Senate Bill 100

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Governor John A. Kitzhaber for Oregon Health Authority)

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.**

Requires health insurance carriers to offer health benefit plan that provides bronze plan coverage. Specifies requirements for catastrophic plan. Transfers responsibility for prescribing basic health plan coverage and terms from Health Insurance Reform Advisory Committee to Department of Consumer and Business Services and eliminates committee. Specifies operative date of January 2, 2014.

A BILL FOR AN ACT

Relating to health benefit plans; creating new provisions; and amending ORS 413.032, 735.616, 742.005, 743.730, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.760, 743.766 and 743.878 and sections 3 and 4, chapter 75, Oregon Laws 2010.

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

SECTION 1. Sections 2, 3 and 4 of this 2011 Act are added to and made a part of ORS 743.730 to 743.773.

SECTION 2. In consultation with the Department of Consumer and Business Services, the Oregon Health Authority shall prescribe by rule the:

(1) Requirements for a bronze plan so that it is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(2) Form, level of coverage and benefit design for the bronze plan to be used by carriers in the health benefit plan market in this state.

SECTION 3. As a condition of transacting business in the health benefit plan market in this state, a carrier shall offer to residents of this state a bronze plan approved by the Department of Consumer and Business Services as meeting the requirements of section 2 of this 2011 Act. A carrier must offer the bronze plan:

(1) Through the Oregon Health Insurance Exchange if the carrier offers a health benefit plan through the exchange.

(2) In the health benefit plan market outside the exchange if the carrier offers a health benefit plan outside the exchange.

SECTION 4. A carrier may offer a catastrophic plan only through the Oregon Health Insurance Exchange and only to an individual who:

(1) Is under 30 years of age at the beginning of the plan year; or

(2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.

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.

SECTION 5. ORS 742.005 is amended to read:

742.005. The Director of the Department of Consumer and Business Services shall disapprove any form requiring the director's approval:

(1) If the director finds it does not comply with the law;

(2) If the director 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 judgment, its use would be prejudicial to the interests of the insurer's policyholders;

(4) If the director finds it contains provisions which are unjust, unfair or inequitable;

(5) If the director finds sales presentation material disapproved by the director 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 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 **for small employers** issued by health care service contractors; or

(c) Credit life and credit health insurance forms subject to ORS 743.371 to 743.380.

SECTION 6. 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 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 **and health benefit plans for small employers**.

(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 provides**

bronze plan coverage and that is required to be offered by all [*small employer*] carriers and approved by the [*director of the*] Department of Consumer and Business Services in accordance with [*ORS 743.736*] **section 3 of this 2011 Act**.

(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) "Bronze plan" means a health benefit plan that meets the criteria prescribed by rule by the Oregon Health Authority pursuant to section 2 of this 2011 Act.

[*(6)*] **(7)** "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.

(8) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange pursuant to section 4 of this 2011 Act.

[*(7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS 743.745.*]

[*(8)*] **(9)** "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) "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)*] **(11)** "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)*] **(12)** "Employee" means any individual employed by an employer.

[*(14)*] **(13)** "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.

(14) "Exchange" means the Oregon Health Insurance Exchange established pursuant to section 17, chapter 595, Oregon Laws 2009.

(15) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(16) [*"Financially impaired" means a member that*] **"Financial impairment" means that a carrier** is not insolvent and is:

(a) Considered by the director [*of the Department of Consumer and Business Services*] 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) "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 for the carrier's:

(A) [*Small employer*] Group health benefit plans **offered to small employers**;

(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) "Grandfathered plan" means a health benefit plan that meets criteria prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18011(e).

