Enrolled
Senate Bill 89

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CHAPTER .....

AN ACT

Relating to health insurance; creating new provisions; amending ORS 413.032, 743.405, 743.601, 743.610, 743.730, 743.731, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.754, 743.758, 743.760, 743.761, 743.766, 743.767, 743.801, 743.804, 743.806, 743.807, 743.845, 743.857, 743.859, 743.861, 743.862, 743.863, 743.864, 743.878, 743A.012, 743A.080, 743A.090, 743A.110, 743A.141, 746.650, 750.055 and 750.333 and sections 12 and 13, chapter 752, Oregon Laws 2007, section 2, chapter 73, Oregon Laws 2009, section 4, chapter 75, Oregon Laws 2010, and section 6, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91); repealing sections 2 and 5, chapter 73, Oregon Laws 2009, and section 5, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91); and declaring an emergency.

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

SECTION 1. Section 2 of this 2011 Act is added to and made a part of ORS 743.730 to 743.773.

SECTION 2. Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services as prescribed by the United States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by federal law.

SECTION 3. Sections 4 and 4a of this 2011 Act are added to and made a part of the Insurance Code.

SECTION 4. (1) As used in this section, "rescind" means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance policy for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

(2) An insurer may not rescind coverage of an individual under a health benefit plan or group or individual health insurance policy unless:

(a) The individual or a person seeking coverage on behalf of the individual:

(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 or policy; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the Department of Consumer and Business Services, to the individual.

(3) An insurer may not rescind coverage of a group under a health benefit plan unless:

(a) The plan sponsor:

(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; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee or policy holder who would be affected by the rescission of coverage.

(4) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

SECTION 4a. (1) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

(2) An insurer shall notify a policyholder in writing if the insurer cancels or does not renew the policyholder's individual health benefit plan. The notice shall be sent to the policyholder's last-known mailing address by first class mail in a specially marked envelope or, if the policyholder has elected to receive communications from the insurer electronically, to the policyholder's last-known electronic mail address using a mechanism that will confirm delivery to the address.

(3) If the cancellation or nonrenewal results in a refund to the policyholder of all or part of a premium, the insurer must mail with the refund a written explanation that includes:

(a) The effective date of the cancellation;

(b) The reason for the cancellation; and

(c) The time period to which the refund is applicable.

(4) For any cancellation or nonrenewal due to a reported death of the policyholder, the insurer must:

(a) Confirm the accuracy of the reported death.

(b) If the death is confirmed:

(A) Provide any dependents covered by the plan with information about how to continue coverage or obtain alternative coverage; and

(B) Issue any refund that is due to the estate of the deceased in accordance with subsection (3) of this section.

(5) If an insurer cancels or does not renew an individual health benefit plan and fails to comply with the requirements of this section, the insurer shall continue the coverage under the plan for the policyholder and any dependents covered by the plan until the date that the insurer has complied with the requirements of this section. The insurer shall waive any premiums owed for the period during which the coverage was continued under this subsection and shall process all claims incurred by the policyholder or any covered dependents according to the terms of the plan.

(6) This section does not apply:

(a) To a cancellation requested by the policyholder if the insurer documents the request and confirms the request with the policyholder; or

(b) To a cancellation or nonrenewal that results from a policyholder making a change in coverage with the same insurer.

SECTION 5. 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 6. ORS 743.405 is amended to read:

743.405. An individual health insurance policy must meet the following requirements:

(1) The entire money and other considerations therefor shall be expressed therein.

(2) The time at which the insurance takes effect and terminates shall be expressed therein.

(3) It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, depend-

ent children or any children under a specified age[*, which shall not exceed 19 years,*] and any other person dependent upon the policyholder.

(4) The policy may not be issued individually to an individual in a group of persons as described in ORS 743.522 for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan.

(5) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. As used in this subsection, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy. Except those required by ORS 743.411 to 743.477 [*and 743A.160*], exceptions and reductions shall be printed at the insurer's option either included with the applicable benefit provision or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the applicable benefit provision.

(7) Each form constituting the policy, including riders and indorsements, must be identified by a form number in the lower left-hand corner of the first page of the policy.

(8) The policy may not contain provisions purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short rate table filed with the Director of the Department of Consumer and Business Services.

SECTION 6a. ORS 743.601 is amended to read:

743.601. (1) As used in subsections (1) to (6) of this section, "plan administrator" means:

(a) The person designated as the plan administrator by the instrument under which the group health insurance plan is operated; or

(b) If no plan administrator is designated, the plan sponsor.

(2) Within 60 days of legal separation or the entry of a judgment of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743.600 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

(3) Within 30 days of the death of a [*certificate holder*] **covered person** whose surviving spouse is eligible for continued coverage under ORS 743.600, the group policyholder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

(4) Within 14 days of receipt of notice under subsection (2) or (3) of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include:

(a) A form for election to continue the coverage;

(b) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment; and

(c) Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

(5) Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection (4) of this section shall terminate the right to continuation of benefits.

(6) If a plan administrator fails to notify the legally separated, divorced or surviving spouse as required by subsection (4) of this section, premiums shall be waived from the date the notice was required until the date notice is received by the legally separated, divorced or surviving spouse.

(7) The provisions of **this section and** ORS 743.600 [*to*] **and** 743.602 apply only to employers with 20 or more employees and group health insurance plans with 20 or more [*certificate holders*] **enrollees on a typical business day during the preceding calendar year**.

SECTION 6b. ORS 743.610 is amended to read:

743.610. **(1) As used in this section and section 2, chapter 73, Oregon Laws 2009:**

(a) "Covered person" means an individual who was a certificate holder under a group health insurance policy:

(A) On the day before a qualifying event; and

(B) During the three-month period ending on the date of the qualifying event.

(b) "Qualified beneficiary" means:

(A) A spouse or dependent child of a covered person who, on the day before a qualifying event, was insured under the covered person's group health insurance policy; or

(B) A child born to or adopted by a covered person during the period of the continuation of coverage under this section who would have been insured under the covered person's policy if the child had been born or adopted on the day before the qualifying event.

(c) "Qualifying event" means the loss of membership in a group health insurance policy caused by:

(A) Voluntary or involuntary termination of the employment of a covered person;

(B) A reduction in hours worked by a covered person;

(C) A covered person becoming eligible for Medicare;

(D) A qualified beneficiary losing dependent child status under a covered person's group health insurance policy;

(E) Termination of membership in the group covered by the group health insurance policy; or

(F) The death of a covered person.

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

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

(3) Continuation of coverage is not available to a [*certificate holder*] **covered person or qualified beneficiary** who is eligible for:

(a) [*Federal*] Medicare [*coverage*]; or

(b) Coverage for hospital or medical expenses under any other program [*which was not covering the certificate holder immediately before the certificate holder's termination of employment or membership*] **that was not covering the covered person or qualified beneficiary on the day before a qualifying event**.

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

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

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

[*(b) Not more than 31 days after the date of termination of employment or membership.*] **a covered person or qualified beneficiary who wishes to continue coverage must provide the insurer with a written request for continuation no later than 10 days after the later of the date of a qualifying event or the date the insurer provides the notice required by subsection (10) of this section.**

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

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

[*(a) Nine months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership.*]

[*(b) The end of the period for which the certificate holder last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.*]

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

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

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

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

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

(a) Nine months after the date of the qualifying event that was the basis for the continuation of coverage.

(b) The end of the period for which the last timely premium payment for the coverage is received by the insurer.

(c) The premium payment due date coinciding with or next following the date that continuation of coverage ceases to be available in accordance with subsection (3) of this section.

