the Conference of Local Health Officials.

(2) With respect to counties that have established joint public health services with another county, either by agreement or the formation of a district board of health, distribution of funds made available under the provisions of this section shall be prorated to such counties as provided by agreement or under ORS 431.510.

SECTION 194. ORS 431.385 is amended to read:

431.385. (1) The local public health authority shall submit an annual plan to the [*Department of Human Services*] **Oregon Health Authority** for performing services pursuant to ORS 431.375 to 431.385 and 431.416. The annual plan shall be submitted no later than May 1 of each year or on a date mutually agreeable to the [*department*] **authority** and the local public health authority.

(2) If the local public health authority decides not to submit an annual plan under the provisions of ORS 431.375 to 431.385 and 431.416, the [*department*] **authority** shall become the local public health authority for that county or health district.

(3) The [*department*] **authority** shall review and approve or disapprove each plan. Variances to the local public health plan must be approved by the [*department*] **authority**. In consultation with the Conference of Local Health Officials, the [*department*] **authority** shall establish the elements of a plan and an appeals process whereby a local health authority may obtain a hearing if its plan is disapproved.

(4) Each local commission on children and families shall reference the local public health plan in the local coordinated comprehensive plan created pursuant to ORS 417.775.

SECTION 195. ORS 431.415 is amended to read:

431.415. (1) The district or county board of health is the policymaking body of the county or district in implementing the duties of local departments of health under ORS 431.416.

(2) The district or county board of health shall adopt rules necessary to carry out its policies under subsection (1) of this section. The county or district board of health shall adopt no rule or policy which is inconsistent with or less strict than any public health law or rule of the [*Department of Human Services*] **Oregon Health Authority**.

(3) With the permission of the county governing body, a county board may, and with the permission of the governing bodies of the counties involved, a district board may, adopt schedules of fees for public health services reasonably calculated not to exceed the cost of the services performed. The health department shall charge fees in accordance with such schedule or schedules adopted.

SECTION 196. ORS 431.416 is amended to read:

431.416. The local public health authority or health district shall:

(1) Administer and enforce the rules of the local public health authority or the health district and public health laws and rules of the [*Department of Human Services*] **Oregon Health Authority**.

(2) Assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction as provided in the annual plan of the authority or district are performed. These activities shall include but not be limited to:

(a) Epidemiology and control of preventable diseases and disorders;

(b) Parent and child health services, including family planning clinics as described in ORS 435.205;

(c) Collection and reporting of health statistics;

(d) Health information and referral services; and

(e) Environmental health services.

SECTION 197. ORS 431.418 is amended to read:

431.418. (1) Each district board of health shall appoint a qualified public health administrator to supervise the activities of the district in accordance with law. Each county governing body in a county that has created a county board of health under ORS 431.412 shall appoint a qualified public health administrator to supervise the activities of the county health department in accordance with law. In making such appointment, the district or county board of health shall consider standards for selection of administrators prescribed by the [*Department of Human Services*] **Oregon Health Authority**.

(2) When the public health administrator is a physician licensed by the Oregon Medical Board, the administrator shall serve as health officer for the district or county board of health. When the public health administrator is not a physician licensed by the Oregon Medical Board, the administrator will employ or otherwise contract for services with a health officer who shall be a licensed physician and who will perform those specific medical responsibilities requiring the services of a physician and shall be responsible to the public health administrator for the medical and paramedical aspects of the health programs.

(3) The public health administrator shall:

(a) Serve as the executive secretary of the district or county health board, act as the administrator of the district or county health department and supervise the officers and employees appointed under paragraph (b) of this subsection.

(b) Appoint with the approval of the health board, administrators, medical officers, public health nurses, environmental health specialists and such other employees as are necessary to carry out the duties and responsibilities of the office.

(c) Provide the board at appropriate intervals information concerning the activities of the county health department and submit an annual budget for the approval of the county governing body except that, in the case of the district public health administrator, the budget shall be submitted to the governing bodies of the participating counties for approval.

(d) Act as the agent of the [*Department of Human Services*] **Oregon Health Authority** in enforcing state public health laws and rules of the [*Department of Human Services*] **authority**, including such sanitary inspection of hospitals and related institutions as may be requested by the [*Department of Human Services*] **authority**.

(e) Perform such other duties as may be required by law.

(4) The public health administrator shall serve until removed by the appointing board. The public health administrator shall engage in no occupation which conflicts with official duties and shall devote sufficient time to duties as public health administrator as may be necessary to fulfill the requirements of subsection (3) of this section. However, if the board of health is not created under ORS 431.412, it may, with the approval of the Director of Human Services, require less than

full-time service of the public health administrator.

(5) The public health administrator shall receive a salary fixed by the appointing board and shall be reimbursed for actual and necessary expenses incurred in the performance of duties.

SECTION 198. ORS 431.530 is amended to read:

431.530. (1) The local public health administrator may take any action which the [*Department of Human Services*] **Oregon Health Authority** or its director could have taken, if an emergency endangering the public health occurs within the jurisdiction of any local public health administrator and:

(a) The circumstances of the emergency are such that the [*department*] **authority** or its director cannot take action in time to meet the emergency; and

(b) Delay in taking action to meet the emergency will increase the hazard to public health.

(2) Any local public health administrator who acts under subsection (1) of this section shall report the facts constituting the emergency and any action taken under the authority granted by subsection (1) of this section to the Director of [*Human Services*] **the Oregon Health Authority** by the fastest possible means.

SECTION 199. ORS 431.550 is amended to read:

431.550. Nothing in ORS 431.412, 431.418 and this section shall be construed to limit the authority of the [*Department of Human Services*] **Oregon Health Authority** to require facts and statistics from local public health administrators under its general supervisory power over all matters relating to the preservation of life and health of the people of the state.

SECTION 200. ORS 431.607 is amended to read:

431.607. In cooperation with representatives of the emergency medical services professions, the [*Department of Human Services*] **Oregon Health Authority** shall develop a comprehensive emergency medical services and trauma system. The [*department*] **authority** shall report progress on the system to the Legislative Assembly.

SECTION 201. ORS 431.609 is amended to read:

431.609. (1) With the advice of the State Trauma Advisory Board, the [*Department of Human Services*] **Oregon Health Authority** shall:

(a) Develop and monitor a statewide trauma system; and

(b) Designate within the state, trauma areas consistent with local resources, geography and current patient referral patterns.

(2) Each trauma area shall have:

(a) Central medical control for all field care and transportation consistent with geographic and current communications capability.

(b) The development of triage protocols.

(c) One or more hospitals categorized according to trauma care capabilities using standards adopted by the [*department*] **authority** by rule. Such rules shall be modeled after the American College of Surgeons Committee on Trauma standards.

(d) The establishment of area trauma advisory boards to develop trauma system plans for each trauma area.

(3) On and after July 1, 1986, the [*department*] **authority** may designate trauma system hospitals in accordance with area trauma advisory board plans which meet state objectives and standards.

(4) Trauma system plans shall be implemented by June 30, 1987, in Health Systems Area I, and June 30, 1988, in Health Systems Areas II and III.

SECTION 202. ORS 431.611 is amended to read:

431.611. (1) Prior to approval and implementation of area trauma plans submitted to the [*Department of Human Services*] **Oregon Health Authority** by area trauma advisory boards, the [*department*] **authority** shall adopt rules pursuant to ORS chapter 183 which specify state trauma objectives and standards, hospital categorization criteria and criteria and procedures to be utilized in designating trauma system hospitals.

(2) For approved area trauma plans recommending designation of trauma system hospitals, the [*department*] **authority** rules shall provide for:

(a) The transport of a member of a health maintenance organization, or other managed health care system, as defined by rule, to a hospital that contracts with the health maintenance organization when central medical control determines that the condition of the member permits such transport; and

(b) The development and utilization of protocols between designated trauma hospitals and health maintenance organizations, or other managed health care systems, as defined by rule, including notification of admission of a member to a designated trauma hospital within 48 hours of admission, and coordinated discharge planning between a designated trauma hospital and a hospital that contracts with a health maintenance organization to facilitate transfer of the member when the medical condition of the member permits.

SECTION 203. ORS 431.613 is amended to read:

431.613. (1) Area trauma advisory boards shall meet as often as necessary to identify specific trauma area needs and problems and propose to the [*Department of Human Services*] **Oregon Health Authority** area trauma system plans and changes that meet state standards and objectives. The [*department*] **authority** acting with the advice of the State Trauma Advisory Board will have the authority to implement these plans.

(2) In concurrence with the Governor, the [*department*] **authority** shall select members for each area from lists submitted by local associations of emergency medical technicians, emergency nurses, emergency physicians, surgeons, hospital administrators, emergency medical services agencies and citizens at large. Members shall be broadly representative of the trauma area as a whole and shall consist of at least 15 members per area trauma advisory board, including:

(a) Three surgeons;

(b) Two physicians serving as emergency physicians;

(c) Two hospital administrators from different hospitals;

(d) Two nurses serving as emergency nurses;

(e) Two emergency medical technicians serving different emergency medical services;

(f) Two representatives of the public at large selected from among those submitting letters of application in response to public notice by the [*department*] **authority**. Public members shall not have an economic interest in any decision of the health care service areas;

(g) One representative of any bordering state which is included within the patient referral area;

(h) One anesthesiologist; and

(i) One ambulance service owner or operator or both.

SECTION 204. ORS 431.619 is amended to read:

431.619. The [*Department of Human Services*] **Oregon Health Authority** shall continuously identify the causes of trauma in Oregon, and propose programs of prevention thereof for consideration by the Legislative Assembly or others.

SECTION 205. ORS 431.623 is amended to read:

431.623. (1) The Emergency Medical Services and Trauma Systems Program is created within the

[*Department of Human Services*] **Oregon Health Authority** for the purpose of administering and regulating ambulances, training and certifying emergency medical technicians, establishing and maintaining emergency medical systems including trauma systems and obtaining appropriate data from the Oregon Injury Registry as necessary for trauma reimbursement, system quality assurance and assuring cost efficiency.

(2) For purposes of ORS 431.607 to 431.619 and ORS chapter 682, the duties vested in the [*department*] **authority** shall be performed by the Emergency Medical Services and Trauma Systems Program.

(3) The program shall be administered by a director.

(4) With moneys transferred to the program by ORS 442.625, the program shall apply those moneys to:

(a) Developing state and regional standards of care;

(b) Developing a statewide educational curriculum to teach standards of care;

(c) Implementing quality improvement programs;

(d) Creating a statewide data system for prehospital care; and

(e) Providing ancillary services to enhance Oregon's emergency medical service system.

SECTION 206. ORS 431.627 is amended to read:

431.627. (1) In addition to and not in lieu of ORS 431.607 to 431.617, the [*Department of Human Services*] **Oregon Health Authority** shall designate trauma centers in areas that are within the jurisdiction of trauma advisory boards other than in the area within the jurisdiction of area trauma advisory board 1.

(2) The [*department*] **authority** shall enter into contracts with designated trauma centers and monitor and assure quality of care and appropriate costs for trauma patients meeting trauma system entry criteria.

(3) All findings and conclusions, interviews, reports, studies, communications and statements procured by or furnished to the [*department*] **authority**, the State Trauma Advisory Board or an area trauma advisory board in connection with obtaining the data necessary to perform patient care quality assurance functions shall be confidential pursuant to ORS 192.501 to 192.505.

(4)(a) All data received or compiled by the State Trauma Advisory Board or any area trauma advisory board in conjunction with [*department*] **authority** monitoring and assuring quality of trauma patient care shall be confidential and privileged, nondiscoverable and inadmissible in any proceeding. No person serving on or communicating information to the State Trauma Advisory Board or an area trauma advisory board shall be examined as to any such communications or to the findings or recommendations of such board. A person serving on or communicating information to the State Trauma Advisory Board or an area trauma advisory board shall not be subject to an action for civil damages for actions taken or statements made in good faith. Nothing in this section affects the admissibility in evidence of a party's medical records not otherwise confidential or privileged dealing with the party's medical care. The confidentiality provisions of ORS 41.675 and 41.685 shall also apply to the monitoring and quality assurance activities of the State Trauma Advisory Board, area trauma advisory boards and the [*department*] **authority**.

(b) As used in this section, "data" includes but is not limited to written reports, notes, records and recommendations.

(5) Final reports by the [*department*] **authority**, the State Trauma Advisory Board and area trauma advisory boards shall be available to the public.

(6) The [*department*] **authority** shall publish a biennial report of the Emergency Medical Ser-

vices and Trauma Systems Program and trauma systems activities.

SECTION 207. ORS 431.633 is amended to read:

431.633. (1) Designated trauma centers and providers, physical rehabilitation centers, alcohol and drug rehabilitation centers and ambulances shall develop a monthly log of all unsponsored, inadequately insured trauma system patients determined by the hospital to have an injury severity score greater than or equal to 13, and submit monthly to the Emergency Medical Services and Trauma Systems Program the true costs and unpaid balance for the care of these patients.

(2) No reimbursement for these patients shall occur until:

(a) All information required by the Emergency Medical Services and Trauma Systems Program rules is submitted to the Oregon Injury Registry; and

(b) The Emergency Medical Services and Trauma Systems Program confirms that the injury severity score, as defined by the [*Department of Human Services*] **Oregon Health Authority** by rule, is greater than or equal to 13.

(3) The Emergency Medical Services and Trauma Systems Program shall cause providers to be reimbursed in the following decreasing order of priority:

(a) Designated trauma centers and providers;

(b) Physical rehabilitation centers;

(c) Alcohol and drug rehabilitation centers; and

(d) Ambulances.

(4) Subject to the availability of funds, the Emergency Medical Services and Trauma Systems Program shall cause the designated trauma centers and providers to be paid first in full. Subsequent providers shall be paid from the balance remaining according to priority.

(5) Any matching funds, available pursuant to the federal Trauma Care Systems and Development Act of 1990 (H.R. 1602), that are available for purposes of the Emergency Medical Services and Trauma Systems Program may be used for related studies and projects and reimbursement for uncompensated care.

SECTION 208. ORS 431.671 is amended to read:

431.671. (1) Subject to available funding from gifts, grants or donations, the Emergency Medical Services for Children Program is established in the [*Department of Human Services*] **Oregon Health Authority**. The Emergency Medical Services for Children Program shall operate in cooperation with the Emergency Medical Services and Trauma Systems Program to promote the delivery of emergency medical and trauma services to the children of Oregon.

(2) The [*Department of Human Services*] **Oregon Health Authority** shall:

(a) Employ or contract with professional, technical, research and clerical staff as required to implement this section.

(b) Provide technical assistance to the State Trauma Advisory Board on the integration of an emergency medical services for children program into the statewide emergency medical services and trauma system.

(c) Provide advice and technical assistance to area trauma advisory boards on the integration of an emergency medical services for children program into area trauma system plans.

(d) Establish an Emergency Medical Services for Children Advisory Committee.

(e) Establish guidelines for:

(A) The approval of emergency and critical care medical service facilities for pediatric care, and for the designation of specialized regional pediatric critical care centers and pediatric trauma care centers.

(B) Referring children to appropriate emergency or critical care medical facilities.

(C) Necessary prehospital and other pediatric emergency and critical care medical service equipment.

(D) Developing a coordinated system that will allow children to receive appropriate initial stabilization and treatment with timely provision of, or referral to, the appropriate level of care, including critical care, trauma care or pediatric subspecialty care.

(E) Protocols for prehospital and hospital facilities encompassing all levels of pediatric emergency services, pediatric critical care and pediatric trauma care.

(F) Rehabilitation services for critically ill or injured children.

(G) An interfacility transfer system for critically ill or injured children.

(H) Initial and continuing professional education programs for emergency medical services personnel, including training in the emergency care of infants and children.

(I) A public education program concerning the Emergency Medical Services for Children Program including information on emergency access telephone numbers.

(J) The collection and analysis of statewide pediatric emergency and critical care medical services data from emergency and critical care medical service facilities for the purpose of quality improvement by such facilities, subject to relevant confidentiality requirements.

(K) The establishment of cooperative interstate relationships to facilitate the provision of appropriate care for pediatric patients who must cross state borders to receive emergency and critical care services.

(L) Coordination and cooperation between the Emergency Medical Services for Children Program and other public and private organizations interested or involved in emergency and critical care for children.

SECTION 209. ORS 431.705 is amended to read:

431.705. As used in ORS 431.705 to 431.760, unless the context requires otherwise:

(1) "Affected territory" means an area that is the subject of a proceedings under ORS 431.705 to 431.760 where there is a danger to public health or an alleged danger to public health.

(2) "Boundary commission" means a local government boundary commission created under ORS 199.410 to 199.430, 199.435 to 199.464, 199.480 to 199.505 and 199.510.

(3) "Commission" means the Environmental Quality Commission.

(4) "Danger to public health" means a condition which is conducive to the propagation of communicable or contagious disease-producing organisms and which presents a reasonably clear possibility that the public generally is being exposed to disease-caused physical suffering or illness, including a condition such as:

(a) Impure or inadequate domestic water.

(b) Inadequate installations for the disposal or treatment of sewage, garbage or other contaminated or putrefying waste.

(c) Inadequate improvements for drainage of surface water and other fluid substances.

[*(5) "Department" means the Department of Human Services.*]

[*(6) "Director" means the Director of Human Services.*]

[*(7)*] **(5)** "District" means any one of the following:

(a) A metropolitan service district formed under ORS chapter 268.

(b) A county service district formed under ORS chapter 451.

(c) A sanitary district formed under ORS 450.005 to 450.245.

(d) A sanitary authority, water authority or joint water and sanitary authority formed under

ORS 450.600 to 450.989.

(e) A domestic water supply district formed under ORS chapter 264.

[*(8)*] **(6)** "Requesting body" means the county court, or local or district board of health that makes a request under ORS 431.715.

[*(9)*] **(7)** "Service facilities" means water or sewer installations or works.

SECTION 210. ORS 431.710 is amended to read:

431.710. (1) ORS 431.705 to 431.760 shall not apply if the affected territory could be subject to an annexation proceeding under ORS 222.840 to 222.915.

(2) If the [*Department of Human Services*] **Oregon Health Authority**, in accordance with ORS 431.705 to 431.760, finds that a danger to public health exists within the affected territory and that such danger could be removed or alleviated by the construction, maintenance and operation of service facilities, the [*department*] **authority** shall initiate proceedings for the formation of or annexation to a district to serve the affected territory. If the affected territory is located within a district that has the authority to provide the service facilities, the [*department*] **authority** shall order the district to provide service facilities in the affected territory.

SECTION 211. ORS 431.715 is amended to read:

431.715. (1) The county court or the local or district board of health having jurisdiction over territory where it believes conditions dangerous to the public health exist shall adopt a resolution requesting the [*Department of Human Services*] **Oregon Health Authority** to initiate proceedings for the formation of a district or annexation of territory to, or delivery of appropriate water or sewer services by, an existing district without vote or consent in the affected territory. The resolution shall:

(a) Describe the boundaries of the affected territory;

(b) Describe the conditions alleged to be causing a danger to public health;

(c) Request the [*department*] **authority** to ascertain whether conditions dangerous to public health exist in the affected territory and whether such conditions could be removed or alleviated by the provision of service facilities; and either

(d) Recommend a district that the affected territory could be included in or annexed to for the purpose of providing the requested service facilities; or

(e) Recommend that an existing district provide service facilities in the affected territory.

(2) The requesting body shall cause a certified copy of the resolution, together with the time schedule and preliminary plans and specifications, prepared in accordance with subsection (3) of this section, to be forwarded to the [*department*] **authority**.

(3) The requesting body shall cause a study to be made and preliminary plans and specifications prepared for the service facilities considered necessary to remove or alleviate the conditions causing a danger to public health. The requesting body shall prepare a schedule setting out the steps necessary to put the facilities into operation and the time required for each step in implementation of the plans.

(4) If the preliminary plans involve facilities that are subject to the jurisdiction of the Environmental Quality Commission, a copy of the documents submitted to the [*department*] **authority** under subsection (2) of this section shall be submitted to the commission for review, in accordance with ORS 431.725, of those facilities that are subject to its jurisdiction. No order or findings shall be adopted under ORS 431.735 or 431.756 until the plans of the requesting body for such facilities, if any, have been approved by the commission.

SECTION 212. ORS 431.720 is amended to read:

431.720. (1) Upon receipt of the documents submitted under ORS 431.715 (4), the Environmental Quality Commission shall review them to determine whether the conditions dangerous to public health within the affected territory could be removed or alleviated by the provision of service facilities that are subject to the jurisdiction of the commission.

(2) If the commission considers such proposed facilities and the time schedule for installation of such facilities adequate to remove or alleviate the dangerous conditions, it shall approve the part of the plans that are subject to its jurisdiction and certify its approval to the [*Department of Human Services*] **Oregon Health Authority**.

(3) If the commission considers the proposed facilities or time schedule inadequate, it shall disapprove the part of the plans that are subject to its jurisdiction and certify its disapproval to the [*department*] **authority**. The commission shall also inform the requesting body of its approval or disapproval and, in case of disapproval, of the particular matters causing the disapproval. The requesting body may then submit additional or revised plans.

SECTION 213. ORS 431.725 is amended to read:

431.725. (1) Upon receipt of the certified copy of a resolution adopted under ORS 431.715, the [*Department of Human Services*] **Oregon Health Authority** shall contact the requesting body within 30 days of receipt of the request and schedule the review and investigation of conditions in the affected territory. The [*department*] **authority** shall review and investigate conditions in the affected territory in accordance with the agreed upon schedule unless both parties agree to an extension. If it finds substantial evidence that a danger to public health exists in the territory, it shall issue an order setting a time and place for a hearing on the resolution. The hearing shall be held within the affected territory, or at a place near the territory if there is no suitable place within the territory at which to hold the hearing, not less than 30 or more than 50 days after the date of the order.

(2) Upon issuance of an order for a hearing, the [*department*] **authority** shall immediately give notice of the time and place of the hearing on the resolution by publishing the order and resolution in a newspaper of general circulation within the territory once each week for two successive weeks and by posting copies of the order in four public places within the territory prior to the hearing.

SECTION 214. ORS 431.730 is amended to read:

431.730. (1) At the hearing on the resolution, any interested person shall be given a reasonable opportunity to be heard or to present written statements. The hearing shall be for the sole purpose of determining whether a danger to public health exists due to conditions in the affected territory and whether such conditions could be removed or alleviated by the provision of service facilities. Hearings under this section shall be conducted by an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605. It shall be conducted in accordance with the provisions of ORS chapter 183. The [*Department of Human Services*] **Oregon Health Authority** shall publish a notice of the issuance of said findings and recommendations in the newspaper utilized for the notice of hearing under ORS 431.725 (2) advising of the opportunity for presentation of a petition under subsection (2) of this section.

(2) Within 15 days after the publication of notice of issuance of findings in accordance with subsection (1) of this section, any person who may be affected by the findings, or the affected district, may petition the Director of [*Human Services*] **the Oregon Health Authority** according to rules of the [*department*] **authority** to present written or oral arguments relative to the proposal. If a petition is received, the director may set a time and place for receipt of argument.

SECTION 215. ORS 431.735 is amended to read:

431.735. (1) If the Director of [*Human Services*] **the Oregon Health Authority** after investi-

gation finds that no danger to public health exists because of conditions within the affected territory, or that such a danger does exist but the conditions causing it could not be removed or alleviated by the provision of service facilities, the director shall issue an order terminating the proceedings under ORS 431.705 to 431.760 with reference to the affected territory.

(2) If the director finds, after investigation and the hearing required by ORS 431.725, that a danger to public health exists because of conditions within the territory, and that such conditions could be removed or alleviated by the provisions of service facilities in accordance with the plans and specifications and the time schedule proposed, the director shall enter findings in an order, directed to the officers described by ORS 431.740, setting out the service facilities to be provided.

(3) If the director determines that a danger to public health exists because of conditions within only part of the affected territory, or that such conditions could be removed or alleviated in only part of the affected territory by the provision of service facilities, the director may, subject to conditions stated in ORS 431.705 to 431.760, reduce the boundaries of the affected territory to that part which presents a danger or in which the conditions could be removed or alleviated if the area to be excluded would not be surrounded by the territory remaining to be annexed and would not be directly served by the sanitary, water or other facilities necessary to remove or alleviate the danger to public health existing within the territory remaining to be annexed. The findings shall describe the boundaries of the area as reduced by the director.

(4) In determining whether to exclude any area the director may consider whether or not such exclusion would unduly interfere with the removal or alleviation of the danger to public health in the area remaining to be annexed and whether the exclusion would result in an illogical boundary for the provision of services.

(5) The requesting body or the boundary commission shall, when requested, aid in the determinations made under subsections (3) and (4) of this section and, if necessary, cause a study to be made.

SECTION 216. ORS 431.740 is amended to read:

431.740. (1) If a boundary commission has jurisdiction of the affected territory, the Director of [*Human Services*] **the Oregon Health Authority** shall file the findings and order with such boundary commission. If the affected territory is not within the jurisdiction of a boundary commission, the director shall file the findings and order with the county court of the county having jurisdiction of the territory.

(2) The [*Department of Human Services*] **Oregon Health Authority** and the Environmental Quality Commission shall use their applicable powers of enforcement to insure that the service facilities are constructed or installed in conformance with the approved plans and schedules.

SECTION 217. ORS 431.745 is amended to read:

431.745. (1) At any time after the adoption of a resolution under ORS 431.715, a petition, signed by not less than 51 percent of the electors registered in the affected territory, may be filed with the [*Department of Human Services*] **Oregon Health Authority**. The petition shall suggest an alternative plan to the proposed formation or annexation for removal or alleviation of the conditions dangerous to public health. The petition shall state the intent of the residents to seek annexation to an existing city or special district authorized by law to provide service facilities necessary to remove or alleviate the dangerous conditions. The petition shall be accompanied by a proposed plan which shall state the type of facilities to be constructed, a proposed means of financing the facilities and an estimate of the time required to construct such facilities and place them in operation.

(2) Upon receipt of the petition, the [*department*] **authority** shall immediately forward a copy

of the petition to the Environmental Quality Commission, if the plan accompanying the petition involves facilities that are subject to the jurisdiction of the commission. The [*department*] **authority** also shall forward a copy of the petition to the requesting body and to the county court or boundary commission where the [*department*] **authority** filed its findings under ORS 431.740 and direct the county court or boundary commission to stay the proceedings pending the review permitted under this section and ORS 431.750.

SECTION 218. ORS 431.750 is amended to read:

431.750. (1) If the alternative plan submitted under ORS 431.745 (1) involves service facilities that are subject to the jurisdiction of the commission, the alternative plan shall be submitted to and reviewed by the Environmental Quality Commission and shall be approved or rejected by the commission within 30 days from the date of filing with the [*Department of Human Services*] **Oregon Health Authority**. In reviewing the alternative plan, the commission shall consider whether, in its judgment, the plan contains a preferable alternative for the alleviation or removal of the conditions dangerous to public health. If the commission determines that the original plan provides the better and most expeditious method of removing or alleviating the dangerous conditions, it shall disapprove the alternative plan and inform the [*department*] **authority** of its decision. The [*department*] **authority** shall order the proceedings on the finding filed under ORS 431.740 to resume.

(2) If the commission finds that the alternative plan provides a preferable method of alleviating or removing the dangerous conditions, the petitioners shall be granted six months within which to present to the commission information showing:

(a) That the affected territory has annexed to a city or special district authorized by law to provide the service facilities necessary to remove or alleviate the dangerous conditions, and that the financing of the extension of such facilities to the territory has been assured.

(b) Detailed plans and specifications for the construction of such facilities.

(c) A time schedule for the construction of such facilities.

(d) That such facilities, if constructed, will remove or alleviate the conditions dangerous to public health in a manner as satisfactory and expeditious as would be accomplished by the formation or annexation proposed by the original plans.

(3) The commission shall review the plan presented to it by the petitioners under subsection (2) of this section and shall promptly certify to the [*department*] **authority** whether the requirements of subsection (2) of this section have been met. If the requirements have been met, the [*department*] **authority** shall certify the alternative plan to the county court or boundary commission having jurisdiction and direct it to proceed in accordance with the alternative plan and in lieu of the plans filed under ORS 431.740. If the requirements of subsection (2) of this section are not met by the petitioners, the [*department*] **authority** shall certify that fact to the county court or boundary commission having jurisdiction and direct it to continue the proceedings on the plans filed under ORS 431.740.

SECTION 219. ORS 431.760 is amended to read:

431.760. (1) A person who owns property or resides within affected territory that is subject to proceedings under the provisions of ORS 431.705 to 431.760 shall not participate in an official capacity in any investigation, hearing or recommendation relating to such proceedings. If the Director of [*Human Services*] **the Oregon Health Authority** is such a person, the director shall so inform the Governor, who shall appoint another person to fulfill the duties of the director in any investigation, hearing or recommendation relating to the such proceeding.

(2) Subsection (1) of this section does not excuse a member of a county court from voting on the

order required by ORS 198.792 (2) or 451.445 (1).

SECTION 220. Section 2, chapter 460, Oregon Laws 2007, is amended to read:

Sec. 2. (1) The [*Department of Human Services*] **Oregon Health Authority** shall develop, by the year 2009, a strategic plan to start to slow the rate of diabetes caused by obesity and other environmental factors by the year 2010.

(2) The [*department*] **authority** shall collaborate with the American Diabetes Association, the Oregon Diabetes Coalition and others such as:

(a) Health care professionals and researchers specializing in diabetes and obesity prevention, treatment or research;

(b) Diabetes educators;

(c) Representatives of medical schools or schools of public health;

(d) High school and post-secondary institution health educators;

(e) Representatives from geographic areas and other population groups at higher risk of diabetes;

(f) Representatives of community-based organizations involved in providing education about or awareness of diabetes; and

(g) Other individuals the [*department*] **authority** determines are necessary.

(3) The plan developed by the department shall include but not be limited to:

(a) Identification of environmental factors that encourage or support physical activity and healthy eating habits;

(b) Identification of preventative strategies that are effective and culturally competent and that meet the populations most at risk for developing diabetes;

(c) Recommendations for evidence-based screening;

(d) Recommendations for redesigning and financing primary care practices that would facilitate adoption of the Chronic Care Model for screening for diabetes, support for patient self-management and regular reporting of preventative clinical screening results;

(e) Identification of actions to be taken to reduce the morbidity and mortality from diabetes by the year 2015 and a time frame for taking those actions; and

(f) Recommendations to the Seventy-fifth Legislative Assembly on statutory changes and funding needed to achieve the [*department's*] **authority's** plan.

SECTION 221. ORS 431.825 is amended to read:

431.825. The [*Department of Human Services*] **Oregon Health Authority** shall provide to the counties of this state pamphlets described in ORS 106.081. The [*department*] **authority** may produce such pamphlets with moneys available for the purpose or may accept a gift of such pamphlets from any public or private source if the content is acceptable to the [*department*] **authority**.

SECTION 222. ORS 431.827 is amended to read:

431.827. The [*Department of Human Services*] **Oregon Health Authority** shall establish and implement appropriate education, prevention and outreach activities in communities that traditionally practice female circumcision, excision or infibulation for the purpose of informing:

(1) Those communities of the health risks and emotional trauma inflicted by the practices;

(2) Those communities and the medical community as to the existence and ramifications of ORS 163.207; and

(3) Those communities that the practices constitute physical injuries to a child for purposes of ORS 419B.005.

SECTION 223. ORS 431.830 is amended to read:

431.830. (1) The [*Department of Human Services*] **Oregon Health Authority** shall establish an acquired immune deficiency syndrome program:

(a) To provide education and prevention services to its clients; and

(b) To provide education and prevention services to the public.

(2) Programs authorized by this section may be operated by the [*department*] **authority** directly or under contract with public and private agencies.

SECTION 224. ORS 431.831 is amended to read:

431.831. (1) The [*Department of Human Services*] **Oregon Health Authority** shall develop a program to reimburse smoking cessation program providers for services provided to residents of this state who are not insured for smoking cessation costs.

(2) The [*department*] **authority** shall adopt rules for the program established under subsection (1) of this section that include but are not limited to criteria for provider and participant eligibility and other program specifications. The rules shall establish a maximum reimbursement limit for each participant.

(3) Costs for smoking cessation programs funded under subsection (1) of this section are eligible for reimbursement from funds received by the State of Oregon from tobacco products manufacturers under the Master Settlement Agreement of 1998.

SECTION 225. ORS 431.832 is amended to read:

431.832. (1) There is established in the General Fund the Tobacco Use Reduction Account.

(2) Amounts credited to the Tobacco Use Reduction Account are continuously appropriated to the [*Department of Human Services*] **Oregon Health Authority** for the funding of prevention and education programs designed to reduce cigarette and tobacco use.

SECTION 226. ORS 431.834 is amended to read:

431.834. The [*Department of Human Services*] **Oregon Health Authority** shall develop and adopt rules for awarding grants to programs for educating the public on the risk of tobacco use, including but not limited to:

(1) Educating children on the health hazards and consequences of tobacco use; and

(2) Promoting enrollment in smoking cessation programs and programs that prevent smoking-related diseases including cancer and other diseases of the heart, lungs and mouth.

SECTION 227. ORS 431.836 is amended to read:

431.836. During each biennium, the [*Department of Human Services*] **Oregon Health Authority** shall prepare a report regarding the awarding of grants from the Tobacco Use Reduction Account and the formation of public-private partnerships in connection with the receipt of funds from the account. The [*department*] **authority** shall present the report to the Governor and to those committees of the Legislative Assembly to which matters of public health are assigned.

SECTION 228. ORS 431.853 is amended to read:

431.853. (1) The [*Department of Human Services*] **Oregon Health Authority** shall:

(a) Coordinate with law enforcement agencies to conduct random, unannounced inspections of Oregon wholesalers and retailers of tobacco products to insure compliance with Oregon laws designed to discourage the use of tobacco by minors including ORS 163.575, 163.580, 167.400, 167.402 and 431.840; and

(b) Submit a report describing:

(A) The activities carried out to enforce the laws listed in paragraph (a) of this subsection during the previous fiscal year;

(B) The extent of success achieved in reducing the availability of tobacco products to minors;

and

(C) The strategies to be utilized for enforcing the laws listed in paragraph (a) of this subsection during the year following the report.

(2) The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules concerning random inspections of places that sell tobacco products consistent with section 1921, Public Law 102-321, 1992. The rules shall provide that inspections may take place:

(a) Only in areas open to the public;

(b) Only during hours that tobacco products are sold or distributed; and

(c) No more frequently than once a month in any single establishment unless a compliance problem exists or is suspected.

SECTION 229. ORS 431.890 is amended to read:

431.890. (1) The Poison Prevention Task Force is created in the Poison Center of the Oregon Health and Science University and consists of five members as follows:

(a) The Medical Director of the Oregon Poison Center or designee, who shall serve as chairperson.

(b) The Director of [*Human Services*] **the Oregon Health Authority** or a designee.

(c) A pediatrician licensed under ORS chapter 677, appointed by the Governor.

(d) A chemist from an academic institution, appointed by the Governor.

(e) A representative of a manufacturer of toxic household products, appointed by the Governor.

(2) Each member shall serve without compensation.

(3) The task force shall meet as considered necessary by the chairperson or on the call of three members of the task force.

(4) The task force shall meet for the purposes of reviewing, granting or denying requests for exemptions from and extensions of the requirements of ORS 431.870 to 431.915.

(5) The task force shall obtain and evaluate statewide poisoning incidence and severity data over a period of every two years for the purpose of making recommendations for the addition or deletion of products to ORS 431.885.

SECTION 230. ORS 431.915 is amended to read:

431.915. (1) Any person who violates any provision of ORS 431.870 to 431.915 shall be liable for a civil penalty not to exceed $5,000 for each day of violation, which shall be assessed and recovered in a civil action brought by the [*Department of Human Services*] **Oregon Health Authority**.

(2) All civil penalties collected pursuant to subsection (1) of this section shall be deposited in the General Fund.

SECTION 231. ORS 431.920 is amended to read:

431.920. The [*Department of Human Services*] **Oregon Health Authority** shall:

(1) Develop accreditation programs for training providers;

(2) Prescribe the requirements for and the manner of testing the competency of license applicants for the protection of the public and as required by federal law;

(3) Prescribe those actions or circumstances that constitute failure to achieve or maintain competency, or that otherwise are contrary to the public interest, for which the agency may refuse to issue or renew or may suspend or revoke a certification;

(4) Develop and conduct programs to screen blood lead levels, to identify hazards and to educate the public, including parents, residential dwelling owners and child care facility operators, about the dangers of lead-based paint hazards and of appropriate precautions that should be taken to reduce the possibility of childhood lead poisoning; and

(5) Impose fees to the extent necessary to pay the costs of the following:

(a) Certification of training curriculums, up to $1,500;

(b) Annual renewal of training providers and curriculums, up to $500;

(c) Certification of trainers, up to $500;

(d) Annual renewal of trainer's certification, up to $250; and

(e) Certification test, up to $85.

SECTION 232. ORS 431.940 is amended to read:

431.940. (1) The [*Department of Human Services*] **Oregon Health Authority** shall adopt by rule standards and a system of registration for tanning devices. Any entity doing business in this state as a tanning facility shall register the tanning devices with the [*department*] **authority** in a manner prescribed by rule.

(2) The registration shall include payment of an annual registration fee, not to exceed $100 per tanning device, prescribed by rule in an amount sufficient to cover the costs of administering the regulatory program.

(3) The [*department*] **authority** may conduct inspections of tanning facilities to ensure compliance with ORS 431.925 to 431.955.

SECTION 233. ORS 431.945 is amended to read:

431.945. (1) A tanning facility shall give each customer a written statement warning that:

(a) Not wearing the protective eye wear provided to each customer by the tanning facility may cause damage to the eyes.

(b) Overexposure to the tanning process causes burns.

(c) Repeated exposure to the tanning process may cause skin cancer or premature aging of the skin, or both.

(d) Abnormal skin sensitivity or burning may result from the tanning process if the customer is also consuming or using certain:

(A) Foods.

(B) Cosmetics.

(C) Medications such as tranquilizers, antibiotics, diuretics, high blood pressure medication, antineoplastics or birth control pills.

(e) Any person taking a prescription or over-the-counter drug should consult a physician before using a tanning device.

(2) In addition to giving customers the written statement required by subsection (1) of this section, the tanning facility shall post a warning sign in any area where a tanning device is used. The [*Department of Human Services*] **Oregon Health Authority** shall adopt by rule the language for the warning sign.

SECTION 234. ORS 431.950 is amended to read:

431.950. The [*Department of Human Services*] **Oregon Health Authority** may impose a civil penalty in an amount not to exceed $500 for a violation of ORS 431.925 to 431.955 or rules of the [*department*] **authority** adopted pursuant to ORS 431.925 to 431.955. Civil penalties under this section shall be imposed in the manner provided by ORS 183.745.

SECTION 235. ORS 431.955 is amended to read:

431.955. Except as otherwise provided by law, all fees and other moneys received by the [*Department of Human Services*] **Oregon Health Authority** pursuant to ORS 431.925 to 431.955 shall be paid into the State Treasury and placed to the credit of the Public Health Account and are continuously appropriated to the [*department*] **authority** for the purposes of carrying out the pro-

visions of ORS 431.925 to 431.955. If moneys received under ORS 431.925 to 431.955 are in excess of moneys required to administer the program authorized by ORS 431.925 to 431.955, the moneys may be used by the [*department*] **authority** to meet expenses of other programs administered by the [*department*] **authority** if an appropriate expenditure increase is approved by the Emergency Board.

SECTION 236. ORS 431.990 is amended to read:

431.990. Unless otherwise specifically provided by any other statute, failure to obey any rules relating to public health of the [*Department of Human Services*] **Oregon Health Authority** or failure to obey any lawful written order relating to public health issued by the Director of [*Human Services*] **the Oregon Health Authority** or any district or county public health administrator is a Class A misdemeanor.

SECTION 237. ORS 192.410 is amended to read:

192.410. As used in ORS 192.410 to 192.505:

(1) "Custodian" means:

(a) The person described in ORS 7.110 for purposes of court records; or

(b) A public body mandated, directly or indirectly, to create, maintain, care for or control a public record. "Custodian" does not include a public body that has custody of a public record as an agent of another public body that is the custodian unless the public record is not otherwise available.

(2) "Person" includes any natural person, corporation, partnership, firm, association or member or committee of the Legislative Assembly.

(3) "Public body" includes every state officer, agency, department, division, bureau, board and commission; every county and city governing body, school district, special district, municipal corporation, and any board, department, commission, council, or agency thereof; and any other public agency of this state.

(4)(a) "Public record" includes any writing that contains information relating to the conduct of the public's business, including but not limited to court records, mortgages, and deed records, prepared, owned, used or retained by a public body regardless of physical form or characteristics.

(b) "Public record" does not include any writing that does not relate to the conduct of the public's business and that is contained on a privately owned computer.

(5) "Regulator" means:

(a) With respect to the regulation of health insurance, health benefit plans, health care service contractors, multiple employer welfare arrangements and third party administrators of health and prescription benefits, the Oregon Health Authority; and

(b) With respect to the regulation of workers' compensation insurance and all other insurance not described in paragraph (a) of this subsection, the Department of Consumer and Business Services.

[*(5)*] **(6)** "State agency" means any state officer, department, board, commission or court created by the Constitution or statutes of this state but does not include the Legislative Assembly or its members, committees, officers or employees insofar as they are exempt under section 9, Article IV of the Oregon Constitution.

[*(6)*] **(7)** "Writing" means handwriting, typewriting, printing, photographing and every means of recording, including letters, words, pictures, sounds, or symbols, or combination thereof, and all papers, maps, files, facsimiles or electronic recordings.

SECTION 238. ORS 192.502 is amended to read:

192.502. The following public records are exempt from disclosure under ORS 192.410 to 192.505:

(1) Communications within a public body or between public bodies of an advisory nature to the extent that they cover other than purely factual materials and are preliminary to any final agency determination of policy or action. This exemption shall not apply unless the public body shows that in the particular instance the public interest in encouraging frank communication between officials and employees of public bodies clearly outweighs the public interest in disclosure.

(2) Information of a personal nature such as but not limited to that kept in a personal, medical or similar file, if public disclosure would constitute an unreasonable invasion of privacy, unless the public interest by clear and convincing evidence requires disclosure in the particular instance. The party seeking disclosure shall have the burden of showing that public disclosure would not constitute an unreasonable invasion of privacy.

(3) Public body employee or volunteer addresses, Social Security numbers, dates of birth and telephone numbers contained in personnel records maintained by the public body that is the employer or the recipient of volunteer services. This exemption:

(a) Does not apply to the addresses, dates of birth and telephone numbers of employees or volunteers who are elected officials, except that a judge or district attorney subject to election may seek to exempt the judge′s or district attorney′s address or telephone number, or both, under the terms of ORS 192.445;

(b) Does not apply to employees or volunteers to the extent that the party seeking disclosure shows by clear and convincing evidence that the public interest requires disclosure in a particular instance;

(c) Does not apply to a substitute teacher as defined in ORS 342.815 when requested by a professional education association of which the substitute teacher may be a member; and

(d) Does not relieve a public employer of any duty under ORS 243.650 to 243.782.

(4) Information submitted to a public body in confidence and not otherwise required by law to be submitted, where such information should reasonably be considered confidential, the public body has obliged itself in good faith not to disclose the information, and when the public interest would suffer by the disclosure.