[*(18)*] **(19)** "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)*] **(20)(a)** "Health benefit plan" means**:**

(A) Any hospital expense, medical expense or hospital or medical expense policy or certificate[,]**;**

(B) Any health care service contractor or health maintenance organization subscriber contract[,]**; or**

(C) 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*]**:**

(A) Accident only **insurance**[,]**.**

(B) Specific disease or condition only **insurance**[,]**.**

(C) Credit **health insurance**[,]**.**

(D) Disability income **insurance**[,]**.**

(E) Coverage of Medicare services pursuant to contracts with the federal government[,]**.**

(F) Medicare supplement insurance policies[,]**.**

(G) Coverage of CHAMPUS services pursuant to contracts with the federal government[,]**.**

(H) 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[,]**.**

(I) Separately offered long term care [*insurance*], **nursing home care, home health care or community based care insurance, or a combination of such types of insurance.**

(J) Hospital indemnity only **or fixed indemnity insurance**[,]**.**

(K) Short term health insurance policies**,** [*(*]the duration of which does not exceed [*six*] **12** months including renewals[*),*]**. As used in this subparagraph, "renewal" means a new short term policy issued by a carrier to a policyholder or dependents of the policyholder no later than 45 days after the termination of a short term policy previously issued by the carrier to the policyholder or to dependents of the policyholder.**

(L) Student accident **insurance policies** and **student** health insurance policies **if excluded from the definition of group health plan under 42 U.S.C. 300gg-91**[,]**.**

(M) Noncoordinated dental only **insurance**[,]**.**

(N) Noncoordinated vision only **insurance** [,]**.**

(O) A policy of stop-loss coverage that meets the requirements of ORS 742.065[,]**.**

(P) Coverage issued as a supplement to liability insurance[,]**.**

(Q) Insurance arising out of a workers' compensation or similar law[,]**.**

(R) 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)*] **(21)** "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*] **director pursuant to ORS 743.745**.

[*(21) "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) "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) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(24) "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 medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

(25) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

[*(25)*] **(26)** "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)*] **(27)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(27)*] **(28)** "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*] **person under 19 years of age**.

[*(28)*] **(29)** "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)*] **(30)** "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)*] **(31)(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) "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 7. ORS 743.733 is amended to read:

743.733. (1) If an affiliated group of employers is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986, a carrier may issue a single group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

(2) If a [*small employer*] carrier determines that an employer has more than 50 employees, the carrier may provide a quote for a group health benefit plan that is not subject to ORS 743.733 to 743.737. If the employer's workforce consists of at least two but not more than 50 eligible employees, the [*small group*] carrier shall inform the employer that if coverage is limited to the eligible employees, the carrier must treat the employer as a small employer and shall provide a separate quote on that basis.

(3) Subsequent to the issuance of a health benefit plan to a small employer, a [*small employer*] carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer. The provisions of ORS 743.733 to 743.737 shall continue to apply to a health benefit plan issued to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

SECTION 8. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, and section 2, chapter 81, Oregon Laws 2010, is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737 **and sections 2, 3 and 4 of this 2011 Act**, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as provided in ORS 743.733 to 743.737 **and 743.745 and sections 2 and 3 of this 2011 Act**, no **state** law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

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

(a) [*Inhibit a small employer carrier from contracting*] **Contract** with providers or groups of providers with respect to health care services or benefits; [*or*] **and**

(b) [*Impose any restriction on the ability of a small employer carrier to*] Negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee **who is 19 years of age or older**, a [*small employer*] carrier shall not use health statements when offering [*small employer*] health benefit plans **to small employers** and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

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

(6) A [*small employer*] carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice **and may not discriminate in favor of highly compensated individuals as defined in section 105(h) of the Internal Revenue Code**. Except as provided in ORS 743.736 [*(10)*] **(8)**:

(a) When a [*small employer*] carrier offers coverage to a small employer with no more than 25 eligible employees, the [*small employer*] carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) When a [*small employer*] carrier offers coverage to a small employer with at least 26 but not more than 50 eligible employees, the [*small employer*] carrier may limit coverage to the categories of employees that the small employer has established as eligible for coverage, provided that the categories are based on bona fide employment-based classifications that are consistent with the employer's usual business practice **and do not discriminate in favor of highly compensated individuals as defined in section 105(h) of the Internal Revenue Code**.