(d) The date that the policy is terminated. However, if the policyholder replaces the terminated policy with similar coverage under another group health insurance policy:

(A) The covered person and qualified beneficiaries may obtain coverage under the replacement policy for the balance of the period that the covered person or qualified beneficiary would have remained covered under the terminated policy in accordance with this section; and

(B) The terminated policy must continue to provide benefits to the covered person and qualified beneficiaries to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

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

[*(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy other-*

wise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section.]

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

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

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

(9) [*A certificate holder who has terminated employment by reason of layoff may not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to*] **A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer may not be subjected to a waiting period for** coverage under the employer's group health insurance policy if the [*certificate holder*] **covered person** was eligible for coverage at the time of the [*termination and*] **layoff,** regardless of whether the [*certificate holder*] **covered person** continued coverage during the layoff.

(10) If an insurer terminates the group health insurance coverage of a covered person or qualified beneficiary without providing replacement coverage that meets the criteria in subsection (7)(d) of this section, the insurer shall provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event under subsection (5) of this section. The notice shall include at least the following information:

(a) Contact information for the insurer;

(b) Forms necessary to request continuation of coverage and instructions for completing the forms;

(c) Information sufficient to determine premium rates for continuation of coverage and instructions for paying premiums;

(d) A clear statement of who is eligible to continue coverage;

(e) Enrollment information relating to other coverage issued by the insurer that is held by the employer or group and for which the covered person or a qualified beneficiary may be eligible;

(f) An explanation of the process to appeal a denial of a claim under the continuation of coverage;

(g) Information, in a form approved by the director, about how to contact the consumer advocacy unit of the Insurance Division of the Department of Consumer and Business Services; and

(h) Other information required by the director.

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

SECTION 6c. ORS 743.610, as amended by section 4, chapter 73, Oregon Laws 2009, is amended to read:

743.610. **(1) As used in this section:**

(a) "Covered person" means an individual who was a certificate holder under a group health insurance policy:

(A) On the day before a qualifying event; and

(B) During the three-month period ending on the date of the qualifying event.

(b) "Qualified beneficiary" means:

(A) A spouse or dependent child of a covered person who, on the day before a qualifying event, was insured under the covered person's group health insurance policy; or

(B) A child born to or adopted by a covered person during the period of the continuation of coverage under this section who would have been insured under the covered person's policy if the child had been born or adopted on the day before the qualifying event.

(c) "Qualifying event" means the loss of membership in a group health insurance policy caused by:

(A) Voluntary or involuntary termination of the employment of a covered person;

(B) A reduction in hours worked by a covered person;

(C) A covered person becoming eligible for Medicare;

(D) A qualified beneficiary losing dependent child status under a covered person's group health insurance policy;

(E) Termination of membership in the group covered by the group health insurance policy; or

(F) The death of a covered person.

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

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

(3) Continuation of coverage is not available to a [*certificate holder*] **covered person or qualified beneficiary** who is eligible for:

(a) [*Federal*] Medicare [*coverage*]; or

(b) Coverage for hospital or medical expenses under any other program [*which was not covering the certificate holder immediately before the certificate holder's termination of employment or membership*] **that was not covering the covered person or qualified beneficiary on the day before a qualifying event**.

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

(5) [*A certificate holder who has terminated employment or membership and who wishes to continue coverage must request continuation in writing:*] **A covered person or qualified beneficiary who wishes to continue coverage must provide the insurer with a written request for continuation no later than 10 days after the later of the date of a qualifying event or the date the insurer provides the notice required by subsection (10) of this section.**

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

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

(6) A [*certificate holder*] **covered person or qualified beneficiary** who requests continuation of coverage shall pay the premium on a monthly basis and in advance[*, as provided in this subsection. The certificate holder shall pay the premium*] to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group

premium rate for the insurance being continued under the group policy as of the date the premium payment is due. [*The certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end.*]

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

[*(a) Nine months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership.*]

[*(b) The end of the period for which the certificate holder last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.*]

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

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

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

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

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

(a) Nine months after the date of the qualifying event that was the basis for the continuation of coverage.

(b) The end of the period for which the last timely premium payment for the coverage is received by the insurer.

(c) The premium payment due date coinciding with or next following the date that continuation of coverage ceases to be available in accordance with subsection (3) of this section.

(d) The date that the policy is terminated. However, if the policyholder replaces the terminated policy with similar coverage under another group health insurance policy:

(A) The covered person and qualified beneficiaries may obtain coverage under the replacement policy for the balance of the period that the covered person or qualified beneficiary would have remained covered under the terminated policy in accordance with this section; and

(B) The terminated policy must continue to provide benefits to the covered person and qualified beneficiaries to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

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

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

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

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

exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due.]

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

(9) [*A certificate holder who has terminated employment by reason of layoff may not be subject upon any rehire that occurs within nine months of the time of the layoff to any waiting period prerequisite to*] **A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer may not be subjected to a waiting period for** coverage under the employer's group health insurance policy if the [*certificate holder*] **covered person** was eligible for coverage at the time of the [*termination and*] **layoff,** regardless of whether the [*certificate holder*] **covered person** continued coverage during the layoff.

(10) If an insurer terminates the group health insurance coverage of a covered person or qualified beneficiary without providing replacement coverage that meets the criteria in subsection (7)(d) of this section, the insurer shall provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event under subsection (5) of this section. The notice shall include at least the following information:

(a) Contact information for the insurer;

(b) Forms necessary to request continuation of coverage and instructions for completing the forms;

(c) Information sufficient to determine premium rates for continuation of coverage and instructions for paying premiums;

(d) A clear statement of who is eligible to continue coverage;

(e) Enrollment information relating to other coverage issued by the insurer that is held by the employer or group and for which the covered person or a qualified beneficiary may be eligible;

(f) An explanation of the process to appeal a denial of a claim under the continuation of coverage;

(g) Information, in a form approved by the Director of the Department of Consumer and Business Services, about how to contact the consumer advocacy unit of the Insurance Division of the Department of Consumer and Business Services; and

(h) Other information required by the director.

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

SECTION 6d. Section 2, chapter 73, Oregon Laws 2009, is amended to read:

Sec. 2. (1) Notwithstanding the limitations of ORS 743.610, the Director of the Department of Consumer and Business Services by rule may extend the period of time during which coverage is available to a [*certificate holder*] **covered person or qualified beneficiary** and may open a new period of time during which a [*certificate holder*] **covered person or qualified beneficiary** may request continuation of [*health benefit coverage under the state continuation of benefits program*] **coverage as** described in ORS 743.610 if:

(a) The establishment of the extension [*and*] **or** new request period is in response to and consistent with federal legislation relating to the continuation of [*health benefit*] coverage; and

(b) The director finds that the rule is necessary to take advantage of a benefit provided to insurers, employers or employees by the federal legislation relating to the continuation of [*health benefit*] coverage.

(2) The rules adopted by the director under subsection (1) of this section may include but need not be limited to:

(a) Changes to the maximum period of coverage;

(b) Adoption of notice requirements for insurers, plan administrators, employers, group policyholders [*and certificate holders*]**, covered persons and qualified beneficiaries**;

(c) Criteria to determine if a [*certificate holder*] **covered person or qualified beneficiary** is eligible for a benefit;

(d) Procedures to allow an additional opportunity [*to request continuation coverage under ORS 743.610 (5) to a certificate holder whose employment was involuntarily terminated between September 1, 2008, and the effective date of this 2009 Act*] **for the covered person or qualified beneficiary to request continuation of coverage under ORS 743.610 if the employment of the covered person was involuntarily terminated between September 1, 2008, and May 31, 2010**;

(e) Any necessary extension of the time by which the [*certificate holder*] **covered person or qualified beneficiary** must pay the first premium as required under ORS 743.610; and

(f) Any necessary extension of the time by which the [*certificate holder*] **covered person or qualified beneficiary** must request or elect continuation **of** coverage.

