House Bill 3441

Sponsored by Representative SHEEHAN

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.**

Prohibits health insurers from denying coverage on basis that individual is taken into custody of law enforcement or is incarcerated. Authorizes law enforcement authority to pay health insurance premiums on behalf of inmates. Extends period for requesting individual health insurance coverage if group coverage terminates due to loss of employment or membership in group, if insured is in custody of law enforcement or is incarcerated.

A BILL FOR AN ACT

Relating to health insurance coverage of inmates; creating new provisions; and amending ORS 743.610 and 743.760.

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

SECTION 1. Section 2 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 2. A policy of health insurance may not exclude coverage of health services or supplies or deny or terminate coverage of an individual residing in this state on the basis that the individual is in the custody of a state or local law enforcement authority, is incarcerated in jail or prison or is entitled to publicly funded medical care.

SECTION 3. The Department of Corrections or a state or local law enforcement authority may elect to continue health insurance coverage and to pay the health insurance premiums on behalf of any person:

(1) Who is in the custody of the department or a law enforcement authority or is incarcerated in jail or prison;

(2) For whom the department or a law enforcement authority must provide medical care; and

(3) Who is eligible to apply for coverage under ORS 743.610 or 743.760, 42 U.S.C. 300gg-41 or section 4980B(f) of the Internal Revenue Code or was enrolled in a health benefit plan paid for in whole or in part by the state.

SECTION 4. ORS 743.610 is amended to read:

743.610. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that certificate holders whose coverage under the policy otherwise would terminate because of termination of employment or membership may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(2) Continuation of coverage is available only to a certificate holder who has been insured continuously under the policy or similar predecessor policy during the three-month period ending on the date of the termination of employment or membership.

(3) Continuation of coverage is not available to a certificate holder who is eligible for:

(a) Federal Medicare coverage; or

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) Coverage for hospital or medical expenses under any other program which was not covering the certificate holder immediately before the certificate holder's termination of employment or membership.

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy additional to hospital and medical expense benefits.

(5) Except as provided by **subsection (8) of this section or by** rule by the Director of the Department of Consumer and Business Services under section 2, chapter 73, Oregon Laws 2009, a certificate holder who has terminated employment or membership and who wishes to continue coverage must request continuation in writing:

(a) Not later than 10 days after the later of the date on which employment or membership terminated and the date on which the employer or group policyholder gave the certificate holder notice of the right to continue coverage; and

(b) Not more than 31 days after the date of termination of employment or membership.

(6) A certificate holder who requests continuation of coverage shall pay the premium on a monthly basis and in advance, as provided in this subsection. The certificate holder shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate for the insurance being continued under the group policy as of the date the premium payment is due. Except as otherwise provided by **subsection (8) of this section or by** rule by the director under section 2, chapter 73, Oregon Laws 2009, the certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end.

(7) Except as otherwise provided by rule by the director under section 2, chapter 73, Oregon Laws 2009, continuation of coverage as provided under this section ends on the earliest of the following dates:

(a) Nine months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership **or, for a certificate holder described in subsection (8) of this section, when the certificate holder is no longer in custody or incarcerated**.

(b) The end of the period for which the certificate holder **or a person acting on behalf of the certificate holder** last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.

(c) The premium payment due date coinciding with or next following the date the certificate holder becomes eligible for federal Medicare coverage.

(d) The date on which the policy is terminated or the certificate holder's employer terminates participation under the policy. However, if the employer replaces the coverage which is terminating for the certificate holder with similar coverage under another group policy:

(A) The certificate holder may obtain coverage under the replacement group policy for the balance of the period that the certificate holder would have remained covered under the replaced group policy under this section;

(B) The replacement group policy must provide, at a minimum, the applicable level of benefits of the replaced policy reduced by any benefits still payable under that policy; and

(C) The replaced policy must continue to provide benefits to the certificate holder to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) A certificate holder who is in the custody of a state or local law enforcement authority or who is incarcerated in jail or prison may continue coverage under this section if

the certificate holder or a person acting on behalf of the certificate holder:

(a) Requests continuation of coverage not later than 63 days after the later of the date the individual was taken into custody or the date the individual was incarcerated; and

(b) Pays the first premium not later than 31 days after the date of the request for continuation of coverage and pays subsequent premiums.

[*(8)*] **(9)** The group health insurance policy must contain a provision that:

(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section.

(b) The spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, upon dissolution of marriage with the certificate holder, with respect to the spouse and any children whose coverage under the policy otherwise would terminate because of the dissolution of marriage, in the same manner that a certificate holder may exercise the right under this section.

(c) A spouse who requests continuation of coverage under this subsection must pay the premium for the spouse and any dependent children, on a monthly basis and in advance, as provided in this paragraph. The spouse shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment under this subsection may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due.