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

(7) A health benefit plan issued to a small employer group through an association health plan is exempt from [*subsection (1) of this section*] **ORS 743.733 to 743.737**. For purposes of this subsection, an association health plan is group health insurance described in ORS 743.522 (2) or a

health benefit plan that:

(a) Is delivered or issued for delivery to:

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

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

(b) Satisfies all of the following:

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

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

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

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

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

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

(B) No longer meet eligibility requirements for membership in the association, including failure to pay association dues;

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

(D) Fail to pay premiums.

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

(c) The director may exempt an association health plan from the 95 percent retention rate requirement in subsection (7) of this section according to criteria prescribed by the director by rule.

SECTION 9. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, and sections 2 and 3, chapter 81, Oregon Laws 2010, is amended to read:

743.734. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737 **and sections 2, 3 and 4 of this 2011 Act**, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as provided in ORS 743.733 to 743.737 **and 743.745 and section 2 and 3 of this 2011 Act**, no **state** law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

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

(a) [*Inhibit a small employer carrier from contracting*] **Contract** with providers or groups of providers with respect to health care services or benefits; [*or*] **and**

(b) [*Impose any restriction on the ability of a small employer carrier to*] Negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee **who is 19 years of age or older**, a [*small employer*] carrier shall not use health statements when offering [*small employer*] health benefit plans **to small employers** and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

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

(6) A [*small employer*] carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice **and may not discriminate in favor of highly compensated individuals as defined in section 105(h) of the Internal Revenue Code**. Except as provided in ORS 743.736 [*(10)*] **(8)**:

(a) When a [*small employer*] carrier offers coverage to a small employer with no more than 25 eligible employees, the [*small employer*] carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) When a [*small employer*] carrier offers coverage to a small employer with at least 26 but not more than 50 eligible employees, the [*small employer*] carrier may limit coverage to the categories of employees that the small employer has established as eligible for coverage, provided that the categories are based on bona fide employment-based classifications that are consistent with the employer's usual business practice **and do not discriminate in favor of highly compensated individuals as defined in section 105(h) of the Internal Revenue Code**.

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

SECTION 10. 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 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 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 by reviewing the basic health benefit plans and commenting on the extent to which the plans meet these criteria.*]

[*(3)*] **(1)** [*After the director's approval of the basic health benefit plans submitted by the committee pursuant to subsection (1) of this section, each small employer*] **A** carrier shall submit to the Director **of the Department of Consumer and Business Services, for approval in accordance with ORS 742.003,** the policy form or forms containing its basic health benefit plan. [*Each policy form must be submitted as prescribed by the director 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.*]

[*(b) Nothing in this subsection shall require a small employer carrier to resubmit small employer health benefit plans that were approved by the director 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)*] **(2)** 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)*] **(3)** [*A small employer*] **A** carrier shall issue to a small employer any [*small employer*] health benefit plan**, including a basic health benefit plan, that is** 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)*] **(4)** 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)*] **(5)** [*A small employer*] **A** carrier shall, pursuant to [*subsections (4) and (5)*] **subsection (3)** of this section, [*offer coverage to or accept applications from a*] **accept applications from and offer coverage to a small employer** 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 **small em-**

ployer 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)*] **(6)** [*No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5)*] **A carrier is not required to accept applications from and offer coverage pursuant to subsection (3)** of this section if the director 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)*] **(7)** [*Every small employer*] **A** carrier shall market fairly all [*small employer*] health benefit plans **that are not grandfathered plans, including basic health benefit plans, that are** offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

[*(10)(a)*] **(8)(a)** [*No small employer carrier shall be*] **A carrier is not** required to **accept applications from or** offer coverage [*or accept applications*] pursuant to [*subsections (4) and (5)*] **subsection (3)** 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 **of a small employer** 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, 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)*] **(9)** 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)*] **(10)** [*A small employer*] **A** carrier that[*, after September 29, 1991,*] elects to discontinue offering all of its [*small employer*] health benefit plans **to small employers** 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*] **to small employers** in this state for a period of five years from one of the following dates:

(a) The date of notice to the director 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 provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering [*small employer*] health benefit plans **to small employers** in this state.