SECTION 7. 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.

(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*] **condition exclusion**;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Basic health benefit plan" means a health benefit plan [*for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Consumer and Business Services in accordance with ORS 743.736*] **approved by the Department of Consumer and Business Services under ORS 743.736**.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. [*300gg-11*] **300gg-91** as amended and in effect on [*July 1, 1997*] **March 23, 2010**.

(6) "Carrier**,**" **except as provided in ORS 743.760,** 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.*]**:**

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

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

[*(8)*] **(7)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on [*July 1, 1997*] **February 17, 2009**, 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)*] **(8)** "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)*] **(9)** "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)*] **(10)** "Employee" means any individual employed by an employer.

[*(14)*] **(11)** "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

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

[*(16)*] **(13)** "Financially impaired" means a [*member*] **carrier** that 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)*] **(14)(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;

(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.

(15) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

[*(18)*] **(16)** "Group eligibility waiting period" means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

[*(19)(a)*] **(17)(a)** "Health benefit plan" means any**:**

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

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

(C) 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**, to the extent that the plan is subject to state regulation**.

(b) "Health benefit plan" does not include**:**

(A) Coverage for accident only, specific disease or condition only, credit[,] **or** disability income[,]**;**

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

(C) Medicare supplement insurance policies[,]**;**

(D) Coverage of [*CHAMPUS*] **TRICARE** services pursuant to contracts with the federal government[,]**;**

(E) 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[,]**;**

(F) Separately offered long term care insurance, **including, but not limited to, coverage of nursing home care, home health care and community-based care;**

(G) [*hospital indemnity only,*] **Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;**

(H) Short term health insurance policies [*(the duration of which does not exceed six months including renewals), student accident and health insurance policies,*] **that are in effect for periods of 12 months or less, including the term of a renewal of the policy;**

(I) Dental only[,] **coverage;**

(J) Vision only[,] **coverage;**

(K) [*a policy of*] Stop-loss coverage that meets the requirements of ORS 742.065[,]**;**

(L) Coverage issued as a supplement to liability insurance[,]**;**

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

(N) 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[.]**; or**

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

[*(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.*]

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

[*(20)*] **(18)** "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement [*developed by the Health Insurance Reform Advisory Committee*] **approved by the director under 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)*] **(19)** "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)*] **(20)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(24)*] **(21)** "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*] **February 17, 2009**;

(b) The individual applies for coverage during an open enrollment period;

(c) A court [*has ordered*] **issues an order** that coverage be provided for a spouse or minor child under [*a covered*] **an** employee's **employer sponsored** 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*] **that** 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*] **TRICARE**, 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*] **after** applying for coverage in a group health benefit plan.

[*(25)*] **(22)** "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)*] **(23)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(27)*] **(24)** "Preexisting [*conditions provision*] **condition exclusion**" 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) **Except for coverage under an individual grandfathered health plan,** a preexisting [*conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090*] **condition exclusion may not exclude coverage for services, charges or expenses incurred by an individual who is under 19 years of age**.

[*(28)*] **(25)** "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)*] **(26)** "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(27) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(30)(a)*] **(28)(a)** "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan [*issued by a small employer carrier*] **offered by the employer**.

(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 8. ORS 743.731 is amended to read:

743.731. The purposes of ORS 743.730 to 743.773 are:

(1) To promote the availability of health insurance coverage to groups regardless of their enrollees' health status or claims experience;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers of small employer, portability and individual health benefit plans;

(4) To establish limitations on the use of preexisting [*conditions provisions*] **condition exclusions**;

(5) To make basic health benefit plans available to all small employers;

(6) To encourage the availability of portability and individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(7) To improve renewability and continuity of coverage for employers and covered individuals;

(8) To improve the efficiency and fairness of the health insurance marketplace; and

(9) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) **and the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152),** and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services.

SECTION 9. 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 10. Section 13, chapter 752, Oregon Laws 2007, as amended by section 4, chapter 81, Oregon Laws 2010, is amended to read:

Sec. 13. The amendments to ORS 731.146, 731.484, 731.486, 743.734 and 743.748 by sections 6 to 8 [*and 10*], chapter 752, Oregon Laws 2007, and [*section 3 of this 2010 Act*] **sections 13 and 18 of this 2011 Act** become operative on January 2, 2014.

SECTION 11. Section 12, chapter 752, Oregon Laws 2007, is amended to read:

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

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

SECTION 12. 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, 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 743A.012 and section 2 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 **or other law**, no health benefit plan offered to a small employer shall:

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

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

(4) Except to determine the application of a preexisting [*conditions provision*] **condition exclusion** 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 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*] **as provided in this section and ORS 743.737**, a [*small employer*] carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee [*in*] **of** a small employer [*group*] that are based on the actual or expected health status of any eligible employee.

(6)**(a)** A [*small employer*] carrier may provide different health benefit plans to different categories of employees of a small employer **that has at least 26 but no more than 50 eligible employees** 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. [*Except as provided in ORS 743.736 (10):*]

[*(a)*] **(b)** [*When*] **Except as provided in ORS 743.736 (9),** a [*small employer*] carrier **that** 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.*]

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

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

(a) Is delivered or issued for delivery to:

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

(B) An association or trust established in another state, that is approved by the Director 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 required under subsection (7) of this section does not apply to 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.

(9) Notwithstanding any other provision of law, an insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual if the individual is under 19 years of age.

SECTION 13. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, sections 2 and 3, chapter 81, Oregon Laws 2010, and section 12 of this 2011 Act, is amended to read:

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

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

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

(2) Except as provided in ORS 743.733 to 743.737 and 743A.012 and section 2 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 ORS 743.733 to 743.737 or other law, no health benefit plan offered to a small employer shall:

(a) Inhibit a carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a 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 condition exclusion for a late enrollee who is 19 years of age or older, a carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected

health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except as provided in this section and ORS 743.737, a carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee of a small employer that are based on the actual or expected health status of any eligible employee.

(6)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer that has at least 26 but no more than 50 eligible employees 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.

(b) Except as provided in ORS 743.736 (9), a carrier that offers coverage to a small employer with no more than 25 eligible employees shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

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

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

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

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

[*(B) An association or trust established in another state, that is approved by the Director 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 required under subsection (7) of this section does not apply to 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.*]

[*(9)*] **(7)** Notwithstanding any other provision of law, an insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual if the individual is under 19 years of age.

SECTION 14. 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*] **As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers an approved basic health benefit plan and all of the other plans of the carrier that have been approved by the Department of Consumer and Business Services for use in the small employer market.**

(2) A carrier shall submit to the [*director*] **department, 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)*] **(3)** 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)*] **(4)** A [*small employer*] 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)*] **(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 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)*] **(6)** A [*small employer*] carrier shall, pursuant to [*subsections (4) and (5)*] **subsection (4)** 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 **regardless of** 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 employer** 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)*] **(7)** [*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 (4)** of this section if the [*director*] **department** 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)*] **(8)** [*Every small employer*] **A** carrier shall market fairly all [*small employer*] health benefit 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)*] **(9)(a) Subsection (4) of this section does not require a** [*No small employer*] carrier [*shall be required*] to offer coverage **to** or accept applications **from** [*pursuant to subsections (4) and (5) of this section in the case of any of the following*]:

(A) [*To*] A small employer if the small employer is not physically located in the carrier's approved service area;

(B) [*To*] An employee **of a small employer** if the employee does not work or reside within the carrier's approved service areas; or

(C) **Small employers located** within an area where the carrier reasonably anticipates, and demonstrates to the [*satisfaction of the director*] **department**, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those **small employer** groups because of its obligations to existing **small employer** 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)*] **(10)** 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)*] **(11)** A [*small employer*] 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)*] **(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 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*] **department** pursuant to ORS 743.737 [*(5)(e)*] **(6)(e)**; or

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

(12) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 15. 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*] **condition exclusion** in a small employer health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting [*conditions provision*] **condition exclusion** in a small employer health benefit plan shall [*terminate its effect*] **expire** as follows:

(a) For an enrollee, [*not later than the first of*] **on the earlier of** the following dates:

(A) Six months [*following*] **after** the enrollee's effective date of coverage; or

(B) Ten months [*following*] **after** the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months [*following*] **after** the late enrollee's effective date of coverage.