(5) Information or records of the Department of Corrections, including the State Board of Parole and Post-Prison Supervision, to the extent that disclosure would interfere with the rehabilitation of a person in custody of the department or substantially prejudice or prevent the carrying out of the functions of the department, if the public interest in confidentiality clearly outweighs the public interest in disclosure.

(6) Records, reports and other information received or compiled by the [*Director of the Department of Consumer and Business Services*] **regulator** in the administration of ORS chapters 723 and 725 not otherwise required by law to be made public, to the extent that the interests of lending institutions, their officers, employees and customers in preserving the confidentiality of such information outweighs the public interest in disclosure.

(7) Reports made to or filed with the court under ORS 137.077 or 137.530.

(8) Any public records or information the disclosure of which is prohibited by federal law or regulations.

(9)(a) Public records or information the disclosure of which is prohibited or restricted or otherwise made confidential or privileged under Oregon law.

(b) Subject to ORS 192.423, paragraph (a) of this subsection does not apply to factual information compiled in a public record when:

(A) The basis for the claim of exemption is ORS 40.225;

(B) The factual information is not prohibited from disclosure under any applicable state or federal law, regulation or court order and is not otherwise exempt from disclosure under ORS 192.410 to 192.505;

(C) The factual information was compiled by or at the direction of an attorney as part of an investigation on behalf of the public body in response to information of possible wrongdoing by the public body;

(D) The factual information was not compiled in preparation for litigation, arbitration or an administrative proceeding that was reasonably likely to be initiated or that has been initiated by or against the public body; and

(E) The holder of the privilege under ORS 40.225 has made or authorized a public statement characterizing or partially disclosing the factual information compiled by or at the attorney's direction.

(10) Public records or information described in this section, furnished by the public body originally compiling, preparing or receiving them to any other public officer or public body in connection with performance of the duties of the recipient, if the considerations originally giving rise to the confidential or exempt nature of the public records or information remain applicable.

(11) Records of the Energy Facility Siting Council concerning the review or approval of security programs pursuant to ORS 469.530.

(12) Employee and retiree address, telephone number and other nonfinancial membership records and employee financial records maintained by the Public Employees Retirement System pursuant to ORS chapters 238 and 238A.

(13) Records of or submitted to the State Treasurer, the Oregon Investment Council or the agents of the treasurer or the council relating to active or proposed publicly traded investments under ORS chapter 293, including but not limited to records regarding the acquisition, exchange or liquidation of the investments. For the purposes of this subsection:

(a) The exemption does not apply to:

(A) Information in investment records solely related to the amount paid directly into an investment by, or returned from the investment directly to, the treasurer or council; or

(B) The identity of the entity to which the amount was paid directly or from which the amount was received directly.

(b) An investment in a publicly traded investment is no longer active when acquisition, exchange or liquidation of the investment has been concluded.

(14)(a) Records of or submitted to the State Treasurer, the Oregon Investment Council, the Oregon Growth Account Board or the agents of the treasurer, council or board relating to actual or proposed investments under ORS chapter 293 or 348 in a privately placed investment fund or a private asset including but not limited to records regarding the solicitation, acquisition, deployment, exchange or liquidation of the investments including but not limited to:

(A) Due diligence materials that are proprietary to an investment fund, to an asset ownership or to their respective investment vehicles.

(B) Financial statements of an investment fund, an asset ownership or their respective investment vehicles.

(C) Meeting materials of an investment fund, an asset ownership or their respective investment vehicles.

(D) Records containing information regarding the portfolio positions in which an investment fund, an asset ownership or their respective investment vehicles invest.

(E) Capital call and distribution notices of an investment fund, an asset ownership or their respective investment vehicles.

(F) Investment agreements and related documents.

(b) The exemption under this subsection does not apply to:

(A) The name, address and vintage year of each privately placed investment fund.

(B) The dollar amount of the commitment made to each privately placed investment fund since inception of the fund.

(C) The dollar amount of cash contributions made to each privately placed investment fund since inception of the fund.

(D) The dollar amount, on a fiscal year-end basis, of cash distributions received by the State Treasurer, the Oregon Investment Council, the Oregon Growth Account Board or the agents of the treasurer, council or board from each privately placed investment fund.

(E) The dollar amount, on a fiscal year-end basis, of the remaining value of assets in a privately placed investment fund attributable to an investment by the State Treasurer, the Oregon Investment Council, the Oregon Growth Account Board or the agents of the treasurer, council or board.

(F) The net internal rate of return of each privately placed investment fund since inception of the fund.

(G) The investment multiple of each privately placed investment fund since inception of the fund.

(H) The dollar amount of the total management fees and costs paid on an annual fiscal year-end basis to each privately placed investment fund.

(I) The dollar amount of cash profit received from each privately placed investment fund on a fiscal year-end basis.

(15) The monthly reports prepared and submitted under ORS 293.761 and 293.766 concerning the Public Employees Retirement Fund and the Industrial Accident Fund may be uniformly treated as exempt from disclosure for a period of up to 90 days after the end of the calendar quarter.

(16) Reports of unclaimed property filed by the holders of such property to the extent permitted by ORS 98.352.

(17) The following records, communications and information submitted to the Oregon Economic and Community Development Commission, the Economic and Community Development Department, the State Department of Agriculture, the Oregon Growth Account Board, the Port of Portland or other ports, as defined in ORS 777.005, by applicants for investment funds, loans or services including, but not limited to, those described in ORS 285A.224:

(a) Personal financial statements.

(b) Financial statements of applicants.

(c) Customer lists.

(d) Information of an applicant pertaining to litigation to which the applicant is a party if the complaint has been filed, or if the complaint has not been filed, if the applicant shows that such litigation is reasonably likely to occur; this exemption does not apply to litigation which has been concluded, and nothing in this paragraph shall limit any right or opportunity granted by discovery or deposition statutes to a party to litigation or potential litigation.

(e) Production, sales and cost data.

(f) Marketing strategy information that relates to applicant's plan to address specific markets and applicant's strategy regarding specific competitors.

(18) Records, reports or returns submitted by private concerns or enterprises required by law to be submitted to or inspected by a governmental body to allow it to determine the amount of any

transient lodging tax payable and the amounts of such tax payable or paid, to the extent that such information is in a form which would permit identification of the individual concern or enterprise. Nothing in this subsection shall limit the use which can be made of such information for regulatory purposes or its admissibility in any enforcement proceedings. The public body shall notify the taxpayer of the delinquency immediately by certified mail. However, in the event that the payment or delivery of transient lodging taxes otherwise due to a public body is delinquent by over 60 days, the public body shall disclose, upon the request of any person, the following information:

(a) The identity of the individual concern or enterprise that is delinquent over 60 days in the payment or delivery of the taxes.

(b) The period for which the taxes are delinquent.

(c) The actual, or estimated, amount of the delinquency.

(19) All information supplied by a person under ORS 151.485 for the purpose of requesting appointed counsel, and all information supplied to the court from whatever source for the purpose of verifying the financial eligibility of a person pursuant to ORS 151.485.

(20) Workers' compensation claim records of the Department of Consumer and Business Services, except in accordance with rules adopted by the Director of the Department of Consumer and Business Services, in any of the following circumstances:

(a) When necessary for insurers, self-insured employers and third party claim administrators to process workers' compensation claims.

(b) When necessary for the director, other governmental agencies of this state or the United States to carry out their duties, functions or powers.

(c) When the disclosure is made in such a manner that the disclosed information cannot be used to identify any worker who is the subject of a claim.

(d) When a worker or the worker's representative requests review of the worker's claim record.

(21) Sensitive business records or financial or commercial information of the Oregon Health and Science University that is not customarily provided to business competitors.

(22) Records of Oregon Health and Science University regarding candidates for the position of president of the university.

(23) The records of a library, including:

(a) Circulation records, showing use of specific library material by a named person;

(b) The name of a library patron together with the address or telephone number of the patron; and

(c) The electronic mail address of a patron.

(24) The following records, communications and information obtained by the Housing and Community Services Department in connection with the department's monitoring or administration of financial assistance or of housing or other developments:

(a) Personal and corporate financial statements and information, including tax returns.

(b) Credit reports.

(c) Project appraisals.

(d) Market studies and analyses.

(e) Articles of incorporation, partnership agreements and operating agreements.

(f) Commitment letters.

(g) Project pro forma statements.

(h) Project cost certifications and cost data.

(i) Audits.

(j) Project tenant correspondence.

(k) Personal information about a tenant.

(L) Housing assistance payments.

(25) Raster geographic information system (GIS) digital databases, provided by private forestland owners or their representatives, voluntarily and in confidence to the State Forestry Department, that is not otherwise required by law to be submitted.

(26) Sensitive business, commercial or financial information furnished to or developed by a public body engaged in the business of providing electricity or electricity services, if the information is directly related to a transaction described in ORS 261.348, or if the information is directly related to a bid, proposal or negotiations for the sale or purchase of electricity or electricity services, and disclosure of the information would cause a competitive disadvantage for the public body or its retail electricity customers. This subsection does not apply to cost-of-service studies used in the development or review of generally applicable rate schedules.

(27) Sensitive business, commercial or financial information furnished to or developed by the City of Klamath Falls, acting solely in connection with the ownership and operation of the Klamath Cogeneration Project, if the information is directly related to a transaction described in ORS 225.085 and disclosure of the information would cause a competitive disadvantage for the Klamath Cogeneration Project. This subsection does not apply to cost-of-service studies used in the development or review of generally applicable rate schedules.

(28) Personally identifiable information about customers of a municipal electric utility or a people's utility district or the names, dates of birth, driver license numbers, telephone numbers, electronic mail addresses or Social Security numbers of customers who receive water, sewer or storm drain services from a public body as defined in ORS 174.109. The utility or district may release personally identifiable information about a customer, and a public body providing water, sewer or storm drain services may release the name, date of birth, driver license number, telephone number, electronic mail address or Social Security number of a customer, if the customer consents in writing or electronically, if the disclosure is necessary for the utility, district or other public body to render services to the customer, if the disclosure is required pursuant to a court order or if the disclosure is otherwise required by federal or state law. The utility, district or other public body may charge as appropriate for the costs of providing such information. The utility, district or other public body may make customer records available to third party credit agencies on a regular basis in connection with the establishment and management of customer accounts or in the event such accounts are delinquent.

(29) A record of the street and number of an employee's address submitted to a special district to obtain assistance in promoting an alternative to single occupant motor vehicle transportation.

(30) Sensitive business records, capital development plans or financial or commercial information of Oregon Corrections Enterprises that is not customarily provided to business competitors.

(31) Documents, materials or other information submitted to the Director of the Department of Consumer and Business Services in confidence by a state, federal, foreign or international regulatory or law enforcement agency or by the National Association of Insurance Commissioners, its affiliates or subsidiaries under ORS 646A.250 to 646A.270, 697.005 to 697.095, 697.602 to 697.842, 705.137, 717.200 to 717.320, 717.900 or 717.905, ORS chapter 59, 722, 723, 725 or 726, the Bank Act or the Insurance Code when:

(a) The document, material or other information is received upon notice or with an understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of

the document, material or other information; and

(b) The director has obligated the Department of Consumer and Business Services not to disclose the document, material or other information.

(32) A county elections security plan developed and filed under ORS 254.074.

(33) Information about review or approval of programs relating to the security of:

(a) Generation, storage or conveyance of:

(A) Electricity;

(B) Gas in liquefied or gaseous form;

(C) Hazardous substances as defined in ORS 453.005 (7)(a), (b) and (d);

(D) Petroleum products;

(E) Sewage; or

(F) Water.

(b) Telecommunication systems, including cellular, wireless or radio systems.

(c) Data transmissions by whatever means provided.

(34) The information specified in ORS 25.020 (8) if the Chief Justice of the Supreme Court designates the information as confidential by rule under ORS 1.002.

SECTION 239. ORS 192.519 is amended to read:

192.519. As used in ORS 192.518 to 192.529:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or

(d) A health care clearinghouse.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist licensed under ORS chapter 675 or an employee of the psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical technician certified under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A radiologic technologist licensed under ORS 688.405 to 688.605 or an employee of the radiologic technologist;

(o) A respiratory care practitioner licensed under ORS 688.800 to 688.840 or an employee of the respiratory care practitioner;

(p) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(q) A dietitian licensed under ORS 691.405 to 691.585 or an employee of the dietitian;

(r) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(s) A health care facility as defined in ORS 442.015;

(t) A home health agency as defined in ORS 443.005;

(u) A hospice program as defined in ORS 443.850;

(v) A clinical laboratory as defined in ORS 438.010;

(w) A pharmacy as defined in ORS 689.005;

(x) A diabetes self-management program as defined in ORS 743A.184; and

(y) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means:

(a) An insurer as defined in ORS 731.106 who offers:

(A) A health benefit plan as defined in ORS 743.730;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.526.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) The state Medicaid program;

(b) The Oregon State Children's Health Insurance Program; [*or*]

(c) The Family Health Insurance Assistance Program established in ORS 735.720 to 735.740[.]**; or**

(d) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 240. ORS 192.527 is amended to read:

192.527. (1) Notwithstanding ORS 179.505, a state health plan or a prepaid managed care health services organization may disclose the protected health information of an individual listed in subsection (2) of this section, without obtaining an authorization from the individual or a personal representative of the individual, to another prepaid managed care health services organization for treatment activities of a prepaid managed care health services organization when the prepaid managed care health services organization is providing behavioral or physical health care services to the individual.

(2) The protected health information that may be disclosed pursuant to subsection (1) of this section includes the following, as defined by the [*Department of Human Services*] **Oregon Health Authority** by rule:

(a) Oregon Health Plan member name;

(b) Medicaid recipient number;

(c) Performing provider number;

(d) Hospital provider name;

(e) Attending physician;

(f) Diagnosis;

(g) Date or dates of service;

(h) Procedure code;

(i) Revenue code;

(j) Quantity of units of service provided; or

(k) Medication prescription and monitoring.

(3) As used in this section, "prepaid managed care health services organization" has the meaning given that term in ORS 414.736.

SECTION 241. ORS 192.535 is amended to read:

192.535. (1) A person may not obtain genetic information from an individual, or from an individual's DNA sample, without first obtaining informed consent of the individual or the individual's representative, except:

(a) As authorized by ORS 181.085 or comparable provisions of federal criminal law relating to the identification of persons, or for the purpose of establishing the identity of a person in the course of an investigation conducted by a law enforcement agency, a district attorney, a medical examiner or the Criminal Justice Division of the Department of Justice;

(b) For anonymous research or coded research conducted under conditions described in ORS 192.537 (2), after notification pursuant to ORS 192.538 or pursuant to ORS 192.547 (7)(b);

(c) As permitted by rules of the [*Department of Human Services*] **Oregon Health Authority** for identification of deceased individuals;

(d) As permitted by rules of the [*Department of Human Services*] **Oregon Health Authority** for newborn screening procedures;

(e) As authorized by statute for the purpose of establishing paternity; or

(f) For the purpose of furnishing genetic information relating to a decedent for medical diagnosis of blood relatives of the decedent.

(2) Except as provided in subsection (3) of this section, a physician licensed under ORS chapter 677 shall seek the informed consent of the individual or the individual's representative for the purposes of subsection (1) of this section in the manner provided by ORS 677.097. Except as provided in subsection (3) of this section, any other licensed health care provider or facility must seek the informed consent of the individual or the individual's representative for the purposes of subsection (1) of this section in a manner substantially similar to that provided by ORS 677.097 for physicians.

(3) A person conducting research shall seek the informed consent of the individual or the individual's representative for the purposes of subsection (1) of this section in the manner provided by ORS 192.547.

(4) Except as provided in ORS 746.135 (1), any person not described in subsection (2) or (3) of this section must seek the informed consent of the individual or the individual's representative for the purposes of subsection (1) of this section in the manner provided by rules adopted by the [*Department of Human Services*] **Oregon Health Authority**.

(5) The [*Department of Human Services*] **Oregon Health Authority** may not adopt rules under subsection (1)(d) of this section that would require the providing of a DNA sample for the purpose of obtaining complete genetic information used to screen all newborns.

SECTION 242. ORS 192.547 is amended to read:

192.547. (1)(a) The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules for conducting research using DNA samples, genetic testing and genetic information. Rules establishing minimum research standards shall conform to the Federal Policy for the Protection of Human Subjects, 45 C.F.R. 46, that is current at the time the rules are adopted. The rules may be changed from time to time as may be necessary.

(b) The rules adopted by the [*Department of Human Services*] **Oregon Health Authority** shall address the operation and appointment of institutional review boards. The rules shall conform to the compositional and operational standards for such boards contained in the Federal Policy for the Protection of Human Subjects that is current at the time the rules are adopted. The rules must require that research conducted under paragraph (a) of this subsection be conducted with the approval of the institutional review board.

(c) Persons proposing to conduct anonymous research, coded research or genetic research that is otherwise thought to be exempt from review must obtain from an institutional review board prior to conducting such research a determination that the proposed research is exempt from review.

(2) A person proposing to conduct research under subsection (1) of this section, including anonymous research or coded research, must disclose to the institutional review board the proposed use of DNA samples, genetic testing or genetic information.

(3) The [*Department of Human Services*] **Oregon Health Authority** shall adopt rules requiring that all institutional review boards operating under subsection (1)(b) of this section register with the department. The Advisory Committee on Genetic Privacy and Research shall use the registry to educate institutional review boards about the purposes and requirements of the genetic privacy statutes and administrative rules relating to genetic research.

(4) The [*Department of Human Services*] **Oregon Health Authority** shall consult with the Advisory Committee on Genetic Privacy and Research before adopting the rules required under subsections (1) and (3) of this section, including rules identifying those parts of the Federal Policy for the Protection of Human Subjects that are applicable to this section.

(5) Genetic research in which the DNA sample or genetic information is coded shall satisfy the following requirements:

(a)(A) The subject has granted informed consent for the specific research project;

(B) The subject has consented to genetic research generally; or

(C) The DNA sample or genetic information is derived from a biological specimen or from clinical individually identifiable health information that was obtained or retained in compliance with ORS 192.537 (2).

(b) The research has been approved by an institutional review board after disclosure by the investigator to the board of risks associated with the coding.

(c) The code is:

(A) Not derived from individual identifiers;

(B) Kept securely and separately from the DNA samples and genetic information; and

(C) Not accessible to the investigator unless specifically approved by the institutional review board.

(d) Data is stored securely in password protected electronic files or by other means with access limited to necessary personnel.

(e) The data is limited to elements required for analysis and meets the criteria in 45 C.F.R 164.514(e) for a limited data set.

(f) The investigator is a party to the data use agreement as provided by 45 C.F.R. 164.514(e) for limited data set recipients.

(6) Research conducted in accordance with this section is rebuttably presumed to comply with ORS 192.535 and 192.539.

(7)(a) Notwithstanding ORS 192.535, a person may use a DNA sample or genetic information obtained, with blanket informed consent, before June 25, 2001, for genetic research.

(b) Notwithstanding ORS 192.535, a person may use a DNA sample or genetic information obtained without specific informed consent and derived from a biological specimen or clinical individually identifiable health information for anonymous research or coded research if an institutional review board operating under subsection (1)(b) of this section:

(A) Waives or alters the consent requirements pursuant to the Federal Policy for the Protection of Human Subjects; and

(B) Waives authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy regulations, 45 C.F.R. parts 160 and 164.

(c) Except as provided in subsection (5)(a) of this section or paragraph (b) of this subsection, a person must have specific informed consent from an individual to use a DNA sample or genetic information of the individual obtained on or after June 25, 2001, for genetic research.

(8) Except as otherwise allowed by rule of the [*Department of Human Services*] **Oregon Health Authority**, if DNA samples or genetic information obtained for either clinical or research purposes is used in research, a person may not recontact the individual or the individual's physician by using research information that is identifiable or coded. The [*Department of Human Services*] **Oregon Health Authority** shall adopt by rule criteria for recontacting an individual or an individual's physician. In adopting the criteria, the department shall consider the recommendations of national organizations such as those created by executive order by the President of the United States and the recommendations of the Advisory Committee on Genetic Privacy and Research.

(9) The requirements for consent to, or notification of, obtaining a DNA sample or genetic information for genetic research are governed by the provisions of ORS 192.531 to 192.549 and the administrative rules that were in effect on the effective date of the institutional review board's most recent approval of the study.

SECTION 243. ORS 192.630, as amended by section 21, chapter 100, Oregon Laws 2007, is amended to read:

192.630. (1) All meetings of the governing body of a public body shall be open to the public and all persons shall be permitted to attend any meeting except as otherwise provided by ORS 192.610 to 192.690.

(2) A quorum of a governing body may not meet in private for the purpose of deciding on or deliberating toward a decision on any matter except as otherwise provided by ORS 192.610 to 192.690.

(3) A governing body may not hold a meeting at any place where discrimination on the basis of race, color, creed, sex, sexual orientation, national origin, age or disability is practiced. However, the fact that organizations with restricted membership hold meetings at the place does not restrict its use by a public body if use of the place by a restricted membership organization is not the primary purpose of the place or its predominate use.

(4) Meetings of the governing body of a public body shall be held within the geographic boundaries over which the public body has jurisdiction, or at the administrative headquarters of the public body or at the other nearest practical location. Training sessions may be held outside the jurisdiction as long as no deliberations toward a decision are involved. A joint meeting of two or more governing bodies or of one or more governing bodies and the elected officials of one or more federally recognized Oregon Indian tribes shall be held within the geographic boundaries over which one of the participating public bodies or one of the Oregon Indian tribes has jurisdiction or at the nearest practical location. Meetings may be held in locations other than those described in this subsection in the event of an actual emergency necessitating immediate action.

(5)(a) It is discrimination on the basis of disability for a governing body of a public body to meet in a place inaccessible to persons with disabilities, or, upon request of a person who is deaf or hard of hearing, to fail to make a good faith effort to have an interpreter for persons who are deaf or hard of hearing provided at a regularly scheduled meeting. The sole remedy for discrimination on the basis of disability shall be as provided in ORS 192.680.

(b) The person requesting the interpreter shall give the governing body at least 48 hours' notice of the request for an interpreter, shall provide the name of the requester, sign language preference and any other relevant information the governing body may request.

(c) If a meeting is held upon less than 48 hours' notice, reasonable effort shall be made to have an interpreter present, but the requirement for an interpreter does not apply to emergency meetings.

(d) If certification of interpreters occurs under state or federal law, the [*Department of Human Services*] **Oregon Health Authority** or other state or local agency shall try to refer only certified interpreters to governing bodies for purposes of this subsection.

(e) As used in this subsection, "good faith effort" includes, but is not limited to, contacting the department or other state or local agency that maintains a list of qualified interpreters and arranging for the referral of one or more qualified interpreters to provide interpreter services.

SECTION 244. ORS 192.549 is amended to read:

192.549. (1) The Advisory Committee on Genetic Privacy and Research is established consisting of 15 members. The President of the Senate and the Speaker of the House of Representatives shall each appoint one member and one alternate. The Director of [*Human Services*] **the Oregon Health Authority** shall appoint one representative and one alternate from each of the following categories:

(a) Academic institutions involved in genetic research;

(b) Physicians licensed under ORS chapter 677;

(c) Voluntary organizations involved in the development of public policy on issues related to genetic privacy;

(d) Hospitals;

[*(e) The Department of Human Services;*]

[*(f)*] **(e)** The [*Department of Consumer and Business Services*] **Oregon Health Authority**;

[*(g)*] **(f)** Health care service contractors involved in genetic and health services research;

[*(h)*] **(g)** The biosciences industry;

[*(i)*] **(h)** The pharmaceutical industry;

[*(j)*] **(i)** Health care consumers;

[*(k)*] **(j)** Organizations advocating for privacy of medical information;

[*(L)*] **(k)** Public members of institutional review boards; and

[*(m)*] **(L)** Organizations or individuals promoting public education about genetic research and genetic privacy and public involvement in policymaking related to genetic research and genetic privacy.

(2) Organizations and individuals representing the categories listed in subsection (1) of this section may recommend nominees for membership on the advisory committee to the President, the Speaker and the director.

(3) Members and alternate members of the advisory committee serve two-year terms and may be reappointed.

(4) Members and alternate members of the advisory committee serve at the pleasure of the appointing entity.

(5) The [*Department of Human Services*] **Oregon Health Authority** shall provide staff for the

advisory committee.

(6) The advisory committee shall report biennially to the Legislative Assembly in the manner provided by ORS 192.245. The report shall include the activities and the results of any studies conducted by the advisory committee. The advisory committee may make any recommendations for legislative changes deemed necessary by the advisory committee.

(7) The advisory committee shall study the use and disclosure of genetic information and shall develop and refine a legal framework that defines the rights of individuals whose DNA samples and genetic information are collected, stored, analyzed and disclosed.

(8) The advisory committee shall create opportunities for public education on the scientific, legal and ethical development within the fields of genetic privacy and research. The advisory committee shall also elicit public input on these matters. The advisory committee shall make reasonable efforts to obtain public input that is representative of the diversity of opinion on this subject. The advisory committee's recommendations to the Legislative Assembly shall take into consideration public concerns and values related to these matters.

SECTION 245. ORS 238.410 is amended to read:

238.410. (1) As used in this section:

(a) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services **or the Oregon Health Authority**, an insurance company or health care service contractor licensed or certified in another state that is operating under the laws of that state, or two or more of those companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation.

(b) "Eligible person" means:

(A) A member of the Public Employees Retirement System who is retired for service or disability and is receiving a retirement allowance or benefit under the system, and a spouse or dependent of that member;

(B) A person who is a surviving spouse or dependent of a deceased retired member of the system or the surviving spouse or dependent of a member of the system who had not retired but who had reached earliest retirement age at the time of death;

(C) A person who is receiving retirement pay or a pension calculated under ORS 1.314 to 1.380 (1989 Edition), and a spouse or dependent of that person; or

(D) A surviving spouse or dependent of a deceased retired member of the system or of a person who was receiving retirement pay or a pension calculated under ORS 1.314 to 1.380 (1989 Edition) if the surviving spouse or dependent was covered at the time of the decedent's death by a health care insurance plan contracted for under this section.

(c) "Health care" means medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies and includes comparable benefits for persons who rely on spiritual means of healing.

(2) The Public Employees Retirement Board shall conduct a continuing study and investigation of all matters connected with the providing of health care insurance protection to eligible persons. The board shall design benefits, devise specifications, invite proposals, analyze carrier responses to advertisements for proposals and do acts necessary to award contracts to provide health care insurance, including insurance that provides coverage supplemental to federal Medicare coverage, with emphasis on features based on health care cost containment principles, for eligible persons. The board is not subject to the provisions of ORS chapters 279A and 279B, except ORS 279B.235,

in awarding contracts under the provisions of this section. The board shall establish procedures for inviting proposals and awarding contracts under this section.

(3) The board shall enter into a contract with a carrier to provide health care insurance for eligible persons for a one or two-year period. The board may enter into more than one contract with one or more carriers, contracting jointly or severally, if in the opinion of the board it is necessary to do so to obtain maximum coverage at minimum cost and consistent with the health care insurance needs of eligible persons. The board periodically shall review a current contract or contracts and make suitable study and investigation for the purpose of determining whether a different contract or contracts can and should, in the best interest of eligible persons, be entered into. If it would be advantageous to eligible persons to do so, the board shall enter into a different contract or contracts. Contracts shall be signed by the chairperson on behalf of the board.

(4) Except as provided in ORS 238.415 and 238.420, the board may deduct monthly from the retirement allowance or benefit, retirement pay or pension payable to an eligible person who elects to participate in a health care insurance plan the monthly cost of the coverage for the person under a health care insurance contract entered into under this section and the administrative costs incurred by the board under this section, and shall pay those amounts into the Standard Retiree Health Insurance Account established under subsection (7) of this section. The board by rule may establish other procedures for collecting the monthly cost of the coverage and the administrative costs incurred by the board under this section if the board does not deduct those costs from the retirement allowance or benefit, retirement pay or pension payable to an eligible person.

(5) Subject to applicable provisions of ORS chapter 183, the board may make rules not inconsistent with this section to determine the terms and conditions of eligible person participation and coverage and otherwise to implement and carry out the purposes and provisions of this section and ORS 238.420.

(6) The board may retain consultants, brokers or other advisory personnel, organizations specializing in health care cost containment or other administrative services when it determines the necessity and, subject to the State Personnel Relations Law, shall employ such personnel as are required to assist in performing the functions of the board under this section.

(7) Pursuant to section 401(h) of the Internal Revenue Code, the Standard Retiree Health Insurance Account is established within the Public Employees Retirement Fund, separate and distinct from the General Fund. All payments made by eligible persons for health insurance coverage provided under this section shall be held in the account. Interest earned by the account shall be credited to the account. All moneys in the account are continuously appropriated to the Public Employees Retirement Board and may be used by the board only to pay the cost of health insurance coverage under this section and to pay the administrative costs incurred by the board under this section.

(8) The sum of all amounts paid by eligible persons into the Standard Retiree Health Insurance Account, by participating public employers into the Retiree Health Insurance Premium Account under ORS 238.415, and by participating public employers into the Retirement Health Insurance Account under ORS 238.420, may not exceed 25 percent of the aggregate contributions made by participating public employers to the Public Employees Retirement Fund on or after July 11, 1987, not including contributions made by participating public employers to fund prior service credits.

(9) Until all liabilities for health benefits under the system are satisfied, contributions and earnings in the Standard Retiree Health Insurance Account, the Retiree Health Insurance Premium Account under ORS 238.415 and the Retirement Health Insurance Account under ORS 238.420 may

not be diverted or otherwise put to any use other than providing health benefits and payment of reasonable costs incurred in administering this section and ORS 238.415 and 238.420. Upon satisfaction of all liabilities for providing health benefits under this section, any amount remaining in the Standard Retiree Health Insurance Account shall be returned to the participating public employers who have made contributions to the account. The distribution shall be made in such equitable manner as the board determines appropriate.

SECTION 246. ORS 243.105 is amended to read:

243.105. As used in ORS 243.105 to 243.285, unless the context requires otherwise:

(1) "Benefit plan" includes, but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Comparable benefits for employees who rely on spiritual means of healing; and

(c) Self-insurance programs managed by the Public Employees' Benefit Board.

(2) "Board" means the Public Employees' Benefit Board.

(3) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services **or the Oregon Health Authority**, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved guarantor of benefit plan coverage and compensation.

(4)(a) "Eligible employee" means an officer or employee of a state agency who elects to participate in one of the group benefit plans described in ORS 243.135. The term includes state officers and employees in the exempt, unclassified and classified service, and state officers and employees, whether or not retired, who:

(A) Are receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or are receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the State of Oregon for its officers and employees;

(B) Are eligible to receive a service retirement allowance under the Public Employees Retirement System and have reached earliest retirement age under ORS chapter 238;

(C) Are eligible to receive a pension under ORS 238A.100 to 238A.245, and have reached earliest retirement age as described in ORS 238A.165; or

(D) Are eligible to receive a service retirement allowance or pension under another retirement benefit plan or system offered by the State of Oregon and have attained earliest retirement age under the plan or system.

(b) "Eligible employee" does not include individuals:

(A) Engaged as independent contractors;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis;

(C) Who are employed on less than half-time basis unless the individuals are employed in positions classified as job-sharing positions, unless the individuals are defined as eligible under rules of the board or unless the individuals are employed as nurses or nursing educators;

(D) Appointed under ORS 240.309;

(E) Provided sheltered employment or make-work by the state in an employment or industries program maintained for the benefit of such individuals; or

(F) Provided student health care services in conjunction with their enrollment as students at the state institutions of higher education.

(5) "Family member" means an eligible employee's spouse and any unmarried child or stepchild within age limits and other conditions imposed by the board with regard to unmarried children or stepchildren.

(6) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of employees of a state agency.

(7) "Premium" means the monthly or other periodic charge for a benefit plan.

(8) "State agency" means every state officer, board, commission, department or other activity of state government.

SECTION 247. ORS 243.860 is amended to read:

243.860. As used in ORS 243.860 to 243.886, unless the context requires otherwise:

(1) "Benefit plan" includes but is not limited to:

(a) Contracts for insurance or other benefits, including medical, dental, vision, life, disability and other health care recognized by state law, and related services and supplies;

(b) Self-insurance programs managed by the Oregon Educators Benefit Board; and

(c) Comparable benefits for employees who rely on spiritual means of healing.

(2) "Carrier" means an insurance company or health care service contractor holding a valid certificate of authority from the Director of the Department of Consumer and Business Services **or the Oregon Health Authority**, or two or more companies or contractors acting together pursuant to a joint venture, partnership or other joint means of operation, or a board-approved provider or guarantor of benefit plan coverage and compensation.

(3) "District" means a common school district, a union high school district, an education service district, as defined in ORS 334.003, or a community college district, as defined in ORS 341.005.

(4)(a) "Eligible employee" includes:

(A) An officer or employee of a district who elects to participate in one of the benefit plans described in ORS 243.864 to 243.874; and

(B) An officer or employee of a district, whether or not retired, who:

(i) Is receiving a service retirement allowance, a disability retirement allowance or a pension under the Public Employees Retirement System or is receiving a service retirement allowance, a disability retirement allowance or a pension under any other retirement or disability benefit plan or system offered by the district for its officers and employees;

(ii) Is eligible to receive a service retirement allowance under the Public Employees Retirement System and has reached earliest service retirement age under ORS chapter 238;

(iii) Is eligible to receive a pension under ORS 238A.100 to 238A.245 and has reached earliest retirement age as described in ORS 238A.165; or

(iv) Is eligible to receive a service retirement allowance or pension under any other retirement benefit plan or system offered by the district and has attained earliest retirement age under the plan or system.

(b) Except as provided in paragraph (a)(B) of this subsection, "eligible employee" does not include an individual:

(A) Engaged as an independent contractor;

(B) Whose periods of employment in emergency work are on an intermittent or irregular basis; or

(C) Who is employed on less than a half-time basis unless the individual is employed in a position classified as a job-sharing position or unless the individual is defined as eligible under rules of the Oregon Educators Benefit Board or under a collective bargaining agreement.

(5) "Family member" means an eligible employee's spouse or domestic partner and any unmarried child or stepchild of an eligible employee within age limits and other conditions imposed by the Oregon Educators Benefit Board with regard to unmarried children or stepchildren.

(6) "Payroll disbursing officer" means the officer or official authorized to disburse moneys in payment of salaries and wages of officers and employees of a district.

(7) "Premium" means the monthly or other periodic charge, including administrative fees of the Oregon Educators Benefit Board, for a benefit plan.

SECTION 248. ORS 291.055 is amended to read:

291.055. (1) Notwithstanding any other law that grants to a state agency the authority to establish fees, all new state agency fees or fee increases adopted after July 1 of any odd-numbered year:

(a) Are not effective for agencies in the executive department of government unless approved in writing by the Director of the Oregon Department of Administrative Services;

(b) Are not effective for agencies in the judicial department of government unless approved in writing by the Chief Justice of the Supreme Court;

(c) Are not effective for agencies in the legislative department of government unless approved in writing by the President of the Senate and the Speaker of the House of Representatives;

(d) Shall be reported by the state agency to the Oregon Department of Administrative Services within 10 days of their adoption; and

(e) Are rescinded on July 1 of the next following odd-numbered year, or on adjournment sine die of the regular session of the Legislative Assembly meeting in that year, whichever is later, unless otherwise authorized by enabling legislation setting forth the approved fees.

(2) This section does not apply to:

(a) Any tuition or fees charged by the State Board of Higher Education and state institutions of higher education.

(b) Taxes or other payments made or collected from employers for unemployment insurance required by ORS chapter 657 or premium assessments required by ORS 656.612 and 656.614 or contributions and assessments calculated by cents per hour for workers' compensation coverage required by ORS 656.506.

(c) Fees or payments required for:

(A) Health care services provided by the Oregon Health and Science University, by the Oregon Veterans' Homes and by other state agencies and institutions pursuant to ORS 179.610 to 179.770.

(B) Assessments and premiums paid to the Oregon Medical Insurance Pool established by ORS 735.614 and 735.625.

(C) Copayments and premiums paid to the Oregon medical assistance program.

(d) Fees created or authorized by statute that have no established rate or amount but are calculated for each separate instance for each fee payer and are based on actual cost of services provided.

(e) State agency charges on employees for benefits and services.

(f) Any intergovernmental charges.

(g) Forest protection district assessment rates established by ORS 477.210 to 477.265 and the Oregon Forest Land Protection Fund fees established by ORS 477.760.

(h) State Department of Energy assessments required by ORS 469.421 (8) and 469.681.

(i) Any charges established by the State Parks and Recreation Director in accordance with ORS 565.080 (3).

(j) Assessments on premiums charged by the Insurance Division of the Department of Consumer and Business Services **or the Oregon Health Authority** pursuant to ORS 731.804 **or sections 131, 134 and 136c of this 2009 Act,** or fees charged by the Division of Finance and Corporate Securities of the Department of Consumer and Business Services to banks, trusts and credit unions pursuant to ORS 706.530 and 723.114.

(k) Public Utility Commission operating assessments required by ORS 756.310 or charges paid to the Residential Service Protection Fund required by chapter 290, Oregon Laws 1987.

(L) Fees charged by the Housing and Community Services Department for intellectual property pursuant to ORS 456.562.

(m) New or increased fees that are anticipated in the legislative budgeting process for an agency, revenues from which are included, explicitly or implicitly, in the legislatively adopted budget for the agency.

(n) Tolls approved by the Oregon Transportation Commission pursuant to ORS 383.004.

(3)(a) Fees temporarily decreased for competitive or promotional reasons or because of unexpected and temporary revenue surpluses may be increased to not more than their prior level without compliance with subsection (1) of this section if, at the time the fee is decreased, the state agency specifies the following:

(A) The reason for the fee decrease; and

(B) The conditions under which the fee will be increased to not more than its prior level.

(b) Fees that are decreased for reasons other than those described in paragraph (a) of this subsection may not be subsequently increased except as allowed by ORS 291.050 to 291.060 and 294.160.

SECTION 249. ORS 291.371 is amended to read:

291.371. (1) As used in this section, "legislative review agency" means the Joint Committee on Ways and Means during the period when the Legislative Assembly is in session and the Emergency Board during the interim period between sessions.

(2) Prior to making any changes in a salary plan, the Oregon Department of Administrative Services shall submit the proposed changes to the legislative review agency.

(3)(a) The Oregon Department of Administrative Services may approve the reallocation of positions or the establishment of new positions not specifically provided for in the budget of the affected agency if it finds that the proposed change:

(A) Can be financed by the agency within the limits of its biennial budget and legislatively approved program;

(B) Will not produce future budgetary increases; and

(C) Conforms to legislatively approved salary policies.

(b) Proposed changes not meeting the requirements of paragraph (a) of this subsection shall be presented to the legislative review agency.

(4) Agencies within the Department of Human Services**, the Oregon Health Authority** and the Department of Corrections shall report on a biennial basis to the legislative review agency. Each report shall include the number of vacant budgeted positions, including all job categories and classifications, within the agency. The legislative review agency shall order the reporting agency to show cause why the budgeted positions have not been filled and shall assess fully the impact the vacancies have on:

(a) The agency's delivery of services, accounting for any seasonal fluctuation in the need for those services;

(b) The agency's budget due to increased use of overtime;

(c) The agency's use of temporary employees; and

(d) Employee workload.

(5) It is declared to be the policy of this state that the total personal services, budget and full-time equivalent positions approved for any state agency shall be the maximum amount necessary to meet the requirements of the agency for the biennium. Notwithstanding ORS 291.232 to 291.260, the Governor and the Oregon Department of Administrative Services may transfer vacant position authority among and within state agencies to achieve maximum utilization of authorized positions within agencies.

SECTION 250. ORS 315.604 is amended to read:

315.604. (1) As used in this section:

(a) "Bone marrow donor expense" means the sum of the amounts paid or incurred during the tax year by an employer for the following:

(A) Development of an employee bone marrow donation program.

(B) Employee education related to bone marrow donation, including but not limited to the need for donors and an explanation of the procedures used to determine tissue type and donate bone marrow.

(C) Payments to a health care provider for determining the tissue type of an employee who agrees to register or registers as a bone marrow donor.

(D) Wages paid to an employee for time reasonably related to tissue typing and bone marrow donation.

(E) Transportation of an employee to the site of a donation or any other service which is determined by the [*Department of Human Services*] **Oregon Health Authority** by rule as essential for a successful bone marrow donation.

(b) "Employee" means an individual who:

(A) Is regularly employed by the taxpayer for more than 20 hours per week;

(B) Who is not a temporary or seasonal employee; and

(C) Whose wages are subject to withholding under ORS 316.162 to 316.221.

(c) "Wages" has the meaning given the term for purposes of ORS 316.162 to 316.221.

(2) A business tax credit against the taxes otherwise due under ORS chapter 316 for the tax year is allowed to a resident employer, or if the employer is a corporation, to the employer against the taxes otherwise due under ORS chapter 317. The amount of the credit is equal to 25 percent of the bone marrow donor expense paid or incurred during the tax year by an employer to provide a program for employees who are potential bone marrow donors or who actually become bone marrow donors.

(3)(a) Except as provided under paragraph (b) of this subsection, the allowance of a credit under this section shall not affect the computation of taxable income for purposes of ORS chapter 316 or 317.

(b) If in determining the amount of the credit for any tax year an amount allowed as a deduction under section 170 of the Internal Revenue Code is included in bone marrow donation expense, the amount allowed as a deduction shall be added to federal taxable income.

(4) The credit allowed under this section shall be allowed to a nonresident employer in the same manner as the credit is allowed to a resident employer.

(5) Any tax credit otherwise allowable under this section which is not used by the taxpayer in a particular tax year may be carried forward and offset against the taxpayer's tax liability for the next succeeding tax year. Any credit remaining unused in such next succeeding tax year may be

carried forward and used in the second succeeding tax year. Any credit remaining unused in such second succeeding tax year may be carried forward and used in the third succeeding tax year. Any credit remaining unused in such third succeeding tax year may be carried forward and used in the fourth succeeding tax year. Any credit remaining unused in such fourth succeeding tax year may be carried forward and used in the fifth succeeding tax year, but may not be used in any tax year thereafter.

SECTION 251. ORS 315.613 is amended to read:

315.613. (1) A resident or nonresident individual certified as eligible under ORS 442.563, licensed under ORS chapter 677, who is engaged in the practice of medicine, and who has a rural practice that amounts to 60 percent of the individual's practice, shall be allowed an annual credit against taxes otherwise due under this chapter in the sum of $5,000 during the time in which the individual retains such practice and membership if the individual is actively practicing in and is a member of the medical staff of one of the following hospitals:

(a) A type A hospital designated as such by the Office of Rural Health;

(b) A type B hospital designated as such by the Office of Rural Health if the hospital is:

(A) Not within the boundaries of a metropolitan statistical area;

(B) Located 30 or more highway miles from the closest hospital within the major population center in a metropolitan statistical area; or

(C) Located in a county with a population of less than 75,000;

(c) A type C rural hospital, if the Office of Rural Health makes the findings required by ORS 315.619; or

(d) A rural critical access hospital.