SECTION 11. 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*] **issued to a small employer may** 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*] **For purposes of** 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 **issued to a small employer** 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 **issued to small employers** 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 **issued to a small employer**, 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*] **Department of Consumer and Business Services**, applicable to all individuals enrolling for the first time in the [*small employer*] health benefit plan.

(4)**(a) A health benefit plan issued to a small employer may not apply a preexisting conditions provision to a person who is under the age of 19.**

(b) Late enrollees **in a health benefit plan issued to a small employer** 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*] **A** health benefit plan **issued to a small employer** shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder [*except*] **unless**:

(a) [*For nonpayment of the required premiums by*] The policyholder, small employer or contract holder **fails to pay required premiums**.

(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*] **an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage**.

(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*] **fails to comply with the** 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 **for small employers** 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 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*] **to small employers** in this state or in the specified service area.

(f) [*When*] The carrier discontinues offering and renewing a [*small employer*] health benefit plan **for small employers** 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 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 are not grandfathered plans** that the carrier offers **to small employers** 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 are not grandfathered plans** that the carrier offers **to small employers** 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 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 contractual obligations.

(i) [*When,*] In the case of a [*small employer*] health benefit plan **for small employers** 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*] **to small employers** 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)*] **(6)** A [*small employer*] carrier may modify a [*small employer*] health benefit plan **issued to a small employer** at the time of coverage renewal. The modification is not a discontinuation of the plan under [*paragraphs (e) and (g) of this subsection*] **subsection (5)(e) and (g) of this section**.

[*(6)*] **(7)** Notwithstanding any provision of [*subsection*] **subsections** (5) **and (6)** of this section to the contrary, **a carrier may rescind** any small employer [*carrier*] health benefit plan**, or the coverage of an enrollee under a 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.*] **if the small employer or the enrollee:**

(a) Performs an act, practice or omission that constitutes fraud; or

(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

[*(7)*] **(8)** 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 medical assistance program under ORS chapter 414.

[*(8)*] **(9)** Premium rates for [*small employer*] health benefit plans **for small employers** shall be subject to the following provisions:

(a) [*Each small employer carrier issuing health benefit plans to small employers*] **A carrier** must file its geographic average rate for a rating period with the director 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*] **the covered** 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 and*] in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established **by a carrier** for a health benefit plan [*by*] **issued to** 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 **to small employers** 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)*] **(10)** 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**, other than grandfathered plans but including the basic health benefit plan,** 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)*] **(11)** [*Each small employer carrier*] **A carrier offering a health benefit plan for small employers** shall**:**

(a) 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 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 director. 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 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 to persons outside the Department of Consumer and Business Services except as agreed to by the [*small employer*] carrier or as ordered by a court of competent jurisdiction.

[*(11)*] **(12)** 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)*] **(13)** For purposes of this section, the date a [*small employer*] health benefit plan **issued to a small employer** is continued shall be the anniversary date of the first issuance of the health benefit plan.

[*(13)*] **(14)** A [*small employer*] carrier must include a provision that offers coverage to all eligible employees and to all dependents to the extent [*the*] **a small** employer chooses to offer coverage to dependents.

[*(14)*] **(15)** All [*small employer*] health benefit plans **offered to small employers** 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**, and any other applicable law**.