(3) In applying a preexisting [*conditions provision*] **condition exclusion** to an enrollee or late enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days [*of*] **after** the enrollment date in the new small employer health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a small employer health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services, as established [*by the Health Insurance Reform Advisory Committee*] **under ORS 743.745**, applicable to all individuals enrolling for the first time in the small employer health benefit plan.

(4) A health benefit plan issued to a small employer may not apply a preexisting condition exclusion to a person under 19 years of age.

[*(4)*] **(5)** Late enrollees **in a small employer health benefit plan** may be [*excluded from coverage for*] **subjected to a group eligibility waiting period of** up to 12 months or**, if 19 years of age or older,** may be subjected to a preexisting [*conditions provision*] **condition exclusion** for up to 12 months. If both [*an exclusion from coverage period*] **a waiting period** and a preexisting [*conditions provision*] **condition exclusion** are applicable to a late enrollee, the combined period shall not exceed 12 months.

[*(5)*] **(6)** Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder [*except*] **unless**:

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

(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 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 in this state or in the specified service area.

(f) [*When*] The carrier discontinues offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the [*director*] **department** and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers **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**, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(i) With respect to plans that are being discontinued **under paragraph (g) or (h) of this subsection**, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all **other** health benefit 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)*] **(j)** [*When*] The Director **of the Department of Consumer and Business Services** 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)*] **(k)** [*When,*] In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

[*(j)*] **(L)** [*When,*] In the case of a health benefit plan that is offered in the small employer market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

[*(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.*]

[*(L)*] **(7)** A [*small employer*] carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under [*paragraphs (e) and (g) of this*] subsection **(6)(e), (g) and (h) of this section**.

[*(6)*] **(8)** Notwithstanding any provision of subsection [*(5)*] **(6)** of this section to the contrary, [*any small employer carrier health benefit plan subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.*] **a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:**

(a) The enrollee or a person seeking coverage on behalf of 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;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) Notwithstanding any provision of subsection (6) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(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;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(7)*] **(10)** 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*] **TRICARE**, 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)*] **(11)** Premium rates for small employer health benefit plans shall be subject to the following provisions:

(a) [*Each small employer carrier issuing health benefit plans to small employers must file its geographic average rate for a rating period with the director at least once every 12 months.*] **Each carrier must file with the department the initial geographic average rate and any changes in the**

geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(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 **health benefit plans 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*] **employer health benefit plans**.

(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**, except rates for small employers with 25 or fewer employees,** 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 **small employer** health benefit plan [*by a small employer carrier*] shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different [*small employer*] health benefit plans offered by a [*small employer*] carrier **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 **small employer** health benefit plans shall comply with the requirements of this section.

[*(9)*] **(12)** In connection with the offering for sale of any health benefit plan to a small employer, each [*small employer*] carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates, and the extent to which the carrier will consider age, family composition and geographic factors in establishing and adjusting rates;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting [*conditions provision*] **condition exclusion**.

[*(10)(a)*] **(13)(a)** Each [*small employer*] carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices **relating to its small employer health benefit 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 small employer*] **A** carrier **offering a small employer health benefit plan** shall file with the [*director*] **department** 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*] **department**. A copy of [*such*] **each** 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*] **department** 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)*] **(14)** 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)*] **(15)** For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

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

[*(14)*] **(17)** All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on [*July 1, 1997*] **February 17, 2009**.

(18) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.

(19) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 16. ORS 743.745 is amended to read:

743.745. **(1)** 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**, portability** and individual health benefit plans, [*the committee shall recommend for approval by*] the 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*]:

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

[*(b) Publication by the department of Consumer and Business Services 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 concerning periodic demonstration by [*small employer carriers,*] carriers offering [*individual*] health benefit plans **to individuals or small employers** and insurance producers that the [*small employer and individual*] carriers **and insurance producers** are marketing or issuing[*, or both,*] health benefit plans [*to small employers or individuals*] in fulfillment of the purposes of ORS 743.730 to 743.773.

(3) [*Subject to the approval of the director of the Department of Consumer and Business Services, the committee*] **The director** 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 17. 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*] **department** 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 18. 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*] **department** 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 19. ORS 743.751 is amended to read:

743.751. (1) Except to determine the application of a preexisting [*conditions provision*] **condition exclusion** for a late enrollee **who is 19 years of age or older or as prescribed by the Department of Consumer and Business Services by rule**, 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 health benefit plans.

SECTION 20. ORS 743.754 is amended to read:

743.754. The following requirements apply to all group health benefit plans **other than small employer health benefit plans** covering two or more certificate holders:

(1) A preexisting [*conditions provision in a group health benefit plan*] **condition exclusion** shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting [*conditions provision in a group health benefit plan*] **condition exclusion may not apply to a person under 19 years of age and** shall [*terminate its effect*] **expire** as follows:

(a) For an enrollee**, on the earlier of** [*not later than the first of*] the following dates:

(A) Six months [*following*] **after** the enrollee's effective date of coverage; or

(B) Twelve months [*following*] **after** the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months [*following*] **after** the late enrollee's effective date of coverage.

(3) In applying a preexisting [*conditions provision*] **condition exclusion** 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*] **after** the enrollment date in the new [*group health benefit*] plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a [*group health benefit*] plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the [*group health benefit*] plan.

(4) Late enrollees may be [*excluded from coverage for*] **subjected to a group eligibility waiting period of** up to 12 months or**, if 19 years of age or older,** may be subjected to a preexisting [*conditions provision*] **condition exclusion** for up to 12 months. If both [*an exclusion from coverage period*] **a waiting period** and a preexisting [*conditions provision*] **condition exclusion** 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*] **Each plan shall contain a special enrollment period** 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*] **February 17, 2009**.

(6) Each [*group health benefit*] plan shall be renewable with respect to all eligible enrollees at the option of the policyholder [*except*] **unless**:

(a) [*For nonpayment of*] **The policyholder fails to pay** the required premiums [*by the policyholder*].

(b) [*For fraud or misrepresentation of*] The policyholder or, with respect to coverage of individual enrollees, [*the enrollees or their representatives*] **an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan**.

(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*] **The policyholder 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 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*] **department** and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) [*When*] The carrier discontinues offering or renewing, or offering and renewing, a health benefit plan**, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health plan for all groups in this state or in a specified service are within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued **under paragraph (g) or (h) of this subsection**, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

[*(h)*] **(j)** [*When*] The Director **of the Department of Consumer and Business Services** 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)*] **(k)** [*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)*] **(L)** [*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)*] **(7)** 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 **(6)(e), (g) and (h) of this section**.

[*(7)*] **(8)** Notwithstanding any provision of subsection (6) of this section to the contrary, [*a group health benefit plan may be rescinded by a carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.*] **a carrier may not rescind the coverage of an enrollee under the plan unless:**

(a) 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;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) Notwithstanding any provision of subsection (6) of this section to the contrary, a carrier may not rescind a plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

(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;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(8)*] **(10)** A carrier that continues to offer coverage in the group market in this state is not required to offer coverage in all of the carrier's group [*health benefit*] plans. If a carrier, however, elects to continue a plan that is closed to new policyholders instead of offering alternative coverage in its other group [*health benefit*] plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (6) of this section.