(2) A nonresident shall be allowed the credit under this section in the proportion provided in ORS 316.117. If a change in the status of a taxpayer from resident to nonresident or from nonresident to resident occurs, the credit allowed by this section shall be determined in a manner consistent with ORS 316.117.

(3) For purposes of this section, an "individual's practice" shall be determined on the basis of actual time spent in practice each week in hours or days, whichever is considered by the Office of Rural Health to be more appropriate. In the case of a shareholder of a corporation or a member of a partnership, only the time of the individual shareholder or partner shall be considered and the full amount of the credit shall be allowed to each shareholder or partner who qualifies in an individual capacity.

(4) As used in this section:

(a) "Type A hospital," "type B hospital" and "type C hospital" have the meaning for those terms provided in ORS 442.470.

(b) "Rural critical access hospital" means a facility that meets the criteria set forth in 42 U.S.C. 1395i-4 (c)(2)(B) and that has been designated a critical access hospital by the Office of Rural Health and the [*Department of Human Services*] **Oregon Health Authority**.

SECTION 252. ORS 343.499 is amended to read:

343.499. (1)(a) There is created the State Interagency Coordinating Council.

(b) The Governor shall appoint members of the council from a list of eligible appointees provided by the council and agencies described in subsection (2) of this section and shall ensure that the membership of the council reasonably represents the population of this state.

(c) The Governor shall designate one member of the council to serve as the chairperson, or if the Governor chooses not to name a chairperson, the council may elect one of its members to serve

as chairperson. However, any member of the council who represents the Department of Education may not serve as the chairperson of the council.

(2) The membership of the council shall be composed as follows:

(a) At least 20 percent of the council members shall be parents, including minority parents, of preschool children with disabilities or of children with disabilities who are 12 years of age or younger who have knowledge of or experience with programs for infants and toddlers with disabilities. At least one council member shall be a parent of an infant or toddler with a disability or of a child with a disability who is six years of age or younger.

(b) At least 20 percent of the council members shall be public or private providers of early intervention and early childhood special education services.

(c) At least one council member shall be a member of the Legislative Assembly.

(d) At least one council member shall be involved in personnel preparation.

(e) At least one council member shall represent the Department of Human Services.

(f) At least one council member shall represent the federal Head Start program.

(g) At least one council member shall represent the Child Care Division of the Employment Department.

(h) At least one council member shall represent the Department of Education.

(i) At least one council member shall represent the [*Department of Consumer and Business Services*] **Oregon Health Authority**.

(j) At least one council member shall represent the State Commission on Children and Families.

(k) At least one council member shall represent the Child Development and Rehabilitation Center of the Oregon Health and Science University.

(L) At least one council member shall be a member of the State Advisory Council for Special Education created under ORS 343.287.

(m) At least one council member shall be a representative designated by the state coordinator for homeless education.

(n) At least one council member shall represent the state child welfare agency responsible for foster care.

(o) At least one council member shall represent the state agency responsible for children's mental health.

[*(p) At least one council member shall be from the agency responsible for the state Medicaid program.*]

[*(q)*] **(p)** The council may include other members appointed by the Governor, including but not limited to one representative from the United States Bureau of Indian Affairs or, where there is no school operated or funded by the bureau, from the Indian Health Service or the tribe or tribal council.

(3) An individual appointed to represent a state agency that is involved in the provision of or payment for services for preschool children with disabilities under subsection (2)(e) and (h) to (k) of this section shall have sufficient authority to engage in making and implementing policy on behalf of the agency.

(4) The State Interagency Coordinating Council shall:

(a) Advise the Superintendent of Public Instruction and the State Board of Education on unmet needs in the early childhood special education and early intervention programs for preschool children with disabilities, review and comment publicly on any rules proposed by the State Board of Education and the distribution of funds for the programs and assist the state in developing and re-

porting data on and evaluations of the programs and services.

(b) Advise and assist the represented public agencies regarding the services and programs they provide to preschool children with disabilities and their families, including public comments on any proposed rules affecting the target population and the distribution of funds for such services, and assist each agency in developing services that reflect the overall goals for the target population as adopted by the council.

(c) Advise and assist the Department of Education and other state agencies in the development and implementation of the policies that constitute the statewide system.

(d) Assist all appropriate public agencies in achieving the full participation, coordination and cooperation for implementation of a statewide system that includes but is not limited to:

(A) Seeking information from service providers, service coordinators, parents and others about any federal, state or local policies that impede timely service delivery; and

(B) Taking steps to ensure that any policy problems identified under subparagraph (A) of this paragraph are resolved.

(e) Advise and assist the Department of Education in identifying the sources of fiscal and other support for preschool services, assigning financial responsibility to the appropriate agencies and ensuring that the provisions of interagency agreements under ORS 343.511 are carried out.

(f) Review and comment on each agency's services and policies regarding services for preschool children with disabilities, or preschool children who are at risk of developing disabling conditions, and their families to the maximum extent possible to assure cost-effective and efficient use of resources.

(g) To the extent appropriate, assist the Department of Education in the resolution of disputes.

(h) Advise and assist the Department of Education in the preparation of applications and amendments thereto.

(i) Advise and assist the Department of Education regarding the transition of preschool children with disabilities.

(j) Prepare and submit an annual report to the Governor and to the United States Secretary of Education on the status of early intervention programs operated within this state.

(5) The council may advise appropriate agencies about integration of services for preschool children with disabilities and at-risk preschool children.

(6) Terms of office for council members shall be three years, except that:

(a) The representative from the State Advisory Council for Special Education shall serve a one-year term; and

(b) The representatives from other state agencies and the representative from the Legislative Assembly shall serve indefinite terms.

(7) Subject to approval by the Governor, the council may use federal funds appropriated for this purpose and available to the council to:

(a) Conduct hearings and forums;

(b) Reimburse nonagency council members pursuant to ORS 292.495 for attending council meetings, for performing council duties, and for necessary expenses, including child care for parent members;

(c) Pay compensation to a council member if the member is not employed or if the member must forfeit wages from other employment when performing official council business;

(d) Hire staff; and

(e) Obtain the services of such professional, technical and clerical personnel as may be neces-

sary to carry out its functions.

(8) Except as provided in subsection (7) of this section, council members shall serve without compensation.

(9) The Department of Education shall provide clerical and administrative support, including staff, to the council to carry out the performance of the council's function as described in this section.

(10) The council shall meet at least quarterly. The meetings shall be announced publicly and, to the extent appropriate, be open and accessible to the general public.

(11) No member of the council shall cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest under state law.

SECTION 253. ORS 343.507 is amended to read:

343.507. (1) Each contractor for early childhood special education and early intervention services shall assist in the development of a local early intervention interagency advisory council in every county within the contractor's service area.

(2) Each local early intervention interagency advisory council shall include as members at least 20 percent parents of preschool children with disabilities, 20 percent providers of early childhood special education and early intervention services or other services to preschool children with disabilities, a representative of the State Commission on Children and Families and representatives from public and private agencies that serve young children and their families, including but not limited to Head Start and Oregon prekindergartens, community child care, the Child Care Division of the Employment Department, local school districts, education service districts, Department of Education regional special education programs, community mental health and developmental disabilities programs, [*Department of Human Services*] **Oregon Health Authority** health programs, child welfare programs and public assistance programs, Indian education agencies, migrant programs serving young children and community colleges.

(3) Each local early intervention interagency advisory council shall select its own chairperson and vice chairperson and fix the duties of its officers.

(4) The department shall establish procedures pursuant to rules of the State Board of Education for seeking and considering local council advice regarding the selection of contractors, coordination of services and procedures for local resolution of disputes.

SECTION 254. ORS 442.800 is amended to read:

442.800. (1) The Advisory Committee on Physician Credentialing Information is established within the Office for Oregon Health Policy and Research. The committee consists of nine members appointed by the Administrator of the Office for Oregon Health Policy and Research as follows:

(a) Three members who are physicians licensed by the Oregon Medical Board or representatives of physician organizations doing business within the State of Oregon;

(b) Three representatives of hospitals licensed by the [*Department of Human Services*] **Oregon Health Authority**; and

(c) Three representatives of health care service contractors that have been issued a certificate of authority to transact health insurance in this state by the [*Department of Consumer and Business Services*] **Oregon Health Authority**.

(2) All members appointed pursuant to subsection (1) of this section shall be knowledgeable about national standards relating to physician credentialing.

(3) The term of appointment for each member of the committee is three years. If, during a

member's term of appointment, the member no longer qualifies to serve as designated by the criteria of subsection (1) of this section, the member must resign. If there is a vacancy for any cause, the administrator shall make an appointment to become immediately effective for the unexpired term.

(4) Members of the committee are not entitled to compensation or reimbursement of expenses.

SECTION 255. ORS 442.807 is amended to read:

442.807. (1) Within 30 days of receiving the recommendations of the Advisory Committee on Physician Credentialing Information, the Administrator of the Office for Oregon Health Policy and Research shall forward the recommendations to the Director of the [*Department of Consumer and Business Services and to the Director of Human Services*] **Oregon Health Authority**. The administrator shall request that the [*Department of Consumer and Business Services and the Department of Human Services*] **Oregon Health Authority** adopt rules to carry out the efficient implementation and enforcement of the recommendations of the committee.

(2) The [*Department of Consumer and Business Services and the Department of Human Services*] **Oregon Health Authority** shall:

(a) Adopt administrative rules in a timely manner, as required by the Administrative Procedures Act, for the purpose of effectuating the provisions of ORS 442.800 to 442.807; and

(b) Consult with each other and with the administrator to ensure that the rules adopted by the [*Department of Consumer and Business Services and the Department of Human Services*] **Oregon Health Authority** are identical and are consistent with the recommendations developed pursuant to ORS 442.805 for affected hospitals and health care service contractors.

(3) The uniform credentialing information required pursuant to the administrative rules of the [*Department of Consumer and Business Services and the Department of Human Services*] **Oregon Health Authority** represent the minimum uniform credentialing information required by the affected hospitals and health care service contractors. Nothing in ORS 442.800 to 442.807 shall be interpreted to prevent an affected hospital or health care service contractor from requesting additional credentialing information from a licensed physician for the purpose of completing physician credentialing procedures used by the affected hospital or health care service contractor.

SECTION 256. ORS 731.016 is amended to read:

731.016. The Insurance Code shall be liberally construed and shall be administered and enforced by the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** to give effect to the policy stated in ORS 731.008.

SECTION 257. ORS 731.036 is amended to read:

731.036. The Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

(3) A religious organization providing insurance benefits only to its employees, which organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

(a) The individual or jointly self-insured program meets the following minimum requirements:

(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

(C) In the case of a joint program of two or more public bodies, the number of covered employees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

(d) Enrollees must be provided copies of summary plan descriptions including:

(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee′s coverage;

(B) The program′s grievance and appeal process; and

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

(i) Known claims, paid and outstanding;

(ii) A history of incurred but not reported claims;

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority**;

(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

(g) The individual or jointly self-insured program shall be subject to assessment in accordance

with ORS 735.614 and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616;

(h) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

(7) All ambulance services.

(8) A person providing any of the services described in this subsection. The exemption under this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

(a) Towing service.

(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

(B) The lessor of the motor vehicle.

(C) The lender who finances the purchase of the motor vehicle.

(D) The assignee of a person described in this paragraph.

(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, which represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

SECTION 258. ORS 731.042 is amended to read:

731.042. (1) An exempt insurer who holds a certificate of exemption issued by the [*Director of the Department of Consumer and Business Services*] **regulator** before January 1, 2003, may continue transacting insurance.

(2) In order to continue a certificate of exemption, an exempt insurer to whom subsection (1) of this section applies must file its annual statement and pay the fees established by the [*director*] **regulator** by March 1 of each year.

(3) An exempt insurer shall be subject to ORS 731.296 to 731.316, 731.414, 731.418, 731.574, 731.988, 731.992, 733.010 to 733.115, 733.140 to 733.210, 743A.040, 746.075 and 746.110.

SECTION 259. ORS 731.072 is amended to read:

731.072. (1) A "certificate of authority" is one issued by the [*Director of the Department of Consumer and Business Services*] **regulator** pursuant to the Insurance Code evidencing the authority of an insurer to transact insurance in this state.

(2) A "license" is authority granted by the [*director*] **regulator** pursuant to the Insurance Code for the licensee to engage in a business or operation of insurance in this state other than as an insurer, and the certificate by which such authority is evidenced.

SECTION 260. ORS 731.096 is amended to read:

731.096. (1) The domicile of an alien insurer, other than insurers formed under the laws of Canada or a province thereof, shall be that state designated by the insurer in writing filed with the [*Director of the Department of Consumer and Business Services*] **regulator** at time of admission to this state or before January 1, 1962, whichever date is the later, and may be any one of the following states:

(a) The state in which the insurer was first authorized to transact insurance;

(b) The state in which is located the insurer's principal place of business in the United States; or

(c) The state in which is held the largest deposit of assets of the insurer in trust for the protection of its policyholders and creditors in the United States.

(2) If the insurer makes no such designation its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

SECTION 261. ORS 731.142 is amended to read:

731.142. (1) "Stock insurer" means an incorporated insurer whose capital is divided into shares and owned by its stockholders.

(2) "Mutual insurer" means an incorporated insurer without capital stock and the governing body of which is elected by its policyholders. This definition does not exclude as a "mutual insurer" a foreign insurer found by the [*Director of the Department of Consumer and Business Services*] **regulator** to be organized on the mutual plan under the laws of its domicile, but having temporary share capital or providing for election of the insurer's governing body on a reasonable basis by policyholders and others.

(3) "Reciprocal insurer" means an unincorporated aggregation of persons known as "subscribers," operating individually and collectively through an attorney in fact common to all such persons, interexchanging among themselves reciprocal agreements of indemnity.

SECTION 262. ORS 731.216 is amended to read:

731.216. The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall have the power to:

(1) Contract for and procure, on a fee or part-time basis, or both, such actuarial, technical or other professional services as may be required for the discharge of duties.

(2) Obtain such other services as the director considers necessary or desirable, including participation in organizations of state insurance supervisory officials and appointment of advisory committees. A member of an advisory committee so appointed shall receive no compensation for services as a member, but, subject to any other applicable law regulating travel and other expenses of state officers, shall receive actual and necessary travel and other expenses incurred in the performance of official duties.

(3) Establish within the Department of Consumer and Business Services a workers' compensation rating bureau to provide rating information that is based upon and relevant to activities conducted in this state, to enable the director to carry out the provisions of ORS chapter 737. In lieu of creating a rating bureau within the department, the director may contract with any rating organization in other states if the director finds that such a contract would provide the information required by this section.

SECTION 263. ORS 731.228 is amended to read:

731.228. (1) No officer or employee of the Department of Consumer and Business Services **or the Oregon Health Authority** delegated responsibilities in the enforcement of the Insurance Code shall:

(a) Be a director, officer, or employee of or be financially interested in any person regulated by the department or office of the department that is delegated responsibility in the enforcement of the Insurance Code, except as a policyholder or claimant under an insurance policy or by reason of rights vested in commissions, fees, or retirement benefits related to services performed prior to affiliation with the department; or

(b) Be engaged in any other business or occupation interfering with or inconsistent with the duties of the office or employment.

(2) No person shall directly or indirectly give or pay, or offer to give or pay, to the Director of the Department of Consumer and Business Services, **the Director of the Oregon Health Authority** or any officer or employee of the department **or authority**, and the director or such officer or employee shall not directly or indirectly solicit, receive or accept any fee, compensation, loan, gift or other thing of value in addition to the compensation and expense allowance provided by law, for:

(a) Any service rendered or to be rendered as such director, officer or employee, or in connection therewith;

(b) Services rendered or to be rendered in relation to legislation;

(c) Extra services rendered or to be rendered; or

(d) Any cause whatsoever related to any person regulated by the department or office of the department that is delegated responsibility in the enforcement of the Insurance Code.

(3) This section does not permit any conduct, affiliation or interest that is otherwise prohibited by public policy.

SECTION 264. ORS 731.232 is amended to read:

731.232. (1) For the purpose of an investigation or proceeding under the Insurance Code, the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of books, papers, correspondence, memoranda, agreements or other documents or records which the director considers relevant or material to the inquiry. Each witness who appears before the director under a subpoena shall receive the fees and mileage provided for witnesses in ORS 44.415 (2).

(2) If a person fails to comply with a subpoena so issued or a party or witness refuses to testify on any matters, the judge of the circuit court for any county, on the application of the director, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued from such court or a refusal to testify therein.

SECTION 265. ORS 731.236 is amended to read:

731.236. (1) The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall enforce the provisions of the Insurance Code for the

public good, and shall execute the duties imposed by the code.

(2) The director has the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code.

(3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the director considers proper to determine whether any person has violated any provision of the Insurance Code or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.

(4) The director has such additional powers and duties as may be provided by other laws of this state.

SECTION 266. ORS 731.240 is amended to read:

731.240. (1) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** shall hold a hearing upon written demand for a hearing by a person aggrieved by any act, threatened act or failure of the director to act. The demand must state the grounds therefor.

(2) To the extent applicable and not inconsistent with subsection (1) of this section, the provisions of ORS chapter 183 shall govern the hearing procedure and any judicial review thereof.

SECTION 267. ORS 731.244 is amended to read:

731.244. In accordance with the applicable provisions of ORS chapter 183, the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** may make reasonable rules necessary for or as an aid to the effectuation of the Insurance Code. No such rule shall extend, modify or conflict with the Insurance Code or the reasonable implications thereof.

SECTION 268. ORS 731.248 is amended to read:

731.248. (1) Orders of the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall be effective only when in writing and signed by the director or by the authority of the director. Orders shall be filed in the Department of Consumer and Business Services **and the Oregon Health Authority**.

(2) Every such order shall state:

(a) Its effective date;

(b) Its intent or purpose;

(c) The grounds on which based; and

(d) The provisions of the Insurance Code pursuant to which action is taken or proposed to be taken.

(3) Except as may be provided in the Insurance Code respecting particular procedures, an order or notice may be given by delivery to the person to be ordered or notified or by mailing it by certified or registered mail, return receipt requested, postage prepaid, addressed to the person at the residence or principal place of business of the person as last of record in the department. Notice so mailed shall be deemed to have been given when deposited in a letter depository of a United States post office.

SECTION 269. ORS 731.252 is amended to read:

731.252. (1) Whenever the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** has reason to believe that any person has been engaged or is engaging or is about to engage in any violation of the Insurance Code, the director may issue an order, directed to such person, to discontinue or desist from such violation or threatened vio-

lation. The copy of the order forwarded to the person involved shall set forth a statement of the specific charges and the fact that the person may request a hearing within 20 days of the date of mailing. Where a hearing is requested, the director shall set a date for the hearing to be held within 30 days after receipt of the request, and shall give the person involved written notice of the hearing date at least seven days prior thereto. The person requesting the hearing must establish to the satisfaction of the director that such order should not be complied with. The order shall become final 20 days after the date of mailing unless within such 20-day period the person to whom it is directed files with the director a written request for a hearing. To the extent applicable and not inconsistent with the foregoing, the provisions of ORS chapter 183 shall govern the hearing procedure and any judicial review thereof. Where the hearing has been requested, the director's order shall become final at such time as the right to further hearing or review has expired or been exhausted.

(2) No order of the director under this section or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

(3) The powers vested in the director pursuant to this section are supplementary and not in lieu of any other powers to suspend or revoke certificates of authority or licenses or to enforce any penalties, fines or forfeitures, authorized by law with respect to any violation for which an order of discontinuance has been issued.

SECTION 270. ORS 731.256 is amended to read:

731.256. (1) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may institute such actions or other lawful proceedings as the director may deem necessary for the enforcement of any provision of the Insurance Code or any order or action made or taken by the director in pursuance of law.

(2) If the director has reason to believe that any person has violated any provision of the Insurance Code or other law applicable to insurance operations, for which criminal prosecution is provided and in the opinion of the director would be in order, the director shall give the information relative thereto to the Attorney General or district attorney having jurisdiction of any such violation. The Attorney General or district attorney promptly shall institute such action or proceedings against such person as the information requires or justifies.

SECTION 271. ORS 731.258 is amended to read:

731.258. (1) The Attorney General**,** upon request of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority,** may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the director.

(2) As used in this section:

(a) "Reciprocal state" means any state the laws of which contain procedures substantially similar to those specified in this section for the enforcement of decrees or orders in equity issued by courts located in other states, against any insurer incorporated or authorized to do business in such state.

(b) "Foreign decree" means any decree or order in equity of a court located in a reciprocal state, including a court of the United States located therein, against any insurer incorporated or authorized to do business in this state.

(c) "Qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state.

(3) The Director of the Department of Consumer and Business Services of this state **or the Director of the Oregon Health Authority** shall determine which states qualify as reciprocal states and shall maintain at all times an up-to-date list of such states.

(4) A copy of any foreign decree authenticated in accordance with the statutes of this state may be filed in the office of the clerk of any circuit court of this state. The clerk, upon verifying with the director that the decree or order qualifies as a foreign decree shall treat the foreign decree in the same manner as a judgment of a circuit court of this state. A foreign decree so filed has the same effect and shall be deemed as a judgment of a circuit court of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating, or staying as a judgment of a circuit court of this state and may be enforced or satisfied in like manner.

(5)(a) At the time of the filing of the foreign decree, the Attorney General shall make and file with the clerk of the court an affidavit setting forth the name and last-known post-office address of the defendant.

(b) Promptly upon the filing of the foreign decree and the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at the address given and to the director of this state and shall make a note of the mailing in the register of the court. In addition, the Attorney General may mail a notice of the filing of the foreign decree to the defendant and to the director of this state and may file proof of mailing with the clerk. Lack of mailing notice of filing by the clerk shall not affect the enforcement proceedings if proof of mailing by the Attorney General has been filed.

(c) No execution or other process for enforcement of a foreign decree filed under subsection (4) of this section shall issue until 30 days after the date the decree is filed.

(6)(a) If the defendant shows the circuit court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court shall stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(b) If the defendant shows the circuit court any ground upon which enforcement of a judgment of any circuit court of this state would be stayed, the court shall stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state for a judgment.

SECTION 272. ORS 731.260 is amended to read:

731.260. No person shall file or cause to be filed with the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** any article, certificate, report, statement, application or any other information required or permitted to be so filed under the Insurance Code and known to such person to be false or misleading in any material respect.

SECTION 273. ORS 731.264 is amended to read:

731.264. (1) A complaint made to the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** against any person regulated by the Insurance Code, and the record thereof, shall be confidential and may not be disclosed except as provided in ORS 705.137. No such complaint, or the record thereof, shall be used in any action, suit or proceeding except to the extent considered necessary by the director in the prosecution of apparent violations of the Insurance Code or other law.

(2) Data gathered pursuant to an investigation by the director of a complaint shall be confi-

dential, may not be disclosed except as provided in ORS 705.137 and may not be used in any action, suit or proceeding except to the extent considered necessary by the director in the investigation or prosecution of apparent violations of the Insurance Code or other law.

(3) Notwithstanding subsections (1) and (2) of this section, the director shall establish by rule a method for publishing an annual statistical report containing the insurer's name and the number, percentage, type and disposition of complaints received by the Department of Consumer and Business Services **and the Oregon Health Authority** against each insurer transacting insurance within this state.

SECTION 274. ORS 731.268 is amended to read:

731.268. (1) Photographs or microphotographs in the form of film or prints of documents and records made by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** for the files of the director shall have the same force and effect as the originals thereof, and duly certified or authenticated reproductions of such photographs or microphotographs shall be as admissible in evidence as are the originals.

(2) Upon request of any person and payment of the applicable fee, the director shall furnish a certified copy of any record in the office of the director which is then subject to public inspection.

(3) Copies of original records or documents in the office of the director certified by the director shall have the same force and effect and be received in evidence in all courts equally and in like manner as if they were originals.

SECTION 275. ORS 731.272 is amended to read:

731.272. (1) The [*Director of the Department of Consumer and Business Services*] **regulator** shall prepare annually, as soon after March 1 as is consistent with full and accurate preparation, a report of the official transactions of the director under the Insurance Code. The report shall include:

(a) In condensed form statements made to the director by every insurer authorized to do business in this state.

(b) A statement of all insurers authorized to do business in this state as of the date of the report.

(c) A list of insurers whose business in this state was terminated and the reason for the termination. If the termination was a result of liquidation or delinquency proceedings brought against the insurer in this or any other state, the report shall include the amount of the insurer's assets and liabilities so far as those amounts are known to the director.

(d) A statement of the operating expenses of the [*Department of Consumer and Business Services*] **regulator** under the Insurance Code, including salaries, transportation, communication, printing, office supplies, fixed charges and miscellaneous expenses.

(e) A detailed statement of the moneys, fees and taxes received by the department under the Insurance Code and from what source.

(f) Any other pertinent information and matters as the director considers to be in the public interest.

(2) The director shall give notice of the publication of the report to:

(a) The office of the Speaker of the House of Representatives;

(b) The office of the President of the Senate; and

(c) The chair or cochairs of the Joint Legislative Committee on Ways and Means if the Legislative Assembly is in session or of the Emergency Board if during the interim.

SECTION 276. ORS 731.276 is amended to read:

731.276. The Director of the Department of Consumer and Business Services shall **work with**

the Director of the Oregon Health Authority to continuously review the Insurance Code and may, from time to time, make recommendations for changes therein.

SECTION 277. ORS 731.280 is amended to read:

731.280. The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall **work together to** publish:

(1) Pamphlet or booklet copies of the insurance laws of this state;

(2) The director's annual report;

(3) Such copies of results of investigations or examinations of insurers for public distribution as the director considers to be in the public interest;

(4) Such compilations as the director considers advisable from time to time of the general orders of the director then in force; and

(5) Such other material as the director may compile and consider relevant and suitable for the effective administration of the Insurance Code.

SECTION 278. ORS 731.282 is amended to read:

731.282. The [*Director of the*] Department of Consumer and Business Services **and the Oregon Health Authority** may sell, at a price reasonably calculated to cover the costs of preparation, any of the copies, compilations or materials described in ORS 731.280.

SECTION 279. ORS 731.288 is amended to read:

731.288. The Department of Consumer and Business Services **and the Oregon Health Authority** shall record each complaint the department receives, including the subsequent disposition of the complaint. The record of a complaint shall be maintained for a period of not less than seven years. The records of complaints shall be indexed whenever applicable both by the name of the insurer and by the name of the insurance producer involved. The [*Director of the Department of Consumer and Business Services*] **department or authority** shall consider such complaints before issuing or continuing any certificate of authority or license of an insurer or insurance producer named in such complaints.

SECTION 280. ORS 731.296 is amended to read:

731.296. The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** may address any proper inquiries to any insurer, licensee or its officers in relation to its activities or condition or any other matter connected with its transactions. Any such person so addressed shall promptly and truthfully reply to such inquiries using the form of communication requested by the director. The reply shall be verified by an officer of such person, if the director so requires. A reply is subject to the provisions of ORS 731.260.

SECTION 281. ORS 731.300 is amended to read:

731.300. (1) The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall examine every authorized insurer, including an audit of the financial affairs of such insurer, as often as the director determines an examination to be necessary but at least once each five years. An examination shall be conducted for the purpose of determining the financial condition of the insurer, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with the Insurance Code. The director may also make such an examination of any surplus lines insurance producer or any person holding the capital stock of an authorized insurer or surplus lines insurance producer for the purpose of controlling the management thereof as a voting trustee or otherwise, or both.

(2) Instead of conducting an examination of an authorized foreign or alien insurer, the director may accept an examination report on the insurer that is prepared by the insurance department for

the state of domicile or state of entry of the insurer if:

(a) At the time of the examination the insurance department of the state was accredited under the Financial Regulation Standards and Accreditation Program or successor program of the National Association of Insurance Commissioners; or

(b) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(3) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the director.

SECTION 282. ORS 731.302 is amended to read:

731.302. (1) When the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** determines that an examination should be conducted, the director shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners. The director may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that the director determines to be appropriate.

(2) When making an examination, the director may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed. The cost of retaining such professionals and specialists shall be borne by the person that is the subject of the examination.

(3) At any time during the course of an examination, the director may take other action pursuant to the Insurance Code.

(4) Facts determined and conclusions made pursuant to an examination shall be presumptive evidence of the relevant facts and conclusions in any judicial or administrative action.

SECTION 283. ORS 731.304 is amended to read:

731.304. The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority**, whenever the director deems it advisable in the interest of policyholders or for the public good, shall investigate into the affairs of any person engaged in, proposing to engage in or claiming or advertising to engage in:

(1) Transacting insurance in this state;

(2) Organizing or receiving subscriptions for or disposing of the stock of or in any manner taking part in the formation or business of an insurer; or

(3) Holding capital stock of one or more insurers for the purpose of controlling the management thereof as voting trustee or otherwise.

SECTION 284. ORS 731.308 is amended to read:

731.308. (1) Upon an examination or investigation the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may examine under oath all persons who may have material information regarding the property or business of the person being examined or investigated.

(2) Every person being examined or investigated shall produce all books, records, accounts, papers, documents and computer and other recordings in its possession or control relating to the

matter under examination or investigation, including, in the case of an examination, the property, assets, business and affairs of the person.

(3) With regard to an examination, the officers, directors and agents of the person being examined shall provide timely, convenient and free access at all reasonable hours at the offices of the person being examined to all books, records, accounts, papers, documents and computer and other recordings. The officers, directors, employees and agents of the person must facilitate the examination.

SECTION 285. ORS 731.312 is amended to read:

731.312. (1) Not later than the 60th day after completion of an examination, the examiner in charge of the examination shall submit to the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** a full and true report of the examination, verified by the oath of the examiner. The report shall comprise only facts appearing upon the books, papers, records, accounts, documents or computer and other recordings of the person, its agents or other persons being examined or facts ascertained from testimony of individuals concerning the affairs of such person, together with such conclusions and recommendations as reasonably may be warranted from such facts.

(2) The director shall make a copy of the report submitted under subsection (1) of this section available to the person who is the subject of the examination and shall give the person an opportunity to review and comment on the report. The director may request additional information or meet with the person for the purpose of resolving questions or obtaining additional information, and may direct the examiner to consider the additional information for inclusion in the report.

(3) Before the director files the examination report as a final examination report or makes the report or any matters relating thereto public, the person being examined shall have an opportunity for a hearing. A copy of the report must be mailed by certified mail to the person being examined. The person may request a hearing not later than the 30th day after the date on which the report was mailed. This subsection does not limit the authority of the director to disclose a preliminary or final examination report as otherwise provided in this section.

(4) The director shall consider comments presented at a hearing requested under subsection (3) of this section and may direct the examiner to consider the comments or direct that the comments be included in documentation relating to the report, although not as part of the report itself. The director may file the report as a final examination report at any time after consideration of the comments or at any time after the period for requesting a hearing has passed if a hearing is not requested.

(5) A report filed as a final examination report is subject to public inspection. The director, after filing any report, if the director considers it for the interest of the public to do so, may publish any report or the result of any examination as contained therein in one or more newspapers of the state without expense to the person examined.

(6) All work papers, recorded information, documents and copies thereof that are produced or obtained by or disclosed to the director or any other person in the course of an examination or in the course of analysis by the director of the financial condition or market conduct of an insurer are confidential and are exempt from public inspection as provided in ORS 705.137. If the director, in the director's sole discretion, determines that disclosure is necessary to protect the public interest, the director may make available work papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the director or any other person in the course of the examination.

(7) The director may disclose the content of an examination report that has not yet otherwise been disclosed or may disclose any of the materials described in subsection (6) of this section as provided in ORS 705.137.

SECTION 286. ORS 731.314 is amended to read:

731.314. (1) No cause of action may arise and no liability may be imposed against the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**, an authorized representative of the director or any examiner appointed by the director for any statements made or conduct performed in good faith pursuant to an examination or investigation.

(2) No cause of action may arise and no liability may be imposed against any person for communicating or delivering information or data to the director or an authorized representative of the director or examiner pursuant to an examination or investigation if the communication or delivery was performed in good faith and without fraudulent intent or an intent to deceive.

(3) This section does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by any person to which subsection (1) or (2) of this section applies.

(4) The court may award reasonable attorney fees to the prevailing party in a cause of action arising out of activities of the director or an examiner in carrying out an examination or investigation.

SECTION 287. ORS 731.316 is amended to read:

731.316. Any person examined under ORS 731.300 shall pay to the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** the just and legitimate costs of the examination as determined by the director, including actual necessary transportation and traveling expenses.

SECTION 288. ORS 731.324 is amended to read:

731.324. (1) Any act set forth in ORS 731.146 by an unauthorized insurer is equivalent to and shall constitute an irrevocable appointment by such insurer, binding upon the insurer, the executor of the insurer or administrator, or successor in interest if a corporation, of the Secretary of State or the successor in office, to be the true and lawful attorney of such insurer. All lawful process in any action in any court by the Director of the Department of Consumer and Business Services**, the Director of the Oregon Health Authority** or by the state and any notice, order, pleading or process in any proceeding before the director which arises out of transacting insurance in this state by such insurer may be served upon the Secretary of State or the successor in office. Transacting insurance in this state by an unauthorized insurer shall be signification of its agreement that lawful process in a court action and any notice, order, pleading, or process in an administrative proceeding before the director so served shall be of the same legal force and validity as personal service of process in this state upon such insurer.

(2) Service of process in such action shall be made by delivering to and leaving with the Secretary of State, or one of the assistants, two copies of the document served and by payment to the Secretary of State of the fee prescribed by law. Service upon the Secretary of State shall be service upon the principal.

(3) The Secretary of State shall forward by certified mail one of the copies of such process or such notice, order, pleading, or process in proceedings before the director to the defendant in such court proceeding or to whom the notice, order, pleading, or process in such administrative proceeding is addressed or directed at its last-known principal place of business and shall keep a record of all process so served on the defendant. Such record shall show the day and hour of service. Ser-

vice is sufficient, provided:

(a) Notice of service and a copy of the court process or the notice, order, pleading, or process in the administrative proceeding are sent within 10 days thereafter by certified mail by the plaintiff or the plaintiff's attorney in the court proceeding or by the director in the administrative proceeding to the defendant at the last-known principal place of business of the defendant.

(b) The defendant's receipt or receipts issued by the post office with which the letter is certified or registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of the plaintiff or the plaintiff's attorney in court proceeding or of the director in administrative proceeding, showing compliance therewith are filed with the clerk of the court in which such action is pending or with the director in administrative proceedings, on or before the date the defendant in the court or administrative proceeding is required to appear or respond thereto, or within such further time as the court or director may allow.

(4) No plaintiff shall be entitled to a judgment or a determination by default in any court or administrative proceeding in which court process or notice, order, pleading, or process in proceedings before the director is served under this section until the expiration of 45 days after the date of filing of the affidavit of compliance.

(5) Nothing in this section shall limit or affect the right to serve any process, notice, order, or demand upon any person or insurer in any other manner now or hereafter permitted by law.

SECTION 289. ORS 731.328 is amended to read:

731.328. (1) Before an unauthorized insurer files or causes to be filed any pleading in any court action or any notice, order, pleading, or process in an administrative proceeding before the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** instituted against such person or insurer, by services made as provided in ORS 731.324, such insurer shall deposit with the clerk of the court in which such action is pending, or with the director in administrative proceedings before the director, cash or securities. The insurer may also file with such clerk or director a bond with good and sufficient sureties, to be approved by the clerk or director, or an irrevocable letter of credit issued by an insured institution, as defined in ORS 706.008, in an amount to be fixed by the court or director sufficient to secure the payment of any final judgment which may be rendered in such action or administrative proceeding.

(2) The director, in any administrative proceeding in which service is made as provided in ORS 731.324, may order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (1) of this section and to defend such action.

(3) Nothing in subsection (1) of this section shall be construed to prevent an unauthorized insurer from filing a motion to quash a writ or to set aside service thereof made in the manner provided in ORS 731.324.

SECTION 290. ORS 731.354 is amended to read:

731.354. No person shall act as an insurer and no insurer shall directly or indirectly transact insurance in this state except as authorized by a subsisting certificate of authority issued to the insurer by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**.

SECTION 291. ORS 731.356 is amended to read:

731.356. When the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** believes, from evidence satisfactory to the director, that any insurer is violating or about to violate the provisions of ORS 731.354, the director may cause

a complaint to be filed in the Circuit Court of Marion County to enjoin and restrain such insurer from continuing such violation. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order or judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

SECTION 292. ORS 731.362 is amended to read:

731.362. (1) A foreign or alien insurer may be authorized to transact insurance in this state when it has complied with the following requirements:

(a) It shall file with the [*Director of the Department of Consumer and Business Services*] **regulator** a certified copy of its charter, articles of incorporation or deed of settlement and a statement of its financial condition and business in all states in such form and detail as the [*director*] **regulator** may require, signed and sworn to by at least two of its executive officers or the United States manager.

(b) It shall satisfy the [*director*] **regulator** that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact.

(c) It shall satisfy the [*director*] **regulator** that it is possessed of and will maintain at all times its required capitalization.

(d) It shall make such deposits with the [*Department of Consumer and Business Services*] **regulator** as are required by the provisions of the Insurance Code.

(2) Upon compliance with the requirements of this section and all other requirements imposed on such insurer by the Insurance Code, the director shall issue to it a certificate of authority.

SECTION 293. ORS 731.363 is amended to read:

731.363. (1) An authorized foreign insurer may become a domestic insurer:

(a) By complying with all of the requirements of law relating to the organization and authorization of a domestic insurer of the same type;

(b) By filing articles of incorporation that are amended to comply with all of the requirements of law relating to the organization and authorization of a domestic insurer of the same type; and

(c) By designating its principal place of business at a place in this state.

(2) If the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** determines that an authorized foreign insurer has complied with the requirements of subsection (1) of this section, the insurer is entitled to a certificate of authority to transact insurance in this state and shall be subject as a domestic insurer to the authority and jurisdiction of this state.

SECTION 294. ORS 731.364 is amended to read:

731.364. A domestic insurer, upon the approval of the [*Director of the Department of Consumer and Business Services*] **regulator**, may transfer its domicile to any other state in which it is admitted to transact the business of insurance. Upon such a transfer the insurer ceases to be a domestic insurer and may be authorized in this state if qualified as a foreign insurer. The [*director*] **regulator** shall approve such a proposed transfer unless the [*director*] **regulator** determines that the transfer is not in the interest of the policyholders of this state.

SECTION 295. ORS 731.365 is amended to read:

731.365. (1) The certificate of authority, insurance producer appointments and licenses, rates and other items allowed by the [*Director of the Department of Consumer and Business Services*] **regulator** pursuant to the discretion of the [*director*] **regulator** that are in existence at the time an authorized insurer transfers its domicile to this or any other state as provided in ORS 731.363 or 731.367 or by merger, consolidation or any other lawful method shall continue in full force and effect upon the

transfer if the insurer remains authorized to transact insurance in this state.

(2) All outstanding policies of a transferring insurer shall remain in full force and effect and need not be indorsed as to the new name of the insurer or its new location unless so ordered by the [*director*] **regulator**. A transferring insurer shall file new policy forms with the [*director*] **regulator** on or before the effective date of the transfer but may use existing policy forms with appropriate indorsements if allowed by the [*director*] **regulator**, according to any conditions established by the [*director*] **regulator**.

(3) Each transferring insurer shall notify the [*director*] **regulator** of the details of the proposed transfer and shall file promptly any resulting amendments to corporate or other organizational documents filed or required to be filed with the [*director*] **regulator**.

(4) This section applies to a domestic insurer that transfers its domicile to another state and to an authorized foreign insurer that transfers its domicile either to this state or to another state.

SECTION 296. ORS 731.367 is amended to read:

731.367. An unincorporated authorized foreign insurer transfers its domicile to this state when the [*Director of the Department of Consumer and Business Services*] **regulator** determines that it has complied with all of the requirements of law relating to the organization and authorization of a domestic insurer of the same type as provided in ORS 731.363. No merger, consolidation or other method shall be required to effect a transfer of the domicile of the unincorporated insurer to this state and no vote or approval of the policyholders, members or subscribers of the unincorporated insurer shall be required. Any agreement of indemnity, appointment or governance or any similar agreement shall continue in full force after the transfer if the unincorporated insurer remains an authorized insurer. The laws of this state, however, shall govern all such agreements regardless of any other law to the contrary, and such agreements shall be considered to be modified to reflect that this state is the principal place of business and domicile of the unincorporated insurer.

SECTION 297. ORS 731.369 is amended to read:

731.369. (1) A reciprocal insurer, through its attorney, shall file with the [*Director of the Department of Consumer and Business Services*] **regulator** a declaration, verified by the oath of such attorney, setting forth:

(a) The name or title of the reciprocal insurer.

(b) The location of the principal office of the reciprocal insurer.

(c) The class or classes of insurance to be effected or exchanged.

(d) A copy of the form of power of attorney or instrument under which such insurance is to be effected or exchanged.

(e) A copy of the policy under or by which such contracts of insurance are effected or exchanged among the subscribers.

(f) That applications have been made for insurance in the amounts required by subsection (2) of this section, and that such applications will be concurrently effective when the reciprocal insurer is authorized to commence business by the [*director*] **regulator**.

(g) If a foreign or alien reciprocal insurer, that there has been deposited and shall be maintained at all times with the State Treasurer or other proper official of the state in which the insurer is domiciled $50,000 in cash or securities, as a general deposit for the benefit of subscribers wherever located. Where the laws of the home state do not provide for the acceptance of such a deposit, the deposit may be made with a bank or trust company in escrow subject to the control of the insurance commissioner of the home state, and such deposit shall be released only upon the written order of such insurance commissioner. A certification from the insurance director or other proper state offi-

cial of the state in which the reciprocal insurer is domiciled shall be attached to the application for the certificate of authority.

(2) The reciprocal insurer must have bona fide applications for insurance aggregating not less than $3 million upon at least 200 risks, except in the case of wet marine hull insurance written by a domestic reciprocal insurer for persons whose earned income, in whole or in part, is derived from taking and selling food resources living in an ocean, bay or river, the applications must cover at least 25 hulls and the insurance must aggregate at least $125,000.

(3) The applicant shall furnish any other relevant information required by the [*director*] **regulator**, except no reciprocal insurer shall be required to furnish or file the names or addresses of its policyholders or subscribers.

SECTION 298. ORS 731.370 is amended to read:

731.370. (1) The application for a certificate of authority shall be accompanied by a sworn statement of a reciprocal insurer showing the financial condition of the insurer as of December 31 immediately preceding. The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may require a supplemental statement to be furnished as of a later date.

(2) Concurrently with the filing of the declaration provided for by the terms of ORS 731.369, the attorney shall file with the director an instrument in writing executed for the subscribers conditioned that upon the issuance of certificate of authority, action may be brought in the county in which the property insured thereunder is situated or where the injured person resides, and service of process may be had as provided in ORS 731.434 in all actions in this state arising out of policies issued by the reciprocal insurer, which service shall be valid and binding upon all subscribers exchanging at any time reciprocal or interinsurance contracts through such attorney. Actions may be brought against or defended in the name of the reciprocal insurer adopted by the subscribers.

