A-Engrossed
Senate Bill 508

Ordered by the Senate May 29
Including Senate Amendments dated May 29

Sponsored by Senators MONNES ANDERSON, KRUSE, Representatives SCHAUFLER, THOMPSON (at the request of Oregon Medical Association)

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.

Requires health insurers to request refunds from providers within [*12*] **24** months of date of payment and to allow six months for payment of refund. **Creates exceptions. Specifies procedures for providers to contest refund requests.**

Requires providers to request additional payment from health insurer within 24 months after date claim was denied and to allow six months for payment of additional amount. Creates exceptions.

[*Declares emergency, effective on passage.*]

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; and amending ORS 743.801, 750.055 and 750.333.

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

SECTION 1. Sections 2 and 3 of this 2009 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(2) Except in the case of fraud or abuse of billing, and except as provided in subsections (3) and (5) of this section, a health insurer may not:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 24 months after the date the payment was made; and

(B) Specifies in the written request why the health insurer believes the provider owes the refund.

(b) Request that a contested refund be paid earlier than six months after the health care provider receives the request.

(3) A health insurer may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 30 months after the date the payment was made;

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.

(B) Specifies in the written request why the health insurer believes the provider owes the refund; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has primary responsibility for payment of the claim.

(b) Request that a contested refund be paid earlier than six months after the provider receives the request.

(4) If a health care provider fails to contest a refund request in writing to the health insurer within 30 days after receiving the request, the request is deemed accepted and the provider must pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the refund within 30 days after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.

(5) A health insurer may at any time request from a health care provider a refund of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and

(b) The health insurer is unable to recover directly from the third party because the third party has already paid or will pay the provider for the health care services covered by the claim.

(6) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a health insurer any payment previously made to satisfy a claim.

(7) This section neither permits nor precludes a health insurer from recovering from a subscriber, enrollee or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy or other benefit agreement.

(8) This section does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans.

SECTION 3. (1) Except in the case of fraud and except as provided in subsection (2) of this section, a health care provider may not:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 24 months after the date the claim was denied or payment intended to satisfy the claim was made; and

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment.

(b) Request that an additional payment be paid earlier than six months after the health insurer receives the request.

(2) A health care provider may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 30 months after the date the claim was denied or payment intended to satisfy the claim was made;

(B) Specifies in the written request why the provider believes the health insurer owes the

additional payment; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has disclaimed responsibility for payment of the claim.

(b) Request that the additional payment be paid earlier than six months after the health insurer receives the request.

(3) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health insurer from choosing at any time to make additional payments to a health care provider to satisfy a claim.

(4) This section does not apply to claims for health care services provided through dental-only health insurers, through Medicare or through Medicare supplemental plans.

SECTION 4. ORS 743.801 is amended to read:

743.801. As used in 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, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.913 and 743A.012 **and sections 2 and 3 of this 2009 Act**:

(1) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) "Emergency services" means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) "Enrollee" has the meaning given that term in ORS 743.730.

(5) "Grievance" means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

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

(6) "Health benefit plan" has the meaning provided for that term in ORS 743.730.

(7) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 743.522, to provide health care services to group members.

(8) "Insurer" has the meaning provided for that term in ORS 731.106. For purposes 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, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.913, 743A.012, 750.055 and 750.333 **and sections 2 and 3 of this 2009 Act**, "insurer" also includes a health care service contractor as defined in ORS 750.005.

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

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

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(10) "Medical services contract" means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. "Medical services contract" does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(11)(a) "Preferred provider organization insurance" means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

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

(12) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

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

(14) "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(15) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

SECTION 5. 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 **and sections 2 and 3 of this 2009 Act**.

(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 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 6. 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 **and sections 2 and 3 of this 2009 Act**.

(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 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 7. ORS 750.333, as amended by section 7, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

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

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

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 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, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184 **and sections 2 and 3 of this 2009 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.044, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

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

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 8. ORS 750.333, as amended by section 4, chapter 263, Oregon Laws 2003, section 11, chapter 182, Oregon Laws 2007, section 8, chapter 313, Oregon Laws 2007, section 6, chapter 504, Oregon Laws 2007, section 6, chapter 566, Oregon Laws 2007, section 6, chapter 872, Oregon Laws 2007, and section 8, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

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

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

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 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, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184 **and sections 2 and 3 of this 2009 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.044, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

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

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 9. ORS 750.333, as amended by section 8, chapter 137, Oregon Laws 2003, section 4, chapter 263, Oregon Laws 2003, section 3, chapter 446, Oregon Laws 2003, section 6, chapter 418, Oregon Laws 2005, section 12, chapter 182, Oregon Laws 2007, section 9, chapter 313, Oregon Laws 2007, section 7, chapter 504, Oregon Laws 2007, section 7, chapter 566, Oregon Laws 2007, section 7, chapter 872, Oregon Laws 2007, and section 9, chapter 22, Oregon Laws 2008, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

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

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

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 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, 743A.012, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110 and 743A.184 **and sections 2 and 3 of this 2009 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.066, 743A.068, 743A.084, 743A.088, 743A.090, 743A.140, 743A.148, 743A.168, 743A.180 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

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

(i) ORS 731.592 and 731.594.

(j) Section 2, chapter 22, Oregon Laws 2008.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 10. Sections 2 and 3 of this 2009 Act apply to contracts entered into or renewed on or after the effective date of this 2009 Act.