[*(9) This section applies only to group health benefit plans that are not small employer health benefit plans.*]

(11) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.

(12) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a group not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 21. ORS 743.758 is amended to read:

743.758. The Department of Consumer and Business Services may adopt rules incorporating, implementing and administering the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191)**, the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152)** and federal regulations that are issued in conjunction with the [*Act*] **Acts** [*, to the extent that such federal law and regulations are not inconsistent with any provision of Oregon law*].

SECTION 22. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

(a) "Carrier" means an insurer authorized to issue a policy of health insurance in this state. "Carrier" does not include a multiple employer welfare arrangement.

(b)(A) "Eligible individual" means an individual who:

(i) Has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application; or

(ii) [*On or after January 1, 1998,*] Meets the eligibility requirements of 42 U.S.C. 300gg-41, [*as amended and in effect on January 1, 1998,*] has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application.

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include an individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

(c) "Portability health benefit plans" and "portability plans" mean health benefit plans for eligible individuals that are required to be offered by all carriers offering group health benefit plans

and that have been approved by the Director of the Department of Consumer and Business Services 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 develop** 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 establish standards for**:

(A) A prevailing benefit plan, which shall reflect the benefit coverages that are prevalent in the group health insurance market; and

(B) A low cost benefit plan, which shall emphasize affordability for eligible individuals.

(b) Except as provided in ORS 743.730 to 743.773, no **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*] **standards for** portability health benefit plans [*if*] **established by** the director **under subsection (2) of this section must** [*determines that the plans*] provide for appropriate accessibility and affordability of needed health care services and comply with all other provisions of this section.

(4) [*After the director's approval of the portability plans submitted by the committee under this section,*] Each carrier offering group health benefit plans shall submit to the director the policy form or forms containing at least one low cost benefit and one prevailing benefit portability plan offered by the carrier that meets the [*required*] standards **established by the director under subsection (2) of this section**. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(5) [*Within*] **No later than** 180 days after [*approval by*] the director [*of the*] **establishes standards for** portability plans [*submitted by the committee*], as a condition of transacting group health insurance in this state, each carrier offering group health benefit plans shall make available to eligible individuals the prevailing benefit and low cost benefit portability plans that have been submitted by the carrier and approved by the director under subsection (4) of this section.

(6) A carrier offering group health benefit plans shall issue to an eligible individual who is leaving or has left group coverage provided by that carrier any portability plan offered by the carrier if the eligible individual applies for the plan within 63 days [*of*] **after** termination of prior coverage and agrees to make the required premium payments and to satisfy the other provisions of the portability plan.

(7) Premium rates for portability plans shall be subject to the following provisions:

(a) Each carrier must file [*the geographic average rate for each of its portability health benefit plans for a rating period*] with the director [*on or before March 15 of each year*] **the carrier's initial geographic average rate and any changes in the geographic average rate with respect to each portability health benefit plan issued by the carrier**.

(b) The premium rates charged during the rating period for each portability health benefit plan shall not vary from the geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. Adjustments for age shall comply with the following:

(A) For each plan, the variation between the lowest premium rate and the highest premium rate shall not exceed 100 percent of the lowest premium rate.

(B) Premium variations shall be determined by applying uniformly the carrier's schedule of age adjustments for portability plans as approved by the director.

(c) Premium variations between the portability plans and the rest of the carrier's group plans must be based solely on objective differences in plan design or coverage and must not include differences based on the actual or expected health status of individuals who select portability health benefit plans. For purposes of determining the premium variations under this paragraph, a carrier may:

(A) Pool all portability plans with all group health benefit plans; or

(B) Pool all portability plans for eligible individuals leaving small employer group health benefit plan coverage with all plans offered to small employers and pool all portability plans for eligible individuals leaving other group health benefit plan coverage with all health benefit plans offered to such other groups.

(d) A carrier may not increase the rates of a portability plan issued to [*an enrollee*] **a policyholder** 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*] **policyholder**. The percentage increase in the premium rate charged to [*an enrollee*] **a policyholder** for a new rating period may not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age.

(8) [*No*] **A** portability [*plans*] **plan** under this section may **not** contain preexisting [*conditions provisions, exclusion periods*] **condition exclusions**, waiting periods or other similar limitations on coverage.

(9) Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee[*, except*] **unless**:

(a) [*For nonpayment of the required premiums by*] The policyholder **fails to pay the required premiums**;

(b) [*For fraud or misrepresentation by*] The policyholder **or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy**;

(c) [*When*] The carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or

(d) [*When*] The director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet its contractual obligations.

(10)(a) [*Each*] **A** carrier offering **a** group health benefit [*plans*] **plan** 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*] **A** carrier **offering a group health benefit plan** shall file with the [*director*] **Department of Consumer and Business Services** 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*] **department**. A copy of [*such*] **each** certification shall be retained by the carrier at its principal place of business.

(c) [*Each such*] **A** carrier **offering a group health benefit plan** shall make the information and documentation described in paragraph (a) of this subsection available to the [*director*] **department** upon request. Except as provided in ORS 743.018 and except in cases of violations of the Insurance Code, the information is proprietary and trade secret information and shall not be subject to disclosure [*by the director*] to persons outside the department [*of Consumer and Business Services*] except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(11) A carrier offering **a** group health benefit [*plans*] **plan** shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell portability plans of the carrier on the basis of an eligible individual's anticipated claims experience.

(12) An individual who is eligible to obtain a portability plan in accordance with this section may obtain such a plan regardless of whether the eligible individual qualifies for a period of continuation coverage under federal law or under ORS 743.600 or 743.610. However, an individual who

has elected such continuation coverage is not eligible to obtain a portability plan until the continuation coverage has been discontinued by the individual or has been exhausted.

(13) Subject to the provisions of section 4 (2) and (4) of this 2011 Act, a carrier may rescind a portability health benefit plan issued to a policyholder only if the policyholder or a representative of the policyholder:

(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 policy.

SECTION 23. ORS 743.761 is amended to read:

743.761. (1) A carrier approved pursuant to subsection (4) of this section that offers individual health benefit plans may satisfy the requirements of ORS 743.760 by issuing any individual health benefit plan offered by the carrier to any eligible individual as defined in ORS 743.760 who:

(a) Is leaving or has left a group health benefit plan provided by that carrier;

(b) Applies for the policy; and

(c) Agrees to make the required premium payments and to satisfy the other provisions of the plan.

(2) All health benefit plans issued pursuant to subsection (1) of this section shall:

(a) Comply with ORS 743.767 and 743.769; and

(b) Contain no preexisting [*conditions provisions, exclusion periods*] **condition exclusions**, waiting periods or other similar limitations on coverage.

(3) A carrier offering plans pursuant to this section shall offer plans that meet the standards and requirements described in ORS 743.760 (2).

(4) The Director of the Department of Consumer and Business Services shall adopt standards for minimum participation in the individual market necessary for a carrier to offer policies under this section and shall develop a program for approval of carriers under this section.

SECTION 24. ORS 743.766 is amended to read:

743.766. (1) All carriers [*who*] **that** offer **an** individual health benefit [*plans*] **plan** 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*] **under ORS 743.745** 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*] **other** than:

(A) A preexisting [*conditions provision*] **condition exclusion** that complies with the following requirements:

(i) The [*provision shall apply*] **exclusion applies** 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*] **exclusion expires** no later than six months [*following*] **after** the individual's effective date of coverage; **and**

(iii) Except for grandfathered health plans, the exclusion does not apply to individuals who are 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) **Except for grandfathered health plans,** pregnancy **of individuals who are under 19 years of age** may **not** 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*] **condition exclusion** 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*] **after** 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*] **unless**:

(a) [*For nonpayment of the required premiums by*] The policyholder **fails to pay the required premiums**.