SECTION 299. ORS 731.380 is amended to read:

731.380. (1) Subject to subsection (2) of this section, any foreign or alien insurer, without being authorized to transact business in this state, may take, acquire, hold and enforce notes secured by real estate mortgages or trust deeds and make commitments to purchase such notes. A foreign or alien insurer may foreclose the mortgages and trust deeds in the courts of this state, acquire the mortgaged property, hold, own and operate the property for a period not exceeding five years and dispose of the property. The activities authorized under this subsection by such a foreign or alien insurer shall not constitute transacting business in this state for the purposes of ORS chapter 60.

(2) Before a foreign or alien insurer engages in any of the activities described in subsection (1) of this section, the foreign or alien insurer shall first file with the [*Department of Consumer and Business Services*] **regulator** a statement signed by its president, secretary, treasurer or general manager that it constitutes the director of the [*Department of Consumer and Business Services*] **regulator** its attorney for service of process, and shall pay an initial filing fee of $200 and an annual license fee of $200. The statement shall include the address of the principal place of business of the foreign or alien insurer.

(3) The director, upon receiving service of process as authorized by subsection (2) of this section, immediately shall forward by registered mail or by certified mail with return receipt all documents served upon the director to the principal place of business of the foreign or alien insurer.

(4) A foreign or alien insurer that indirectly engages in the activities described in subsection (1) of this section because of its beneficial interest in a pool of notes secured by real estate mortgages or trust deeds need not comply with subsection (2) of this section.

SECTION 300. ORS 731.385 is amended to read:

731.385. (1) The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall establish standards by rule for determining whether the continued operation of an authorized insurer may be hazardous to the policyholders or to the insurance-buying public generally, for the purpose of carrying out ORS chapter 734 and other provisions of the Insurance Code that authorize the director to take action against such an insurer. If the director makes such a determination, the director may order the insurer to take one or more of the following actions:

(a) Reduce the total amount of present and potential liability for policy benefits by reinsurance.

(b) Reduce, suspend or limit the volume of business being accepted or renewed.

(c) Reduce general insurance and commission expenses by methods specified by the director.

(d) Increase the capital and surplus of the insurer.

(e) Suspend or limit the declaration and payment of dividends by the insurer to its stockholders or to its policyholders.

(f) Limit or withdraw from certain investments or discontinue certain investment practices to the extent the director determines such action to be necessary.

(2) The director may exercise authority under subsection (1) of this section in addition to or instead of any other authority that the director may exercise under the Insurance Code.

(3) The director may issue an order under this section with or without a hearing. An insurer subject to an order issued without a hearing may file a written request for a hearing to review the order. Such a request shall not stay the effect of the order. The hearing shall be held within 30 days after the filing of the request. The director shall complete the review within 30 days after the record for the hearing is closed, and shall discontinue the action taken under subsection (1) of this section if the director determines that none of the conditions giving rise to the action exists.

SECTION 301. ORS 731.386 is amended to read:

731.386. The Director of the Department of Consumer and Business Services [*shall*] **and the Director of the Oregon Health Authority may** not grant or continue authority to transact insurance in this state for any insurer:

(1) The management of which is found by the director to be untrustworthy or so lacking in insurance experience as to make the proposed operation or the continued operation hazardous to the insurance-buying public; or

(2) That the director has good reason to believe is affiliated directly or indirectly through ownership, control, reinsurance transactions or other insurance or business relations, with any person whose business operations are or have been marked to the detriment of policyholders, stockholders, investors, creditors or the public, by manipulation or dissipation of assets, manipulation of accounts or reinsurance, or by similar injurious actions.

SECTION 302. ORS 731.398 is amended to read:

731.398. The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** at any time may amend an insurer's certificate of authority to accord with lawful changes in the insurer's charter or insuring powers.

SECTION 303. ORS 731.402 is amended to read:

731.402. (1) The Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall issue to an insurer a certificate of authority if upon completion of the application for a certificate of authority by the insurer the director finds, from the application and such other investigation and information the director may acquire, that the insurer

is fully qualified and entitled thereto under the Insurance Code.

(2) The director shall take all necessary action and shall either issue or refuse to issue a certificate of authority within a reasonable time after the completion of the application for such authority.

(3) The certificate of authority, if issued, shall specify the class or classes of insurance the insurer is authorized to transact in this state. The director may issue authority limited to particular subclasses of insurance or types of insurance coverages within the scope of a class of insurance.

SECTION 304. ORS 731.406 is amended to read:

731.406. (1) An insurer's subsisting certificate of authority is evidence of its authority to transact in this state the class or classes of insurance specified therein, either as direct insurer or as reinsurer or as both.

(2) Although issued to the insurer the certificate of authority is at all times the property of this state. Upon any suspension, revocation or termination thereof the insurer promptly shall deliver the certificate of authority to the [*Director of the Department of Consumer and Business Services.*] **regulator.**

SECTION 305. ORS 731.410 is amended to read:

731.410. (1) A certificate of authority shall continue in force as long as the insurer is entitled thereto under the Insurance Code and until suspended or revoked by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**, or terminated at the request of the insurer; subject, however, to continuance of the certificate by the insurer each year by:

(a) Payment prior to April 1 of the continuation fee established by the director;

(b) Due filing by the insurer of its annual statement for the calendar year preceding;

(c) Due filing by the insurer of each annual statement supplement; and

(d) Payment by the insurer of premium taxes with respect to the preceding calendar year as required by ORS 731.808 to 731.828.

(2) A certificate of authority that is not continued by the insurer under subsection (1) of this section expires on the 60th day after the date on which the payment or filing is due.

(3) The director promptly shall notify the insurer of impending expiration of its certificate of authority.

(4) The director, in the discretion of the director, upon the insurer's request made not later than the 90th day after expiration, may reinstate a certificate of authority which the insurer has permitted to expire, after the insurer has cured all its failures which resulted in the expiration and has paid the fee for reinstatement established by the director. Otherwise the insurer shall be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this state.

SECTION 306. ORS 731.414 is amended to read:

731.414. (1) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** shall refuse to continue, or shall suspend or revoke, an insurer's certificate of authority if:

(a) As a foreign insurer, it no longer meets the requirements for the authority; or as a domestic insurer, it has failed to cure an impairment of required capitalization within the time allowed therefor by the director under ORS 732.230;

(b) The insurer knowingly exceeds its charter powers or powers granted under its certificate of authority; or

(c) As a foreign or alien insurer, its certificate of authority to transact insurance is suspended or revoked by its domicile.

(2) Except in cases of impairment of required capitalization or suspension or revocation by another domicile as referred to in subsection (1)(c) of this section, the director shall refuse, suspend or revoke the certificate of authority only after a hearing granted to the insurer, unless the insurer waives such hearing in writing.

SECTION 307. ORS 731.418 is amended to read:

731.418. (1) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may refuse to continue or may suspend or revoke an insurer's certificate of authority if the director finds after a hearing that:

(a) The insurer has violated or failed to comply with any lawful order of the director, or any provision of the Insurance Code other than those for which suspension or revocation is mandatory.

(b) The insurer is in unsound condition, or in such condition or using such methods and practices in the conduct of its business, as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.

(c) The insurer has failed, after written request by the director, to remove or discharge an officer or director who has been convicted in any jurisdiction of an offense which, if committed in this state, constitutes a misdemeanor involving moral turpitude or a felony, or is punishable by death or imprisonment under the laws of the United States, in any of which cases the record of the conviction shall be conclusive evidence.

(d) The insurer is affiliated with and under the same general management, interlocking directorate or ownership as another insurer that transacts direct insurance in this state without having a certificate of authority therefor, except as permitted under the Insurance Code.

(e) The insurer or an affiliate or holding company of the insurer refuses to be examined or any director, officer, employee or representative of the insurer, affiliate or holding company refuses to submit to examination relative to the affairs of the insurer, or to produce its accounts, records, and files for examination when required by the director or an examiner of the Department of Consumer and Business Services, or refuse to perform any legal obligation relative to the examination.

(f) The insurer has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking issued or guaranteed by it, within 30 days after the judgment became final, or within 30 days after time for taking an appeal has expired, or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

(g) The insurer fails to comply with ORS 742.534 (1).

(h) The insurer has failed to comply with ORS 476.270 (1), (2) or (3) or 654.097 (1).

(2) Without advance notice or a hearing thereon, the director may suspend immediately the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings, have been commenced in any state by the public insurance supervisory official of such state.

SECTION 308. ORS 731.422 is amended to read:

731.422. (1) All suspensions or revocations of, or refusals to continue, an insurer's certificate of authority shall be by order of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** order.

(2) Upon suspending, revoking or refusing to continue the insurer's certificate of authority, the director forthwith shall give notice thereof to the insurer's insurance producers in this state of record in the Department of Consumer and Business Services, and likewise shall suspend or revoke

the authority of such insurance producers to represent the insurer. The director also shall give notice to the insurance supervisory authority in jurisdictions in which the insurer is authorized, if a domestic insurer, or in its domicile if a foreign or alien insurer.

(3) In the discretion of the director, the director may publish notice of such suspension, revocation or refusal in one or more newspapers of general circulation in this state.

SECTION 309. ORS 731.426 is amended to read:

731.426. (1) In an order suspending the certificate of authority of an insurer, the [*Director of the Department of Consumer and Business Services*] **regulator** may provide that the suspension expires at the end of a specified period or when the [*director*] **regulator** determines that the cause or causes of the suspension have terminated. During the suspension the [*director*] **regulator** may rescind or shorten the suspension by further order.

(2) During the suspension period the insurer shall not solicit or write any new business in this state, but shall file its annual statement and pay fees, licenses and taxes as required under the Insurance Code, and may service its business already in force in this state, as if the certificate of authority had continued in full force.

(3) Upon expiration of a specific suspension period, if within such period the certificate of authority has not terminated, the insurer's certificate of authority automatically shall reinstate unless the [*director*] **regulator** finds that the cause or causes of the suspension have not terminated, or that the insurer is otherwise not in compliance with the requirements of the Insurance Code, and of which the [*director*] **regulator** shall give the insurer notice not less than 30 days in advance of the expiration of the suspension period.

(4) When the [*director*] **regulator** determines that a suspension should expire because the cause or causes have terminated, the [*director*] **regulator** shall reinstate the certificate of authority of the insurer unless the certificate of authority has expired within the suspension period.

(5) Upon reinstatement of the insurer's certificate of authority, the authority of its insurance producers in this state to represent the insurer shall likewise reinstate. The [*director*] **regulator** promptly shall notify the insurer and its insurance producers in this state of record in the Department of Consumer and Business Services, of such reinstatement. If pursuant to ORS 731.422 the [*director*] **regulator** has published notice of suspension, in like manner the [*director*] **regulator** shall publish notice of the reinstatement.

SECTION 310. ORS 731.428 is amended to read:

731.428. (1) A person who is prohibited by 18 U.S.C. 1033 from engaging or participating in the business of insurance because of a conviction of a felony involving dishonesty or a breach of trust or conviction of a crime under 18 U.S.C. 1033 may apply to the [*Director of the Department of Consumer and Business Services*] **regulator** for a written consent to engage or participate in the business of insurance.

(2) The [*director*] **regulator** shall establish by rule a procedure and standards by which the [*director*] **regulator** may issue a written consent to engage or participate in the business of insurance to a person convicted of a crime described in subsection (1) of this section.

(3) The [*director*] **regulator** shall not issue a license under the Insurance Code to an applicant who has been convicted of a crime referred to in subsection (1) of this section unless the [*director*] **regulator** also issues a written consent.

(4) If a person issued a license under the Insurance Code has been convicted of a crime referred to in subsection (1) of this section or is subsequently the subject of such a conviction, the [*director*] **regulator** shall revoke, suspend or refuse to renew the license. The person may apply to

the [*director*] **regulator** for a written consent as provided in subsection (1) of this section.

SECTION 311. ORS 731.430 is amended to read:

731.430. (1) No insurer shall be formed or authorized to transact insurance in this state which has or will have, or which uses or will use as an assumed business name, a name or principal identifying name factor:

(a) That is the same as or deceptively similar to:

(A) Any other insurer so formed or authorized;

(B) Any name reserved or registered as authorized by this section;

(C) Any name on file with the Secretary of State pursuant to ORS chapter 60, 65 or 648; or

(D) The name of any insurer that was authorized to transact insurance in this state within the preceding 10 years if insurance policies issued by such other insurer still are outstanding in this state. With the consent of the insurer issuing such policies, the [*Director of the Department of Consumer and Business Services*] **regulator** may waive this provision if the director **of the regulator** finds that the waiver will not be detrimental to the public; or

(b) That is deceptive or misleading as to the type of organization of the insurer or that does not indicate the insurer is transacting insurance.

(2) Any insurer doing business in this state may file and register with the director in writing, in its articles of incorporation or otherwise, an assumed name that it will use in transacting insurance in this state. Such name may not be a name prohibited by subsection (1) of this section.

(3) Any person may reserve a name for use as a corporate name or an assumed business name in transacting insurance in this state by filing in writing with the director a reservation of such name. Such name may not be a name prohibited by subsection (1) of this section. Such reservation shall expire six months after the date of filing unless:

(a) If filed by an insurer, it is using such name as an authorized insurer; or

(b) If filed by a noninsurer, it has filed with the director a formal application for a permit to form an insurer in this state. If a valid reservation is on file, the director may accept the filing of a same or deceptively similar name by another person which filing shall become effective, in the order of filing, at the expiration of the six-month provision unless the original reservation does not expire pursuant to this subsection.

(4) When an insurer is merged as provided in the Insurance Code, the surviving insurer may retain the use of the name for a period of five years after the effective date of merger. If such name is retained, use of the same or deceptively similar name by other insurers shall be prohibited as specified under this section during the five-year period.

SECTION 312. ORS 731.434 is amended to read:

731.434. (1) The provisions, procedures and requirements of ORS chapter 60 relating to a registered office, registered agent and to service of process, notice and demand shall govern all insurers transacting insurance in this state, whether authorized or unauthorized, except that the director of the [*Department of Consumer and Business Services*] **regulator** shall be substituted for the Secretary of State as the person with whom all filings shall be made and upon whom, in the circumstances specified by statute, such service may be effected.

(2) This section shall not apply to insurers for whom a certificate of authority is not required under ORS 731.374.

SECTION 313. ORS 731.466 is amended to read:

731.466. (1) The rights and power of the attorney of a reciprocal insurer shall be as provided in the power of attorney given it by the subscribers.

(2) The power of attorney must set forth:

(a) The powers of the attorney.

(b) That the attorney may accept service of process on behalf of the insurer.

(c) The services to be performed by the attorney in general.

(d) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney.

(e) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount not less than one nor more than 10 times the premium or premium deposit stated in the policy.

(3) The power of attorney may:

(a) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(b) Impose such restrictions upon the exercise of the power as are agreed upon by the subscribers;

(c) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(d) Contain other lawful provisions.

(4) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no such power or agreement or any amendment thereof, shall be used or be effective in this state until approved by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**.

SECTION 314. ORS 731.470 is amended to read:

731.470. (1) Any instrument required to be verified by the oath of the attorney for a reciprocal insurer may, in case of an incorporated attorney, be verified by the oath of the president, vice president, secretary or other executive officer of such corporation.

(2) The certificate of authority of a reciprocal insurer shall be issued to its attorney in the name of the insurer.

(3) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may refuse, suspend or revoke the certificate of authority, in addition to other grounds therefor, for failure of a reciprocal insurer's attorney to comply with any provision of the Insurance Code.

(4) The attorney for an authorized foreign or alien reciprocal insurer shall not, by virtue of discharge of its duties as such attorney with respect to the insurer's transactions in this state, be thereby deemed to be doing business in this state within the meaning of any laws of this state applying to foreign persons.

SECTION 315. 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 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 ORS 743.354.

(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 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 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 **of the Oregon Health Authority** determines that the association or trust meets applicable standards under ORS 743.522 (1)(b) or (c) or (2).

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

(9) The Director **of the Department of Consumer and Business Services and the Director of the Oregon Health Authority** may adopt rules to carry out this section.

SECTION 316. ORS 731.486, as amended by section 8, chapter 752, Oregon Laws 2007, 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*] **regulator** determines that the exemption applies.

(2) The insurer shall submit evidence to the [*director*] **regulator** that the exemption applies. When a master policy 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*] **regulator** shall review the evidence submitted and may request additional evidence as needed.

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

(5) The [*director*] **regulator** may order an insurer to cease offering a policy or coverage under a policy if the [*director*] **regulator** 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*] **regulator** 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) This section does not apply to any master policy issued to a multistate employer or labor union.

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

SECTION 317. ORS 731.488 is amended to read:

731.488. (1) Each insurer shall have an annual audit conducted by an independent certified public accountant and shall file an audited financial report annually with the [*Director of the Department of Consumer and Business Services*] **regulator**. The annual audited financial report shall disclose:

(a) The financial position of the insurer as of the end of the most recent calendar year; and

(b) The results of the insurer's operations, cash flows and changes in capital and surplus for the year then ended.

(2) The [*director*] **regulator** shall adopt rules with respect to the following matters as needed for carrying out the requirements of this section:

(a) Required contents and format of the audited financial report.

(b) Requirements for filing the report.

(c) Requirements applicable to qualifications and designation of certified public accountants for purposes of audits under this section. The requirements may include limitations on length of service for certified public accountants and may permit recognition of accountants comparably qualified under the laws of another country.

(d) Requirements applicable to evaluation of the accounting procedures of an insurer and its system of internal control by a certified public accountant.

(e) Standards governing the scope and preparation of the audit.

(f) Requirements and procedures relating to the reporting of the adverse financial condition of an insurer by a certified public accountant.

(g) Requirements and procedures relating to the reporting of significant deficiencies for internal controls of an insurer.

(h) Exemptions.

(i) Any other matter that the [*director*] **regulator** determines to be needed for preparation of or inclusion in the financial report.

SECTION 318. ORS 731.504 is amended to read:

731.504. (1) No insurer shall retain any risk on any one subject of insurance, whether a domestic risk or not, in an amount exceeding 10 percent of its surplus to policyholders, or in the case of title insurance, more than 50 percent of such surplus, except that an insurance company, including a reciprocal insurance company, comprised solely of 1,000 or more licensed Oregon physicians organized for the purpose of insuring for professional liability may consider aggregate insurance as surplus to policyholders for purposes of this section and shall not be allowed to retain the risk on any one subject of insurance in excess of two and one-half percent of such aggregate insurance.

(2) For purposes of this section, aggregate insurance is insurance which provides coverage in the event that the total fund of an insurance company, including a reciprocal insurance company, which is available to pay claims for occurrences of any one year, is exhausted. Aggregate insurance shall be in an amount equal to at least five times the annual premium collected by the insurance company.

(3) A "subject of insurance" for the purposes of this section:

(a) As to insurance against fire and hazards other than windstorm, earthquake and other catastrophic hazards, includes all properties insured by the same insurer that customarily are considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of any other hazard insured against;

(b) As to group life and health insurance, refers individually to each person benefited under the

group policy as a separate subject; and

(c) As to mortgage insurance, includes all obligations secured by real property in a single tract, or in multiple tracts not separated by at least one-half mile.

(4) Reinsurance ceded as authorized by ORS 731.508 shall be deducted in determining risk retained. As to surety risks, deduction also shall be made of the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged, or held subject to the surety's consent and for the surety's protection.

(5) As to alien insurers, this section relates only to risks and surplus to policyholders of the insurer's United States branch.

(6) As used in this section, "surplus to policyholders," in addition to the insurer's capital and surplus, includes any voluntary reserves that are not required pursuant to law, includes the contingency reserve held for mortgage insurance as required by ORS 733.100, and shall be determined from the last sworn statement of the insurer on file with the [*Director of the Department of Consumer and Business Services*] **regulator**, or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(7) This section does not apply to wet marine and transportation insurance or to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

SECTION 319. ORS 731.508 is amended to read:

731.508. (1) An insurer may accept reinsurance only of such risks, and retain risk thereon within such limits, as it is otherwise authorized to insure.

(2) Except as provided in ORS 731.512, 732.517 to 732.546 or 742.150 to 742.162, an insurer may reinsure risks with an insurer authorized to transact such insurance in this state, or in any other solvent insurer approved or accepted by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** for the purpose of such reinsurance. The director shall not approve or accept any such reinsurance by a ceding domestic insurer in an unauthorized insurer which the director finds for good cause would be contrary to the interests of the policyholders or stockholders of such domestic insurer.

(3) Credit shall not be allowed, as an asset or as a deduction from liability, to any ceding insurer for reinsurance unless the reinsurance contract provides, in substance, that in the event of the insolvency of the ceding insurer, the reinsurance shall be payable under a contract or contracts reinsured by the assuming insurer on the basis of reported claims allowed by the court hearing the liquidation proceeding, without diminution because of the insolvency of the ceding insurer. Such payments shall be made directly to the ceding insurer or to its domiciliary liquidator except:

(a) When the contract or other written agreement specifically provides another payee of the reinsurance in the event of the insolvency of the ceding insurer; or

(b) When the assuming insurer, with the consent of the direct insured or insureds, has assumed the policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under such policies and in substitution for the obligations of the ceding insurer to such payees.

(4) For the purposes of subsection (3) of this section, the reinsurance agreement may provide that the domiciliary liquidator of an insolvent ceding insurer shall, within a reasonable time after the claim is filed in the liquidation proceeding, give written notice to the assuming insurer of the pendency of a claim against the ceding insurer on the contract reinsured. During the pendency of the claim, an assuming insurer may investigate the claim and interpose, at its own expense, in the

proceeding in which the claim is to be adjudicated any defenses that the assuming insurer determines to be available to the ceding insurer or its liquidator. The expense may be filed as a claim against the insolvent ceding insurer to the extent of a proportionate share of the benefit that may accrue to the ceding insurer solely as a result of the defense undertaken by the assuming insurer. When two or more assuming insurers are involved in the same claim and a majority in interest elect to interpose one or more defenses to the claim, the expense shall be apportioned in accordance with the terms of the reinsurance agreement as though the expense had been incurred by the ceding insurer.

(5) The director may disallow credit that would otherwise be allowed if the director determines that allowing credit would be contrary to accurate financial reporting or proper financial management, or may be hazardous to policyholders of the insurer or the insurance-buying public generally. The director may make such a determination only according to standards established by the director by rule. This subsection applies only to insurers who transact life insurance or health insurance, or both.

(6) Upon request of the director, a ceding insurer promptly shall inform the director in writing of the cancellation or any other material change of any of its reinsurance treaties or arrangements.

(7) This section does not apply to wet marine and transportation insurance.

SECTION 320. ORS 731.509 is amended to read:

731.509. (1) The purpose of ORS 731.509, 731.510, 731.511, 731.512 and 731.516 is to protect the interests of insureds, claimants, ceding insurers, assuming insurers and the public generally. The Legislative Assembly declares that its intent is to ensure adequate regulation of insurers and reinsurers and adequate protection for those to whom they owe obligations. In furtherance of that state interest, the Legislative Assembly mandates that upon the insolvency of an alien insurer or reinsurer that provides security to fund its United States obligations in accordance with ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the assets representing the security shall be maintained in the United States and claims shall be filed with and valued by the state insurance commissioner with regulatory oversight, and the assets shall be distributed in accordance with the insurance laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic United States insurers. The Legislative Assembly declares that the laws contained in ORS 731.509, 731.510, 731.511, 731.512 and 731.516 are fundamental to the business of insurance in accordance with 15 U.S.C. 1011 and 1012.

(2) The Director of the Department of Consumer and Business Services [*shall*] **and the Director of the Oregon Health Authority may** not allow credit for reinsurance to a domestic ceding insurer as either an asset or a reduction from liability on account of reinsurance ceded unless credit is allowed as provided under ORS 731.508 and unless the reinsurer meets the requirements of:

(a) Subsection (3) of this section;

(b) Subsection (4) of this section;

(c) Subsections (5) and (8) of this section;

(d) Subsections (6) and (8) of this section; or

(e) Subsection (7) of this section.

(3) Credit shall be allowed when the reinsurance is ceded to an authorized assuming insurer that accepts reinsurance of risks, and retains risk thereon within such limits, as the assuming insurer is otherwise authorized to insure in this state as provided in ORS 731.508.

(4) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state as provided in ORS 731.511. The director shall not allow credit

to a domestic ceding insurer if the accreditation of the assuming insurer has been revoked by the director after notice and opportunity for hearing.

(5) Credit shall be allowed when the reinsurance is ceded to a foreign assuming insurer or a United States branch of an alien assuming insurer meeting all of the following requirements:

(a) The foreign assuming insurer must be domiciled in a state employing standards regarding credit for reinsurance that equal or exceed the standards applicable under this section. The United States branch of an alien assuming insurer must be entered through a state employing such standards.

(b) The foreign assuming insurer or United States branch of an alien assuming insurer must maintain a combined capital and surplus in an amount not less than $20,000,000. The requirement of this paragraph does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(c) The foreign assuming insurer or United States branch of an alien assuming insurer must submit to the authority of the director to examine its books and records.

(6) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that maintains a trust fund meeting the requirements of this subsection and additionally complies with other requirements of this subsection. The trust fund must be maintained in a qualified United States financial institution, as defined in ORS 731.510 (1), for the payment of the valid claims of its United States policyholders and ceding insurers and their assigns and successors in interest. The assuming insurer must report annually to the director information substantially the same as that required to be reported on the annual statement form by ORS 731.574 by authorized insurers, in order to enable the director to determine the sufficiency of the trust fund. The following requirements apply to such a trust fund:

(a) In the case of a single assuming insurer, the trust fund must consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers. In addition, the assuming insurer must maintain a trusteed surplus of not less than $20,000,000.

(b) In the case of a group including incorporated and individual unincorporated underwriters:

(A) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group.

(B) For reinsurance ceded under reinsurance agreements with an inception date on or before July 31, 1995, and not amended or renewed after that date, notwithstanding the other provisions of ORS 731.509, 731.510, 731.511, 731.512 and 731.516, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States.

(C) In addition to the trusts described in subparagraphs (A) and (B) of this paragraph, the group shall maintain in trust a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account.

(D) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

(E) Within 90 days after the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the director an annual certification by the group's

domiciliary regulator of the solvency of each underwriter member or, if certification is unavailable, financial statements of each underwriter member of the group prepared by independent certified public accountants.

(c) In the case of a group of incorporated insurers described in this paragraph, the trust must be in an amount equal to the group's several liabilities attributable to business ceded by United States ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group. This paragraph applies to a group of incorporated insurers under common administration that complies with the annual reporting requirements contained in this subsection and that has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation. Such a group must have an aggregate policyholders' surplus of $10,000,000,000 and must submit to the authority of this state to examine its books and records and bear the expense of the examination. The group shall also maintain a joint trusteed surplus of which $100,000,000 must be held jointly for the benefit of United States ceding insurers of any member of the group as additional security for any such liabilities. Each member of the group shall make available to the director an annual certification of the member's solvency by the member's domiciliary regulator and its independent certified public accountant.

(d) The form of the trust and any amendment to the trust shall have been approved by the insurance commissioner of the state in which the trust is domiciled or by the insurance commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

(e) The form of the trust and any trust amendments also shall be filed with the insurance commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument must provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust must vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers and their assigns and successors in interest. The trust and the assuming insurer are subject to examination as determined by the director. The trust must remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust.

(f) Not later than March 1 of each year, the trustees of each trust shall report to the director in writing the balance of the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(7) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of subsection (3), (4), (5) or (6) of this section, but only as to the insurance of risks located in jurisdictions in which the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) If the assuming insurer is not authorized to transact insurance in this state or accredited as a reinsurer in this state, the director shall not allow the credit permitted by subsections (5) and (6) of this section unless the assuming insurer agrees in the reinsurance agreement to the provisions stated in this subsection. This subsection is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement. The assuming insurer must agree in the reinsurance agreement:

(a) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States,

will comply with all requirements necessary to give the court jurisdiction and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

(b) To designate the director or a designated attorney as its true and lawful attorney upon whom any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding company may be served.

(9) If the assuming insurer does not meet the requirements of subsection (3), (4) or (5) of this section, the credit permitted by subsection (6) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the applicable amount required by subsection (6)(a), (b) or (c) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of the grantor's state or country of domicile, the trustee shall comply with an order of the insurance commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the insurance commissioner with regulatory oversight all the assets of the trust fund.

(b) The assets shall be distributed by and claims shall be filed with and valued by the insurance commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(c) If the insurance commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the insurance commissioner according to the laws of that state and according to the terms of the trust agreement not inconsistent with the laws of that state.

(d) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this subsection.

SECTION 321. ORS 731.510 is amended to read:

731.510. (1) Subject to the provisions of ORS 731.508 relating to allowance of credit for reinsurance, the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** shall allow a reduction from liability for the reinsurance ceded by a domestic insurer to a reinsurer not meeting the requirements of ORS 731.509 in an amount not exceeding the liabilities carried by the ceding insurer, as provided in this section. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the reinsurer as security for the payment of obligations thereunder, if the security:

(a) Is held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer; or

(b) In the case of a trust, is held in a qualified United States financial institution. For purposes of this paragraph, a qualified United States financial institution is an institution that:

(A) Is organized, or, in the case of a United States branch or agency office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(B) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

(2) The security for purposes of subsection (1) of this section may be in any of the following

forms:

(a) Cash.

(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners and qualifying as allowed assets.

(c) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, effective not later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit issued or confirmed by an institution meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall continue to be acceptable as security, notwithstanding the subsequent failure of the issuing or confirming institution to meet applicable standards of issuer acceptability, until their expiration, extension, renewal, modification or amendment, whichever occurs first. For purposes of this paragraph, a qualified United States financial institution is an institution that:

(A) Is organized or, in the case of a United States office of a foreign banking organization, is licensed, under the laws of the United States or any state thereof;

(B) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(C) Has been determined by the director to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the director. For the purpose of making a determination under this subparagraph, the director shall consider and may accept determinations made by the Securities Valuation Office of the National Association of Insurance Commissioners as to whether a financial institution meets its standards of financial conditions and standing.

(d) Any other form of security acceptable to the director.

SECTION 322. ORS 731.511 is amended to read:

731.511. (1) For purposes of allowing credit to a ceding domestic insurer under ORS 731.509 when the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state, an insurer may be accredited as a reinsurer in this state if the insurer:

(a) Files and maintains with the [*Director of the Department of Consumer and Business Services*] **regulator** evidence of its submission to the jurisdiction of this state;

(b) Submits to the authority of the [*director*] **regulator** to examine its books and records;

(c) Is authorized or licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an alien assuming insurer, is entered through and authorized or licensed to transact insurance or reinsurance in at least one state;

(d) Files annually with the [*director*] **regulator** a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(e) Satisfies either of the following requirements:

(A) Maintains combined capital and surplus in an amount that is not less than $20,000,000. An application for accreditation by an insurer who maintains the amount of combined capital and surplus specified in this subparagraph is considered to be approved if the application is not disapproved on or before the 90th day after the application is complete and is filed with the [*director*] **regulator**.

(B) Maintains combined capital and surplus in an amount less than $20,000,000. An insurer applying for accreditation who maintains the amount of combined capital and surplus specified in this

subparagraph is not accredited until the application for accreditation is approved by the [*director*] **regulator**.

(2) An insurer that is accredited as a reinsurer in this state may accept reinsurance only of those risks and retain the risk thereon within such limits as the accredited reinsurer is otherwise authorized to insure directly in a state in which the accredited reinsurer is authorized or licensed to transact insurance.

(3) The [*director*] **regulator** may revoke the accreditation of an assuming insurer if the [*director*] **regulator** determines that the assuming insurer has failed to continue to meet any of the requirements of subsection (1) of this section.

SECTION 323. ORS 731.512 is amended to read:

731.512. (1) No insurer shall withdraw from this state until its direct liability to its policyholders and obligees under all its insurance policies then in force in this state has been assumed by another authorized insurer under an agreement approved by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**. In the case of a life insurer, its liability pursuant to policies issued in this state in settlement of proceeds under its policies shall likewise be so assumed.

(2) The director may waive this requirement if the director finds upon examination that a withdrawing insurer then is fully solvent and that the protection to be given its policyholders in this state will not be impaired by the waiver.

(3) The assuming insurer within a reasonable time shall replace the assumed insurance policies with its own, or by indorsement thereon acknowledge its liability thereunder.

(4) This section is in addition to the requirements of ORS 732.517 to 732.546 and 742.150 to 742.162.

SECTION 324. ORS 731.554 is amended to read:

731.554. (1) Except as provided in subsections (2) to (6) of this section and ORS 731.562 and 731.566, to qualify for authority to transact insurance in this state an insurer shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $2.5 million.

(2) An insurer transacting any workers′ compensation insurance business shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $5 million.

(3) An insurer transacting mortgage insurance shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $4 million.

(4) A home protection insurer shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than 10 percent of the aggregate of premiums charged on its policies currently in force, but the required amount shall not be less than $250,000 or more than $1 million.

(5) A domestic insurer applying for its original certificate of authority in this state shall possess, when first so authorized, additional capital or surplus, or any combination thereof, of not less than $500,000. However, the additional amount in the case of a home protection insurer shall be not less than $10,000.

(6) For the protection of the public, the Director of the Department of Consumer and Business Services **and the Director of the Oregon Health Authority** may require an insurer to possess and maintain capital or surplus, or any combination thereof, in excess of the amount otherwise required under this section, ORS 731.562 or 731.566, owing to the type, volume and nature of insurance business transacted by the insurer, if the director determines that the greater amount is necessary for maintaining the insurer′s solvency according to standards established by rule. In developing such standards, the director shall consider model standards adopted by the National Association of In-

surance Commissioners. For the purpose of determining the reasonableness and adequacy of an insurer's capital and surplus, the director must consider at least the following factors, as applicable:

(a) The size of the insurer, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria.

(b) The extent to which the business of the insurer is diversified among the several lines of insurance.

(c) The number and size of risks insured in each line of business.

(d) The extent of the geographical dispersion of the insured risks of the insurer.

(e) The nature and extent of the reinsurance program of the insurer.

(f) The quality, diversification and liquidity of the investment portfolio of the insurer.

(g) The recent past and projected future trend in the size of the investment portfolio of the insurer.

(h) The combined capital and surplus maintained by other comparable insurers.

(i) The adequacy of the reserves of the insurer.

(j) The quality and liquidity of investments in affiliates. The director may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of the director the investment so warrants.

(k) The quality of the earnings of the insurer and the extent to which the reported earnings include extraordinary items.

SECTION 325. Section 5, chapter 318, Oregon Laws 2001, as amended by section 3, chapter 33, Oregon Laws 2003, is amended to read:

Sec. 5. (1) To qualify for authority to transact insurance in this state on and after January 1, 2002, an insurer that is not authorized to transact insurance in this state on the day before January 1, 2002, must possess and thereafter maintain the applicable capital and surplus required by ORS 731.554, 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001.

(2) To qualify for authority to transact health care services in this state on and after January 1, 2002, a health care service contractor that is not authorized to transact health care services in this state on the day before January 1, 2002, must possess and thereafter maintain the applicable capital and surplus required by ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001.

(3) An insurer that is authorized to transact insurance in this state on the day before January 1, 2002, and that possesses on that date the applicable capital and surplus required under ORS 731.554, 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001, must thereafter maintain that capital and surplus.

(4) A health care service contractor that is authorized to transact health care services in this state on the day before January 1, 2002, and that possesses on that date the applicable capital and surplus required under ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001, must thereafter maintain that capital and surplus.

(5) Notwithstanding the effective date of chapter 318, Oregon Laws 2001 **(January 1, 2002)**, an insurer that is authorized to transact insurance in this state on the day before January 1, 2002, and that does not possess on January 1, 2002, the applicable capital and surplus required under ORS 731.554 (1) and (2), 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001, must possess and maintain at least the amounts of capital and surplus as follows:

(a) For insurers other than insurers transacting workers' compensation insurance:

(A) $1,300,000, not later than December 31, 2002.

(B) $1,600,000, not later than December 31, 2003.

(C) $1,900,000, not later than December 31, 2004.

(D) $2,200,000, not later than December 31, 2005.

(E) $2,500,000, not later than December 31, 2006.

(b) For insurers transacting workers' compensation insurance:

(A) $3,400,000, not later than December 31, 2002.

(B) $3,800,000, not later than December 31, 2003.

(C) $4,200,000, not later than December 31, 2004.

(D) $4,600,000, not later than December 31, 2005.

(E) $5,000,000, not later than December 31, 2006.

(6) Notwithstanding the effective date of chapter 318, Oregon Laws 2001, a health care service contractor that is authorized to transact health care services in this state on the day before January 1, 2002, and that does not possess on January 1, 2002, the applicable capital and surplus required under ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001, must possess and maintain at least the amounts of capital and surplus as follows:

(a) As of each date specified in this paragraph, a health care service contractor other than one to which ORS 750.045 (3) applies shall possess and maintain capital or surplus, or any combination thereof, of not less than the minimum amount specified in connection with the date or an amount equal to 50 percent of the average claims as defined in ORS 750.005 for the preceding 12-month period, whichever is greater. The required amount of capital and surplus for each date, however, shall not be more than the maximum amount specified in connection with that date. The dates and minimum and maximum required amounts of capital and surplus are as follows:

(A) As of December 31, 2002, not less than $650,000 and not more than $1,300,000.

(B) As of December 31, 2003, not less than $800,000 and not more than $1,600,000.

(C) As of December 31, 2004, not less than $950,000 and not more than $1,900,000.

(D) As of December 31, 2005, not less than $1,100,000 and not more than $2,200,000.

(E) As of December 31, 2006, not less than $2,500,000.

(b) As of each date specified in this paragraph, a health care service contractor to which ORS 750.045 (3) applies shall possess and maintain capital or surplus, or any combination thereof, of not less than the minimum amount specified in connection with the date or an amount equal to 50 percent of the average claims as defined in ORS 750.005 for the preceding 12-month period, whichever is greater. The required amount of capital and surplus for each date, however, shall not be more than the maximum amount specified in connection with that date. The dates and minimum and maximum required amounts of capital and surplus are as follows:

(A) As of December 31, 2002, not less than $300,000 and not more than $600,000.

(B) As of December 31, 2003, not less than $350,000 and not more than $700,000.

(C) As of December 31, 2004, not less than $400,000 and not more than $800,000.

(D) As of December 31, 2005, not less than $450,000 and not more than $900,000.

(E) As of December 31, 2006, not less than $1 million.

(7) An insurer authorized to transact insurance in this state on the day before January 1, 2002, shall not be granted authority to transact any other or additional class of insurance until the insurer complies with the applicable provisions of ORS 731.554, 731.562 or 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001.

(8) An insurer or health care service contractor authorized to transact insurance or health care services in this state on the day before January 1, 2002, that reapplies for a certificate of authority

after having a certificate of authority revoked for any cause shall not be granted authority to transact any insurance or health care services until the insurer or health care service contractor complies with the applicable provisions of ORS 731.554, 731.562, 731.566 or 750.045, as amended by sections 1 to 3 and 6, chapter 318, Oregon Laws 2001.

(9) If an insurer to which subsection (5) of this section applies or a health care service contractor to which subsection (6) of this section applies does not possess and maintain the minimum amount of capital and surplus required by ORS 731.554 (1) and (2), 731.562, 731.566 and 750.045, as amended by sections 1 to 3 and 6, chapter 318, Oregon Laws 2001, on or before December 31, 2006, the insurer or health care service contractor may apply to the [*Director of the Department of Consumer and Business Services*] **regulator** for an extension of time within which to attain the amount. The application must state the reasons for the failure to attain the required minimum amount, the date by which the amount is expected to be attained and the means and likelihood of attaining the amount by that date. The [*director*] **regulator** may grant the extension if the [*director*] **regulator** determines that the extension is reasonable and appropriate in the circumstances, taking into account factors that include but are not limited to the following:

(a) Whether the insurer or health care service contractor has made reasonable progress toward attaining the required minimum amount during the time periods specified in this section; and

(b) Whether the insurer or health care service contractor is likely to attain the required minimum amount by the date proposed by the insurer or health care service contractor.

SECTION 326. ORS 731.570 is amended to read:

731.570. No advancement made by the subscribers or the attorney of a reciprocal insurer shall be withdrawn or refunded except out of the surplus of the insurer in excess of its required capitalization, and then only upon the written consent of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**.

SECTION 327. ORS 731.574 is amended to read:

731.574. (1) Except as provided in subsection (4) of this section, every authorized insurer shall file with the [*Director of the Department of Consumer and Business Services*] **regulator**, on or before March 1 of each year, a financial statement for the year ending December 31 immediately preceding. This statement shall be on a form prescribed by the [*director*] **regulator**. The statement shall contain such detailed exhibit of the condition and transactions of the insurer, in such form and otherwise, as the [*director*] **regulator** prescribes. The [*director*] **regulator** shall consider and may prescribe the annual statement blank or other form established by the National Association of Insurance Commissioners, including instructions prepared by the National Association of Insurance Commissioners for completing the blank or other form. If the [*director*] **regulator** prescribes the blank or other form established by the National Association of Insurance Commissioners, including the instructions, an insurer submitting the annual statement blank or form established by the National Association of Insurance Commissioners must complete the blank or form according to the instructions. The [*director*] **regulator** may require the filing of information in addition to the information required in the annual statement. The [*director*] **regulator** may also require additional filings as the [*director*] **regulator** determines necessary.

(2) The financial statement filed by an insurer under subsection (1) of this section shall be verified by the oaths of the president and secretary of the insurer or, in their absence, by two other principal officers. The statement of an alien company shall embrace only its condition and transactions in the United States, unless the [*director*] **regulator** requires otherwise, and shall be verified by the oath of its resident manager or principal representatives in the United States. Facsimile

signatures are acceptable and shall have the same force as original signatures.

(3) The [*director*] **regulator** may grant an extension of time for filing the annual statement.

(4) A home protection insurer may adopt a fiscal year other than the calendar year for its financial statements filed with the [*director*] **regulator** under subsection (1) of this section by declaring the fiscal year in its application for a certificate of authority. An adopted fiscal year may not be changed without the consent of the insurance supervisory official of the insurer's domicile. The financial statement of a home protection insurer on other than the calendar year basis shall be filed with the [*director*] **regulator** on or before the first day of the third month which follows the end of the fiscal year.

(5) An insurer, subject to requirements set forth in rules made by the [*director*] **regulator**, may publish financial statements, or information based on financial statements, prepared on a basis that is in accordance with requirements of a competent authority and differs from the basis of the statements required to be filed with the [*director*] **regulator**.

(6) It is the intention of the Legislative Assembly that the [*director*] **regulator** consider and follow the accounting, reporting and other standards, practices and procedures established by the National Association of Insurance Commissioners in order to:

(a) Strengthen and improve regulation of insurer solvency by the Department of Consumer and Business Services **and the Oregon Health Authority**;

(b) Promote uniform and consistent regulation of insurance by this state and the other states;

(c) Reduce regulatory costs owing to unnecessary differences in the laws of the various states; and

(d) Obtain and maintain accreditation of this state's insurance regulatory program by the National Association of Insurance Commissioners.

SECTION 328. ORS 731.608 is amended to read:

731.608. (1) Except as provided in subsection (2) of this section, deposits made in this state under ORS 731.624 shall be held for the faithful performance by the insurer of all insurance obligations, including claims for unearned premiums, with respect to domestic risks pertaining to the particular class of insurance for which the deposit was made. However, there shall be excluded from each such obligation the same amount as is excluded in determining the obligation of the Oregon Insurance Guaranty Association under ORS 734.510 to 734.710.