SECTION 12. ORS 743.745 is amended to read:

743.745. The Director of the Department of Consumer and Business Services 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, the committee shall recommend*] **Determine** 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*] **director may** 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)*] **(a)** Preferred provider provisions;

[*(B)*] **(b)** Utilization review of health care services including review of medical necessity of hospital and physician services;

[*(C)*] **(c)** Case management benefit alternatives;

[*(D)*] **(d)** Other managed care provisions;

[*(E)*] **(e)** Selective contracting with hospitals, physicians and other health care providers; and

[*(F)*] **(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 within the time period established by the director. The health benefit plans and other recommendations shall be deemed approved unless expressly disapproved by the director within 30 days after the date the director receives the plans.*]

(2) In order to ensure the broadest availability of [*small employer and individual*] health benefit plans **for small employers and individuals**, the [*committee shall recommend for approval by the director*] **director may approve** market conduct and other requirements for carriers and insurance producers[*, including requirements developed as a result of a request by the director, relating to the following*] **for**:

(a) Registration by each carrier with the Department of Consumer and Business Services of its intention to [*be a small employer carrier*] **offer health benefit plans to small employers** under ORS 743.733 to 743.737 or [*a carrier offering*] **to offer** individual health benefit plans, or both.

[*(b) Publication by the department of Consumer and Business Services 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)*] **(b)** To the extent deemed necessary by the [*committee*] **director** 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)*] **(c)** Methods **for** [*concerning periodic demonstration by small employer*] carriers **offering health benefit plans to small employers**, carriers offering individual health benefit plans and insurance producers **periodically to demonstrate** that the [*small employer and individual*] carriers **and producers** are marketing [*or issuing, or both,*] **and issuing** health benefit plans to small em-

ployers or individuals in [*fulfillment of the purposes of*] **accordance with** ORS 743.730 to 743.773.

(3) [*Subject to the approval of*] The director [*of the Department of Consumer and Business Services, 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[*, 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 13. ORS 743.751 is amended to read:

743.751. (1) Except to determine the application of a preexisting conditions provision for a late enrollee **who is 19 years of age or older**, a carrier offering group health benefit plans shall not use health statements when offering such plans to a group of two or more prospective certificate holders and shall not use any other method to determine the actual or expected health status of eligible prospective enrollees. Nothing in this section shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan or from obtaining aggregate group information related to historical medical claims expenses and health behavior surveys for rating purposes.

(2) Subsection (1) of this section [*applies only to group health benefit plans that are not small employer*] **does not apply to** health benefit plans **for small employers**.

SECTION 14. ORS 743.752 is amended to read:

743.752. (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS 743.754 (6)(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 group market in this state for a period of five years from one of the following dates:

(a) The date of notice to the Director of the Department of Consumer and Business Services pursuant to ORS 743.754 (6)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering group health benefit plans in this state.

(3) Subsection (1) of this section [*applies only to group health benefit plans that are not small employer*] **does not apply to** health benefit plans **for small employers**.

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that**:**

(a) Does not relate to the actual or expected health status of the employees or their dependents[.]**; and**

(b) Does not discriminate in favor of highly compensated individuals as defined in section

105(h) of the Internal Revenue Code.

(5) 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 or their subsidiaries as that covered by the arrangement. The arrangement [*shall*] **must** 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.

SECTION 15. 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 **not apply to a person under 19 years of age and 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 **who is 19 years of age or older**, 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 **who are 19 years of age or older** 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 **and other applicable law**.

(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 **intentional** misrepresentation of **a material fact by** 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 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 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 **except grandfathered 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 **and that the policyholder is eligible to purchase under applicable law**.

(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 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 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)*] **(k)** 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*] **or intentional** misrepresentation [*or concealment*] **of a material fact** by a policyholder and the coverage of an enrollee may be rescinded for fraud[*, material*] **or intentional** misrepresentation [*or concealment*] **of a material fact** 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*] **does not apply to** health benefit plans **for small employers**.

SECTION 16. 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)*] **(11)** 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 ex-

pected 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 **shall adopt** 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 **shall develop**:

(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) The portability health plans developed by the director shall provide for appropriate accessibility and affordability of needed health care services and shall comply with all other provisions of this section.