[*(9)*] **(10)** A certificate holder who has terminated employment by reason of layoff may not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to coverage under the employer's group health insurance policy if the certificate holder was eligible for coverage at the time of the termination and regardless of whether the certificate holder continued coverage during the layoff.

[*(10)*] **(11)** This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986.

SECTION 5. ORS 743.610, as amended by section 4, chapter 73, Oregon Laws 2009, is amended to read:

743.610. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that certificate holders whose coverage under the policy otherwise would terminate because of termination of employment or membership may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(2) Continuation of coverage is available only to a certificate holder who has been insured continuously under the policy or similar predecessor policy during the three-month period ending on the date of the termination of employment or membership.

(3) Continuation of coverage is not available to a certificate holder who is eligible for:

(a) Federal Medicare coverage; or

(b) Coverage for hospital or medical expenses under any other program which was not covering the certificate holder immediately before the certificate holder's termination of employment or membership.

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy additional to hospital and medical expense benefits.

(5) **Except as provided by subsection (8) of this section,** a certificate holder who has terminated employment or membership and who wishes to continue coverage must request continuation in writing:

(a) Not later than 10 days after the later of the date on which employment or membership terminated and the date on which the employer or group policyholder gave the certificate holder notice of the right to continue coverage; and

(b) Not more than 31 days after the date of termination of employment or membership.

(6) A certificate holder who requests continuation of coverage shall pay the premium on a monthly basis and in advance, as provided in this subsection. The certificate holder shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate for the insurance being continued under the group policy as of the date the premium payment is due. **Except as provided by subsection (8) of this section,** the certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end.

(7) Continuation of coverage as provided under this section ends on the earliest of the following dates:

(a) Nine months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership **or, for a certificate holder described in subsection (8) of this section, when the certificate holder is no longer in custody or incarcerated**.

(b) The end of the period for which the certificate holder **or a person acting on behalf of the certificate holder** last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.

(c) The premium payment due date coinciding with or next following the date the certificate holder becomes eligible for federal Medicare coverage.

(d) The date on which the policy is terminated or the certificate holder's employer terminates participation under the policy. However, if the employer replaces the coverage which is terminating for the certificate holder with similar coverage under another group policy:

(A) The certificate holder may obtain coverage under the replacement group policy for the balance of the period that the certificate holder would have remained covered under the replaced group policy under this section;

(B) The replacement group policy must provide, at a minimum, the applicable level of benefits of the replaced policy reduced by any benefits still payable under that policy; and

(C) The replaced policy must continue to provide benefits to the certificate holder to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) A certificate holder who is in the custody of a state or local law enforcement authority or who is incarcerated in jail or prison may continue coverage under this section if the certificate holder or a person acting on behalf of the certificate holder:

(a) Requests continuation of coverage not later than 63 days after the later of the date the individual was taken into custody or the date the individual was incarcerated; and

(b) Pays the first premium not later than 31 days after the date of the request for continuation of coverage and pays subsequent premiums.

[*(8)*] **(9)** The group health insurance policy must contain a provision that:

(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section.

(b) The spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, upon dissolution of marriage with the certificate holder, with respect to the spouse and any children whose coverage under the policy otherwise would terminate because of the dissolution of marriage, in the same manner that a certificate holder may exercise the right under this section.

(c) A spouse who requests continuation of coverage under this subsection must pay the premium for the spouse and any dependent children, on a monthly basis and in advance, as provided in this paragraph. The spouse shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment under this subsection may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due.

[*(9)*] **(10)** A certificate holder who has terminated employment by reason of layoff may not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to coverage under the employer's group health insurance policy if the certificate holder was eligible for coverage at the time of the termination and regardless of whether the certificate holder continued coverage during the layoff.

[*(10)*] **(11)** This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986.

SECTION 6. 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**; or**

(iii) Is not described in sub-subparagraph (i) or (ii) of this subparagraph but:

(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 or meets the eligibility requirements of 42 U.S.C. 300gg-41;

(II) Is taken into the custody of a state or local law enforcement authority or is incarcerated in jail or prison in this state not later than 63 days after leaving coverage as described in this sub-subparagraph; and

(III) Applies for portability coverage not later than 63 days after the later of the date the

individual is taken into custody or the date the individual is incarcerated.

(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 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 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:

(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 shall approve the portability health benefit plans if the director 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 approval of the portability plans submitted by the committee under this section, each carrier offering group health benefit plans shall submit to the director 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 and is subject to review and approval pursuant to ORS 742.003.

(5) Within 180 days after approval by the director 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 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 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.

(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 orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the 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 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. 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 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 to persons outside the Department of Consumer and Business Services 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 7. Section 2 of this 2011 Act applies to health insurance policies issued or renewed on or after the effective date of this 2011 Act.