(2) If at any time a deposit made under ORS 731.624 by a particular insurer is insufficient to perform the insurance obligations upon the faithful performance of which the deposit was conditioned, then any other deposit made under ORS 731.624 by that insurer shall be so used to the extent that such other deposit is not used to perform the insurance obligations upon the faithful performance of which such other deposit was conditioned.

(3) Deposits made by insurers and reinsurers in this state under ORS 731.628 shall be held for the payment of compensation benefits to workers employed by insured employers other than those insured with the State Accident Insurance Fund Corporation to whom the insurer has issued a guaranty contract under ORS chapter 656. Deposits made by insurers and reinsurers under ORS 731.628 also shall be held to reimburse the Department of Consumer and Business Services, subject to approval by the Director of the Department of Consumer and Business Services, for costs incurred by the department in processing workers' compensation claims of insurers which have been placed in liquidation, receivership, rehabilitation or other such status for the orderly conservation or distribution of assets, pursuant to the laws of this state or any other state.

(4) A deposit made in this state by a domestic insurer transacting insurance in another juris-

diction, and as required by the laws of such jurisdiction, shall be held for the purpose or purposes required by such laws.

(5) Deposits of foreign and alien insurers required pursuant to ORS 731.854 shall be held for such purposes as are required by such law, and as specified by the [*director's*] **regulator's** order by which the deposit is required.

(6) Deposits of domestic reciprocal insurers required pursuant to ORS 731.632 shall be held for the benefit of subscribers wherever located.

SECTION 329. ORS 731.608, as amended by section 26, chapter 241, Oregon Laws 2007, is amended to read:

731.608. (1) Except as provided in subsection (2) of this section, deposits made in this state under ORS 731.624 shall be held for the faithful performance by the insurer of all insurance obligations, including claims for unearned premiums, with respect to domestic risks pertaining to the particular class of insurance for which the deposit was made. However, there shall be excluded from each such obligation the same amount as is excluded in determining the obligation of the Oregon Insurance Guaranty Association under ORS 734.510 to 734.710.

(2) If at any time a deposit made under ORS 731.624 by a particular insurer is insufficient to perform the insurance obligations upon the faithful performance of which the deposit was conditioned, then any other deposit made under ORS 731.624 by that insurer shall be so used to the extent that such other deposit is not used to perform the insurance obligations upon the faithful performance of which such other deposit was conditioned.

(3) Deposits made by insurers and reinsurers in this state under ORS 731.628 shall be held for the payment of compensation benefits to workers employed by insured employers other than those insured with the State Accident Insurance Fund Corporation to whom the insurer has issued a workers' compensation insurance policy under ORS chapter 656. Deposits made by insurers and reinsurers under ORS 731.628 also shall be held to reimburse the Department of Consumer and Business Services, subject to approval by the Director of the Department of Consumer and Business Services, for costs incurred by the department in processing workers' compensation claims of insurers which have been placed in liquidation, receivership, rehabilitation or other such status for the orderly conservation or distribution of assets, pursuant to the laws of this state or any other state.

(4) A deposit made in this state by a domestic insurer transacting insurance in another jurisdiction, and as required by the laws of such jurisdiction, shall be held for the purpose or purposes required by such laws.

(5) Deposits of foreign and alien insurers required pursuant to ORS 731.854 shall be held for such purposes as are required by such law, and as specified by the [*director's*] **regulator's** order by which the deposit is required.

(6) Deposits of domestic reciprocal insurers required pursuant to ORS 731.632 shall be held for the benefit of subscribers wherever located.

SECTION 330. ORS 731.616 is amended to read:

731.616. (1) For the purpose of determining the sufficiency of its deposit in this state the assets of the insurer on deposit shall be valued at current market value.

(2) If assets deposited by an insurer are subject to material fluctuations in market value, the [*Director of the Department of Consumer and Business Services*] **regulator**, in the discretion of the [*director*] **regulator**, may require the insurer to deposit and maintain on deposit additional assets in such amount as reasonably is necessary to assure that the deposit at all times will have a market

value of not less than the amount specified under or pursuant to the law by which the deposit is required.

(3) If for any reason the current market value of such assets falls below the amount of deposit required of the insurer, the insurer shall promptly deposit other or additional assets eligible for deposit in an amount sufficient to cure the deficiency. The insurer has 30 days in which to cure the deficiency after notice thereof from the [*director*] **regulator**.

SECTION 331. ORS 731.620 is amended to read:

731.620. (1) The insurer shall assign in trust to the director of the [*Department of Consumer and Business Services*] **regulator** and successors in office all securities being deposited through the director under the Insurance Code that are not negotiable by delivery; or, in lieu of such assignment, the insurer may give the director an irrevocable power of attorney authorizing the director to transfer the securities or any part thereof for any purpose within the scope of the Insurance Code.

(2) Upon release to the insurer, or other person entitled thereto, of any such security the director shall reassign the security to such insurer or person; or, in the case of power of attorney given pursuant to subsection (1) of this section, the director shall deliver the power of attorney, together with the securities covered thereby, to the insurer or person entitled thereto.

SECTION 332. ORS 731.636 is amended to read:

731.636. (1) Except as provided in subsection (3) of this section, every alien insurer, before transacting insurance in this state as an authorized insurer, shall deposit with the Department of Consumer and Business Services the sum of the following amounts:

(a) The amount of its outstanding liabilities arising out of its insurance transactions in the United States; and

(b) Its required capitalization.

(2) ORS 731.640 (1)(d) does not apply with respect to such deposit.

(3) In lieu of such deposit, the insurer may furnish evidence satisfactory to the [*Director of the Department of Consumer and Business Services*] **regulator** that it maintains in the United States, by way of trust deposits with public depositories or with trust institutions acceptable to the [*director*] **regulator**, assets at least equal to the deposit otherwise required by this section.

SECTION 333. ORS 731.640 is amended to read:

731.640. (1) Deposits which are required or permitted under the Insurance Code shall consist only of the following:

(a) Cash.

(b) Amply secured obligations of the United States, a state or a political subdivision thereof.

(c) Certificates of deposit or other investments described in ORS 733.650 (4). The [*Director of the Department of Consumer and Business Services*] **regulator** may promulgate rules to limit such investments.

(d) A surety bond, approved by the [*director*] **regulator**, executed by an authorized surety insurer that is not under common ownership, management or control with the person making the deposit. This paragraph does not apply to deposits made by surety insurers or to workers' compensation deposits made under ORS 731.628.

(e) Amply secured obligations of a corporation rated by the National Association of Insurance Commissioners as Class 1. This paragraph applies only to that portion of the total deposit that exceeds $50 million. The [*director*] **regulator** may adopt rules to require periodic review of the secured obligations of a corporation allowed under this paragraph.

(2) Deposits of domestic insurers made pursuant to the laws of other jurisdictions shall consist

of cash or securities as required or permitted by the laws of such jurisdictions.

SECTION 334. ORS 731.642 is amended to read:

731.642. The [*Director of the Department of Consumer and Business Services*] **regulator**, in performing duties under ORS 731.604 to 731.652 and after consultation with the State Treasurer, may enter into contracts with banks qualified to act as trust companies and as depositories of state funds to hold and service securities deposited by insurers with the [*Department of Consumer and Business Services*] **regulator**. The insurers whose securities are held and serviced by the banks shall pay for the cost of such contracts.

SECTION 335. ORS 731.644 is amended to read:

731.644. (1) Except as otherwise provided in the Insurance Code, no judgment creditor or other claimant of an insurer shall have the right to levy upon any of the assets or securities of the insurer held on deposit in this state.

(2) As to deposits made in this state pursuant to ORS 731.854, levy thereupon shall be permitted only if expressly so provided in the order of the [*Director of the Department of Consumer and Business Services*] **regulator** under which the deposit is required.

SECTION 336. ORS 731.648 is amended to read:

731.648. (1) Every deposit made in this state by an insurer pursuant to the Insurance Code shall be so held as long as there is outstanding any liability of the insurer as to which the deposit was required, except as follows:

(a) If the deposit was required under ORS 731.854, the deposit shall be held for so long as the basis of such retaliation exists.

(b) If the deposit was required of a reinsurer under ORS 731.628, the deposit shall be held as long as there is outstanding any liability of the reinsurer with respect to which the deposit was made.

(2) No surety insurer shall be permitted to withdraw its deposit for a period of three years after discontinuing business within this state.

(3) The [*Director of the Department of Consumer and Business Services*] **regulator** shall release a deposit:

(a) To the insurer upon extinguishment by reinsurance or otherwise of all liability of the insurer for the security of which the deposit is held. If extinguishment is by reinsurance, the assuming insurer shall be one authorized to transact such insurance in this state.

(b) To the insurer, while unimpaired, to the extent such deposit is in excess of the amount required.

(c) To the surviving corporation or to such person as it may designate for the purpose, upon effectuation of a merger of the depositing insurer, if the surviving insurer is authorized to transact insurance in this state.

(4) The [*director*] **regulator** shall release a deposit by an insurer upon order of a court of competent jurisdiction, to the receiver, conservator, rehabilitator, or liquidator of the insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets pursuant to delinquency proceedings brought against the insurer. The [*director*] **regulator** shall release a deposit by a reinsurer under ORS 731.628 upon order of a court of competent jurisdiction, to the receiver, conservator, rehabilitator, or liquidator of the ceding insurer, or to any other properly designated official or officials who succeed to the management and control of the insurer's assets pursuant to delinquency proceedings brought against the ceding insurer.

SECTION 337. ORS 731.652 is amended to read:

731.652. (1) Before releasing any deposit or portion thereof to the insurer, as provided in ORS 731.648, the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** shall require the insurer to file with the director a written statement in such form and with such verification as the director deems advisable setting forth the facts upon which it bases its entitlement to such release.

(2) If release of the deposit is claimed by the insurer upon the ground that all its liabilities, as to which the deposit was held, have been assumed by another insurer authorized to transact insurance in this state, the insurer shall file with the director a copy of the contract or agreement of such reinsurance duly attested under the oath of an officer of each of the insurers that are parties thereto.

(3) If release of the deposit is claimed by a domestic insurer upon the ground that all its liabilities, as to which the deposit was held, have been terminated other than by reinsurance, the director shall make an examination of the affairs of the insurer for determination of the actuality of such termination.

(4) Upon being satisfied by such statement and reinsurance contract, or examination of the insurer if required under subsection (3) of this section, or by such other examination of the affairs of the insurer as the director deems advisable to make, that the insurer is entitled to the release of its deposit or portion thereof as provided in ORS 731.648, the director shall release the deposit or excess portion thereof to the insurer or its authorized representative.

(5) If the director willfully fails faithfully to keep, deposit, account for or surrender any such assets or securities deposited through the director in the manner as authorized or required under the Insurance Code, the director shall be liable therefor upon the director's official bond, and suit may be brought upon the bond by any person injured by such failure. The director shall not, however, have any liability as to any assets or securities of an insurer released by the director in good faith pursuant to the authority vested in the director under the Insurance Code.

SECTION 338. ORS 731.730 is amended to read:

731.730. (1) Every authorized insurer shall file with the National Association of Insurance Commissioners, on or before March 1 of each year, a copy of its annual statement blank, along with additional filings required by the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** for the preceding year. The information filed with the National Association of Insurance Commissioners must be in the same format and scope as that required by the director and must include the signed jurat page and the actuarial certification. Each amendment and each addendum to the annual statement filing subsequently filed with the director must also be filed with the National Association of Insurance Commissioners.

(2) A foreign insurer that is domiciled in a state having a law substantially similar to the provisions of subsection (1) of this section is considered to be in compliance with this section.

(3) An insurer making a filing under subsection (1) of this section must pay the National Association of Insurance Commissioners the fee established by the National Association of Insurance Commissioners for filing, reviewing or processing the information.

SECTION 339. ORS 731.731 is amended to read:

731.731. Except in the case of malfeasance in office or willful or wanton neglect of duty or authority, there shall be no liability on the part of, and no cause of action of any nature shall arise against, any of the following persons by virtue of their collection, review, analysis or dissemination of the data and information collected from the filings required by ORS 731.730:

(1) Members of the National Association of Insurance Commissioners and the delegates and au-

thorized committees, subcommittees and task forces of the National Association of Insurance Commissioners.

(2) Employees of the National Association of Insurance Commissioners.

(3) The Director of the Department of Consumer and Business Services**, the Director of the Oregon Health Authority** or any representative of the director.

(4) The insurance regulatory official of another state or any representative of such an official.

SECTION 340. ORS 731.735 is amended to read:

731.735. All financial analysis ratios and examination synopses concerning insurers that are submitted to the [*Director of the Department of Consumer and Business Services*] **regulator** by the Insurance Regulatory Information System of the National Association of Insurance Commissioners are confidential as provided in ORS 705.137.

SECTION 341. ORS 731.737 is amended to read:

731.737. (1) A person or other entity described in this subsection acting without malice, fraudulent intent or bad faith is not subject to civil liability, and no cause of action of any nature may exist against such a person or entity, when the person is performing authorized functions, including publication or dissemination of information, regarding any activity described in subsection (3) of this section. This subsection applies to the following persons and entities:

(a) Law enforcement officials and their agents and employees.

(b) The National Association of Insurance Commissioners, the Department of Consumer and Business Services, **the Oregon Health Authority,** a federal or state governmental agency established to detect and prevent activities described in subsection (3) of this section and any other organization established for the same purpose, and agents, employees or designees of any such person or entity.

(2) A person acting without malice, fraudulent intent or bad faith is not subject to liability by virtue of filing reports or furnishing information regarding any activity described in subsection (3) of this section with or to any person or other entity described in subsection (1) of this section.

(3) The activities referred to in subsections (1) and (2) of this section include but are not limited to the following, whether any activity is suspected or anticipated or has occurred:

(a) Acts or omissions by a person who presents a statement described in this paragraph to or by an insurer or an insurance producer, causes such a statement to be presented to or by an insurer or an insurance producer, or prepares such a statement with knowledge or belief that it will be presented to or by an insurer or an insurance producer. This paragraph applies to any statement that the person knows to contain false information as part of, in support of or concerning any fact relating to the following, or conceals relevant information relating to the following:

(A) An application for the issuance of insurance.

(B) The rating of insurance.

(C) A claim for payment or benefit pursuant to any insurance.

(D) Premiums paid on insurance.

(E) Payments made in accordance with the terms of insurance coverage.

(F) An application for a certificate of authority.

(G) The financial condition of an insurer.

(H) The acquisition of any insurer.

(b) Solicitation or an attempt to solicit new or renewal insurance by or for an insolvent insurer or other person subject to regulation under the Insurance Code.

(c) Removal or an attempt to remove assets or any record of assets, transactions and affairs

from the home office or other place of business of the insurer or other person subject to regulation under the Insurance Code, or from the place of safekeeping of such a person, or who conceals or attempts to conceal the assets or record from the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**.

(d) Diversion, an attempt to divert or a conspiracy to divert funds of an insurer or other person subject to regulation under the Insurance Code, or of any other person, in connection with:

(A) The transaction of insurance.

(B) The conduct of business activities by an insurer or other person subject to regulation under the Insurance Code.

(C) The formation, acquisition or dissolution of an insurer or other person subject to regulation under the Insurance Code.

(4) This section does not abrogate or modify in any way any common law or statutory privilege or immunity otherwise enjoyed by a person or entity made immune from liability under this section.

(5) The court may award reasonable attorney fees to the prevailing party in any tort action against a person who claims immunity under the provisions of this section.

SECTION 342. ORS 731.750 is amended to read:

731.750. (1) A report filed with the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** according to requirements established by rule for disclosure of material acquisitions or dispositions of assets and disclosure of material nonrenewals, cancellations and revisions of ceded reinsurance agreements shall be confidential as provided in ORS 705.137.

(2) The director may direct the insurer to furnish copies of a report described in subsection (1) of this section to the National Association of Insurance Commissioners.

(3) The director may disclose or use a report as considered necessary by the director in the administration of the Insurance Code or other law.

(4) Information contained in documents described in subsections (1) to (3) of this section that is also contained in financial statements of insurers filed under ORS 731.574 or in final examination reports filed under ORS 731.312 is not confidential under this section.

SECTION 343. ORS 731.752 is amended to read:

731.752. (1) A report filed with the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** according to requirements established by rule for the purpose of determining the amount of capital or surplus, or any combination thereof, that should be possessed and maintained by an insurer under ORS 731.554 or by a health care service contractor under ORS 750.045, or under the laws of another state establishing similar requirements, shall be confidential and shall not be disclosed except as provided in ORS 705.137.

(2) A financial plan of action stating corrective actions to be taken by an insurer or health care service contractor in response to a determination of inadequate capital or surplus, or any combination thereof, that is filed by the insurer or health care service contractor with the director according to requirements established by rule shall be confidential and shall not be disclosed except as provided in ORS 705.137.

(3) The results or report of any examination or analysis of an insurer or health care service contractor performed by the director in connection with a financial plan described in subsection (2) of this section and any corrective order issued by the director pursuant to such an examination or analysis shall be confidential and shall not be disclosed except as provided in ORS 705.137.

(4) Information contained in documents described in subsections (1) to (3) of this section that is

also contained in financial statements of insurers or health care service contractors filed under ORS 731.574 or in final examination reports filed under ORS 731.312 is not confidential under this section.

SECTION 344. ORS 731.754 is amended to read:

731.754. (1) The [*Director of the Department of Consumer and Business Services*] **regulator** may use the following only for the purpose of monitoring the solvency of insurers and health care service contractors and the need for possible corrective action with respect to insurers and health care service contractors:

(a) Reports and financial plans of action that are made confidential under ORS 731.752; and

(b) Instructions adopted and amended by the National Association of Insurance Commissioners for use by insurers and health care service contractors in preparing reports and financial plans of action referred to in paragraph (a) of this subsection.

(2) The [*director*] **regulator** may not use reports, financial plans of action and instructions referred to in subsection (1) of this section for ratemaking, for reviewing rate filings or in a rate proceeding related thereto, or to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer, a health care service contractor or an affiliate is authorized to transact. Such reports and financial plans of action also shall not be introduced as evidence in a rate proceeding.

(3) This section does not restrict the authority of the [*director*] **regulator** to use information included in reports, financial plans or instructions referred to in subsection (1) of this section that is available from other sources.

SECTION 345. ORS 731.762 is amended to read:

731.762. (1) ORS 731.761 does not limit the authority of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** to acquire any insurance compliance self-evaluative audit document or to examine any person in connection with the document. If the director determines that the actions of an insurer are egregious, the director may introduce and use the document in any administrative proceeding or civil action under the Insurance Code. The director may require that an insurer submit an insurance compliance self-evaluative audit document for the purpose of an examination or investigation conducted under this chapter. An insurer may also voluntarily submit an insurance compliance self-evaluative audit document to the director.

(2) Any insurance compliance self-evaluative audit document submitted to the director under this section and in the possession of the director remains the property of the insurer and is not subject to disclosure or production under ORS 192.410 to 192.505.

(3)(a) The director shall consider the corrective action taken by an insurer to eliminate problems identified in the insurance compliance self-evaluative audit document as a mitigating factor when determining a civil penalty or other action against the insurer.

(b) The director may, in the director's sole discretion, decline to impose a civil penalty or take other action against an insurer based on information obtained from an insurance compliance self-evaluative audit document if the insurer has taken reasonable corrective action to eliminate the problems identified in the document.

(4) Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntarily or pursuant to compulsion of law, does not constitute a waiver of the privilege set forth in ORS 731.761 for any other purpose.

(5) The director may not be compelled to produce an insurance compliance self-evaluative audit document.

SECTION 346. ORS 731.764 is amended to read:

731.764. (1) The privilege set forth in ORS 731.761 does not apply to the extent that the privilege is expressly waived by the insurer that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) The privilege set forth in ORS 731.761 does not apply in any civil, criminal or administrative proceeding commenced by the Attorney General relating to Medicaid fraud, without regard to whether the proceeding is brought on behalf of the state, a state agency or a federal agency. An insurer may request an in camera review of any document or other evidence to be released or used under this subsection and may request that appropriate protective orders be entered governing release and use of the material.

(3) In any civil proceeding a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in ORS 731.761 is asserted if the court determines that the material is not subject to the privilege, or that the privilege is asserted for a fraudulent purpose, including but not limited to an assertion of the privilege for an insurance compliance audit that was conducted for the purpose of concealing a violation of any federal, state or local law or rule. Nothing in this subsection shall be construed to limit the authority of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** to acquire, examine and use insurance compliance self-evaluative audit documents under ORS 731.762.

(4) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in ORS 731.761 is asserted if the court determines that:

(a) The privilege is asserted for a fraudulent purpose, including but not limited to an assertion of the privilege for an insurance compliance audit that was conducted for the purpose of concealing a violation of any federal, state or local law or rule;

(b) The material is not subject to the privilege; or

(c) The material contains evidence relevant to commission of a criminal offense, and:

(A) A district attorney or the Attorney General has a compelling need for the information;

(B) The information is not otherwise available; or

(C) The district attorney or Attorney General is unable to obtain the substantial equivalent of the information by any other means without incurring unreasonable cost and delay.

SECTION 347. ORS 731.812 is amended to read:

731.812. Every foreign or alien insurer, in its annual statement to the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority**, shall set forth the gross amount of premiums received by it or its insurance producers, return premiums paid, dividend payments made to policyholders, savings paid or credited to the accounts of subscribers in the case of a reciprocal insurer, and insurance benefit payments to policyholders, from and under its policies covering direct domestic risks in the preceding calendar year.

SECTION 348. ORS 731.822 is amended to read:

731.822. (1) Every insurer with a tax obligation under section 2, chapter 786, Oregon Laws 1995, ORS 731.820 or ORS 731.854 and 731.859 shall make prepayment of the tax obligations under section 2, chapter 786, Oregon Laws 1995, ORS 731.820, 731.854 and 731.859 for the current calendar year's business, if the sum of the tax obligations under section 2, chapter 786, Oregon Laws 1995, ORS 731.820, 731.854 and 731.859 for the preceding calendar year's business is $400 or more.

(2) The [*Director of the Department of Consumer and Business Services*] **regulator** shall credit the prepayment toward the appropriate tax obligations of the insurer for the current calendar year under section 2, chapter 786, Oregon Laws 1995, or ORS 731.820 or ORS 731.854 and 731.859.

(3) The amounts of the prepayments shall be percentages of the insurer's tax obligation based on the preceding calendar year's business adjusted, if necessary, to reflect the declining percentages set forth in section 2 (3), chapter 786, Oregon Laws 1995, applicable for the current year, and shall be paid to the [*director*] **regulator** by the due dates and in the following amounts:

(a) On or before June 15, 45 percent;

(b) On or before September 15, 25 percent; and

(c) On or before December 15, 25 percent.

(4) The effect of transferring policies of insurance from one insurer to another insurer is to transfer the tax prepayment obligation with respect to such policies.

(5) On or before June 1 of each year, the [*director*] **regulator** shall notify each insurer required to make prepayments in that year of the amount of each prepayment, and shall provide remittance forms to be used by the insurer. However, an insurer's responsibility to make prepayments is not affected by failure of the [*director*] **regulator** to send, or the insurer to receive, the notice or forms.

SECTION 349. ORS 731.836 is amended to read:

731.836. The [*Director of the Department of Consumer and Business Services*] **regulator** shall commence an action for the recovery of taxes payable under ORS 731.820, 731.824, 731.828 and 731.859 not later than the later of the following:

(1) Five years after the date such taxes were payable to the [*director*] **regulator** under such sections; or

(2) Three years after the date on which the report of examination by the domiciliary state of the insurer, disclosing that such taxes were owing by the insurer under such sections, was filed with the [*director*] **regulator**.

SECTION 350. ORS 731.842 is amended to read:

731.842. (1) The Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** may grant, for good cause shown, a request for an adjustment of the amount of the prepayment due under ORS 731.822 or an extension of time for payment of taxes under ORS 731.808 to 731.828 and 731.859. The extension shall be requested no later than the due date and may not exceed 30 days or one month, whichever is longer, except that an extension of time for payments under ORS 731.822 may not exceed 10 days.

(2) Interest at the rate of two-thirds of one percent per month or fraction of a month shall accrue on any such tax payment not made by the due date (determined without regard to extensions).

(3) A penalty of 10 percent of the tax amount shall be imposed upon any late payment of any such tax, except for a payment made within an extension period as provided in subsection (1) of this section or when the director believes extenuating circumstances justify waiver of the penalty.

SECTION 351. ORS 731.854 is amended to read:

731.854. (1) When by or pursuant to the laws of any other state or foreign country any taxes, licenses and other fees, in the aggregate, and any fines, penalties, deposit requirements or other material obligations, prohibitions or restrictions are or would be imposed upon insurers domiciled in this state, or upon the insurance producers or representatives of such insurers, which are in excess of such taxes, licenses and other fees, in the aggregate, or which are in excess of the fines, penalties, deposit requirements or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon the insurance producers or representatives of such insurers, of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses and other fees, in the aggregate, or fines, penalties or deposit requirements or other material obligations, prohibitions, or restrictions

of whatever kind shall be imposed by the [*Director of the Department of Consumer and Business Services*] **regulator** upon the insurers, or upon the insurance producers or representatives of such insurers, of such other state or country doing business or seeking to do business in this state. Any tax, license or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on insurers domiciled in this state or their insurance producers or representatives shall be deemed to be imposed by such state or country within the meaning of this subsection.

(2) Foreign reciprocal or interinsurance exchanges filing a consolidated return for purposes of ORS chapter 317 shall prepare and file a separate individual retaliatory tax calculation. The excise tax for the consolidated group shall be allocated for retaliatory tax purposes among the individual foreign insurers writing Oregon premiums. The allocation, after excluding the domestic share as determined by the [*Director of the Department of Consumer and Business Services*] **regulator** by rule, shall be in the proportion that the premiums written in Oregon by a foreign insurer of the group bears to the total premiums written in Oregon by all foreign insurers in the group writing premiums in Oregon.

(3) This section does not apply as to personal income taxes, nor as to local ad valorem taxes on real or personal property nor as to special purpose obligations or assessments heretofore imposed by another state in connection with particular classes of insurance, other than property insurance; except that deductions, from premium taxes or other taxes otherwise payable, allowed on account of real estate or personal property taxes paid shall be taken into consideration by the [*director*] **regulator** in determining the propriety and extent of retaliatory action under this section.

(4) For the purpose of applying this section to an alien insurer, its domicile shall be determined in accordance with ORS 731.092 and 731.096.

(5) For the purpose of applying this section to foreign and alien insurers, the following specifically shall be treated as taxes imposed by this state:

(a) The corporate excise tax imposed under ORS chapter 317.

(b) The assessments imposed under ORS 731.804 made to support the legislatively authorized budget of the Department of Consumer and Business Services with respect to the functions of the department under the Insurance Code.

(c) The assessments paid by insurers on behalf of their insureds under ORS 656.612.

SECTION 352. ORS 731.859 is amended to read:

731.859. (1) On or before April 1 of each year, each foreign or alien insurer shall:

(a) Determine and report to the [*Director of the Department of Consumer and Business Services*] **regulator** whether the provisions of the laws of any state or country require the imposition of the burdens specified by ORS 731.854;

(b) Compute the amount owing under ORS 731.854; and

(c) Pay to the [*director*] **regulator** that amount.

(2) If the [*director*] **regulator**, during the period in which the [*director*] **regulator** under ORS 731.836 may collect taxes owing under this section, finds the amount of such taxes paid by an insurer to have been incorrect, the [*director*] **regulator** shall charge or credit the insurer with the difference between the correct amount of tax and the amount actually paid.

SECTION 353. ORS 731.988 is amended to read:

731.988. (1) Any person who violates any provision of the Insurance Code, any lawful rule or final order of the Director of the Department of Consumer and Business Services**, the Director of the Oregon Health Authority** or any judgment made by any court upon application of the director,

shall forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director of not more than $10,000 for each offense. In the case of individual insurance producers, adjusters or insurance consultants, the civil penalty shall be not more than $1,000 for each offense. Each violation shall be deemed a separate offense.

(2) In addition to the civil penalty set forth in subsection (1) of this section, any person who violates any provision of the Insurance Code, any lawful rule or final order of the director or any judgment made by any court upon application of the director, may be required to forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed the amount by which such person profited in any transaction which violates any such provision, rule, order or judgment.

(3) In addition to the civil penalties set forth in subsections (1) and (2) of this section, any insurer that is required to make a report under ORS 742.400 and that fails to do so within the specified time may be required to pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed $10,000.

(4) A civil penalty imposed under this section may be recovered either as provided in subsection (5) of this section or in an action brought in the name of the State of Oregon in any court of appropriate jurisdiction.

(5) Civil penalties under this section shall be imposed and enforced in the manner provided by ORS 183.745.

(6) The provisions of this section are in addition to and not in lieu of any other enforcement provisions contained in the Insurance Code.

SECTION 354. ORS 732.521 is amended to read:

732.521. (1) Unless the provisions of ORS 732.517 to 732.546 are first satisfied, a person shall not engage in any of the activities described in this subsection as follows:

(a) A person other than the issuer of voting securities of a domestic insurer shall not acquire or attempt to acquire control of the domestic insurer. For purposes of this paragraph, a person acquires or attempts to acquire control of a domestic insurer when the person engages in any of the actions described in this paragraph, in the open market or otherwise, and if after consummation thereof the person would directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the domestic insurer. The actions are as follows:

(A) Making a tender offer for or a request or invitation for tenders of any voting security of the domestic insurer;

(B) Entering into any agreement to exchange securities for any voting security of the domestic insurer; or

(C) Acquiring or seeking to acquire any voting security of the domestic insurer.

(b) A person shall not enter into an agreement to merge with or otherwise acquire control of a domestic insurer.

(c) A person shall not engage or attempt to engage in any of the following activities:

(A) Acquiring, directly or indirectly, ownership of all or a significant portion of the assets of a domestic insurer. For purposes of this subparagraph, such an acquisition includes an offer, a request or invitation for offers, an acquisition or series of acquisitions in the open market, an exchange offer or agreement, an agreement providing an option to purchase, or a purchase of or offer to purchase securities convertible into voting securities.

(B) Bulk reinsurance by one insurer of all or a significant portion of the insurance, or a major class of such insurance, in force with another insurer or related or affiliated group of insurers. The

provisions of this subparagraph do not apply to ordinary or customary reinsurance, or reinsurance pursuant to a treaty or treaties approved by the director.

(C) Any other arrangement that brings together under common ownership, control or responsibility all or a significant portion of the assets, liabilities or insurance in force of two or more persons, at least one of which is a domestic insurer.

(2) The provisions of subsection (1) of this section do not apply to any offer, request, invitation, agreement or acquisition exempted by the [*Director of the Department of Consumer and Business Services*] **regulator** by order as:

(a) Not having been made or entered into for the purpose and not having the effect of changing or influencing the control or ownership of a domestic insurer; or

(b) Otherwise not comprehended within the purposes of subsection (1) of this section.

(3) Subject to the requirements of ORS 732.517 to 732.546, a domestic stock insurer, domestic mutual insurer, domestic reciprocal insurer or domestic health care service contractor that is a corporation for profit may merge or consolidate with a stock insurer, mutual insurer, reciprocal insurer or health care service contractor that is a corporation for profit.

SECTION 355. ORS 732.531 is amended to read:

732.531. (1) If a statement filed under ORS 732.523 will result in the acquisition by a stock insurer of all or a significant portion of the assets of a domestic mutual insurer or domestic reciprocal insurer, or reinsurance in a stock insurer of all or a significant portion of the insurance in force of a domestic mutual insurer or domestic reciprocal insurer, the plan must provide for consideration to each eligible member of the domestic mutual insurer or each eligible subscriber of the domestic reciprocal insurer as provided in this section.

(2) A member of a domestic mutual insurer or a subscriber of a domestic reciprocal insurer shall be an eligible member or eligible subscriber if the policy of the member or subscriber is in force as of the record date, which is the date that the board of directors of the domestic mutual insurer or the domestic reciprocal insurer approves the proposed activity or some other date specified as the record date in the statement and approved by the [*Director of the Department of Consumer and Business Services*] **regulator**.

(3) Any consideration to be received by the eligible members or eligible subscribers shall be described in the statement. The consideration shall be allocated among the eligible members or eligible subscribers in the manner described in ORS 732.612 (6) if the domestic mutual insurer or domestic reciprocal insurer transacts primarily life or health insurance, or both. The consideration shall be allocated among the eligible members or eligible subscribers in the manner described in ORS 732.612 (7) if the domestic mutual insurer or domestic reciprocal insurer transacts primarily property or casualty insurance, or both. The allocation of the consideration among the eligible members or eligible subscribers shall be approved by the [*director*] **regulator**.

(4) If the proposed activity described in the statement is primarily a plan to convert the domestic mutual insurer or domestic reciprocal insurer to a stock insurer, the [*director*] **regulator** may require that the proposed activity be governed by ORS 732.600 to 732.630.

SECTION 356. ORS 733.080 is amended to read:

733.080. For all health insurance policies the insurer shall maintain reserves which place a sound value on its liabilities under such policies and which are not less than the reserves according to appropriate standards set forth in rules issued by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**. Except for policies of credit health insurance, such reserves for nondisabled lives shall not be less in the aggregate than the pro rata gross unearned

premiums for such policies calculated in accordance with ORS 733.060.

SECTION 357. ORS 733.630 is amended to read:

733.630. (1) Except as provided in this section, funds of an insurer may be invested in common stock, preferred stock, debt obligations and other securities of one or more corporations without regard to the provisions and limitations of ORS 733.590, 733.620, 733.770 and 733.780 (1)(a) if the corporation is engaged, or will be engaged, in the kind of business or activity which is related to the insurance business as described in ORS 733.635, provided 80 percent or more of the shares of the corporation having voting powers are owned by the insurer either by itself or with prior approval of the Director of the Department of Consumer and Business Services **or the Director of the Oregon Health Authority** in cooperation with one or more other persons.

(2) Except as provided in subsection (3) of this section, the amount of funds so invested may not exceed the lesser of 10 percent of the insurer's assets or 50 percent of the amount of the insurer's combined capital and surplus. However, after such investments, the combined capital and surplus of the insurer must be reasonable in relation to the outstanding liabilities of the insurer and adequate to its financial needs. For the purpose of this subsection, the amount of investments by an insurer shall be calculated by:

(a) Excluding the admitted value of investments in subsidiaries of the insurer;

(b) Adding the total moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the insurance subsidiary or the shareholders' equity of a noninsurance subsidiary, whether or not represented by the purchase of capital stock or issuance of other securities;

(c) Adding to the sum determined under paragraph (b) of this subsection all amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities of a subsidiary, and all contributions to the capital or surplus of an insurance subsidiary or the shareholders' equity of a noninsurance subsidiary, subsequent to its acquisition or formation; and

(d) Subtracting from the sum determined under paragraph (c) of this subsection the return of any amount included in paragraph (b) or (c) of this subsection, whether the return is in the form of cash, securities or other property.

(3) Funds of an insurer may be invested in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer. However, each subsidiary must agree to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subsection (2) of this section or in ORS 733.510 to 733.780 that apply to the insurer. For the purpose of this subsection, the total investment of the insurer includes:

(a) Any direct investment by the insurer in an asset; and

(b) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary.

(4) With the approval of the director, an insurer may invest any greater amount in common stock, preferred stock, debt obligations or other securities of one or more subsidiaries. However, after such an investment, the combined capital and surplus of the insurer must be reasonable in relation to the outstanding liabilities of the insurer and adequate to its financial needs.

(5) An insurer must determine whether any investment pursuant to subsection (2), (3) or (4) of this section meets the applicable requirements on the last day of the month immediately preceding

the day on which the investment is made. The determination must be made prior to the investment by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

SECTION 358. ORS 733.770 is amended to read:

733.770. (1) An insurer shall not have any combination of investments in or secured by the stocks, obligations, and property of one person, corporation or political subdivision in excess of 10 percent of the insurer's assets, nor shall it invest more than 10 percent of its assets in a single parcel of real property or in any other single investment. This subsection does not apply to:

(a) Investments in, or loans upon, the security of the general obligations of a sovereign;

(b) Policy loans by insurers issuing life insurance policies;

(c) Investments by a title insurer in its title plant, or in real property not in excess of 50 percent of the insurer's combined capital and surplus; or

(d) Investments by a health care service contractor in all real or personal property used exclusively by such contractor to provide authorized health care services or in real property used primarily for its home office.

(2) Notwithstanding subsection (1) of this section and subject to approval by the [*Director of the Department of Consumer and Business Services*] **regulator** in writing, a domestic insurer organized before 1950 may invest an amount not exceeding 15 percent of its assets in real property used primarily for its home office.

SECTION 359. ORS 734.760 is amended to read:

734.760. As used in ORS 734.750 to 734.890, unless the context requires otherwise:

(1) "Account" means any of the three accounts created under ORS 734.800.

(2) "Association" means the Oregon Life and Health Insurance Guaranty Association created under ORS 734.800.

(3) "Contractual obligation" means any obligation under covered policies.

(4) "Covered policy" means any policy or contract to which ORS 734.750 to 734.890 apply.

(5) "Impaired insurer" means a member insurer deemed by the [*Director of the Department of Consumer and Business Services after September 13, 1975,*] **regulator** to be potentially unable to fulfill its contractual obligations, excluding insolvent insurers.

(6) "Insolvent insurer" means an insurer:

(a) That was a member insurer either at the time the policy was issued or when the insured event occurred, or any insurer that has acquired direct policy obligations from a member insurer through purchase, merger, consolidation, reinsurance or otherwise, whether or not the acquiring insurer held a certificate of authority to transact insurance in this state at the time the policy was issued or when the insured event occurred; and

(b) That[*, after September 13, 1975,*] becomes insolvent and is placed under a final order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

(7) "Member insurer" means any insurer authorized to transact in this state any kind of insurance to which ORS 734.750 to 734.890 apply.

(8) "Premiums" means direct gross insurance, including annuity, premiums written on covered policies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Premiums" does not include premiums on contracts between insurers and reinsurers or any premiums on policies or contracts excluded under ORS 734.790.

(9) "Resident" means a person to whom contractual obligations are owed by a member insurer which is determined to be an impaired or insolvent insurer at a time when the person is a resident of this state.

SECTION 360. ORS 734.770 is amended to read:

734.770. The purpose of ORS 734.750 to 734.890 is to protect the persons specified in ORS 734.790, subject to certain limitations, against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in ORS 734.790, because of the impairment or insolvency of the insurer issuing such policies or contracts. To provide this protection:

(1) An association of insurers is created to enable the guarantee of payment of benefits and continuation of coverages;

(2) Members of the Oregon Life and Health Insurance Guaranty Association are subject to assessment to provide funds to carry out the purpose of ORS 734.750 to 734.890; and

(3) The association is authorized to assist the [*Director of the Department of Consumer and Business Services*] **regulator**, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

SECTION 361. ORS 734.800 is amended to read:

734.800. (1) There is created a nonprofit legal entity to be known as the Oregon Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under ORS 734.820, and shall exercise its powers through a board of directors established under ORS 734.805. For purposes of administration and assessment, the association shall maintain three accounts:

(a) The health insurance account;

(b) The life insurance account; and

(c) The annuity account.

(2) The association shall come under the immediate supervision of the Director of the Department of Consumer and Business Services **and the Oregon Health Authority** and shall be subject to the applicable provisions of the insurance laws of this state.

SECTION 362. ORS 734.805 is amended to read:

734.805. (1) The board of directors of the Oregon Life and Health Insurance Guaranty Association shall consist of not less than five nor more than nine member insurers, serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the Director of the Department of Consumer and Business Services **and the Oregon Health Authority**. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the director. To select the initial board of directors, and initially organize the association, the director **and the authority** shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the director **and the authority** may appoint the initial members.

(2) In approving selections or in appointing members to the board, the director **and the authority** shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for

expenses incurred by them as members of the board, but members of the board shall not otherwise be compensated by the association for their services.

SECTION 363. ORS 734.810 is amended to read:

734.810. In addition to the other powers and duties enumerated in ORS 734.750 to 734.890:

(1) If a domestic insurer is an impaired insurer, the Oregon Life and Health Insurance Guaranty Association may, subject to any conditions imposed by the association and approved by the impaired insurer and the [*Director of the Department of Consumer and Business Services*] **regulator**, other than those which impair the contractual obligations of the impaired insurer:

(a) Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurer.

(b) Provide such money, pledges, notes, guarantees or other means as are proper to implement paragraph (a) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(c) Loan money to the impaired insurer.

(2) If a member insurer is an insolvent insurer, the association shall, subject to the approval of the [*director*] **regulator**:

(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the insolvent insurer;

(b) Assure payment of the contractual obligations of the insolvent insurer; and

(c) Provide such money, pledges, notes, guarantees or other means as are reasonably necessary to discharge such duties.

(3)(a) In carrying out its duties under subsection (2) of this section, permanent policy liens or contract liens may be imposed in connection with any guaranteed, assumption or reinsurance agreement, if the court finds that the amounts which can be assessed under ORS 734.750 to 734.890 are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations or that the economic or financial conditions affecting member insurers are sufficiently adverse to render the imposition of policy or contract liens to be in the public interest, and approves the specific policy liens or contract liens to be used.

(b) Before being obligated under subsection (2) of this section the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans, in addition to any contractual provisions for deferral of cash or policy loan values, and such temporary moratoriums and liens may be imposed if they are approved by the court.

(4) If the association fails to act as required in subsection (2) of this section within a reasonable time, the [*director*] **regulator** shall have the powers and duties of the association under ORS 734.750 to 734.890 with respect to insolvent insurers.

(5) The association may render assistance and advice to the [*director*] **regulator**, upon request of the [*director*] **regulator**, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of any impaired or insolvent insurer.

(6) The association shall have standing to appear before any court in this state having jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under ORS 734.750 to 734.890. Such standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations. The association may also appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the asso-

ciation is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the policyholders of the insurer.

(7)(a) Any person receiving benefits under ORS 734.750 to 734.890 shall be considered to have assigned the rights under, and any causes of action relating to, the covered policy to the association to the extent of the benefits received because of ORS 734.750 to 734.890, whether the benefits are payments of or on account of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by ORS 734.750 to 734.890 upon such person. The association shall be subrogated to these rights against the assets of any insolvent insurer.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under ORS 734.750 to 734.890.

(8) The contractual obligations of the insolvent insurer for which the association becomes or may become liable shall not exceed the lesser of:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an insolvent insurer, unless such obligations are reduced as permitted by subsection (3) of this section; or

(b) The applicable following benefits, subject to subsection (9) of this section:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance, with respect to any one life, regardless of the number of policies or contracts.

(B) $100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, with respect to any one life, regardless of the number of policies or contracts.

(C) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to any one life, regardless of the number of policies or contracts.

(D) $100,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, with respect to each individual participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased.

(9) The association shall not be liable for more than $300,000 in the aggregate with respect to any one individual under subsection (8)(b) of this section.

(10) Subject to the applicable limitation with respect to any one individual under subsections (8) and (9) of this section, the benefits for which the association may become liable with respect to any one owner of policies or contracts other than an unallocated annuity contract to which subsection (8)(b)(D) of this section applies, whether the owner is an individual, corporation or other person, shall not exceed $5 million in benefits in the aggregate for all persons covered by such policies or contracts, regardless of the number of the policies and contracts held by the owner.