(b) [*For fraud or misrepresentation by*] The policyholder **or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy**.

(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*] **department** and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) [*When*] The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan**, other than a grandfathered health 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.

(f) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(g) With respect to plans that are being discontinued **under paragraph (e) or (f) of this subsection**, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, [*one or more individual*] **all** health benefit plans that the carrier offers **to individuals** 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)*] **(h)** [*When*] The Director **of the Department of Consumer and Business Services** 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)*] **(i)** [*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)*] **(j)** [*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)*] **(6)** 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 **(5)(c), (e) and (f) of this section**.

[*(6)*] **(7)** Notwithstanding any other provision of this section, **and subject to the provisions of section 4 (2) and (4) of this 2011 Act,** a carrier may rescind an individual health benefit plan [*for fraud, material misrepresentation or concealment by an enrollee.*] **if the policyholder or a representative of the policyholder:**

(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 policy.

[*(7)*] **(8)** 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)*] **(9)** 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.

(10) An individual health benefit plan may not impose lifetime limits on the dollar amount of the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law.

(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 25. ORS 743.767 is amended to read:

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

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

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. For age

adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

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

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

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

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

SECTION 26. ORS 743.801 is amended to read:

743.801. As used in **this section and** ORS [*743.801,*] 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917[,] **and** 743.918 [*and 743A.012*] **and section 4 of this 2011 Act**:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

(2) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

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

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

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

[*(4)*] **(3)** "Enrollee" has the meaning given that term in ORS 743.730.

[*(5)*] **(4)** "Grievance" means [*a written complaint*]**:**

(a) A request submitted by [*or on behalf of*] an enrollee **or an authorized representative of an enrollee:**

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

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

[*(b)*] **(B)** Claims payment, handling or reimbursement for health care services **and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination**; or

[*(c)*] **(C)** Matters pertaining to the contractual relationship between an enrollee and an insurer.

[*(6)*] **(5)** "Health benefit plan" has the meaning [*provided for*] **given** that term in ORS 743.730.

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

[*(8)*] **(7)** "Insurer" [*has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.012, 750.055 and 750.333, "insurer" also*] includes a health care service contractor as defined in ORS 750.005.

(8) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 27. ORS 743.804 is amended to read:

743.804. All insurers offering a health benefit plan in this state shall:

[*(1) Have a written policy that recognizes the rights of enrollees:*]

[*(a) To voice grievances about the organization or health care provided;*]

[*(b) To be provided with information about the organization, its services and the providers providing care;*]

[*(c) To participate in decision making regarding their health care; and*]

[*(d) To be treated with respect and recognition of their dignity and need for privacy.*]

[*(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating providers upon request and to all enrollees either directly or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees.*]

[*(3) Have a timely and organized system for resolving grievances and appeals. The system shall include:*]

[*(a) A systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken;*]

[*(b) Written procedures explaining the grievance and appeal process, including a procedure to assist enrollees in filing written grievances;*]

[*(c) Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms;*]

[*(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical urgency of the situation;*]

[*(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file a complaint with the Director of the Department of Consumer and Business Services; and*]

[*(f) An appeal process for grievances that includes at least the following:*]

[*(A) Three levels of review, the second of which shall be by persons not previously involved in the dispute and the third of which shall provide external review pursuant to an external review program meeting the requirements of ORS 743.857, 743.859 and 743.861;*]

[*(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and*]

[*(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.*]

[*(4) If the insurer has a prescription drug formulary, have:*]

[*(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and*]

[*(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.*]

[*(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:*]

[*(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area, and the availability of continuity of care as required by ORS 743.854;*]

[*(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;*]

[*(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;*]

[*(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;*]

[*(e) Procedures for notifying enrollees of:*]

[*(A) A change in or termination of any benefit;*]

[*(B) If applicable, termination of a primary care delivery office or site; and*]

[*(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;*]

[*(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment status;*]

[*(g) Procedures, if any, for changing providers;*]

[*(h) Procedures for voicing grievances, including the option of obtaining external review under the insurer's program established pursuant to ORS 743.857, 743.859 and 743.861;*]

[*(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;*]

[*(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;*]

[*(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;*]

[*(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;*]

[*(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;*]

[*(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information;*]

[*(o) A description of any assistance provided to non-English-speaking enrollees;*]

[*(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;*]

[*(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and*]

[*(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.*]

[*(6) Provide the following information upon the request of an enrollee or prospective enrollee:*]

[*(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;*]

[*(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;*]

[*(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;*]

[*(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;*]

[*(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services;*]

[*(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care; and*]

[*(g) A description of the insurer's external review program established pursuant to ORS 743.857, 743.859 and 743.861.*]

[*(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria. Nothing in this section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.*]

[*(8) Provide the following information to an enrollee when the enrollee has filed a grievance:*]

[*(a) Detailed information on the insurer's grievance and appeal procedures and how to use them;*]

[*(b) Information on how to access the complaint line of the Department of Consumer and Business Services; and*]

[*(c) Information explaining how an enrollee applies for external review of the insurer's actions under the external review program established by the insurer pursuant to ORS 743.857.*]

[*(9) Provide annual summaries to the Department of Consumer and Business Services of the insurer's aggregate data regarding grievances, appeals and applications for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, appeals and applications for external review.*]

[*(10) Ensure that the confidentiality of specified patient information and records is protected, and to that end:*]

[*(a) Adopt and implement written confidentiality policies and procedures;*]

[*(b) State the insurer's expectations about the confidentiality of enrollee information and records in medical service contracts; and*]

[*(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal information by the insurer, except as otherwise permitted or required by law.*]

[*(11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the insurer notifies the enrollee of an adverse decision. The notification shall include:*]

[*(a) Notice of the right of the enrollee to apply for internal and external review of the adverse decision;*]

[*(b) A statement whether a decision by an independent review organization is binding on the insurer and enrollee;*]

[*(c) A statement that if the decision is not binding on the insurer and if the insurer does not comply with the decision, the enrollee may sue the insurer as provided in ORS 743.864; and*]

[*(d) Information on filing a complaint with the Director of the Department of Consumer and Business Services.*]

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

(D) To be provided with the information described in this section.

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the department by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe drugs not included on the formulary;

(E) Procedures for the coverage of prescription drugs not included on the formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743.856.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743.854.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743.807, 743.814 and 743.817.

(2) Establish procedures for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations in a form and manner approved by the department or prescribed by the department by rule.

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions meeting criteria established by the Director of the Department of Consumer and Business Services by rule.

(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual and portability health benefit plans. If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and is conducted in a manner approved by the department or prescribed by the department by rule, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

(a) A change in or termination of any benefit; and

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS 743.859 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) Provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743.801 (4)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

(b) A general description of the reason for the grievance.

(c) The date the grievance was received by the insurer.

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

(9) Allow the exercise of any rights described in this section by an authorized representative.

SECTION 28. ORS 743.806 is amended to read:

743.806. All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

(1) The criteria used in the review process and the method of development of the criteria shall be made available for review to a party to such medical services contract upon request.

(2) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(3) Any [*patient or*] provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(4) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

SECTION 29. ORS 743.807 is amended to read:

743.807. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria used in the utilization review process and the method of development of the criteria shall be made available for review to contracting providers upon request.