[*(b)*] **(c)** Except as provided in ORS 743.730 to 743.773, no **state** 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)*] **(3)** [*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)*] **(4)** Within 180 days after [*approval by*] the director [*of*] **adopts** 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)*] **(3)** of this section.

[*(6)*] **(5)** 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)*] **(6)** 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 **for small employers** 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)*] **(7)** No portability plans under this section may contain preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

[*(9)*] **(8)** 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 **intentional** misrepresentation **of a material fact** 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)*] **(9)(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)*] **(10)** 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)*] **(11)** 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 17. 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*] **Director of the Department of Consumer and Business Services** 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; **and**

(iii) The provision shall not apply to a person who is under 19 years of age;

(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 **intentional** misrepresentation **of a material fact** 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 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 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 are not grandfathered 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 are not grandfathered 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 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 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, **intentional** material misrepresentation **of a material fact** 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.

SECTION 18. Section 3, chapter 75, Oregon Laws 2010, is amended to read:

Sec. 3. (1) In the administration of [*small employer*] group health insurance **issued to small employers** or individual health insurance, an insurer may communicate one or more of the following by electronic means:

(a) Quote information.

(b) Sale and enrollment information.

(c) Payment, remittance and reconciliation information.

(d) Explanation of benefits.

(e) Plan renewal information.

(f) Notifications required by law.

(g) Other communications, documentation, revisions or materials otherwise provided on paper.

(2) Electronic administration of [*small employer*] group or individual health insurance [*plans*] shall be transacted using secure systems specifically designed by the insurer for the purpose of electronic health insurance administration.

SECTION 19. Section 4, chapter 75, Oregon Laws 2010, is amended to read:

Sec. 4. (1) An insurer who elects to offer discounted rates for a health insurance plan utilizing electronic administration shall include the schedule of discounts for utilization of electronic administration as part of **rate filing for** a [*small employer*] group health insurance **issued to small employers** or individual health insurance [*rate filing*]. The rate discounts may be graduated and must be proportionate to the amount of administrative cost savings the insurer anticipates as a result of the use of electronic transactions described in section 3**, chapter 75, Oregon Laws 2010** [*of this 2010 Act*].

(2) Discounted rates allowed under this section shall be applied uniformly to all similarly situated [*small employer group or*] **purchasers of group health insurance for small employers or** individual health insurance [*purchasers of an insurer*].

(3) Discounts in premium rates under this section are not premium rate variations for purposes of ORS 743.737 [*(8)*] **(9)** or 743.767.

SECTION 20. ORS 413.032 is amended to read:

413.032. (1) The Oregon Health Authority is established. The authority shall:

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

(b) Develop a plan for the Oregon Health Insurance Exchange in accordance with section 17, chapter 595, Oregon Laws 2009;

(c) Administer the Oregon Prescription Drug Program;

(d) Administer the Family Health Insurance Assistance Program;

(e) 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;

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

(g) 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;

(h) In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

(i) Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

(j) Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage; and

(k) Develop, in consultation with the Department of Consumer and Business Services [*and the Health Insurance Reform Advisory Committee*], one or more products designed to provide more affordable options for the small group market.

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

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

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

(c) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the

authority's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(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 Oregon Health Authority by ORS 413.006 to 413.064 or by other statutes.

SECTION 21. ORS 735.616 is amended to read:

735.616. (1) An applicant may qualify for portability health insurance coverage under the Oregon Medical Insurance Pool if:

(a) An application for coverage is made not later than the 63rd day after the date of first eligibility; and

(b) The individual is an Oregon resident at the time of the application.