(11) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 734.750 to 734.890.

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under ORS 734.815.

(c) Borrow money to effect the purposes of ORS 734.750 to 734.890. Any notes or other evidence

of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under ORS 734.750 to 734.890.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of ORS 734.750 to 734.890 and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue policies other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

SECTION 364. ORS 734.815 is amended to read:

734.815. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the Oregon Life and Health Insurance Guaranty Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. The board shall collect the assessments after 30 days' written notice to the member insurers before payment is due.

(2) There shall be two assessments, as follows:

(a) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other general expenses whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under ORS 734.810 with regard to an impaired or insolvent insurer.

(3)(a) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or other basis. If pro rata, the board may provide that the class A assessment be credited against future class B assessments. An assessment on another basis shall not exceed $150 per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies covered by each account, for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums, bears to the premiums received by such insurer for such calendar year on all covered policies.

(b) Class B assessments for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of ORS 734.750 to 734.890. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or de-

ferred shall be assessed against the other member insurers.

(5) A member insurer shall not be required to pay assessments in any one calendar year exceeding two percent of the insurer's premiums in this state on the policies covered by the account. If a member insurer's total assessment cannot be collected in any one year because of this limitation, the remaining amount due shall be collected from the insurer in future years.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends for any kind of insurance within the scope of ORS 734.750 to 734.890, to consider the amount reasonably necessary to meet its assessment obligations under ORS 734.750 to 734.890.

(8) The association shall issue to each insurer paying an assessment under ORS 734.750 to 734.890, other than a class A assessment, a certificate of contribution in a form prescribed by the [*Director of the Department of Consumer and Business Services*] **regulator** for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the [*director*] **regulator** may approve.

(9) The association may assess and collect interest on the amount of an assessment owed by a member insurer that fails to pay the assessment when due. The annual rate that may be charged under this subsection shall not exceed the rate established by the [*director*] **regulator** by rule.

SECTION 365. ORS 734.820 is amended to read:

734.820. (1)(a) The Oregon Life and Health Insurance Guaranty Association shall maintain on file with the [*Director of the Department of Consumer and Business Services*] **regulator** a plan of operation and shall submit any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. Amendments to the plan shall become effective upon approval in writing by the [*director*] **regulator**.

(b) If the association fails to submit suitable amendments to the plan, the [*director*] **regulator** shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to implement the provisions of ORS 734.750 to 734.890. Such rules shall continue in force until modified by the [*director*] **regulator** or superseded by amendments submitted by the association and approved by the [*director*] **regulator**.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in ORS 734.750 to 734.890:

(a) Establish procedures for handling the assets of the association.

(b) Establish the amount and method of reimbursing members of the board of directors.

(c) Establish regular places and times for meetings of the board of directors.

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(e) Establish the procedures whereby selections for the board of directors will be made and

submitted to the [*director*] **regulator**.

(f) Establish any additional procedures for assessments under ORS 734.815.

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under of ORS 734.810 (11)(c) and 734.815, may be delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the [*director*] **regulator**, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by ORS 734.750 to 734.890.

SECTION 366. ORS 734.825 is amended to read:

734.825. In addition to the duties and powers enumerated elsewhere in ORS 734.750 to 734.820 and 734.830 to 734.890:

(1) The [*Director of the Department of Consumer and Business Services*] **regulator** shall:

(a) Upon request of the board of directors, provide the Oregon Life and Health Insurance Guaranty Association with a statement of the premiums in the appropriate states for each member insurer.

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under ORS 734.750 to 734.890.

(2) The [*director*] **regulator** may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the [*director*] **regulator** may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(3) Any action of the board of directors or the association may be appealed to the [*director*] **regulator** by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the [*director*] **regulator** shall be subject to judicial review in a court of competent jurisdiction.

(4) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of ORS 734.750 to 734.890.

SECTION 367. ORS 734.830 is amended to read:

734.830. To aid in the detection and prevention of insurer impairments and insolvencies:

(1) The board of directors shall, upon majority vote, notify the [*Director of the Department of Consumer and Business Services*] **regulator** of any information indicating any member insurer may be an impaired insurer or insolvent insurer.

(2) The board of directors may, upon majority vote, request that the [*director*] **regulator** order an examination of any member insurer which the board in good faith believes to be an impaired or insolvent insurer. The [*director*] **regulator** may conduct such examination. The examination may be

conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the [*director*] **regulator** designates. The cost of such examination shall be paid by the Oregon Life and Health Insurance Guaranty Association and the examination report shall be treated as are other examination reports in this state. In no event shall the examination report be released to the board of directors of the association prior to its release to the public, but this shall not excuse the [*director*] **regulator** from the obligation to comply with subsection (3) of this section. The [*director*] **regulator** shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the [*director*] **regulator** but it shall not be open to public inspection prior to the release of the examination report to the public and shall be released at that time only if the examination discloses that the examined insurer is an impaired insurer or insolvent insurer.

(3) The [*director*] **regulator** shall report to the board of directors when the [*director*] **regulator** has reasonable cause to believe that any member insurer examined at the request of the board of directors may be an impaired insurer or insolvent insurer.

(4) The board of directors may, upon majority vote, make reports and recommendations to the [*director*] **regulator** upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public records.

(5) The board of directors may, upon majority vote, make recommendations to the [*director*] **regulator** for the detection and prevention of insurer impairments or insolvencies.

(6) The board of directors shall, at the conclusion of any insurer impairment or insolvency in which the association carried out its duties under ORS 734.750 to 734.890 or exercised any of its powers under ORS 734.750 to 734.890, prepare a report on the history and causes of such impairment or insolvency, based on the information available to the association, and submit such report to the [*director*] **regulator**.

SECTION 368. ORS 734.835 is amended to read:

734.835. (1) A member insurer may offset against its corporate excise tax liabilities to this state an assessment described in ORS 734.815 (8), at the rate of 20 percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium or corporate excise tax liabilities for the year it ceases doing business.

(2) Any sums acquired by refund pursuant to ORS 734.815 (6) from the Oregon Life and Health Insurance Guaranty Association which have theretofore been written off by contributing insurers and offset against premium or corporate excise taxes as provided in subsection (1) of this section, and are not then needed for purposes of ORS 734.750 to 734.890, shall be paid by the association to the [*Director of the Department of Consumer and Business Services*] **regulator** and deposited by the [*director*] **regulator** with the State Treasurer for credit to the General Fund of this state.

SECTION 369. ORS 734.850 is amended to read:

734.850. The Oregon Life and Health Insurance Guaranty Association shall be subject to examination and regulation by the [*Director of the Department of Consumer and Business Services*] **regulator**. The board of directors shall submit to the [*director*] **regulator**, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the [*director*] **regulator**, and a report of its activities during the preceding calendar year.

SECTION 370. ORS 734.870 is amended to read:

734.870. There shall be no liability on the part of, and no cause of action of any nature shall

arise against, any member insurer or its agents or employees, the Oregon Life and Health Insurance Guaranty Association or its agents or employees, members of the board of directors, or the [*Director of the Department of Consumer and Business Services*] **regulator** or the representatives of the [*director*] **regulator**, for any action taken by them in the performance of their powers and duties under ORS 734.750 to 734.890.

Note: Section 371 was deleted. Subsequent sections were not renumbered.

SECTION 372. ORS 742.003 is amended to read:

742.003. (1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the [*Director of the Department of Consumer and Business Services*] **regulator**. This section does not apply to:

(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject;

(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder;

(c) Forms of group life or health insurance policies, or both, that have been agreed upon as a result of negotiations between the policyholder and the insurer; or

(d) Forms complying with specific requirements regarding delivery or issuance for delivery in this state established by the [*director*] **regulator** by rule.

(2) The [*director*] **regulator** shall within 30 days after the filing of any such form approve or disapprove the form. The [*director*] **regulator** shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

(3) The 30-day period referred to in subsection (2) of this section may be extended by the [*director*] **regulator** for an additional period not to exceed 30 days if the [*director*] **regulator** gives written notice within the first 30-day period to the insurer proposing to deliver the form that the [*director*] **regulator** needs such additional time for the consideration of such form.

(4) The [*director*] **regulator** may at any time request an insurer to furnish the [*director*] **regulator** a copy of any form exempted under subsection (1) of this section.

SECTION 373. ORS 742.005 is amended to read:

742.005. The [*Director of the Department of Consumer and Business Services*] **regulator** shall disapprove any form requiring the [*director's*] **regulator's** approval:

(1) If the [*director*] **regulator** finds it does not comply with the law;

(2) If the [*director*] **regulator** finds it contains any provision, including statement of premium, or has any label, description of its contents, title, heading, backing or other indication of its provisions, which is unintelligible, uncertain, ambiguous or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued;

(3) If, in the [*director's*] **regulator's** judgment, its use would be prejudicial to the interests of the insurer's policyholders;

(4) If the [*director*] **regulator** finds it contains provisions which are unjust, unfair or inequitable;

(5) If the [*director*] **regulator** finds sales presentation material disapproved by the [*director*] **regulator** pursuant to ORS 742.009 is being used with respect to the form; or

(6) If, with respect to any of the following forms, the [*director*] **regulator** finds the benefits

provided therein are not reasonable in relation to the premium charged:

(a) Individual health insurance policy forms, including benefit certificates issued by fraternal benefit societies and individual policies issued by health care service contractors, but excluding policies referred to in ORS 743.402 as exempt from the application of ORS 743.405 to 743.498, 743A.160 and 743A.164;

(b) Small employer group health benefit plan forms for small employers as that term is defined in ORS 743.730, including small employer group policies issued by health care service contractors; or

(c) Credit life and credit health insurance forms subject to ORS 743.371 to 743.380.

SECTION 374. ORS 742.041 is amended to read:

742.041. (1) Except as provided in this section, when more than one class of insurance as defined in ORS 731.150 to 731.194 is effected by an insurer each class shall be written in a separate and distinct policy. Any such policy may be canceled, surrendered or otherwise terminated without affecting other premiums paid or policies held by the same insured.

(2) Except as provided in this section, the same policy shall not include insurance coverages as to which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred or undetermined loss claims is estimated in a different manner.

(3) Insurance in one policy may be effected upon automobiles and vehicles, and the accessories and other property transported upon and used in connection therewith, against loss or damage by fire, collision and explosion, and against loss by legal liability for damage to persons or property, or both, resulting from the maintenance, use or operation of such automobiles or vehicles, and against loss by burglary, embezzlement or theft, or any one or more of them. Premiums and losses for such insurance are to be reported to the [*Director of the Department of Consumer and Business Services*] **regulator** under the title "automobile insurance." For this purpose an insurer need not use the standard fire insurance policy required by ORS 742.202.

(4) Insurance in one policy may be effected against loss or damage of property and against personal injury and death, and liability therefor, from explosion of steam boilers, tanks and engines, pipes and machinery connected therewith, and breakage of flywheels and machinery. Premiums and losses for such insurance are to be reported to the [*director*] **regulator** under the title "steam boiler insurance."

(5) Insurance under the classes of life and health insurance may be effected in one policy.

(6) Insurance in one policy effected against any physical loss or damage occurring to properties may include coverage as to other perils, either on an unspecified basis as to coverage or for a single premium.

(7) Insurance in one policy effected against loss or destruction of baggage while traveling which is written on a single premium nonrenewable basis may include travel ticket health insurance benefits.

(8) Insurance under more than one class of insurance may be effected in one policy if the [*director*] **regulator** finds that the issuance of the policy is in the best interest of the public.

SECTION 375. ORS 742.420 is amended to read:

742.420. As used in ORS 742.420 to 742.440:

(1) "Discount medical plan" means a contract, agreement or other business arrangement between a discount medical plan organization and a plan member in which the organization, in exchange for fees, service or subscription charges, dues or other consideration, offers or purports to offer the plan member access to providers and the right to receive medical and ancillary services

at a discount from providers.

(2) "Discount medical plan organization" means a person that contracts on behalf of plan members with a provider, a provider network or another discount medical plan organization for access to medical and ancillary services at a discounted rate and determines what plan members will pay as a fee, service or subscription charge, dues or other consideration for a discount medical plan.

(3) "Licensee" means a discount medical plan organization that has obtained a license from the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** in accordance with ORS 742.426.

(4) "Medical and ancillary services" means, except when administered by or under contract with the State of Oregon, any care, service, treatment or product provided for any dysfunction, injury or illness of the human body including, but not limited to, physician care, inpatient care, hospital and surgical services, emergency and ambulance services, audiology services, dental care services, vision care services, mental health services, substance abuse counseling or treatment, chiropractic services, podiatric care services, laboratory services, home health care services, medical equipment and supplies or prescription drugs.

(5) "Plan member" means an individual who pays fees, service or subscription charges, dues or other consideration in exchange for the right to participate in a discount medical plan.

(6)(a) "Provider" means a person that has contracted or otherwise agreed with a discount medical plan organization to provide medical and ancillary services to plan members at a discount from the person's ordinary or customary fees or charges.

(b) "Provider" does not include:

(A) A person that, apart from any agreement or contract with a discount medical plan organization, provides medical and ancillary services at a discount or at fixed or scheduled prices to patients or customers the person serves regularly; or

(B) A person that does not charge fees, service or subscription charges, dues or other consideration in exchange for providing medical and ancillary services at a discount or at fixed or scheduled prices.

(7) "Provider network" means a person that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider that provides medical or ancillary services to plan members.

SECTION 376. ORS 742.434 is amended to read:

742.434. (1) A person may not use or disseminate in marketing, advertising, promotional, sales or plan documents or other informational materials for discount medical plans or in communications with plan members or prospective plan members:

(a) Misleading, deceptive or false statements; or

(b) The terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting condition," "guaranteed issue," "premium," "preferred provider organization" or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance.

(2) For the purposes of subsection (1) of this section, "misleading, deceptive or false statements" includes, but is not limited to, statements that:

(a) Are misleading in fact or implication, including statements that, while containing truthful elements, conceal or omit information necessary or relevant for a consumer to make informed decisions concerning discount medical plans; or

(b) Have a capacity or tendency to mislead or deceive based on the overall impression a rea-

sonable consumer may form after seeing or hearing the statements.

(3) A person may not represent in any marketing, advertising, promotional, sales or plan documents or other informational materials for a discount medical plan or in communications with plan members or prospective plan members that the State of Oregon reviews or approves the discount medical plan.

(4) Before a person uses an advertisement, a brochure, a discount card or promotional or marketing material for marketing, promoting, selling or distributing a discount medical plan, the discount medical plan organization shall approve the material in writing.

(5) At the request of the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, a discount medical plan organization shall submit to the director an advertisement, a brochure, a discount card or promotional or marketing material used for marketing, promoting, selling or distributing a discount medical plan.

SECTION 377. ORS 743.013 is amended to read:

743.013. (1) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt by rule requirements for disclosure by group and individual health insurers to individual and group health insurance policyholders the difference between coverage under the existing policy and coverage being offered to replace that coverage.

(2) The provisions of this section do not apply to disability income insurance.

(3) The [*director*] **authority** shall adopt by rule requirements for nonduplication and replacement of major medical, Medicare supplement, long term care and special illness policies for applicants 65 years of age and older. The insurance producer shall offer to compare for any applicants 65 years of age and older the applicant's existing policy or policies and coverage being offered to replace or supplement the applicant's existing coverage.

SECTION 378. ORS 743.015 is amended to read:

743.015. (1) All credit life and credit health insurance policies subject to ORS 743.371 to 743.380, and all certificates of insurance, notices of proposed insurance, applications for insurance, indorsements and riders used in connection with such kinds of policies, delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the [*Director of the Department of Consumer and Business Services*] **regulator**. Such forms are subject to approval, disapproval or withdrawal of approval by the [*director*] **regulator** as provided in ORS 742.003, 742.005 and 742.007.

(2) An insurer may revise the schedules of premium rates from time to time and shall file the revised schedules with the [*director*] **regulator**. An insurer may not issue any credit life or credit health insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the [*director*] **regulator**.

(3) If a group policy of credit life or credit health insurance has been or is delivered in another state, the insurer shall file only the group certificate, the individual application and the notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and (4). The [*director*] **regulator** shall approve the group certificate, the individual application and the notice of proposed insurance if the forms conform with the requirements specified in ORS 743.377 (2) and (4) and the schedules of premium rates applicable to the insurance evidenced by the certificate or notice are not in excess of the insurer's schedules of premium rates filed with the [*director*] **regulator**.

SECTION 379. ORS 743.018 is amended to read:

743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015,

every insurer shall file with the [*Director of the Department of Consumer and Business Services*] **regulator** all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables.

(2) Except as provided ORS 743.737 and 743.760 and subsection (3) of this section, a rate filing by a carrier for any of the following health benefit plans subject to ORS 743.730 to 743.773 shall be available for public inspection immediately upon submission of the filing to the [*director*] **regulator**:

(a) Health benefit plans for small employers.

(b) Portability health benefit plans.

(c) Individual health benefit plans.

(3) The [*director*] **regulator**, upon request by a carrier, may exempt from disclosure any part of the filing that the [*director*] **regulator** determines to contain trade secrets and that would, if disclosed, harm competition. The part that the [*director*] **regulator** determines to be exempt from disclosure shall be considered confidential for purposes of ORS 705.137. The [*director*] **regulator** may not disclose a part of a filing subject to a carrier's request pending the [*director's*] **regulator's** determination under this subsection.

SECTION 380. ORS 743.028 is amended to read:

743.028. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall prescribe uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this state and by all state agencies that require health insurance claim forms for their records.

SECTION 381. ORS 743.106 is amended to read:

743.106. (1) No policy form shall be delivered or issued for delivery in this state unless:

(a) The policy text achieves a score of 40 or more on the Flesch reading ease test, or an equivalent score on any comparable test as provided in subsection (3) of this section;

(b) The policy, except for specification pages, schedules and tables is printed in not less than 10-point type, one point leaded;

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, including the text of any indorsements or riders; and

(d) The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the number of words if the policy has more than three pages.

(2) For the purposes of this section, a Flesch reading ease test score shall be calculated as follows:

(a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(c) The total number of syllables in the text shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted from 206.835 equals the Flesch reading ease test score for the policy form.

(e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be

used:

(A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be counted as one word.

(B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence.

(C) A "syllable" means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) As used in this section, "text" includes all written matter except the following:

(A) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules or tables; and

(B) Policy language drafted to conform to the requirements of any state or federal law, regulation or agency interpretation; policy language required by any collectively bargained agreement; medical terminology; and words that are defined in the policy. However, the insurer shall identify the language or terminology excepted by this subparagraph and shall certify in writing that the language or terminology is entitled to be excepted by this subparagraph.

(3) Any other reading test may be approved by the [*Director of the Department of Consumer and Business Services*] **regulator** as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the minimum required reading ease score on the test used, or stating that the score is lower than the minimum required but should be authorized in accordance with ORS 743.107. To confirm the accuracy of a certification, the [*director*] **regulator** may require the submission of further information.

(5) At the option of the insurer, riders, indorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

SECTION 382. ORS 743.378 is amended to read:

743.378. (1) Each individual policy or group certificate of credit life or credit health insurance, or both, shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. However, the [*Director of the Department of Consumer and Business Services*] **regulator** shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the [*director*] **regulator**.

(2) If a creditor requires a debtor to make any payment for credit life insurance or credit health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(3) The amount charged to a debtor for credit life insurance and for credit health insurance shall not exceed the respective premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

SECTION 383. ORS 743.405 is amended to read:

743.405. An individual health insurance policy must meet the following requirements:

(1) The entire money and other considerations therefor shall be expressed therein.

(2) The time at which the insurance takes effect and terminates shall be expressed therein.

(3) It shall purport to insure only one person, except that a policy may insure, originally or by

subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder.

(4) The policy may not be issued individually to an individual in a group of persons as described in ORS 743.522 for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan.

(5) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. As used in this subsection, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy. Except those required by ORS 743.411 to 743.477, 743A.160 and 743A.164, exceptions and reductions shall be printed at the insurer's option either included with the applicable benefit provision or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the applicable benefit provision.

(7) Each form constituting the policy, including riders and indorsements, must be identified by a form number in the lower left-hand corner of the first page of the policy.

(8) The policy may not contain provisions purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short rate table filed with the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**.

SECTION 384. ORS 743.408 is amended to read:

743.408. Except as provided in ORS 742.021, a health insurance policy shall contain the provisions set forth in ORS 743.411 to 743.444 and 743A.160. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may approve.

SECTION 385. ORS 743.447 is amended to read:

743.447. Except as provided in ORS 742.021, provisions in a health insurance policy respecting the matters set forth in ORS 743.450 to 743.477 and 743A.164 shall be in the words which appear in such sections. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may approve.

SECTION 386. ORS 743.459 is amended to read:

743.459. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this

insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.462, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the [*director*] **authority**. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage."

SECTION 387. ORS 743.462 is amended to read:

743.462. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.459, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be

approved by the [*director*] **authority**. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage."

SECTION 388. ORS 743.465 is amended to read:

743.465. (1) A health insurance policy may contain a provision as follows: "RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings of the insured for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

(2) The policy provision set forth in subsection (1) of this section may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the [*director*] **authority** or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.

SECTION 389. ORS 743.472 is amended to read:

743.472. An insurer selling individual health insurance policies may cancel or refuse to renew an individual health insurance policy only if the insurer makes a determination to cancel or not to renew all policies of the same type and form as the individual policy, or if the ground for cancellation or nonrenewal is any of the following and is stated as a provision of the policy:

(1) A fraudulent or material misstatement made by the applicant in an application for the health policy. A material misstatement is subject to any time limit, as specified by law and included in the policy, for voiding the policy on the basis of a misstatement. For purposes of this subsection, a misstatement may include an incorrect statement or a misrepresentation, omission or concealment

of fact;

(2) Excess or other insurance in the same insurer, as described in ORS 743.456;

(3) Nonpayment of premium; or

(4) Any other reason specified by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** by rule.

SECTION 390. ORS 743.498 is amended to read:

743.498. (1) A health insurance policy which is noncancelable or guaranteed renewable as those terms are used in ORS 743.495, except that the insured's right is for a limited period of more than one year rather than for life, shall contain the applicable one of the following statements, or such other statement which, in the opinion of the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, is equally clear or more definite as to the subject matter:

(a) "THIS POLICY IS NONCANCELABLE _____" (designating the applicable period such as, for example, "to age _____ (specify)," or "for the period of _____ (specify) years from date of issuance") if the policy is noncancelable for such period.

(b) "THIS POLICY IS GUARANTEED RENEWABLE _____" (designating the applicable period such as, for example, "to age_____ (specify)," or "for the period of _____ (specify) years from date of issuance") if the policy is guaranteed renewable for such period.

(2) Except for policies meeting the conditions specified in ORS 743.495 or subsection (1) of this section, and except as provided in subsection (3) of this section, a health insurance policy shall contain the applicable one of the following statements, or such other statement which, in the opinion of the [*director*] **authority**, is equally clear or more definite as to the subject matter:

(a) "THIS POLICY MAY BE CANCELED BY THE INSURER ONLY FOR A REASON PERMITTED BY LAW" if the policy contains a provision for cancellation by the insurer.

(b) "THE INSURER MAY REFUSE TO RENEW THIS POLICY ONLY FOR A REASON PERMITTED BY LAW" if the policy is not guaranteed renewable.

(3) The limitations and requirements as to the use of terms contained in ORS 743.495 and this section shall not prohibit the use of other terms for policies having other guarantees of renewability, provided such terms, in the opinion of the [*director*] **Oregon Health Authority** are accurate, clear and not likely to be confused with the terms contained in ORS 743.495 and this section, and are incorporated in a concise statement relating to the guarantees of renewability.

(4) The statement required by this section shall be printed in a type not smaller than the type used for captions. It shall appear prominently on the first page of the policy and shall be a part of the brief description if the policy has a brief description on its first page.

SECTION 391. ORS 743.522 is amended to read:

743.522. (1) "Group health insurance" means that form of health insurance covering groups of persons described in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

(a) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. As used in this paragraph, "employees" includes:

(A) The officers, managers and employees of the employer;

(B) The individual proprietor or partners if the employer is an individual proprietor or partnership;

(C) The officers, managers and employees of subsidiary or affiliated corporations;

(D) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise;

(E) The trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(F) The leased workers of a client employer; and

(G) Elected or appointed officials if a policy issued to insure employees of a public body provides that the term "employees" includes elected or appointed officials.

(b) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employees or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(c) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as described in paragraph (b) of this subsection, insuring employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. As used in this paragraph, "employees" may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(d) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.

(2) Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsection (1) of this section may be delivered if:

(a) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** finds that:

(A) The issuance of the policy is in the best interest of the public;

(B) The issuance of the policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged; and

(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both.

(3) As used in this section and ORS 743.533:

(a) "Client employer" means an employer to whom workers are provided under contract and for a fee on a leased basis by a worker leasing company licensed under ORS 656.850.

(b) "Employee" may include a retired employee.

(c) "Leased worker" means a worker provided by a worker leasing company licensed under ORS 656.850.

SECTION 392. ORS 743.524 is amended to read:

743.524. (1) An insurer may not offer a policy of group health insurance to an association as the policyholder or offer coverage under such a policy, whether issued in this or another state, unless the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** de-

termines that the association satisfies the requirements of an association under ORS 743.522 (1)(b).

(2) An insurer shall submit evidence to the [*director*] **authority** that the association satisfies the requirements under ORS 743.522 (1)(b). The [*director*] **authority** shall review the evidence and may request additional evidence as needed.

(3) An insurer shall submit to the [*director*] **authority** any changes in the evidence submitted under subsection (2) of this section.

(4) The [*director*] **authority** may order an insurer to cease offering health insurance to an association if the [*director*] **authority** determines that the association does not meet the standards under ORS 743.522 (1)(b).

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

SECTION 393. ORS 743.526 is amended to read:

743.526. (1) An insurer may not offer a policy of group health insurance described in ORS 743.522 (1)(c) that insures persons in this state or offer coverage under such a policy, whether the policy is to be issued in this or another state, unless the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** determines that the requirements of this section and ORS 743.522 (1)(c) are satisfied.

(2) The [*director*] **authority** shall determine with respect to a policy whether the trustees are the policyholder. If the [*director*] **authority** determines that the trustees are the policyholder and if the policy is issued or proposed to be issued in this state, the policy is subject to the Insurance Code. If the [*director*] **authority** determines that the trustees are not the policyholder, the evidence of coverage that is issued or proposed to be issued in this state to a participating employer, labor union or association shall be deemed to be a group health insurance policy subject to the provisions of the Insurance Code. The [*director*] **authority** may determine that the trustees are not the policyholder if:

(a) The evidence of coverage issued or proposed to be issued to a participating employer, labor union or association is in fact the primary statement of coverage for the employer, labor union or association; and

(b) The trust arrangement is under the actual control of the insurer.

(3) An insurer shall submit evidence to the [*director*] **authority** showing that the requirements of subsection (2) of this section and ORS 743.522 (1)(c) are satisfied. The [*director*] **authority** shall review the evidence and may request additional evidence as needed.

(4) An insurer shall submit to the [*director*] **authority** any changes in the evidence submitted under subsection (3) of this section.

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

SECTION 394. ORS 743.527 is amended to read:

743.527. (1) Every group health insurance policy delivered or issued for delivery in this state shall contain in substance the following provisions, applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when the premium for the policy or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees insured under the policy due to a strike or lockout, the policy, upon timely payment of the premium, will continue in effect with respect to those employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

(b) A provision that, when an employee insured under the policy pays a contribution pursuant

to paragraph (a) of this subsection, if the policyholder is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be:

(A) The rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy; or

(B) If the policy does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under the policy at the date of cessation of work by the total number of persons insured under the policy on such date.

(c) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.

(2) Every group health insurance policy delivered or issued for delivery in this state may contain in substance the following provisions applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy is contingent upon the collection of individual contributions by the union representing the employees when the policyholder is not a trustee and by the policyholder or the policyholder's agent when the policyholder is a trustee.

(b) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy on each employee is contingent upon timely payment of contributions by the employees and timely payment of the premium by the entity responsible for collecting the individual contributions.

(c) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, each individual premium rate under the policy may be increased by not more than 20 percent, or by any higher percentage approved by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, during the period of cessation of work in order to provide sufficient compensation to the insurer for increased administrative costs and increased mortality and morbidity. If the policy contains the provision allowed under this paragraph, an employee's contribution paid under subsection (1)(a) of this section shall be increased by the same percentage.

(d) A provision that, when the policy is a policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section, if the premium is unpaid at the date of cessation of work and the premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of the premium prior to the date the next premium becomes due under the terms of the policy.

(e) Any provision with respect to the continuation of the policy as provided in subsection (1)(a) of this section that the [*director*] **authority** may approve.

(3) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of a policy to increase or decrease the premium rates before, during or after a cessation of work by employees insured under the policy when the insurer had the right to increase the premium rates even if the cessation of work did not occur. If such a premium rate change is made, it shall be effective on such date as the insurer shall determine in accordance with the terms of the policy.

(4) Nothing in this section shall be deemed to require continuation of any coverage in a group health insurance policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section for longer than:

(a) The time that 75 percent of insured employees continue such coverage;

(b) For an individual employee, the time at which the employee takes full-time employment with another employer; or

(c) Six months after cessation of work by the insured employees.

SECTION 395. ORS 743.529 is amended to read:

743.529. (1) Every group health insurance policy that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy for any person insured under the policy who is hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this section is subject to all terms, limitations and conditions of the policy except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy are exhausted, whichever is earlier.

(2) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may adopt rules providing for uninterrupted coverage for individuals insured under a group health insurance policy providing coverage for hospital or medical expenses, when such a policy is replaced by a policy of similar benefits, whether issued by the same insurer or another.

SECTION 396. ORS 743.534 is amended to read:

743.534. "Blanket health insurance" means that form of a health insurance covering groups of persons defined in this section and issued on one of the following bases:

(1) Under a policy issued to a common carrier or to an operator, owner or lessee of a means of transportation, who shall be deemed the policyholder, insuring a group of persons who may become passengers and which group is defined by reference to their travel status on such common carrier or means of transportation.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, insuring any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) Under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, insuring students, teachers or employees.

(4) Under a policy issued to a religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(5) Under a policy issued to a sports team, camp or sponsor thereof, who shall be deemed the policyholder, insuring members, campers, employees, officials or supervisors.

(6) Under a policy issued to a volunteer fire department, first aid, civil defense, or other such volunteer organization, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(7) Under a policy issued to a newspaper or other publisher, which shall be deemed the

policyholder, insuring its carriers.

(8) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(9) Under a policy issued to cover any other risk or class of risks which, in the discretion of the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, may be properly eligible for blanket health insurance. The discretion of the [*director*] **authority** may be exercised on an individual risk basis or class of risks basis, or both.

SECTION 397. ORS 743.537 is amended to read:

743.537. A blanket health insurance policy shall contain provisions which in the opinion of the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** are not less favorable to the policyholder and the individual insureds than the provisions described in ORS 743.411, 743.423, 743.426, 743.429, 743.432, 743.438 and 743.441.

SECTION 398. ORS 743.546 is amended to read:

743.546. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may exempt from the policy form filing and approval requirements of ORS 742.003, for so long as the [*director*] **authority** deems proper, any blanket health insurance policy to which in the opinion of the [*director*] **authority** such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the [*director*] **authority**, it is not desirable or necessary for the protection of the public.

SECTION 399. ORS 743.655 is amended to read:

743.655. (1)[*(a)*] The Director of the [*Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, program for public understanding, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwriting at time of application, requirements for replacement, recurrent conditions and definitions of terms.

[*(b) In adopting rules setting standards under this section, the director must give timely notice to, and shall consider recommendations from the Director of Human Services.*]

(2) A long term care insurance policy may not:

(a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(d) Exclude coverage for Alzheimer's disease and related dementias;

(e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days, except as otherwise provided by rule; or

(f) Be sold to provide less than 24 months' coverage.

(3)(a) A long term care insurance policy or certificate other than a policy or certificate issued to a group described in ORS 743.652 (3)(a), (b) or (c) may not use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) A long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group described in ORS 743.652 (3)(a), (b) or (c) may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The director [*of the Department of Consumer and Business Services*] may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, over the 10 years immediately prior to the date of application, and, on the basis of the answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. A long term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection.

(4) A long term care insurance policy may not be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium or post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(5)(a) A long term care insurance policy containing post-confinement, post-acute care or recuperative benefits must clearly label in a separate paragraph of the policy or certificate titled "Limitations or Conditions of Eligibility for Benefits" all such limitations or conditions, including any required number of days of confinement.

(b) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(6) Individual long term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group described in ORS 743.652 (3)(a), the applicant is not satisfied for any reason. This subsection also applies to denials of ap-

plications. Any refund must be made within 30 days of the return or denial.

(7)(a)(A) An outline of coverage shall be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means that prominently direct the attention of the recipient to the document and its purpose.

(B) The [*director*] **Oregon Health Authority** by rule must prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(C) In the case of solicitations by an insurance producer, the insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(D) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(E) In the case of a policy issued to a group described in ORS 743.652 (3)(a), an outline of coverage is not required to be delivered as long as the information described in paragraph (b) of this subsection is contained in other materials related to the enrollment. Upon request, these other materials must be made available to the [*director*] **authority**.

(b) The outline of coverage must include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the principal exclusions, reductions and limitations contained in the policy;

(C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) A description of the terms under which the policy or certificate may be returned and premium refunded;

(F) A brief description of the relationship of cost of care and benefits; and

(G) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be qualified long term care insurance as defined in ORS 743.652.

(8) A certificate issued pursuant to a group long term care insurance policy if the policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(9) If an application for a long term care insurance policy or certificate is approved, the insurer must deliver the policy or certificate to the applicant no later than 30 days after the date of approval.

(10) At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request must make delivery not later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include the provisions required in this subsection. The required provision may be incorporated into a basic illustration or into the life insurance policy summary if required by rule. The following provisions must be included in the summary:

(a) An explanation of how the long term care benefit interacts with other components of the

policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits of long term care;

(d) A statement that any long term care inflation protection option required by rule is not available under the policy; and

(e) If applicable to the policy type, the following:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(11) When a long term care benefit that is funded through a life insurance policy by an acceleration of the death benefit is in benefit payment status, the insurer must provide a monthly report to the policyholder. The report must include:

(a) Any long term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, owing to payment of long term care benefits; and

(c) The amount of long term care benefits existing or remaining.

(12) If a claim under a long term care insurance policy is denied, then not later than the 60th day after the date of a written request by the policyholder or certificate holder, or a representative of either, the insurer must:

(a) Provide a written explanation of the reasons for the denial; and

(b) Make available all information directly related to the denial.

(13) A policy may not be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.664.

(14) Rules adopted pursuant to ORS 743.650 to 743.664 shall be in accordance with the provisions of ORS chapter 183.

(15) This section is exempt from ORS 743A.001.

SECTION 400. ORS 743.684 is amended to read:

743.684. (1) Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to ORS 743.682 shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state. However, no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

(2) Medicare supplement policies shall return benefits which are reasonable in relation to the premium charged. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt by rule minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices. Every entity providing Medicare supplement policies or certificates in this state shall file annually its rates, rating schedule and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of ORS 743.680 to 743.689.

(3) No entity shall provide compensation to insurance producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group.

SECTION 401. ORS 743.685 is amended to read:

743.685. (1) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. The [*director*] **authority** shall consult with the Governor's Commission on Senior Services concerning the content and format of the outline of coverage, especially in reference to the ease with which senior citizens may understand the form and compare the coverage provided under the policy to which the outline of coverage refers. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage required by subsection (1) of this section shall include at least the following:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) Insurers shall fill out the standardized form and have the completed information included on the form approved by the [*director*] **authority** before selling supplemental Medicare coverage in this state.

(4) In the purchase or renewal of a Medicare supplement policy, a copy of the outline of coverage must be used in explaining policy coverage to a purchaser and shall be provided to the applicant at the time the sales presentation is made. The completed outline of coverage shall be considered part of the sales presentation materials for the purposes of ORS 742.009.

(5) The insurer shall obtain acknowledgment of receipt or certify delivery of the outline of coverage at the time of sale.

(6) The [*director*] **authority** may adopt by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the [*director*] **authority** may require by rule that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the [*director*] **authority** may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(7) The [*director*] **authority** may adopt by rule captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all health insurance policies sold to persons eligible for Medicare, other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(8) The [*director*] **authority** may adopt rules governing the full and fair disclosure of the information in connection with the replacement of health insurance policies, subscriber contracts or certificates by persons eligible for Medicare.

SECTION 402. ORS 743.687 is amended to read:

743.687. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** of this state for review or approval by the [*director*] **authority** to the extent it may be required under state law.

SECTION 403. ORS 743.730 is amended to read:

743.730. For purposes of ORS 743.730 to 743.773:

(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*] **Oregon Health Authority** that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, 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 and portability 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 in lieu of a preexisting conditions provision;

(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) "Basic health benefit plan" means a health benefit plan for small employers that is required to be offered by all small employer carriers and approved by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** in accordance with ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-11 as amended and in effect on July 1, 1997.

(6) "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

(7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS 743.745.

(8) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as

amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the enrollee obtains new coverage.

[*(9) "Department" means the Department of Consumer and Business Services.*]

[*(10)*] **(9)** "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

[*(11) "Director" means the Director of the Department of Consumer and Business Services.*]

[*(12)*] **(10)** "Eligible employee" means an employee of a small employer who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

[*(13)*] **(11)** "Employee" means any individual employed by an employer.

[*(14)*] **(12)** "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

[*(15)*] **(13)** "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

[*(16)*] **(14)** "Financially impaired" means a member that is not insolvent and is:

(a) Considered by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** 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.

[*(17)(a)*] **(15)(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*] **authority** for the carrier's:

(A) Small employer group health benefit plans;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or family composition.

[*(18)*] **(16)** "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.

[*(19)(a)*] **(17)(a)** "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any 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.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, 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, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed

six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, 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.

(c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

[*(20)*] **(18)** "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement developed by the Health Insurance Reform Advisory Committee.

[*(21)*] **(19)** "Implementation of chapter 836, Oregon Laws 1989" means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

[*(22)*] **(20)** "Individual coverage waiting period" means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

[*(23)*] **(21)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(24)*] **(22)** "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 as amended and in effect on July 1, 1997;

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

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's 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 who 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, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

[*(25)*] **(23)** "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.

[*(26)*] **(24)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(27)*] **(25)** "Preexisting conditions provision" means a health benefit plan 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 ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.

[*(28)*] **(26)** "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.

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

[*(30)(a)*] **(28)(a)** "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan issued by a small employer carrier.

(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

[*(31)*] **(29)** "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers. A fully insured multiple employer welfare arrangement otherwise exempt under ORS 750.303 (4) may elect to be a small employer carrier governed by the provisions of ORS 743.733 to 743.737.

SECTION 404. ORS 743.731 is amended to read:

743.731. The purposes of ORS 743.730 to 743.773 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, portability and individual health benefit plans;

(4) To establish limitations on the use of preexisting conditions provisions;

(5) To make basic health benefit plans available to all small employers;

(6) To encourage the availability of portability and individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(7) To improve renewability and continuity of coverage for employers and covered individuals;

(8) To improve the efficiency and fairness of the health insurance marketplace; and

(9) 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 that enforcement authority for those requirements is retained by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**.

SECTION 405. ORS 743.736 is amended to read:

743.736. (1) In order to improve the availability and affordability of health benefit coverage for small employers, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Au-**

thority two basic health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. 300e et seq.

(2)(a) The [*director*] **authority** shall approve the basic health benefit plans following a determination that the plans provide for maximum accessibility and affordability of needed health care services and following a determination that the basic health benefit plans substantially meet the social values that underlie the ranking of benefits by the Health Services Commission and that the basic health benefit plans are substantially similar to the Medicaid reform program under chapter 836, Oregon Laws 1989, funded by the Legislative Assembly.

(b) The basic health benefit plans shall include benefits mandated under ORS 743A.168 until mental health, alcohol and chemical dependency services are fully integrated into the Health Services Commission's priority list, and as funded by the Legislative Assembly, and chapter 836, Oregon Laws 1989, is implemented.

(c) The commission shall aid the [*director*] **authority** by reviewing the basic health benefit plans and commenting on the extent to which the plans meet these criteria.

(3) After the [*director's*] **authority's** approval of the basic health benefit plans submitted by the committee pursuant to subsection (1) of this section, each small employer carrier shall submit to the [*director*] **authority** the policy form or forms containing its basic health benefit plan. Each policy form must be submitted as prescribed by the [*director*] **authority** and is subject to review and approval pursuant to ORS 742.003.

(4)(a) As a condition of transacting business in the small employer health insurance market in this state, every small employer carrier shall offer small employers an approved basic health benefit plan and any other plans that have been submitted by the small employer carrier for use in the small employer market and approved by the [*director*] **authority**.

(b) Nothing in this subsection shall require a small employer carrier to resubmit small employer health benefit plans that were approved by the [*director*] **Director of the Department of Consumer and Business Services** prior to October 1, 1996, nor shall small employer carriers be required to reinitiate new plan selection procedures for currently enrolled small employers prior to the small employer's next health benefit plan coverage anniversary date.

(c) A carrier that offers a health benefit plan in the small employer market only through one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

(5) A small employer carrier shall issue to a small employer any small employer health benefit plan offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

(6) A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

(7) A small employer carrier shall, pursuant to subsections (4) and (5) of this section, offer cov-

erage to or accept applications from a group covered under an existing small employer health benefit plan whether or not a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a small employer carrier accepts an application for such a group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

(8) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5) of this section if the [*director*] **authority** finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(9) Every small employer carrier shall market fairly all small employer health benefit plans offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(10)(a) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5) of this section in the case of any of the following:

(A) To a small employer if the small employer is not physically located in the carrier's approved service area;

(B) To an employee if the employee does not work or reside within the carrier's approved service areas; or

(C) Within an area where the carrier reasonably anticipates, and demonstrates to the satisfaction of the [*director*] **authority**, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection shall not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

(11) For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(12) A small employer carrier that, after September 29, 1991, elects to discontinue offering all of its small employer health benefit plans under ORS 743.737 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the small employer market in this state for a period of five years from one of the following dates:

(a) The date of notice to the [*director*] **authority** pursuant to ORS 743.737 (5)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the [*director*] **authority** provides notice to the carrier that the [*director*] **authority** has determined that the carrier has effectively discontinued offering small employer health benefit plans in this state.

SECTION 406. ORS 743.737 is amended to read:

743.737. Health benefit plans covering small employers shall be subject to the following provisions:

(1) A preexisting conditions provision in a small employer health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a small employer health benefit plan shall terminate its effect as follows:

(a) For an enrollee, not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Ten months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new small employer health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a small employer health benefit plan, application of:

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

(b) An exclusion period for specified covered services, as established by the Health Insurance Reform Advisory Committee, applicable to all individuals enrolling for the first time in the small employer health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder except:

(a) For nonpayment of the required premiums by the policyholder, small employer or contract holder.

(b) For fraud or misrepresentation of the policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

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

(d) For noncompliance with the small employer carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its small employer health benefit plans in this state or in a specified service area within this state. In order

to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** 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, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(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; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the small employer market in this state or in the specified service area.