(b) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(c) Any [*patient or*] provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(d) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

SECTION 30. ORS 743.845 is amended to read:

743.845. (1) [*For purposes of this section:*]

[*(a) "Pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.*]

[*(b)*] **As used in this section,** "women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider if:

(a) The women's health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and

(b) The women's health care provider requests that the insurer make the provider available for designation as a primary care provider.

(3) If a female enrollee has designated a primary care provider who is not a women's health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women's health care provider [*for the following services:*]**, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.**

[*(a) At least one annual preventative women's health examination;*]

[*(b) Medically necessary follow-up visits resulting from a preventative women's health examination. A health plan may require the women's health care provider to notify and consult with the enrollee's primary care provider; and*]

[*(c) Pregnancy care.*]

(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women's health care providers necessary to serve a defined population or geographic service area.

SECTION 31. ORS 743.857 is amended to read:

743.857. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS [*743.859 and*] 743.861 **and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS 743.861**. Each insurer shall provide the external review through an independent review organization that is under contract with the director [*of the Department of Consumer and Business Services*] to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer **or the director**, to obtain review by an independent review organization of a dispute relating to an adverse [*decision*] **benefit determination** by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the [*insurer shall request the director to*] **director shall** appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization [*and*] **no later than five business days after the appointment. The insurer** shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. [*The insurer shall furnish all such records, materials and information in a timely manner in order to enable a timely decision by the independent review organization. The director may establish timelines for the purpose*

of this subsection.] **An independent review organization may reverse the adverse benefit determination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.**

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

[*(4)*] **(b)** [*An insurer shall expedite an enrollee's case*] If a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION 32. ORS 743.859 is amended to read:

743.859. [*(1)*] An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

[*(a)*] **(1)** A statement of the right of enrollees to apply for external review by an independent review organization; and

[*(b) A statement of whether the insurer agrees to be bound by decisions of independent review organizations.*]

[*(2) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is not bound by the decisions of independent review organizations, the plan and the written information provided by the plan must prominently disclose that:*]

[*(a) The insurer is not bound by the decisions of independent review organizations;*]

[*(b) The insurer may follow nonetheless a decision by an independent review organization; and*]

[*(c)*] **(2) A statement that** if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer.

[*(3) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is bound by the decisions of independent review organizations, the plan must prominently disclose that fact. The plan must also state that the insurer agrees to act in accordance with the decision of the independent review organization notwithstanding the definition of medical necessity in the plan.*]

SECTION 33. ORS 743.861 is amended to read:

743.861. (1) An enrollee shall apply in writing for external review of an adverse [*decision*] **benefit determination** by the insurer of a health benefit plan not later than the 180th day after receipt of the insurer's final written decision following its **grievance and** internal [*review through its grievance and*] appeal process under ORS 743.804. An enrollee is eligible for external review only if the enrollee has satisfied the following requirements:

(a) The enrollee must have signed a waiver granting the independent review organization access to the medical records of the enrollee.

(b) The enrollee must have exhausted the plan's internal [*grievance*] **appeal** procedures established pursuant to ORS 743.804 **or be deemed to have exhausted the plan's internal appeal procedures**. The insurer may waive the requirement of compliance with the internal [*grievance*] **appeal** procedures and have a dispute referred directly to external review upon the enrollee's consent. **An enrollee is deemed to have exhausted the internal appeal procedures if the insurer fails to strictly comply with ORS 743.804 and federal requirements for internal appeals.**

(2) An enrollee who applies for external review of an adverse [*decision*] **benefit determination** shall provide complete and accurate information to the independent review organization [*in a timely manner*] **as provided in ORS 743.857**.

SECTION 34. ORS 743.862 is amended to read:

743.862. (1) An independent review organization shall perform the following duties when appointed under ORS 743.857 to review a dispute under a health benefit plan between an insurer and an enrollee:

(a) Decide whether the dispute [*is covered by the conditions established in ORS 743.857 for external review*] **pertains to an adverse benefit determination** and notify the enrollee and insurer in writing of the decision. If the decision is against the enrollee, the independent review organization shall notify the enrollee of the right to file a complaint with or seek other assistance from the [*Director of the*] Department of Consumer and Business Services and the availability of other assistance as specified by the [*director*] **department**.

(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization.

(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide, and when the information must be submitted **as provided in ORS 743.857**.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted **as provided in ORS 743.857**.

(e) Decide the dispute relating to the adverse [*decision*] **benefit determination** of the insurer [*under ORS 743.857 (1)*] and issue the decision in writing.

(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States. An independent review organization must make its decision in accordance with the coverage described in the health benefit plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment if the independent review organization determines that the standards of the insurer are unreasonable or are inconsistent with sound medical practice.

(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the insurer for an expedited review **or the Director of the Department of Consumer and Business Services orders an expedited review**.

(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the insurer for a review **or the director orders a review**.

(5) An independent review organization shall file synopses of its decisions with the director according to the format and other requirements established by the director. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.501 and 192.502 or that may otherwise allow identification of an enrollee. The director shall make the synopses public.

SECTION 35. ORS 743.863 is amended to read:

743.863. (1) **An insurer shall comply in a timely manner with a decision of an independent review organization under ORS 743.862 that reverses, in whole or in part, an adverse benefit determination.** If an insurer [*has agreed under the provisions of a health benefit plan to be bound by the decision of an independent review organization and the insurer fails to comply with such a decision*] **fails to comply with the decision**, the Director of the Department of Consumer and Business Services [*shall*] **may** impose on the insurer a civil penalty of [*not less than $100,000 and*] not more than $1 million.

(2) A decision of an independent review organization is admissible in any legal proceeding involving the insurer or the enrollee and involving the disputed issues subject to external review.

(3) The sanctions under subsection (1) of this section and the remedies under subsection (2) of this section are in addition to and not in lieu of other sanctions, rights and remedies provided by law or contract.

SECTION 36. ORS 743.864 is amended to read:

743.864. (1) An enrollee who is the subject of a decision of an independent review organization has a private right of action against the insurer for damages arising from an adverse [*decision*] **benefit determination** by the insurer that is subject to external review if[*:*]

[*(a) The insurer states in the health benefit plan in which the enrollee is enrolled that the insurer is not bound by the decisions of an independent review organization; and*]

[*(b)*] the insurer fails to comply with the decision.

(2) The Legislative Assembly intends that there is no private right of action under subsection (1) of this section if a court finds [*either subsection (1)(a) or (b)*] **subsection (1)** of this section to be unconstitutional or otherwise void.

SECTION 37. 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 38. ORS 743A.012 is amended to read:

743A.012. **(1) As used in this section:**

(a) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

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

(c) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(d) "Grandfathered health plan" has the meaning given that term in ORS 743.730.

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

(f) "Prior authorization" has the meaning given that term in ORS 743.801.

(g) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant women who is in active labor, to perform the delivery, including the delivery of the placenta.

[*(1)*] **(2)** All insurers offering a health benefit plan shall provide coverage without prior authorization for[*:*]

[*(a)*] emergency [*medical screening exams;*] **services.**

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage required by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

[*(b) Stabilization of an emergency medical condition; and*]

[*(c) Emergency services provided by a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a participating provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.*]

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible, unless the deductible applies generally to nonparticipating providers; and

(D) Subject only to an out-of-pocket maximum that applies to all services from nonparticipating providers.

[*(2)*] **(4)** All insurers [*described in subsection (1) of this section*] **offering a health benefit plan** shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

[*(3)*] **(5)** An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and [*shall*] **may** not deny coverage for emergency services solely because 9-1-1 was used.

[*(4)*] **(6)** This section is exempt from ORS 743A.001.

SECTION 39. ORS 743A.080 is amended to read:

743A.080. **(1) As used in this section, "pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.**

(2) All health benefit plans as defined in ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care[*, as defined by ORS 743.845,*] and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses and enrolled dependents.