(2) In addition to individuals otherwise qualified under ORS 735.615, the following individuals qualify for portability health insurance coverage under the Oregon Medical Insurance Pool:

(a) An individual who has left coverage that was in effect for a minimum of 180 consecutive days under one or more group health benefit plans, if the terminated coverage was in a plan issued or established in a state other than Oregon;

(b) An eligible individual, as defined in ORS 743.760, who has left coverage under a group health benefit plan or a portability health benefit plan and whose carrier cannot offer a portability plan under ORS 743.760 [*(6)*] **(5)** because of:

(A) A change in residence of the eligible individual within Oregon;

(B) A change in the geographic area served by the group carrier; or

(C) The carrier's withdrawal from the group market in Oregon in accordance with ORS 743.737 and 743.754;

(c) An individual who has left coverage that was in effect for an uninterrupted period of 180 days or more under one or more Oregon group health benefit plans and the terminated coverage was provided by:

(A) An employee welfare benefit plan that is exempt from state regulation under the federal Employee Retirement Income Security Act of 1974, as amended;

(B) A multiple employer welfare arrangement subject to ORS 750.301 to 750.341; or

(C) A public body of this state in accordance with ORS 731.036; and

(d) On or after January 1, 1998, an individual who meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, and does not otherwise qualify to obtain portability coverage from an Oregon group carrier in accordance with ORS 743.760.

(3) Eligibility for coverage pursuant to subsections (1) and (2) of this section is subject to the following provisions:

(a) An eligible individual does not include:

(A) 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;

(B) An individual who is covered under another health benefit plan at the time that portability coverage would commence;

(C) An individual who is eligible to enroll in another health benefit plan offered by the employer, other than as a late enrollee, at the time that portability coverage would commence; or

(D) An individual who is eligible for the federal Medicare program.

(b) If an eligible individual has left group coverage issued by an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including any period of continuation coverage that was elected by the individual under federal law or under ORS 743.600 or 743.610.

(c) If an eligible individual has left group coverage issued by an entity other than an insurance company, a health care service contractor or a health maintenance organization, the date of first eligibility is the day following the termination date of the group coverage, including the full extent of continuation coverage available to the individual under federal law and ORS 743.600 and 743.610.

(d) If an individual is eligible for coverage pursuant to subsection (2)(b) of this section, the date of first eligibility is the day following the loss of the group or portability coverage.

(4) Coverage under the Oregon Medical Insurance Pool pursuant to subsections (1) and (2) of this section shall be offered according to the following provisions:

(a) Coverage is subject to ORS 743.760 (2) and [*(8)*] **(7)**;

(b) Coverage may not be subject to a preexisting conditions provision, exclusion period, waiting period, residency period or other similar limitation on coverage; and

(c) The individual shall be required to pay a premium rate not more than the applicable portability risk rate determined by the Oregon Medical Insurance Pool Board pursuant to ORS 735.625.

SECTION 22. ORS 743.748 is amended to read:

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

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

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

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

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

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

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

(B) The total amount of the surplus maintained;

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

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

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

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

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and

Business Services by rule [*after obtaining a recommendation from the Health Insurance Reform Advisory Committee*].

(3) The [*advisory committee*] **director** 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 shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 23. 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 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 by rule [*after obtaining a recommendation from the Health Insurance Reform Advisory Committee*].

(3) The [*advisory committee*] **director** 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 shall make the information reported under this section available to the

public through a searchable public website on the Internet.

SECTION 24. 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:

[*(a)*] **(1)** Upon request by the director, 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)*] **(2)** 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)*] **(3)** Information prescribed by the director 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 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 25. Sections 2, 3 and 4 of this 2011 Act and the amendments to ORS 413.032, 735.616, 742,005, 743.730, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.760, 743.766 and 743.878 and sections 3 and 4, chapter 75, Oregon Laws 2010, by sections 5 to 24 of this 2011 Act become operative on January 2, 2014.

SECTION 26. The Director of the Department of Consumer and Business Services may take any action before the operative date specified in section 25 of this 2011 Act that is necessary to enable the director to exercise, on and after the operative date specified in section 25 of this 2011 Act, all of the duties, functions and powers conferred on the director by this 2011 Act.