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

(A) Must give notice to the [*director*] **authority** and to all policyholders covered by the plan;

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

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all health benefit plans that the carrier offers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

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

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

(h) When the [*director*] **authority** orders the carrier to discontinue coverage in accordance with procedures specified or approved by the [*director*] **authority** upon finding that the continuation of the coverage would:

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

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

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

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

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider

network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A small employer carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(6) Notwithstanding any provision of subsection (5) of this section to the contrary, any small employer carrier health benefit plan subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(7) A small employer carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan.

(8) Premium rates for small employer health benefit plans shall be subject to the following provisions:

(a) Each small employer carrier issuing health benefit plans to small employers must file its geographic average rate for a rating period with the [*director*] **authority** at least once every 12 months.

(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers may not vary from the geographic average rate by more than 50 percent on or after January 1, 2008, except as provided in subparagraph (D) of this paragraph.

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on the factors specified in subparagraph (C) of this paragraph. A small employer carrier may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium rates for small employers. The factors that are based on contributions or participation may vary with the size of the employer. All other factors must be applied in the same actuarially sound way to all small employers.

(C) The variations in premium rates described in subparagraph (A) of this paragraph may be based on one or more of the following factors:

(i) The ages of enrolled employees and their dependents;

(ii) The level at which the small employer contributes to the premiums payable for enrolled employees and their dependents;

(iii) The level at which eligible employees participate in the health benefit plan;

(iv) The level at which enrolled employees and their dependents engage in tobacco use;

(v) The level at which enrolled employees and their dependents engage in health promotion, disease prevention or wellness programs;

(vi) The period of time during which a small employer retains uninterrupted coverage in force with the same small employer carrier; and

(vii) Adjustments to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition.

(D)(i) The premium rates determined in accordance with this paragraph may be further adjusted by a small employer carrier to reflect the expected claims experience of a small employer, but the extent of this adjustment may not exceed five percent of the annual premium rate otherwise payable by the small employer. The adjustment under this subparagraph may not be cumulative from year to year.

(ii) Except for small employers with 25 or fewer employees, the premium rates adjusted under this subparagraph are not subject to the provisions of subparagraph (A) of this paragraph.

(E) A small employer carrier shall apply the carrier's schedule of premium rate variations as approved by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established for a health benefit plan by a small employer carrier shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different small employer health benefit plans offered by a small employer carrier must be based solely on objective differences in plan design or coverage and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age, except an additional adjustment may be made to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition.

(e) Premium rates for health benefit plans shall comply with the requirements of this section.

(9) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates, and the extent to which the carrier will consider age, family composition and geographic factors in establishing and adjusting rates;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting conditions provision.

(10)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the [*director*] **authority** at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the small employer carrier are actuarially sound. Each such certification shall be in a uniform form and manner and shall contain such information as specified by the [*di-*

rector] **authority**. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the [*director*] **authority** upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743.733 to 743.737, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the [*director*] **authority** to persons outside the [*Department of Consumer and Business Services*] **authority** except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(11) A small employer carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(12) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

(13) A small employer carrier must include a provision that offers coverage to all eligible employees and to all dependents to the extent the employer chooses to offer coverage to dependents.

(14) All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

SECTION 407. ORS 743.745 is amended to read:

743.745. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall appoint a Health Insurance Reform Advisory Committee. This committee shall consist of at least one insurance producer, one representative of a health maintenance organization, one representative of a health care service contractor, one representative of a domestic insurer, one representative of a labor organization and one representative of consumer interests and shall have representation from the broad range of interests involved in the small employer and individual market and shall include members with the technical expertise necessary to carry out the following duties:

(1)(a) Subject to approval by the [*director*] **authority**, the committee shall recommend the form and level of coverages under the basic health benefit plans pursuant to ORS 743.736 to be made available by small employer carriers and the portability health benefit plans to be made available pursuant to ORS 743.760 or 743.761. The committee shall take into consideration the levels of health benefit plans provided in Oregon and the appropriate medical and economic factors and shall establish benefit levels, cost sharing, exclusions and limitations. The health benefit plans described in this section may include cost containment features including, but not limited to:

(A) Preferred provider provisions;

(B) Utilization review of health care services including review of medical necessity of hospital and physician services;

(C) Case management benefit alternatives;

(D) Other managed care provisions;

(E) Selective contracting with hospitals, physicians and other health care providers; and

(F) Reasonable benefit differentials applicable to participating and nonparticipating providers.

(b) The committee shall submit the basic and portability health benefit plans and other recommendations to the [*director*] **authority** within the time period established by the [*director*] **authority**. The health benefit plans and other recommendations shall be deemed approved unless

expressly disapproved by the [*director*] **authority** within 30 days after the date the [*director*] **authority** receives the plans.

(2) In order to ensure the broadest availability of small employer and individual health benefit plans, the committee shall recommend for approval by the [*director*] **authority** market conduct and other requirements for carriers and insurance producers, including requirements developed as a result of a request by the [*director*] **authority**, relating to the following:

(a) Registration by each carrier with the [*Department of Consumer and Business Services*] **authority** of its intention to be a small employer carrier under ORS 743.733 to 743.737 or a carrier offering individual health benefit plans, or both.

(b) Publication by the [*Department of Consumer and Business Services*] **authority** or the committee of a list of all small employer carriers and carriers offering individual health benefit plans, including a potential requirement applicable to insurance producers and carriers that no health benefit plan be sold to a small employer or individual by a carrier not so identified as a small employer carrier or carrier offering individual health benefit plans.

(c) To the extent deemed necessary by the committee to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer, portability and individual health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued, or both, to small employers and individuals.

(d) Methods concerning periodic demonstration by small employer carriers, carriers offering individual health benefit plans and insurance producers that the small employer and individual carriers are marketing or issuing, or both, health benefit plans to small employers or individuals in fulfillment of the purposes of ORS 743.730 to 743.773.

(3) Subject to the approval of the [*Director of the Department of Consumer and Business Services*] **authority**, the committee shall develop a standard health statement to be used for all late enrollees and by all carriers offering individual policies of health insurance.

(4) Subject to the approval of the [*director*] **authority**, the committee shall develop a list of the specified services for small employer and portability plans for which carriers may impose an exclusion period, the duration of the allowable exclusion period for each specified service and the manner in which credit will be given for exclusion periods imposed pursuant to prior health insurance coverage.

SECTION 408. 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*] **Oregon Health Authority** 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*] **authority** 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;

(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*] **authority** shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 409. ORS 743.748, as amended by section 10, chapter 752, Oregon Laws 2007, 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*] **Oregon Health Authority** 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.

(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*] **authority** 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.

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

SECTION 410. ORS 743.754 is amended to read:

743.754. The following requirements apply to all group health benefit plans covering two or more certificate holders:

(1) A preexisting conditions provision in a group health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a group health benefit plan shall terminate its effect as follows:

(a) For an enrollee not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Twelve months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all group benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new group health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a group health benefit plan, application of:

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

(b) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the group health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall

not exceed 12 months.

(5) All group health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

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

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation of the policyholder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

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

(d) For noncompliance with the carrier's employer contribution requirements under the health benefit plan.

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

(A) Must give notice of the decision to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** 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, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(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; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the group market in this state or in the specified service area.

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

(A) Must give notice of the decision to the [*director*] **authority** and to all policyholders covered by the plan;

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

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

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers 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) When the [*director*] **authority** orders the carrier to discontinue coverage in accordance with procedures specified or approved by the [*director*] **authority** upon finding that the continuation of the coverage would:

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

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

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

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

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(7) Notwithstanding any provision of subsection (6) of this section to the contrary, a group health benefit plan may be rescinded by a carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(8) A carrier that continues to offer coverage in the group market in this state is not required to offer coverage in all of the carrier's group health benefit plans. If a carrier, however, elects to continue a plan that is closed to new policyholders instead of offering alternative coverage in its other group health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (6) of this section.

(9) This section applies only to group health benefit plans that are not small employer health benefit plans.

SECTION 411. ORS 743.758 is amended to read:

743.758. The [*Department of Consumer and Business Services*] **Oregon Health Authority** may adopt rules incorporating, implementing and administering the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and federal regulations that are issued in conjunction with the Act, to the extent that such federal law and regulations are not inconsistent with any provision of Oregon law.

SECTION 412. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

(a) "Carrier" means an insurer authorized to issue a policy of health insurance in this state. "Carrier" does not include a multiple employer welfare arrangement.

(b)(A) "Eligible individual" means an individual who:

(i) Has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident

at the time of such application; or

(ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application.

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include an individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

(c) "Portability health benefit plans" and "portability plans" mean health benefit plans for eligible individuals that are required to be offered by all carriers offering group health benefit plans and that have been approved by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** in accordance with this section.

(2)(a) In order to improve the availability and affordability of health benefit plans for individuals leaving coverage under group health benefit plans, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the [*director*] **authority** two portability health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the type of coverage provided by health maintenance organizations. For each type of portability plan, the committee shall design and submit to the [*director*] **authority**:

(A) A prevailing benefit plan, which shall reflect the benefit coverages that are prevalent in the group health insurance market; and

(B) A low cost benefit plan, which shall emphasize affordability for eligible individuals.

(b) Except as provided in ORS 743.730 to 743.773, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to portability health benefit plans.

(3) The [*director*] **authority** shall approve the portability health benefit plans if the [*director*] **authority** determines that the plans provide for appropriate accessibility and affordability of needed health care services and comply with all other provisions of this section.

(4) After the [*director's*] **authority's** approval of the portability plans submitted by the committee under this section, each carrier offering group health benefit plans shall submit to the [*director*] **authority** the policy form or forms containing at least one low cost benefit and one prevailing benefit portability plan offered by the carrier that meets the required standards. Each policy form must be submitted as prescribed by the [*director*] **authority** and is subject to review and approval pursuant to ORS 742.003.

(5) Within 180 days after approval by the [*director*] **authority** of the portability plans submitted by the committee, as a condition of transacting group health insurance in this state, each carrier offering group health benefit plans shall make available to eligible individuals the prevailing benefit and low cost benefit portability plans that have been submitted by the carrier and approved by the [*director*] **authority** under subsection (4) of this section.

(6) A carrier offering group health benefit plans shall issue to an eligible individual who is leaving or has left group coverage provided by that carrier any portability plan offered by the carrier if the eligible individual applies for the plan within 63 days of termination of prior coverage and agrees to make the required premium payments and to satisfy the other provisions of the portability plan.

(7) Premium rates for portability plans shall be subject to the following provisions:

(a) Each carrier must file the geographic average rate for each of its portability health benefit plans for a rating period with the [*director*] **authority** on or before March 15 of each year.

(b) The premium rates charged during the rating period for each portability health benefit plan shall not vary from the geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. Adjustments for age shall comply with the following:

(A) For each plan, the variation between the lowest premium rate and the highest premium rate shall not exceed 100 percent of the lowest premium rate.

(B) Premium variations shall be determined by applying uniformly the carrier's schedule of age adjustments for portability plans as approved by the [*director*] **authority**.

(c) Premium variations between the portability plans and the rest of the carrier's group plans must be based solely on objective differences in plan design or coverage and must not include differences based on the actual or expected health status of individuals who select portability health benefit plans. For purposes of determining the premium variations under this paragraph, a carrier may:

(A) Pool all portability plans with all group health benefit plans; or

(B) Pool all portability plans for eligible individuals leaving small employer group health benefit plan coverage with all plans offered to small employers and pool all portability plans for eligible individuals leaving other group health benefit plan coverage with all health benefit plans offered to such other groups.

(d) A carrier may not increase the rates of a portability plan issued to an enrollee more than once in any 12-month period. Annual rate increases shall be effective on the anniversary date of the plan issued to the enrollee. The percentage increase in the premium rate charged to an enrollee for a new rating period may not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age.

(8) No portability plans under this section may contain preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(9) Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee, except:

(a) For nonpayment of the required premiums by the policyholder;

(b) For fraud or misrepresentation by the policyholder;

(c) When the carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or

(d) When the [*director*] **authority** orders the carrier to discontinue coverage in accordance with procedures specified or approved by the [*director*] **authority** upon finding that the continuation of the coverage would:

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

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

(10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its portability plans, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each such carrier shall file with the [*director*] **authority** annually on or before March 15

an actuarial certification that the carrier is in compliance with this section and that its rating methods are actuarially sound. Each such certification shall be in a form and manner and shall contain such information as specified by the [*director*] **authority**. A copy of such certification shall be retained by the carrier at its principal place of business.

(c) Each such carrier shall make the information and documentation described in paragraph (a) of this subsection available to the [*director*] **authority** upon request. Except as provided in ORS 743.018 and except in cases of violations of the Insurance Code, the information is proprietary and trade secret information and shall not be subject to disclosure by the [*director*] **authority** to persons outside the [*Department of Consumer and Business Services*] **authority** except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(11) A carrier offering group health benefit plans shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell portability plans of the carrier on the basis of an eligible individual's anticipated claims experience.

(12) An individual who is eligible to obtain a portability plan in accordance with this section may obtain such a plan regardless of whether the eligible individual qualifies for a period of continuation coverage under federal law or under ORS 743.600 or 743.610. However, an individual who has elected such continuation coverage is not eligible to obtain a portability plan until the continuation coverage has been discontinued by the individual or has been exhausted.

SECTION 413. ORS 743.761 is amended to read:

743.761. (1) A carrier approved pursuant to subsection (4) of this section that offers individual health benefit plans may satisfy the requirements of ORS 743.760 by issuing any individual health benefit plan offered by the carrier to any eligible individual as defined in ORS 743.760 who:

(a) Is leaving or has left a group health benefit plan provided by that carrier;

(b) Applies for the policy; and

(c) Agrees to make the required premium payments and to satisfy the other provisions of the plan.

(2) All health benefit plans issued pursuant to subsection (1) of this section shall:

(a) Comply with ORS 743.767 and 743.769; and

(b) Contain no preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(3) A carrier offering plans pursuant to this section shall offer plans that meet the standards and requirements described in ORS 743.760 (2).

(4) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt standards for minimum participation in the individual market necessary for a carrier to offer policies under this section and shall develop a program for approval of carriers under this section.

SECTION 414. ORS 743.766 is amended to read:

743.766. (1) All carriers who offer individual health benefit plans and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established by the Health Insurance Reform Advisory Committee and may not use any other method to determine the health status of an individual. Nothing in this subsection shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the carrier shall not impose exclusions or limitations on coverage greater than:

(A) A preexisting conditions provision that complies with the following requirements:

(i) The provision shall apply 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; and

(ii) The provision shall terminate its effect no later than six months following the individual's effective date of coverage;

(B) An individual coverage waiting period of 90 days; or

(C) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) Pregnancy may constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting conditions provision or an individual coverage waiting period provision, the carrier shall reduce the duration of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.

(5) If a carrier accepts an individual for coverage under an individual health benefit plan, the carrier shall renew the policy except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation by the policyholder.

(c) When the carrier discontinues offering or renewing, or offering and renewing, all of its 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) Must give notice of the decision to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** 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, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(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; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the individual market in this state or in the specified service area.

(d) When the carrier discontinues 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) Must give notice of the decision to the [*director*] **authority** and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required

under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other 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) When the carrier discontinues offering or renewing, or offering and renewing, an individual health benefit 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. With respect to plans that are being discontinued, the carrier must:

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

(f) When the [*director*] **authority** orders the carrier to discontinue coverage in accordance with procedures specified or approved by the [*director*] **authority** 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 its contractual obligations.

(g) When, 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.

(h) When, 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.

(i) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide service to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(j) 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 paragraphs (c) and (e) of this subsection.

(6) Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan for fraud, material misrepresentation or concealment by an enrollee.

(7) A carrier that withdraws from the market for individual health benefit plans must continue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

(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 its 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.

Note: Section 415 was deleted. Subsequent sections were not renumbered.

SECTION 416. ORS 743.769 is amended to read:

743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier.

(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

(4) Rejection by a carrier of an application for coverage shall be in writing and shall state the reason or reasons for the rejection.

(5) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may establish by rule additional standards to provide for the fair marketing and broad availability of individual health benefit plans.

(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743.766 (5)(c) or to discontinue offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the [*director*] **authority** pursuant to ORS 743.766 (5)(c) or, if such notice is not provided, from the date on which the [*director*] **authority** provides notice to the carrier that the [*director*] **authority** has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.

SECTION 417. ORS 743.790 is amended to read:

743.790. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may adopt rules to implement ORS 743.788 and may consider any relevant standards developed by a standards development organization accredited by the American National Standards Institute that represents organizations interested in electronic standardization with the pharmacy services sector of the health care industry and the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

SECTION 418. ORS 743.804 is amended to read:

743.804. All insurers offering a health benefit plan in this state shall:

(1) Have a written policy that recognizes the rights of enrollees:

(a) To voice grievances about the organization or health care provided;

(b) To be provided with information about the organization, its services and the providers providing care;

(c) To participate in decision making regarding their health care; and

(d) To be treated with respect and recognition of their dignity and need for privacy.

(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating providers upon request and to all enrollees either directly or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees.

(3) Have a timely and organized system for resolving grievances and appeals. The system shall include:

(a) A systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken;

(b) Written procedures explaining the grievance and appeal process, including a procedure to assist enrollees in filing written grievances;

(c) Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms;

(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical urgency of the situation;

(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file a complaint with the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**; and

(f) An appeal process for grievances that includes at least the following:

(A) Three levels of review, the second of which shall be by persons not previously involved in the dispute and the third of which shall provide external review pursuant to an external review program meeting the requirements of ORS 743.857, 743.859 and 743.861;

(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and

(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.

(4) If the insurer has a prescription drug formulary, have:

(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.

(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:

(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area, and the availability of continuity of care as required by ORS 743.854;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;

(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;

(e) Procedures for notifying enrollees of:

(A) A change in or termination of any benefit;

(B) If applicable, termination of a primary care delivery office or site; and

(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;

(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment

status;

(g) Procedures, if any, for changing providers;

(h) Procedures for voicing grievances, including the option of obtaining external review under the insurer's program established pursuant to ORS 743.857, 743.859 and 743.861;

(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;

(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;

(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;

(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;

(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;

(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information;

(o) A description of any assistance provided to non-English-speaking enrollees;

(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;

(q) Notice of the enrollee's right to file a complaint or seek other assistance from the [*Director of the Department of Consumer and Business Services*] **authority**; and

(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the [*Department of Consumer and Business Services*] **authority** pursuant to ORS 743.804, 743.807, 743.814 and 743.817.

(6) Provide the following information upon the request of an enrollee or prospective enrollee:

(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) A copy of the insurer's annual report on grievances and appeals as submitted to the [*department*] **authority** under subsection (9) of this section;

(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;

(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services;

(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care; and

(g) A description of the insurer's external review program established pursuant to ORS 743.857, 743.859 and 743.861.

(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, a written

summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria. Nothing in this section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.

(8) Provide the following information to an enrollee when the enrollee has filed a grievance:

(a) Detailed information on the insurer's grievance and appeal procedures and how to use them;

(b) Information on how to access the complaint line of the [*Department of Consumer and Business Services*] **authority**; and

(c) Information explaining how an enrollee applies for external review of the insurer's actions under the external review program established by the insurer pursuant to ORS 743.857.

(9) Provide annual summaries to the [*Department of Consumer and Business Services*] **authority** of the insurer's aggregate data regarding grievances, appeals and applications for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, appeals and applications for external review.

(10) Ensure that the confidentiality of specified patient information and records is protected, and to that end:

(a) Adopt and implement written confidentiality policies and procedures;

(b) State the insurer's expectations about the confidentiality of enrollee information and records in medical service contracts; and

(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal information by the insurer, except as otherwise permitted or required by law.

(11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the insurer notifies the enrollee of an adverse decision. The notification shall include:

(a) Notice of the right of the enrollee to apply for internal and external review of the adverse decision;

(b) A statement whether a decision by an independent review organization is binding on the insurer and enrollee;

(c) A statement that if the decision is not binding on the insurer and if the insurer does not comply with the decision, the enrollee may sue the insurer as provided in ORS 743.864; and

(d) Information on filing a complaint with the [*Director of the Department of Consumer and Business Services*] **authority**.

SECTION 419. ORS 743.807 is amended to read:

743.807. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the [*Department of Consumer and Business Services*] **Oregon Health Authority** that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria used in the utilization review process and the method of development of the criteria shall be made available for review to contracting providers upon request.

(b) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists

in making such recommendations.

(c) Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(d) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

SECTION 420. ORS 743.814 is amended to read:

743.814. All insurers offering managed health insurance in this state shall:

(1) Have a quality assessment program that enables the insurer to evaluate, maintain and improve the quality of health services provided to enrollees. The program shall include data gathering that allows the plan to measure progress on specific quality improvement goals chosen by the insurer.

(2) File an annual summary with the [*Department of Consumer and Business Services*] **Oregon Health Authority** that describes quality assessment activities, including any activities related to credentialing of providers, and reports any progress on the insurer's quality improvement goals.

(3) File annually with the [*department*] **authority** the following information:

(a) Results of all publicly available federal Centers for Medicare and Medicaid Services reports and accreditation surveys by national accreditation organizations.

(b) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer. In addition to the summary required in this paragraph, the consortium established pursuant to ORS 743.831 shall develop recommendations for, and the [*department*] **authority** shall adopt rules requiring, reporting of an insurer's health promotion and disease prevention activities related to:

(A) Two specific preventive measures;

(B) One specific chronic condition; and

(C) One specific acute condition.

SECTION 421. ORS 743.817 is amended to read:

743.817. An insurer offering managed health insurance or preferred provider organization insurance in this state shall:

(1) File an annual summary with the [*Department of Consumer and Business Services*] **Oregon Health Authority** that reports on the scope and adequacy of the insurer's network and the insurer's ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees. The [*Director of the Department of Consumer and Business Services*] **authority** shall adopt rules establishing uniform indicators that insurers offering managed health insurance or preferred provider organization insurance must use for reporting under this subsection, including but not limited to reporting on the scope and adequacy of networks. For the purpose of developing the rules, the [*director*] **authority** shall consult with an advisory committee appointed by the [*director*] **authority**. The advisory committee must include representatives of persons likely to be affected by the rules, including consumers, purchasers of health insurance and insurers that offer managed health insurance or preferred provider organization insurance.

(2) Establish a means to provide to the insurer's managed care plan or preferred provider organization insurance enrollees, purchasers and providers a meaningful opportunity to participate in the development and implementation of insurer policy and operation through:

(a) The establishment of advisory panels;

(b) Consultation with advisory panels on major policy decisions; or

(c) Other means including but not limited to:

(A) Governing board meetings or special meetings at which enrollees, purchasers and providers are invited to express opinions; and

(B) Enrollee councils that are given a reasonable opportunity to meet with the governing board or its designee.

SECTION 422. ORS 743.823 is amended to read:

743.823. The [*Department of Consumer and Business Services*] **Oregon Health Authority** shall enforce insurer compliance with the federal Newborns' and Mothers' Health Protection Act of 1996.

SECTION 423. ORS 743.827 is amended to read:

743.827. The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall appoint a Health Care Consumer Protection Advisory Committee with fair representation of health care consumers, providers and insurers. The committee shall advise the [*director*] **authority** regarding the implementation of ORS 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839 and 743A.012 and other issues related to health care consumer protection.

SECTION 424. ORS 743.831 is amended to read:

743.831. (1) The Administrator of the Office for Oregon Health Policy and Research shall establish a consortium of interested parties that shall:

(a) Develop, on a voluntary basis, standardized, quantitative performance measurements of managed health insurance organizations for use by health care consumers, purchasers and providers to continuously assess the quality of clinical and service-related aspects of health care arranged for or provided by managed health insurance organizations;

(b) Encourage managed health insurance organizations to collect, on a voluntary basis, the performance measurements specified in paragraph (a) of this subsection and share that information with the consortium;

(c) Develop, test, refine and produce one or more managed health care performance scorecards to provide consumers and purchasers with accurate, reliable and timely comparisons of managed health insurance organizations with respect to:

(A) Organizational characteristics;

(B) Clinical quality measurements;

(C) Service-related quality measurements; and

(D) Member and patient satisfaction; and

(d) Carry out the activities specified in this subsection with the objective of:

(A) Utilizing, to the greatest extent feasible and desirable, nationally developed quality assessment tools; and

(B) Minimizing duplicative quality assessment activities and associated administrative costs.

(2) The consortium established pursuant to subsection (1) of this section shall be comprised of representatives of:

(a) Health care consumers;

(b) Private-sector and public-sector health care purchasers;

(c) Managed health insurance organizations;

(d) Health care providers, including but not limited to physicians, nurses and hospitals;

(e) State agencies, including but not limited to the [*Department of Consumer and Business Services and the Department of Human Services*] **Oregon Health Authority**;

(f) Oregon institutions of higher education with relevant professional expertise; and

(g) Other groups or organizations as determined to be appropriate by the administrator to ensure broad representation of interests and expertise.

(3) The Office for Oregon Health Policy and Research shall:

(a) Provide staffing for the consortium; and

(b) Seek public and private funds to assist in the work of the consortium.

SECTION 425. ORS 743.857 is amended to read:

743.857. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743.859 and 743.861. Each insurer shall provide the external review through an independent review organization that is under contract with the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer, to obtain review by an independent review organization of a dispute relating to an adverse decision by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the insurer shall request the [*director*] **authority** to appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization and shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. The insurer shall furnish all such records, materials and information in a timely manner in order to enable a timely decision by the independent review organization. The [*director*] **authority** may establish timelines for the purpose of this subsection.

(4) An insurer shall expedite an enrollee's case if a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION 426. ORS 743.858 is amended to read:

743.858. (1) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall contract with independent review organizations as provided in this section for the purpose of providing external review under ORS 743.857. The [*director*] **authority** may have contracts with no more than five independent review organizations at any one time. Contracts shall be let with independent review organizations on a biennial basis. A contract may be renewed if both parties agree.

(2) The [*director*] **authority** shall seek public comment when the [*director*] **authority** proposes to enter into a contract with an independent review organization or proposes to renew or not renew a contract.

(3) When evaluating proposals to contract with independent review organizations, the [*director*] **authority** shall consider factors that include but are not limited to relative expertise, professionalism, quality of compliance with the rules established under subsection (4) of this section,

cost and record of past performance.

(4) The [*director*] **authority** shall adopt rules governing independent review organizations, their composition and their conduct. The rules shall include but need not be limited to:

(a) Professional qualifications of health care providers, physicians or contract specialists making external review determinations;

(b) Criteria requiring independent review organizations to demonstrate protections against bias and conflicts of interest;

(c) Procedures for conducting external reviews;

(d) Procedures for complaint investigations;

(e) Procedures for ensuring the confidentiality of medical records transmitted to the independent review organizations for use in external reviews;

(f) Fairness of procedures used by independent review organizations;

(g) Fees for external reviews;

(h) Timelines for decision making and notice to the parties; and

(i) Quality assurance mechanisms to ensure timeliness and quality of review.

(5) The [*director*] **authority** shall develop procedures for assigning cases filed by enrollees to independent review organizations under contract with the [*director*] **authority**. The cases shall be assigned on a random basis. The procedures shall allow an insurer only one opportunity to reject the assignment of an independent review organization to a particular case.

SECTION 427. ORS 743.862 is amended to read:

743.862. (1) An independent review organization shall perform the following duties when appointed under ORS 743.857 to review a dispute under a health benefit plan between an insurer and an enrollee:

(a) Decide whether the dispute is covered by the conditions established in ORS 743.857 for external review and notify the enrollee and insurer in writing of the decision. If the decision is against the enrollee, the independent review organization shall notify the enrollee of the right to file a complaint with or seek other assistance from the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** and the availability of other assistance as specified by the [*director*] **authority**.

(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization.

(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide, and when the information must be submitted.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted.

(e) Decide the dispute relating to the adverse decision of the insurer under ORS 743.857 (1) and issue the decision in writing.

(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States. An independent review organization must make its decision in accordance with the coverage described in the health benefit plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment if the independent review organization determines that the standards of the insurer are unreasonable or are inconsistent with sound medical practice.

(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the insurer for an expedited review.

(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the insurer for a review.

(5) An independent review organization shall file synopses of its decisions with the [*director*] **authority** according to the format and other requirements established by the [*director*] **authority**. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.501 and 192.502 or that may otherwise allow identification of an enrollee. The [*director*] **authority** shall make the synopses public.

SECTION 428. ORS 743.863 is amended to read:

743.863. (1) If an insurer has agreed under the provisions of a health benefit plan to be bound by the decision of an independent review organization and the insurer fails to comply with such a decision, the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall impose on the insurer a civil penalty of not less than $100,000 and not more than $1 million.

(2) A decision of an independent review organization is admissible in any legal proceeding involving the insurer or the enrollee and involving the disputed issues subject to external review.

(3) The sanctions under subsection (1) of this section and the remedies under subsection (2) of this section are in addition to and not in lieu of other sanctions, rights and remedies provided by law or contract.

SECTION 429. ORS 743.874 is amended to read:

743.874. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of an enrollee's costs for an in-network procedure or service covered by the enrollee's health benefit plan, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number; and

(d) If requested by the insurer, the site where the procedure or service will be performed.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service; and

(d) Any applicable benefit maximum.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the [*Department of Consumer and Business Services*] **Oregon Health Authority** and the address for the [*department's*] **authority's** consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and in-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section.

SECTION 430. ORS 743.876 is amended to read:

743.876. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of the enrollee's costs for an out-of-network procedure or service covered by the enrollee's health benefit plan, including the difference between the insurer's allowable charge and the billed charge for the procedure or service, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number;

(d) If requested by the insurer, the site where the procedure or service will be performed; and

(e) The provider's billed charge amount.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service;

(d) Any applicable benefit maximum;

(e) The difference between the insurer's allowable charge and the billed charge for the procedure or service; and

(f) The insurer's average payment or allowable charge for the procedure or service if performed in-network.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the [*Department of Consumer and Business Services*] **Oregon Health Authority** and the address for the [*department's*] **authority's** consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and out-of-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section.

SECTION 431. ORS 743.878 is amended to read:

743.878. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must submit to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**:

(a) Upon request by the [*director*] **authority**, the methodology used to determine the insurer's allowable charges for out-of-network procedures and services or, if the insurer uses a third party to determine the charges, the methodology used by the third party to determine allowable charges;

(b) For approval, a written explanation of the method used by the insurer to determine the allowable charge, that is in plain language and that must be provided upon request to enrollees directly, or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees; and

(c) Information prescribed by the [*director*] **authority** as necessary to assess the effect of the disclosure requirements in ORS 743.874 and 743.876 on the individual and group health insurance markets.

(2) The [*director*] **authority** shall consider the recommendations of the Health Insurance Reform Advisory Committee in prescribing the information required for submission under subsection (1)(c) of this section.

SECTION 432. ORS 743.911 is amended to read:

743.911. (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than

30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743.913 or has the effect of relieving either party of their obligations under this section and ORS 743.913.

(3) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(4) This section does not create an assignment of payment to a provider.

(5) Each insurer shall report to the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** annually on its compliance under this section according to requirements established by the [*director*] **authority**.

(6) The [*director*] **authority** shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicare claims.

SECTION 433. ORS 743A.144 is amended to read:

743A.144. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses shall include coverage for prosthetic and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. The coverage required by this subsection includes all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

(2) As used in this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck.

(b) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(3) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt and annually update rules listing the prosthetic and orthotic devices covered under this section. The list shall be no more restrictive than the list of prosthetic and orthotic devices and supplies in the Medicare fee schedule for Durable Medical Equipment, Prosthetics, Orthotics and Supplies, but only to the extent consistent with this section.

(4) The coverage required by subsection (1) of this section may be made subject to, and no more restrictive than, the provisions of a health insurance policy that apply to other benefits under the policy.

(5) The coverage required by subsection (1) of this section shall include any repair or replacement of a prosthetic or orthotic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(6) If coverage under subsection (1) of this section is provided through a managed care plan, the insured shall have access to medically necessary clinical care and to prosthetic and orthotic devices and technology from not less than two distinct Oregon prosthetic and orthotic providers in the

managed care plan's provider network.

SECTION 434. ORS 743A.168 is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(A) A health care facility;

(B) A residential program or facility;

(C) A day or partial hospitalization program;

(D) An outpatient service; or

(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) A screening interview or treatment program under ORS 813.021.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved by the [*Department of Human Services*] **Oregon Health Authority**;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to licensed clinical social workers, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners or a clinical social worker licensed by the State Board of Clinical Social Workers, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-

view. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all eligible providers.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress.

(14) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority**, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions.

SECTION 435. ORS 744.062 is amended to read:

744.062. (1) Unless the [*Director of the Department of Consumer and Business Services*] **regulator** refuses to issue or renew a license pursuant to ORS 744.074, a person who has met the requirements of ORS 744.058 and 744.059, or ORS 744.063, shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following classes of insurance:

(a) Life insurance as defined in ORS 731.170.

(b) Health insurance as defined in ORS 731.162.

(c) Property insurance as defined in ORS 731.182.

(d) Casualty insurance as defined in ORS 731.158.

(e) Variable life insurance, including variable annuities.

(f) Property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(g) Limited class credit insurance.

(h) Any form of insurance designated by the [*director*] **regulator** as a form of limited class insurance.

(i) Title insurance as defined in ORS 731.190. A license for the class of title insurance may be

issued only to a resident insurance producer.

(j) Any other class of insurance permitted under the Insurance Code or rules adopted thereunder.

(2) For assistance in performance of the [*director's*] **regulator's** duties, the [*director*] **regulator** may participate with the National Association of Insurance Commissioners, or any affiliate or subsidiary that the National Association of Insurance Commissioners oversees, in a centralized producer licensing registry in which insurance producer licenses and appointments are centrally or simultaneously effected for all states that require an insurance producer license. The [*director*] **regulator** may adopt by rule any uniform standards and procedures as are necessary to participate in the registry, including the centralized collection of fees for licenses or appointments that are processed through the registry.

(3) An insurance producer may apply to amend a license for the purpose of adding or deleting a class of insurance on the license in the manner prescribed for license application in ORS 744.059 or 744.063, or as otherwise prescribed by the [*director*] **regulator**.

SECTION 436. ORS 744.063 is amended to read:

744.063. (1) Unless the [*Director of the Department of Consumer and Business Services*] **regulator** refuses to issue or renew a license pursuant to ORS 744.074, a nonresident person shall receive a nonresident insurance producer license if:

(a) The person is currently licensed as a resident insurance producer and is in good standing in the person's home state;

(b) The person has submitted the proper request for a nonresident insurance producer license and has paid the applicable fees;

(c) The person has submitted or transmitted to the [*director*] **regulator** the resident insurance producer license application that the person submitted to the person's home state, or in lieu of that application, a completed Uniform Application; and

(d) The person's home state grants nonresident insurance producer licenses to residents of this state on the same basis.

(2) The [*director*] **regulator** may verify the insurance producer's licensing status through the Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(3) A nonresident insurance producer licensed in this state who moves from one state to another state or a resident insurance producer who moves from this state to another state shall file with the [*director*] **regulator** a change of address and provide certification from the new resident state not later than the 30th day after the change of legal residence. No fee or license application is required under this subsection.

(4) A person licensed as a surplus lines insurance producer in the person's home state shall receive a nonresident surplus lines insurance producer license pursuant to subsection (1) of this section. Except as provided in subsection (1) of this section, nothing in this section supersedes any provision of ORS 735.400 to 735.495.

(5) Notwithstanding any other provision of ORS 744.052 to 744.089, the [*director*] **regulator** shall issue a nonresident limited class insurance producer license pursuant to subsection (1) of this section to a person who is licensed as a limited class credit insurance producer or as another type of limited class insurance producer under the laws of the person's home state that restrict the authority of the license to less than the authority prescribed in ORS 744.062 for the classes of life insurance, health insurance, property insurance or casualty insurance.

(6) A license for the class of title insurance may not be issued to a nonresident insurance producer.

(7) The [*director*] **regulator** is the attorney in fact of a person to whom a license is issued under this section, and upon whom all legal process in any action or proceeding against the person may be served. Any legal process against the person that is served upon the [*director*] **regulator** has the same legal force and validity as if served upon the person. The authority of the [*director*] **regulator** under this subsection continues as long as any liability remains outstanding in this state. The [*director*] **regulator** becomes the attorney in fact of the person on the date that the [*director*] **regulator** issues the nonresident insurance producer license to the person.

SECTION 437. ORS 744.067 is amended to read:

744.067. (1) An individual who applies for a resident insurance producer license in this state who is or was previously licensed as an insurance producer for the same lines of authority in another state is not required to complete any prelicensing education or examination. The exemption under this subsection is available only if the individual is currently licensed in the other state or if the application is received by the [*Director of the Department of Consumer and Business Services*] **regulator** not later than the 90th day after the applicant's previous license was terminated and if the other state issues a certification that, at the time of termination, the applicant was in good standing in that state or the state's Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries indicate that the applicant is or was licensed in good standing for the class of insurance requested.

(2) A person licensed as an insurance producer in another state who moves to this state must apply for a resident insurance producer license not later than the 90th day after the date on which the person established legal residence in order to qualify for a resident insurance producer license pursuant to ORS 744.059. Neither prelicensing education nor an examination is required of a person to whom this subsection applies in order to obtain a license in a class of insurance described in ORS 744.062 if the person held a license in that class in the other state, except when the [*director*] **regulator** has determined otherwise by rule.

(3) An individual who holds an industry designation described in this subsection is not required to complete prelicensing education or the examination required in ORS 744.058 if the [*director*] **regulator** is satisfied, by examination or otherwise, that the applicant is knowledgeable in the particulars of the applicable provisions of the Insurance Code. This subsection applies to:

(a) An applicant for a license authorizing the applicant to transact property or casualty insurance or both, upon whom the American Institute for Chartered Property Casualty Underwriters has conferred the Chartered Property Casualty Underwriter (C.P.C.U.) designation.

(b) An applicant for a license authorizing the applicant to transact life or health insurance, or both, upon whom the American College has conferred the Chartered Life Underwriter (C.L.U.) designation.

(4) The [*director*] **regulator** may recognize one or more industry designations as exempting an applicant from the prelicensing education requirement or the examination required in ORS 744.058 or both. For each industry designation that the [*director*] **regulator** recognizes and for the extent of the exemption to be given, the [*director*] **regulator** shall consider the content, quality and scope of the educational program required for the designation as well as other factors determined by the [*director*] **regulator** to be relevant.

(5) An individual is not required to complete prelicensing education or the examination required in ORS 744.058 or 744.064 for the following licenses:

(a) A license authorizing the individual to transact a type of limited class insurance, except as the [*director*] **regulator** otherwise provides by rule.

(b) A license authorizing the individual to transact title insurance.

SECTION 438. ORS 744.088 is amended to read:

744.088. (1) An individual may not sell, solicit or negotiate long term care insurance unless the individual is licensed as an insurance producer for health or life insurance and satisfies the following training requirements:

(a) The individual must complete a one-time training course of not less than eight hours before selling, soliciting or negotiating long term care insurance; and

(b) The individual must complete ongoing training of not less than four hours in each 24-month period following the one-time training course.

(2) The [*Director of the Department of Consumer and Business Services*] **regulator** may approve as continuing education courses under ORS 744.072 any courses offered to satisfy the training requirements of this section.

(3) The training required by this section must consist of topics related to long term care insurance, long term care services and, if applicable, qualified state long term care insurance partnership programs, including but not limited to:

(a) State and federal rules and requirements and the relationship between qualified state long term care insurance partnership programs and other public and private coverage of long term care services, including Medicaid.

(b) Available long term care services and providers.

(c) Changes or improvements in long term care services or providers.

(d) Alternatives to the purchase of private long term care insurance.

(e) The effect of inflation on benefits and the importance of inflation protection.

(f) Consumer suitability standards and guidelines.

(4) The training required by this section may not include training that is insurer or company product specific or that includes any sales or marketing information, materials or training, other than those required by state or federal law.

(5) An insurer must:

(a) Obtain verification that an insurance producer receives training required by this section before an insurance producer sells, solicits or negotiates the insurer's long term care insurance products.

(b) Maintain records subject to the state's record retention requirements.

(c) Make the verification obtained under paragraph (a) of this subsection available to the [*director*] **regulator** upon request.

(6) An insurer must maintain records with respect to the training of its insurance producers concerning the distribution of its partnership policies that will allow the [*director*] **regulator** to provide assurance to the state Medicaid agency that insurance producers have received training on the topics described in subsection (3)(a) of this section and that insurance producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long term care, including Medicaid, in this state. An insurer must make the records available to the [*director*] **regulator** upon request.

(7) The satisfaction in any state of the training required by this section is considered to satisfy the training required by this section.

SECTION 439. ORS 744.091 is amended to read:

744.091. (1) An insurer or insurance producer may charge a commission, a service fee or a combination of the two when transacting insurance in other than the following categories of insurance:

(a) Insurance that covers an individual's person, property or liability;

(b) Life or health insurance for groups of fewer than 51 lives; or

(c) Insurance on a commercial or public entity paying combined annual premiums of less than $100,000 for the insurance.

(2) An insurer or insurance producer may charge a commission or service fee other than the commission or fee filed in accordance with ORS 737.205 only if the insurer or insurance producer has a written agreement with the prospective insured prior to the binding or issuance of an insurance policy. The [*Director of the Department of Consumer and Business Services*] **regulator** may establish by rule minimum conditions for written agreements entered into under this subsection. An insurer or insurance producer who enters into a written agreement as provided in this subsection is not in violation of ORS 746.035 or 746.045.

SECTION 440. ORS 744.338 is amended to read:

744.338. (1) The [*Director of the Department of Consumer and Business Services*] **regulator** may suspend, revoke, refuse to issue or refuse to renew a license of a licensee if the [*director*] **regulator** finds one or more of the following with respect to the licensee or applicant for a license:

(a) Dishonesty, fraud or gross negligence in the conduct of business as a licensee, or the licensee or applicant is otherwise shown to be untrustworthy or incompetent to act as a licensee.

(b) The life settlement provider demonstrates a pattern of unreasonable payments to policyholders or certificate holders.

(c) Falsification by the applicant or licensee of an application for the license or renewal thereof, or misrepresentation or engagement in any other dishonest act in relation to the application.

(d) Conduct resulting in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280.

(e) Conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States.

(f) Refusal to renew or cancellation, revocation or suspension of authority to transact insurance or business as a life settlement provider, life settlement broker or similar entity in another state.

(g) Failure to pay a civil penalty imposed by final order of the [*director*] **regulator** or to carry out terms of probation set by the [*director*] **regulator**.

(h) Refusal by a licensee to be examined or to produce accounts, records or files for examination, refusal by any officers to give information with respect to the affairs of the licensee or refusal to perform any other legal obligation as to the examination when required by the [*director*] **regulator**.

(i) Affiliation with or under the same general management or interlocking directorate or ownership as another life settlement provider or life settlement broker or an insurer, any of which unlawfully transacts business in this state.

(j) Failure at any time to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the [*director*] **regulator**.

(k) Violation of any rule or order of the [*director*] **regulator** or any provision of the Insurance Code.

(2) The [*director*] **regulator** may suspend or refuse to renew a license immediately and without hearing if the [*director*] **regulator** determines that one or both of the following circumstances exist:

(a) The licensee is insolvent.

(b) The financial condition or business practices of the licensee otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(3) A life settlement provider or life settlement broker holding a license that has not been renewed or has been revoked shall surrender the license to the [*director*] **regulator** at the [*director's*] **regulator's** request.

(4) The [*director*] **regulator** may take any other administrative action authorized under the Insurance Code in addition to or in lieu of the actions authorized under this section.

SECTION 441. ORS 744.531 is amended to read:

744.531. When the [*Director of the Department of Consumer and Business Services*] **regulator** issues a license authorizing a person to act as an adjuster, the [*director*] **regulator** shall indorse on the license the class or classes of insurance described in this section with respect to which the person is authorized to adjust losses. The classes of insurance are as follows:

(1) Property and casualty insurance. Under this class, in addition to property and casualty insurance, an adjuster may also adjust losses with respect to marine and transportation and surety insurance.

(2) Health insurance, whether provided by an insurer or a health care service contractor as defined in ORS 750.005.

(3) Any class of insurance designated by the [*director*] **regulator** by rule.

SECTION 442. ORS 744.626 is amended to read:

744.626. When the [*Director of the Department of Consumer and Business Services*] **regulator** issues a license authorizing a person to act as an insurance consultant, the [*director*] **regulator** shall indorse on the license the class or classes of insurance described in this section with respect to which the person is authorized to act as an insurance consultant. The classes of insurance are as follows:

(1) Life insurance.

(2) Health insurance.

(3) Property and casualty insurance. Under this class, in addition to property and casualty insurance, an insurance consultant may also act as insurance consultant with respect to marine and transportation and surety insurance.

(4) Any class of insurance designated by the [*director*] **regulator** by rule.

SECTION 443. ORS 744.702 is amended to read:

744.702. (1) Subject to ORS 744.704, a person shall not transact business or purport or offer to transact business as a third party administrator in this state unless the person holds a third party administrator license issued by the [*Director of the Department of Consumer and Business Services*] **regulator**.

(2) For purposes of ORS 744.700 to 744.740, a person transacts or purports or offers to transact business as a third party administrator when the person directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on, residents of this state or residents of another state from offices in this state, in connection with life insurance or health insurance coverage.

(3) Nothing in ORS 744.700 to 744.740 exempts a third party administrator from any other applicable licensing requirement when the third party administrator performs the functions of an insurance producer, adjuster or insurance consultant.

SECTION 444. ORS 744.704 is amended to read:

744.704. (1) The following persons are exempt from the licensing requirement for third party administrators in ORS 744.702 and from all other provisions of ORS 744.700 to 744.740 applicable to third party administrators:

(a) A person licensed under ORS 744.002 as an adjuster, whose activities are limited to adjustment of claims and whose activities do not include the activities of a third party administrator.

(b) A person licensed as an insurance producer as required by ORS 744.053 and authorized to transact life or health insurance in this state, whose activities are limited exclusively to the sale of insurance and whose activities do not include the activities of a third party administrator.

(c) An employer acting as a third party administrator on behalf of:

(A) Its employees;

(B) The employees of one or more subsidiary or affiliated corporations of the employer; or

(C) The employees of one or more persons with a dealership, franchise, distributorship or other similar arrangement with the employers.

(d) A union, or an affiliate thereof, acting as a third party administrator on behalf of its members.

(e) An insurer that is authorized to transact insurance in this state with respect to a policy issued and delivered in and pursuant to the laws of this state or another state.

(f) A creditor acting on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors.

(g) A trust and the trustees, agents and employees of the trust, when acting pursuant to the trust, if the trust is established in conformity with 29 U.S.C. 186.

(h) A trust exempt from taxation under section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to the trust, or a voluntary employees beneficiary association described in section 501(c) of the Internal Revenue Code, its agents and employees and a custodian and the custodian's agents and employees acting pursuant to a custodian account meeting the requirements of section 401(f) of the Internal Revenue Code.

(i) A financial institution that is subject to supervision or examination by federal or state financial institution regulatory authorities, or a mortgage lender, to the extent the financial institution or mortgage lender collects and remits premiums to licensed insurance producers or authorized insurers in connection with loan payments.

(j) A company that issues credit cards and advances for and collects premiums or charges from its credit card holders who have authorized collection. The exemption under this paragraph applies only if the company does not adjust or settle claims.

(k) A person who adjusts or settles claims in the normal course of practice or employment as an attorney at law. The exemption under this subsection applies only if the person does not collect charges or premiums in connection with life insurance or health insurance coverage.

(L) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974. A person to whom this paragraph applies must comply with the requirements of ORS 744.714.

(m) The Oregon Medical Insurance Pool Board, established under ORS 735.600 to 735.650, and the administering insurer or insurers for the board, for services provided pursuant to ORS 735.600 to 735.650.

(n) An entity or association owned by or composed of like employers who administer partially or fully self-insured plans for employees of the employers or association members.

(o) A trust established by a cooperative body formed between cities, counties, districts or other political subdivisions of this state, or between any combination of such entities, and the trustees, agents and employees acting pursuant to the trust.

(p) Any person designated by the [*Director of the Department of Consumer and Business Services*] **regulator** by rule.

(2) A third party administrator is not required to be licensed as a third party administrator in this state if the following conditions are met:

(a) The third party administrator has its principal place of business in another state;

(b) The third party administrator is not soliciting business as a third party administrator in this state; and

(c) In the case of any group policy or plan of insurance serviced by the third party administrator, the lesser of five percent or 100 certificate holders reside in this state.

SECTION 444a. ORS 744.714 is amended to read:

744.714. A person who is exempt from the requirement of a license as a third party administrator under ORS 744.704 because the person acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization, or both, for which the Insurance Code is preempted pursuant to the Employee Retirement Income Security Act of 1974, shall register with the [*Director of the Department of Consumer and Business Services*] **regulator** annually, verifying the status of the person as qualifying for the exemption.

SECTION 445. ORS 744.718 is amended to read:

744.718. (1) The [*Director of the Department of Consumer and Business Services*] **regulator** shall suspend, revoke or refuse to renew a license of a third party administrator if the [*director*] **regulator** finds that the third party administrator:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of business so as to render further transaction of business by the third party administrator in this state hazardous or injurious to insured persons or to the public; or

(c) Has failed to pay any judgment rendered against the third party administrator in this state within 60 days after the judgment has become final.

(2) The [*director*] **regulator** may suspend, revoke, refuse to issue or refuse to renew a license of a third party administrator if the [*director*] **regulator** finds one or more of the following with respect to a third party administrator or an applicant for a license therefor:

(a) Falsification by the applicant or licensee of an application for the license or renewal thereof, or engagement in any dishonest act in relation to the application;

(b) Dishonesty, fraud or gross negligence in the transaction of insurance or in the conduct of business as a third party administrator;

(c) Conduct resulting in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280;

(d) Conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States;

(e) Refusal to renew or cancellation, revocation or suspension of authority to transact insurance or business as a third party administrator or similar entity in another state;

(f) Failure to pay a civil penalty imposed by final order of the [*director*] **regulator** or to carry out terms of probation set by the [*director*] **regulator**;

(g) Refusal to be examined or to produce accounts, records or files for examination, refusal by

any officers to give information with respect to the affairs of the third party administrator or refusal to perform any other legal obligation as to the examination when required by the [*director*] **regulator**;

(h) Affiliation with or under the same general management or interlocking directorate or ownership as another administrator or insurer that unlawfully transacts business in this state;

(i) Failure at any time to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the [*director*] **regulator**; or

(j) Violation of any rule or order of the [*director*] **regulator** or any provision of the Insurance Code.

(3) The [*director*] **regulator** may suspend or refuse to renew a license immediately and without hearing if the [*director*] **regulator** determines that one or more of the following circumstances exist:

(a) The third party administrator is insolvent;

(b) A proceeding for receivership, conservatorship or rehabilitation or other delinquency proceeding regarding the third party administrator has been commenced in any state; or

(c) The financial condition or business practices of the third party administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(4) A third party administrator holding a license that has not been renewed or has been revoked shall surrender the license to the [*director*] **regulator** at the [*director's*] **regulator's** request.

(5) The [*director*] **regulator** may take any other administrative action authorized under the Insurance Code in addition to or in lieu of the actions authorized under this section.

SECTION 446. ORS 746.230 is amended to read:

746.230. (1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

(a) Misrepresenting facts or policy provisions in settling claims;

(b) Failing to acknowledge and act promptly upon communications relating to claims;

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;

(d) Refusing to pay claims without conducting a reasonable investigation based on all available information;

(e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;

(f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;

(g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;

(h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;

(j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

(k) Delaying investigation or payment of claims by requiring a claimant or the physician of the claimant to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

(L) Failing to promptly settle claims under one coverage of a policy where liability has become

reasonably clear in order to influence settlements under other coverages of the policy; or

(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim.

(2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages provided by its policies with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:

(a) A substantial increase in the number of complaints against the insurer received by the [*Department of Consumer and Business Services*] **regulator**;

(b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by claimants; or

(c) Other relevant evidence.

(3)(a) No health maintenance organization, as defined in ORS 750.005, shall unreasonably withhold the granting of participating provider status from a class of statutorily authorized health care providers for services rendered within the lawful scope of practice if the health care providers are licensed as such and reimbursement is for services mandated by statute.

(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection shall be subject to discipline under ORS 746.015.

(c) This subsection does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act.

SECTION 447. ORS 746.600 is amended to read:

746.600. As used in ORS 746.600 to 746.690:

(1)(a) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that the insurance producer represents and that is requested by an applicant.

(D) In the case of life or health insurance coverage, an offer to insure at higher than standard rates.

(E) In the case of insurance coverage other than life or health insurance coverage:

(i) Placement by an insurer or insurance producer of a risk with a residual market mechanism, an unauthorized insurer or an insurer that specializes in substandard risks.

(ii) The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished.

(iii) An increase in any charge imposed by the insurer for any personal insurance in connection with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a service fee is not a charge.

(b) "Adverse underwriting decision" does not mean any of the following actions, but the insurer or insurance producer responsible for the occurrence of the action must nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

(A) The termination of an individual policy form on a class or statewide basis.

(B) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person

who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(3) "Applicant" means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage that is not individually underwritten.

(4) "Consumer" means an individual, or the personal representative of the individual, who seeks to obtain, obtains or has obtained one or more insurance products or services from a licensee that are to be used primarily for personal, family or household purposes, and about whom the licensee has personal information.

(5) "Consumer report" means any written, oral or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used in connection with an insurance transaction.

(6) "Consumer reporting agency" means a person that, for monetary fees or dues, or on a cooperative or nonprofit basis:

(a) Regularly engages, in whole or in part, in assembling or preparing consumer reports;

(b) Obtains information primarily from sources other than insurers; and

(c) Furnishes consumer reports to other persons.

(7) "Control" means, and the terms "controlled by" or "under common control with" refer to, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power of the person is the result of a corporate office held in, or an official position held with, the controlled person.

(8) "Covered entity" means:

(a) A health insurer;

(b) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 746.607 or by rules adopted under ORS 746.608; or

(c) A health care clearinghouse.

(9) "Credit history" means any written or other communication of any information by a consumer reporting agency that:

(a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

(b) Is used or expected to be used, or collected in whole or in part, as a factor in determining eligibility, premiums or rates for personal insurance.

(10) "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in part, by an insurer or insurance producer of an application for requested insurance coverage.

(12) "Health care" means care, services or supplies related to the health of an individual.

(13) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

(14) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist licensed under ORS chapter 675 or an employee of the psychologist, occupational therapist, clinical social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical technician certified under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A radiologic technologist licensed under ORS 688.405 to 688.605 or an employee of the radiologic technologist;

(o) A respiratory care practitioner licensed under ORS 688.800 to 688.840 or an employee of the respiratory care practitioner;

(p) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(q) A dietitian licensed under ORS 691.405 to 691.585 or an employee of the dietitian;

(r) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(s) A health care facility as defined in ORS 442.015;

(t) A home health agency as defined in ORS 443.005;

(u) A hospice program as defined in ORS 443.850;

(v) A clinical laboratory as defined in ORS 438.010;

(w) A pharmacy as defined in ORS 689.005;

(x) A diabetes self-management program as defined in ORS 743.694; and

(y) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(15) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(16) "Health insurer" means:

(a) An insurer who offers:

(A) A health benefit plan as defined in ORS 743.730;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(17) "Homeowner insurance" means insurance for residential property consisting of a combination of property insurance and casualty insurance that provides coverage for the risks of owning or occupying a dwelling and that is not intended to cover an owner's interest in rental property or commercial exposures.

(18) "Individual" means a natural person who:

(a) In the case of life or health insurance, is a past, present or proposed principal insured or certificate holder;

(b) In the case of other kinds of insurance, is a past, present or proposed named insured or certificate holder;

(c) Is a past, present or proposed policyowner;

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

(f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate that is subject to ORS 746.600 to 746.690.

(19) "Individually identifiable health information" means any oral or written health information that is:

(a) Created or received by a covered entity or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(20) "Institutional source" means a person or governmental entity that provides information about an individual to an insurer, insurance producer or insurance-support organization, other than:

(a) An insurance producer;

(b) The individual who is the subject of the information; or

(c) A natural person acting in a personal capacity rather than in a business or professional capacity.

(21) "Insurance producer" or "producer" means a person licensed by [*the Director of the Department of Consumer and Business Services*] **a regulator** as a resident or nonresident insurance producer.

(22) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit history.

(23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in part, in assembling or collecting information about natural persons for the primary purpose of providing the information to an insurer or insurance producer for insurance transactions, including:

(A) The furnishing of consumer reports to an insurer or insurance producer for use in connection with insurance transactions; and

(B) The collection of personal information from insurers, insurance producers or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) "Insurance-support organization" does not mean insurers, insurance producers, governmental institutions or health care providers.

(24) "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails:

(a) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

(b) The servicing of an insurance application, policy or certificate.

(25) "Insurer" has the meaning given that term in ORS 731.106.

(26) "Investigative consumer report" means a consumer report, or portion of a consumer report, for which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

(27) "Licensee" means an insurer, insurance producer or other person authorized or required to be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

(28) "Loss history report" means a report provided by, or a database maintained by, an insurance-support organization or consumer reporting agency that contains information regarding the claims history of the individual property that is the subject of the application for a homeowner insurance policy or the consumer applying for a homeowner insurance policy.

(29) "Nonaffiliated third party" means any person except:

(a) An affiliate of a licensee;

(b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the licensee; and

(c) As designated by the [*director*] **regulator** by rule.

(30) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(31)(a) "Personal financial information" means:

(A) Information that is identifiable with an individual, gathered in connection with an insurance transaction from which judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit or any other personal characteristics; or

(B) An individual's name, address and policy number or similar form of access code for the individual's policy.

(b) "Personal financial information" does not mean information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law.

(32) "Personal information" means:

(a) Personal financial information;

(b) Individually identifiable health information; or

(c) Protected health information.

(33) "Personal insurance" means the following types of insurance products or services that are to be used primarily for personal, family or household purposes:

(a) Private passenger automobile coverage;

(b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and renters coverage;

(c) Personal dwelling property coverage;

(d) Personal liability and theft coverage, including excess personal liability and theft coverage; and

(e) Personal inland marine coverage.

(34) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 746.611.

(35) "Policyholder" means a person who:

(a) In the case of individual policies of life or health insurance, is a current policyowner;

(b) In the case of individual policies of other kinds of insurance, is currently a named insured; or

(c) In the case of group policies of insurance under which coverage is individually underwritten, is a current certificate holder.

(36) "Pretext interview" means an interview wherein the interviewer, in an attempt to obtain personal information about a natural person, does one or more of the following:

(a) Pretends to be someone the interviewer is not.

(b) Pretends to represent a person the interviewer is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

(37) "Privileged information" means information that is identifiable with an individual and that:

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving the individual.

(38)(a) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(39) "Residual market mechanism" means an association, organization or other entity involved in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance Code relating to insurance applicants who are unable to procure insurance through normal insurance markets.

(40) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure of a premium to be paid as required by the policy.

(41) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 448. ORS 746.608 is amended to read:

746.608. (1) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall adopt rules implementing ORS 746.607. In adopting rules under this section, the [*director*] **authority** shall consider the information privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the federal Gramm-Leach-Bliley Act (P.L. 106-102).

(2) The rules adopted under subsection (1) of this section shall include but are not limited to:

(a) Permitted uses and disclosures of:

(A) Personal financial information for business, professional or insurance purposes; and

(B) Protected health information for treatment, payment and health care operations.

(b) Requirements for notice of privacy practices for protected health information and notice of information practices for personal financial information.

SECTION 449. ORS 746.650 is amended to read:

746.650. (1) In the event of an adverse underwriting decision, the insurer or insurance producer responsible for the decision must:

(a) Either provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise the consumer that upon written request the consumer may receive the specific reason or reasons in writing; and

(b) Provide the consumer proposed for coverage with a summary of the rights established under

subsection (2) of this section and ORS 746.640 and 746.645.

(2) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to a consumer proposed for coverage, the insurer or insurance producer shall furnish to the consumer within 21 business days from the date of receipt of the written request:

(a) The specific reason or reasons for the adverse underwriting decision, in writing, if this information was not initially furnished in writing pursuant to subsection (1) of this section;

(b) The specific items of personal information and privileged information that support these reasons, subject to the following:

(A) The insurer or insurance producer is not required to furnish specific items of privileged information if the insurer or insurance producer has a reasonable suspicion, based upon specific information available for review by the [*Director of the Department of Consumer and Business Services*] **regulator**, that the consumer proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure; and

(B) Specific items of individually identifiable health information supplied by a health care provider shall be disclosed either directly to the consumer about whom the information relates or to a health care provider designated by the consumer and licensed to provide health care with respect to the condition to which the information relates, whichever the insurer or insurance producer prefers; and

(c) The names and addresses of the institutional sources that supplied the specific items of information described in paragraph (b) of this subsection. However, the identity of any health care provider must be disclosed either directly to the consumer or to the designated health care provider, whichever the insurer or insurance producer prefers.

(3) The obligations imposed by this section upon an insurer or insurance producer may be satisfied by another insurer or insurance producer authorized to act on its behalf.

(4) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection (1) of this section may be given orally.

(5) Notwithstanding subsection (1) of this section, when an adverse underwriting decision is based in whole or in part on credit history or insurance score, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A summary of no more than four of the most significant credit reasons for the adverse underwriting decision, listed in decreasing order of importance, that clearly identifies the specific credit history or insurance score used to make the adverse underwriting decision. An insurer or insurance producer may not use "poor credit history" or a similar phrase as a reason for an adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the consumer report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the credit history of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's consumer report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a consumer report furnished by the consumer reporting agency.

(6) Notwithstanding subsection (1) of this section, an insurer or insurance producer responsible for an adverse underwriting decision that is based in whole or in part on credit history or insurance score must provide the notice required by subsection (5) of this section only when the insurer or insurance producer makes the initial adverse underwriting decision regarding a consumer.

(7) Notwithstanding subsection (1) of this section, when an adverse underwriting decision relating to homeowner insurance is based in whole or in part on a loss history report, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A description of a specific claim or claims that are the basis for the specific loss history report used to make the adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the loss history report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the loss history report of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's loss history report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a loss history report furnished by the consumer reporting agency.

(8) When an adverse underwriting decision relating to homeowner insurance is based in part on credit history and in part on a loss history report, the insurer or insurance producer responsible for the adverse underwriting decision may provide the notices required by subsections (5) and (7) of this section in a single notice.

SECTION 450. ORS 748.211 is amended to read:

748.211. (1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided. The certificate, together with any riders or indorsements attached to it, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. The laws of the society need not be stated in full in the certificate, except as provided in this section. A copy of the application for insurance and declaration of insurability, if any, shall be indorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall

govern and control the benefit contract in all respects the same as though the changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired, its board of directors or corresponding body may require that there be paid by the owner to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made:

(a) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(b) In lieu of or in combination with paragraph (a) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate.

(5) The society may specify the manner of the election of the alternatives specified in subsection (4) of this section and which alternative is to be presumed if no election is made.

(6) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions of the documents.

(7) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with and approved by the [*Director of the Department of Consumer and Business Services*] **regulator**, and is subject to withdrawal of approval, in the manner provided for like policies issued by life and health insurers in this state. Every life, accident, health or disability insurance certificate and every annuity certificate issued on or after one year from January 1, 1988, shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life and health insurers in this state, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificates shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, shall result in the termination or reduction of benefits payable under the certificate. In addition, except for contracts issued on a variable basis as authorized by ORS 748.409, the certificate shall contain a provision stating the substance of the society's laws required under subsections (4) and (5) of this section. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(8) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of the certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to the transfer shall be specified in the certificate.

(9) A society may specify the terms and conditions on which benefit contracts may be assigned.

SECTION 451. ORS 748.403 is amended to read:

748.403. (1) Standards of valuation for certificates issued prior to January 1, 1989, shall be those provided by the laws applicable immediately prior to January 1, 1988.

(2) The minimum standards of valuation for certificates issued on or after January 1, 1989, shall be based on the following tables:

(a) For certificates of life insurance, the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers; or

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits, the tables that are authorized for use by life insurers in this state.

(3) The tables referred to in subsection (2) of this section shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(4) The [*Director of the Department of Consumer and Business Services*] **regulator** may accept other standards for valuation if the [*director*] **regulator** finds that the reserves produced will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in subsection (2) of this section. The [*director*] **regulator** may vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(5) Any society, with the consent of the director of insurance of the state of domicile of the society and under conditions the [*director*] **regulator** may impose, may establish and maintain reserves on its certificates in excess of the reserves required, but the contractual rights of any benefit member shall not be affected.

SECTION 452. ORS 750.045 is amended to read:

750.045. (1) A health care service contractor that is a for-profit or not-for-profit corporation shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $2.5 million.

(2) A health care service contractor that is a for-profit or not-for-profit corporation shall file a surety bond or such other bond or securities in the sum of $250,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095. In lieu of such bond or securities, a health care service contractor may file an irrevocable letter of credit issued by an insured institution as defined in ORS 706.008 in the sum of $250,000. This subsection does not apply to a health care service contractor that has at least 75 percent of its assets invested in health care service facilities pursuant to ORS 733.700.

(3) Subsections (1) and (2) of this section do not apply to a health care service contractor furnishing only complementary health services, dental service or optometrical service operated on a for-profit or not-for-profit basis if:

(a) The services referred to in this subsection maintain capital or surplus, or any combination thereof, of not less than $1 million.

(b) The services referred to in this subsection file a surety bond or other such bond or securities in the sum of $50,000 as are authorized by the Insurance Code as a guarantee of the due execution

of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095.

(4) A health care service contractor that is a for-profit or not-for-profit corporation applying for its original certificate of authority in this state shall possess, when first so authorized, additional capital or surplus, or any combination thereof, of not less than $500,000.

(5) For the protection of the public, the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may require a health care service contractor to possess and maintain capital or surplus, or any combination thereof, in excess of the amount otherwise required under this section owing to the type, volume and nature of insurance business transacted by the health care service contractor, if the [*director*] **authority** determines that the greater amount is necessary for maintaining the health care service contractor's solvency according to standards established by rule. In developing such standards, the [*director*] **authority** shall consider model standards adopted by the National Association of Insurance Commissioners or its successor organization. For the purpose of determining the reasonableness and adequacy of a health care service contractor's capital and surplus, the [*director*] **authority** must consider at least the following factors, as applicable:

(a) The size of the health care service contractor, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria.

(b) The number of lives insured.

(c) The extent of the geographical dispersion of the lives insured by the health care service contractor.

(d) The nature and extent of the reinsurance program of the health care service contractor.

(e) The quality, diversification and liquidity of the investment portfolio of the health care service contractor.

(f) The recent past and projected future trend in the size of the investment portfolio of the health care service contractor.

(g) The combined capital and surplus maintained by comparable health care service contractors.

(h) The adequacy of the reserves of the health care service contractor.

(i) The quality and liquidity of investments in affiliates. The director may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of the director the investment so warrants.

(j) The quality of the earnings of the health care service contractor and the extent to which the reported earnings include extraordinary items.

SECTION 453. ORS 750.055, as amended by section 5, chapter 22, Oregon Laws 2008, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992 and section 2, chapter 22, Oregon Laws 2008.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

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

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.664, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.913, 743A.010, 743A.012, 743A.036, 743A.048, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.110, 743A.140, 743A.148, 743A.160, 743A.164, 743A.168, 743A.184, 743A.188 and 743A.190.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

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

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

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

(4) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 454. ORS 750.055, as amended by section 7, chapter 137, Oregon Laws 2003, section 3, chapter 263, Oregon Laws 2003, sections 501 and 502, chapter 22, Oregon Laws 2005, sections 5 and 6, chapter 255, Oregon Laws 2005, section 5, chapter 418, Oregon Laws 2005, section 3, chapter 128, Oregon Laws 2007, section 9, chapter 182, Oregon Laws 2007, section 6, chapter 313, Oregon Laws 2007, section 4, chapter 504, Oregon Laws 2007, section 4, chapter 566, Oregon Laws 2007, section 4, chapter 872, Oregon Laws 2007, and section 6, chapter 22, Oregon Laws 2008, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992 and section 2, chapter 22, Oregon Laws 2008.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695

to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.913, 743A.010, 743A.012, 743A.036, 743A.048, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.110, 743A.140, 743A.148, 743A.160, 743A.164, 743A.168, 743A.184 and 743A.190.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

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

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

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

(4) The [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 455. ORS 750.085 is amended to read:

750.085. (1) When a final order of liquidation with a finding of insolvency has been entered with respect to a health care service contractor by a court of competent jurisdiction in the domicile of the health care service contractor, subscribers of the health care service contractor shall be offered replacement coverage as provided in this section.

(2) All insurers and health care service contractors that participated with the insolvent health care service contractor in the open enrollment process at the last regular open enrollment period for a group shall offer members of the group that are subscribers of the insolvent health care service contractor an open enrollment period of 30 days, commencing on the date on which the final order of liquidation with a finding of insolvency was entered. Each of the insurers and health care service contractors shall offer the subscribers of the insolvent health care service contractor the same coverages and rates that the insurer or health care service contractor had offered to members of the group at its last regular open enrollment period.

(3) If no other insurer or health care service contractor offered health insurance coverage to a

group or groups whose members are enrolled with the insolvent health care service contractor, or if the other insurers and health care service contractors lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group subscribers of the insolvent health care service contractor, the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** shall equitably allocate the contract or contracts for the group or groups among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The [*director*] **authority** shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which a group or groups are so allocated shall offer to each such group the existing coverage of the health care service contractor, at rates determined by the health care service contractor in accordance with its existing rating methodology. Each health care service contractor to whom a group or groups are allocated may reevaluate the group or groups at the end of the contractual period or at the end of six months after the allocation, whichever occurs first, in order to determine the appropriate premium for each such group.

(4) The [*director*] **authority** shall equitably allocate the nongroup subscribers of the insolvent health care service contractor that are unable to obtain other coverage among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The [*director*] **authority** shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which nongroup subscribers are allocated shall offer its existing individual or conversion coverage to nongroup subscribers, at rates determined in accordance with its existing rating methodology. A health care service contractor that does not offer direct nongroup enrollment may aggregate all of the allocated nongroup subscribers into one group for rating and coverage purposes.

SECTION 456. ORS 750.303 is amended to read:

750.303. (1) An association or group of employers shall not provide health benefits to employees of the association or employees of any of the employers through a multiple employer welfare arrangement in this state except as authorized by a subsisting certificate of multiple employer welfare arrangement issued by the [*Director of the Department of Consumer and Business Services*] **regulator**.

(2) Only health benefits may be transacted through a multiple employer welfare arrangement. Health benefits may include benefits for disablement only if the benefits for disablement do not exceed $2,000 each year for each person covered by the disablement benefit.

(3) Life insurance or insurance for disablement other than benefits described in subsection (2) of this section, or both, may be provided through a multiple employer welfare arrangement only if the insurance benefits meet the following conditions:

(a) The insurance benefits must be fully insured through an authorized insurer.

(b) The insurance benefits must be ancillary to the health benefits being provided under subsection (2) of this section.

(4) ORS 750.301 to 750.341 do not apply to a multiple employer welfare arrangement that is fully insured within the meaning of section 514(b)(6) of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1144(b)(6).

SECTION 457. ORS 750.309 is amended to read:

750.309. The following requirements apply to the trust carrying out a multiple employer welfare arrangement:

(1) The trust must hold and maintain adequate facilities for purposes of the multiple employer

welfare arrangement and either must have sufficient personnel to service the employee benefit plan or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services. For purposes of satisfying the requirements of this subsection, the trust may use the premises, facilities and personnel of the association or group of employers and pay reasonable compensation to the association or group for such use.

(2) The trust must hold and maintain an excess loss insurance policy issued to the board of trustees in the name of the multiple employer welfare arrangement by an insurer authorized to transact casualty or health insurance in Oregon. Except as provided in this subsection, the policy must insure the multiple employer welfare arrangement against its liabilities for health benefits with regard to any one participant in excess of 10 percent of the capital and surplus of the trust. A trust may demonstrate to the [*Director of the Department of Consumer and Business Services*] **regulator** that the trust is capable of supporting an exposure exceeding 10 percent of the capital and surplus of the trust. The trust may make such a demonstration only by means of a certification by a qualified actuary that the capital and surplus of the trust is sufficient to support the increased exposure. In any event, such a trust shall not have any exposure exceeding 15 percent of the capital and surplus of the trust. For purposes of this subsection, "participant" refers individually to each person benefited as a separate subject under the plan operated by the multiple employer welfare arrangement. The following also apply to a policy required under this subsection:

(a) The coverage must be evidenced by a binder or policy.

(b) The excess loss insurance policy must contain a provision that it may not be terminated for any reason by any person unless the [*Director of the Department of Consumer and Business Services*] **regulator** receives a written notice of termination from the insurer at least 30 days before the effective date of the termination.

(c) If more than one policy is purchased, the expiration dates of all such policies must be the same.

(3) The trust must possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $250,000 or an amount equal to 35 percent of incurred claims for the preceding 12-month period by the trust, whichever is greater. However, the required amount under this subsection may not be more than $500,000.

(4) As a guarantee of the due execution of the trust obligation under the benefit plan or plans to be entered into by the trust in accordance with ORS 750.301 to 750.341, the trust must make and maintain a deposit with the [*Department of Consumer and Business Services*] **regulator** as provided in this subsection. The deposit required under this subsection is in addition to the capital and surplus or other amount required to be possessed and maintained by the trust under subsection (3) of this section and may not be included in or counted toward the required capital and surplus or other amount. The following provisions apply to the deposit:

(a) As a condition of obtaining a certificate of multiple employer welfare arrangement, a trust shall make an initial deposit in an amount that is the greater of $50,000 or the amount of the deposit required under paragraph (b) of this subsection.

(b) The amount of the deposit to be maintained under this subsection shall be the lesser of $250,000 or a current required amount calculated by determining the average monthly amount of claims paid by the trust during the preceding 12-month period and multiplying the average monthly amount by three. The current required amount of the deposit shall be calculated as of March 31, June 30, September 30 and December 31 of each calendar year.

(5) In lieu of the deposit required by subsection (4) of this section, a trust may file and maintain

a surety bond or such other bond or cash or securities in the sum of $250,000 as are authorized by the Insurance Code.

(6) A trust carrying out a multiple employer welfare arrangement that is established after January 1, 1993, shall maintain the deposit required under subsection (4) of this section during the first four calendar quarters described in subsection (4)(b) of this section following the issuance of its certificate of multiple employer welfare arrangement as provided in this subsection. At the beginning of the second, third and fourth calendar quarters after such a trust receives its certificate of multiple employer welfare arrangement, the current required amount of the deposit to be maintained by the trust shall be calculated by determining the average monthly amount of claims paid during the preceding quarter. Beginning with the fifth calendar quarter following the issuance of its certificate of multiple employer welfare arrangement, the trust shall maintain the deposit as provided in subsection (4) of this section.

SECTION 458. ORS 750.323 is amended to read:

750.323. (1) A trust shall provide notice of the following in writing to each individual applying to be covered by a multiple employer welfare arrangement:

(a) The fact that the multiple employer welfare arrangement is subject to less stringent solvency protection and regulation than are insurers holding certificates of authority.

(b) The fact that in the event the trust does not pay medical expenses that are eligible for payment under the multiple employer welfare arrangement, the individuals covered through the multiple employer welfare arrangement may be liable for those expenses.

(2) Each evidence of health benefits provided through a multiple employer welfare arrangement must state that the coverage is obtained through a multiple employer welfare arrangement and that the coverage is not subject to the provisions of ORS 734.750 to 734.890 relating to the Oregon Life and Health Insurance Guaranty Association, and that if the multiple employer welfare arrangement or the trust issuing the coverage becomes insolvent, the Oregon Life and Health Insurance Guaranty Association has no obligation to pay claims under the coverage.

(3) The notice required under subsection (1) of this section and the statement required under subsection (2) of this section are subject to prior review and approval by the [*Director of the Department of Consumer and Business Services*] **regulator**.

SECTION 459. ORS 107.092 is amended to read:

107.092. (1) The clerk of the court shall furnish to both parties in a suit for legal separation or for dissolution, at the time the suit is filed, a notice of ORS 743.600, 743.601, 743.602 and 743.610 entitling a spouse to continue health insurance coverage.

(2) The notice shall be prepared by the [*Director of the Department of Consumer and Business Services*] **Oregon Health Authority** and also shall include a summary of the provisions of ORS 743.600.

(3) A clerk of the court is not liable for damages arising from information contained in or omitted from a notice furnished under this section.

SECTION 460. ORS 25.323 is amended to read:

25.323. (1) Except as provided in this section, whenever a child support order is entered or modified under this chapter, ORS chapter 107, 108, 109, 110 or ORS 416.400 to 416.465, 419B.400 or 419C.590, the court or the enforcing agency shall order one or both parties to provide satisfactory health care coverage that is reasonable in cost and accessible to the child. An order for health care coverage under this subsection may include health care coverage provided by a public entity.

(2) In addition to ordering health care coverage under subsection (1) of this section, the court

or enforcing agency may order one or both parties to pay medical support for the child. Medical support ordered under this subsection must be reasonable in cost.

(3) If the court or the enforcing agency finds that the parties cannot provide satisfactory health care coverage because satisfactory health care coverage that is reasonable in cost and accessible to the child is not available at the time the child support order is entered, the court or the enforcing agency:

(a) Shall order one or both parties to provide satisfactory health care coverage that is reasonable in cost and accessible to the child when the coverage becomes available; and

(b) May order that, until the court or enforcing agency determines that satisfactory health care coverage that is reasonable in cost and accessible to the child is available and modifies the order, one or both parties pay medical support that is reasonable in cost. The court or enforcing agency shall make written findings on whether to order the payment of medical support under this paragraph.

(4) The cost of any amount ordered to provide satisfactory health care coverage and medical support under this section must be included in the child support calculation made under ORS 25.275.

[*(5) The court or enforcing agency may not order a party to pay medical support under this section if the party is eligible to receive medical assistance under ORS 414.032, or has a dependent child in the household who is eligible to receive medical assistance under ORS 414.032.*]

[*(6)*] **(5)** The Department of Justice shall adopt rules for determining the reasonableness of the cost of satisfactory health care coverage and of medical support for the purposes of this section, and for determining how the costs of providing health care coverage and medical support affect the total support obligation for a child under ORS 25.275.

SECTION 461. ORS 65.800 is amended to read:

65.800. For purposes of ORS 65.803 to 65.815:

(1) "Hospital" means a hospital as defined in ORS 442.015 [*(19)*].

(2) "Noncharitable entity" means any person or entity that is not a public benefit or religious corporation and is not wholly owned or controlled by one or more public benefit or religious corporations.

SECTION 462. ORS 127.646 is amended to read:

127.646. As used in ORS 127.646 to 127.654:

(1) "Health care organization" means a home health agency, hospice program, hospital, long term care facility or health maintenance organization.

(2) "Health maintenance organization" has the meaning given that term in ORS 750.005, except that "health maintenance organization" includes only those organizations that participate in the federal Medicare or Medicaid programs.

(3) "Home health agency" has the meaning given that term in ORS 443.005.

(4) "Hospice program" has the meaning given that term in ORS 443.850.

(5) "Hospital" has the meaning given that term in ORS 442.015 [*(19)*], except that "hospital" does not include a special inpatient care facility.

(6) "Long term care facility" has the meaning given that term in ORS 442.015, except that "long term care facility" does not include an intermediate care facility for individuals with mental retardation.

SECTION 463. ORS 409.720 is amended to read:

409.720. (1) As used in this section:

(a) "Adult foster home" has the meaning given that term in ORS 443.705 (1).

(b) "Health care facility" has the meaning given that term in ORS 442.015 [*(16)*].

(c) "Residential facility" has the meaning given that term in ORS 443.400 (6).

(2) Every adult foster home, health care facility and residential facility licensed or registered by the Department of Human Services shall:

(a) Adopt a plan to provide for the safety of persons who are receiving care at or are residents of the home or facility in the event of an emergency that requires immediate action by the staff of the home or facility due to conditions of imminent danger that pose a threat to the life, health or safety of persons who are receiving care at or are residents of the home or facility; and

(b) Provide training to all employees of the home or facility about the responsibilities of the employees to implement the plan required by this section.

(3) The department shall adopt by rule the requirements for the plan and training required by this section. The rules adopted shall include, but are not limited to, procedures for the evacuation of the persons who are receiving care at or are residents of the adult foster home, health care facility or residential facility to a place of safety when the conditions of imminent danger require relocation of those persons.

SECTION 464. ORS 414.720 is amended to read:

414.720. (1) The Health Services Commission shall conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates representing seniors, persons with disabilities, mental health services consumers and low-income Oregonians, representatives of commercial carriers, representatives of small and large Oregon employers and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) The commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The list submitted by the commission pursuant to this subsection is not subject to alteration by any other state agency. The recommendation may include practice guidelines reviewed and adopted by the commission pursuant to subsection (4) of this section.

(4) In order to encourage effective and efficient medical evaluation and treatment, the commission:

(a) May include clinical practice guidelines in its prioritized list of services. The commission shall actively solicit testimony and information from the medical community and the public to build a consensus on clinical practice guidelines developed by the commission.

(b) Shall consider both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance using peer-reviewed medical literature as defined in ORS 743A.060.

(5) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Governor, the Speaker of the House of Representatives and the President of the Senate.

(6) The commission may alter the list during interim only under the following conditions:

(a) Technical changes due to errors and omissions; and

(b) Changes due to advancements in medical technology or new data regarding health outcomes.

(7) If a service is deleted or added and no new funding is required, the commission shall report to the Speaker of the House of Representatives and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the commission must report to the Emergency Board to request the funding.

(8) The report listing services to be provided pursuant to ORS [*414.036,*] 414.042, 414.065, [*414.107,*] 414.705 to 414.725 and 414.735 to 414.750 shall remain in effect from October 1 of the odd-numbered year through September 30 of the next odd-numbered year.

SECTION 465. ORS 432.500 is amended to read:

432.500. As used in ORS 432.510 to 432.550 and 432.900:

(1) "Clinical laboratory" means a facility where microbiological, serological, chemical, hematological, immunohematological, immunological, toxicological, cytogenetical, exfoliative cytological, histological, pathological or other examinations are performed on material derived from the human body, for the purpose of diagnosis, prevention of disease or treatment of patients by physicians, dentists and other persons who are authorized by license to diagnose or treat humans.

(2) "Department" means the Department of Human Services or its authorized representative.

(3) "Health care facility" means a hospital, as defined in ORS 442.015 [*(19)*], or an ambulatory surgical center, as defined in ORS 442.015.

(4) "Practitioner" means any person whose professional license allows the person to diagnose or treat cancer in patients.

SECTION 466. ORS 442.700 is amended to read:

442.700. As used in ORS 442.700 to 442.760:

(1) "Board of governors" means the governors of a cooperative program as described in ORS 442.720.

(2) "Cooperative program" means a program among two or more health care providers for the purpose of providing heart and kidney transplant services including, but not limited to, the sharing, allocation and referral of physicians, patients, personnel, instructional programs, support services, facilities, medical, diagnostic, laboratory or therapeutic services, equipment, devices or supplies, and other services traditionally offered by health care providers.

(3) "Director" means the Director of Human Services.

(4) "Health care provider" means a hospital, physician or entity, a significant part of whose activities consist of providing hospital or physician services in this state. For purposes of the immunities provided by ORS 442.700 to 442.760 and 646.740, "health care provider" includes any officer, director, trustee, employee, or agent of, or any entity under common ownership and control with, a health care provider.

(5) "Hospital" means a hospital, as defined in ORS 442.015 [*(19)*], or a long term care facility or an ambulatory surgical center, as those terms are defined in ORS 442.015, that is licensed under ORS 441.015 to 441.089. "Hospital" includes community health programs established under ORS 430.610 to 430.695.

(6) "Order" means a decision issued by the director under ORS 442.710 either approving or denying an application for a cooperative program and includes modifications of an original order under ORS 442.730 (3)(b) and ORS 442.740 (1) and (4).

(7) "Party to a cooperative program agreement" or "party" means an entity that enters into the principal agreement to establish a cooperative program and applies for approval under ORS 442.700 to 442.760 and 646.740 and any other entity that, with the approval of the director, becomes a member of a cooperative program.

(8) "Physician" means a physician defined in ORS 677.010 (13) and licensed under ORS chapter 677.

SECTION 467. ORS 678.730 is amended to read:

678.730. (1) Any individual is qualified for licensure as a nursing home administrator who:

(a) Meets the training or experience and other standards established by rules of the Board of Examiners of Nursing Home Administrators. The board shall accept one year of experience as an administrator serving a dual facility in lieu of any residency or intern requirement established pursuant to this paragraph; and

(b) Has passed an examination as provided in ORS 678.740.

(2) Each license as a nursing home administrator may be renewed by the board upon compliance by the licensee with the requirements of ORS 678.760 and by presenting evidence of the completion of the continuing education work required by the board. The board may require up to 50 hours of continuing education in any one-year period.

(3) In establishing educational standards pursuant to subsection (1)(a) of this section, the board shall require a baccalaureate degree from an accredited school of higher education. However, the educational requirement does not apply to any person who:

(a) Was a licensed administrator in any jurisdiction of the United States prior to January 1, 1983; or

(b) Was an administrator of a dual facility meeting the experience requirements pursuant to subsection (1)(a) of this section.

(4) Notwithstanding the requirements established under subsection (1) of this section, upon the request of the governing body of a hospital, as defined in ORS 442.015 [*(19)*], the board shall deem a health care administrator to have met the requirements for licensure as a nursing home administrator if the health care administrator possesses an advanced degree in management and has at least 10 years of experience in health care management.

OPERATIVE DATE

SECTION 468. Except as otherwise specifically provided in section _____ of this 2009 Act, sections _____ to _____ of this 2009 Act become operative on January 1, 2010.

UNIT CAPTIONS

SECTION 469. The unit captions used in this 2009 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2009 Act.

EFFECTIVE DATE

SECTION 470. This 2009 Act takes effect on the 91st day after the date on which the regular session of the Seventy-fifth Legislative Assembly adjourns sine die.