SECTION 40. ORS 743A.090 is amended to read:

743A.090. (1) All individual and group health [*insurance policies providing hospital, medical or surgical expense benefits*] **benefit plans, as defined in ORS 743.730,** that include coverage for a

family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A [*newly born*] child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.

(2) The coverage of [*newly born*] **natural** and adopted children required by subsection (1) of this section shall consist of coverage **of preventive health services and treatment** of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of [*a specific*] **an additional** premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished **to** the insurer within 31 days after the date of birth or date of placement in order to **effectuate the coverage required by this section and to** have the coverage extended beyond the 31-day period.

(4) [*The following requirements apply to coverage of an adopted child required by subsection (1)(b) of this section:*]

[*(a)*] In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

[*(b) A policy may not restrict coverage of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.*]

(5) This section does not prohibit an insurer from denying or limiting coverage based on a preexisting condition of a child who is 19 years of age or older.

[*(5)*] **(6)** As used in this section:

[*(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.*]

(a) "Child" means an individual who is under 26 years of age.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743A.001 do not apply to this section.

SECTION 41. ORS 743A.110 is amended to read:

743A.110. (1) All insurers offering a health benefit plan as defined in ORS 743.730 shall provide payment, coverage or reimbursement for the following mastectomy-related services as determined by the attending physician and enrollee to be part of the enrollee's course or plan of treatment:

(a) All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts and stippling of the nipple and areola;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(c) Prostheses;

(d) Treatment of physical complications of the mastectomy, including lymphedemas; and

(e) Inpatient care related to the mastectomy and post-mastectomy services.

(2) An insurer providing coverage under subsection (1) of this section shall provide written notice describing the coverage to the enrollee at the time of enrollment in the health benefit plan and annually thereafter.

(3) A health benefit plan must provide a single determination of prior authorization for all mastectomy-related services covered under subsection (1) of this section that are part of the enrollee's course or plan of treatment.

(4) When an enrollee requests an external review of an adverse [*decision*] **benefit determination as defined in ORS 743.801** by the insurer regarding services described in subsection (1) of this section, the insurer **or the Director of the Department of Consumer and Business Services** must expedite the enrollee's case pursuant to ORS 743.857 [*(4)*] **(5)**.

(5) The coverage required under subsection (1) of this section is subject to the same terms and conditions in the plan that apply to other benefits under the plan.

(6) This section is exempt from ORS 743A.001.

SECTION 42. ORS 746.650 is amended to read:

746.650. **Except as otherwise provided in ORS 743.804, 743.806, 743.857 and 743.861:**

(1) In the event of an adverse underwriting decision, the insurer or insurance producer responsible for the decision must:

(a) Either provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise the consumer that upon written request the consumer may receive the specific reason or reasons in writing; and

(b) Provide the consumer proposed for coverage with a summary of the rights established under subsection (2) of this section and ORS 746.640 and 746.645.

(2) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to a consumer proposed for coverage, the insurer or insurance producer shall furnish to the consumer within 21 business days from the date of receipt of the written request:

(a) The specific reason or reasons for the adverse underwriting decision, in writing, if this information was not initially furnished in writing pursuant to subsection (1) of this section;

(b) The specific items of personal information and privileged information that support these reasons, subject to the following:

(A) The insurer or insurance producer is not required to furnish specific items of privileged information if the insurer or insurance producer has a reasonable suspicion, based upon specific information available for review by the Director of the Department of Consumer and Business Services, that the consumer proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure; and

(B) Specific items of individually identifiable health information supplied by a health care provider shall be disclosed either directly to the consumer about whom the information relates or to a health care provider designated by the consumer and licensed to provide health care with respect to the condition to which the information relates, whichever the insurer or insurance producer prefers; and

(c) The names and addresses of the institutional sources that supplied the specific items of information described in paragraph (b) of this subsection. However, the identity of any health care provider must be disclosed either directly to the consumer or to the designated health care provider, whichever the insurer or insurance producer prefers.

(3) The obligations imposed by this section upon an insurer or insurance producer may be satisfied by another insurer or insurance producer authorized to act on its behalf.

(4) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection (1) of this section may be given orally.

(5) Notwithstanding subsection (1) of this section, when an adverse underwriting decision is based in whole or in part on credit history or insurance score, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A summary of no more than four of the most significant credit reasons for the adverse underwriting decision, listed in decreasing order of importance, that clearly identifies the specific credit history or insurance score used to make the adverse underwriting decision. An insurer or

insurance producer may not use "poor credit history" or a similar phrase as a reason for an adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the consumer report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the credit history of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's consumer report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a consumer report furnished by the consumer reporting agency.

(6) Notwithstanding subsection (1) of this section, an insurer or insurance producer responsible for an adverse underwriting decision that is based in whole or in part on credit history or insurance score must provide the notice required by subsection (5) of this section only when the insurer or insurance producer makes the initial adverse underwriting decision regarding a consumer.

(7) Notwithstanding subsection (1) of this section, when an adverse underwriting decision relating to homeowner insurance is based in whole or in part on a loss history report, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A description of a specific claim or claims that are the basis for the specific loss history report used to make the adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the loss history report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the loss history report of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's loss history report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a loss history report furnished by the consumer reporting agency.

(8) When an adverse underwriting decision relating to homeowner insurance is based in part on credit history and in part on a loss history report, the insurer or insurance producer responsible for the adverse underwriting decision may provide the notices required by subsections (5) and (7) of this section in a single notice.

SECTION 42a. ORS 743A.141 is amended to read:

743A.141. (1) As used in this section, "hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

(2) A health benefit plan, as defined in ORS 743.730, shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if:

(a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and

(b) Necessary for the treatment of hearing loss in an enrollee in the plan who is:

(A) [*Under*] 18 years of age **or younger**; or

(B) [*18 years of age or older, eligible as a dependent under the plan*] **19 to 25 years of age** and enrolled in **a secondary school or** an accredited educational institution.

(3)(a) The maximum benefit amount required by this section is $4,000 every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. The benefit amount shall be adjusted on January 1 of each year to reflect the increase since January 1, 2010, in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor.

(b) A health benefit plan may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

(4) A health benefit plan may subject the payment, coverage or reimbursement required under this section to provisions of the plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.

(5) This section is exempt from ORS 743A.001.

SECTION 43. ORS 750.055 is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992 and 731.870.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.066, 743A.068, 743A.070, 743A.080, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.188, 743A.190 and 743A.192 **and sections 2, 4 and 4a of this 2011 Act**.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 44. ORS 750.333 is amended to read:

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

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

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

(c) ORS chapter 734.

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

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.760 to 743.773), 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.912, 743.917, 743A.012, 743A.020, 743A.052, 743A.064, 743A.080, 743A.100, 743A.104, 743A.110, 743A.144, 743A.170, 743A.175, 743A.184 and 743A.192 **and sections 2, 4 and 4a of this 2011 Act**.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

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

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

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

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

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

(c) Contributions shall be considered premiums.

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

SECTION 45. 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 a small employer group health insurance 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** [*3 of this 2010 Act*].

(2) Discounted rates allowed under this section shall be applied uniformly to all similarly situated small employer group 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)*] **(11)** or 743.767.

SECTION 46. The Health Insurance Reform Advisory Committee is abolished.

SECTION 47. (1) Sections 2 and 4 of this 2011 Act and the amendments to statutes and session laws by sections 5, 6, 7 to 9, 12, 14 to 17 and 19 to 45 of this 2011 Act apply to policies

or certificates issued or renewed on or after September 23, 2010, and in effect on or after the effective date of this 2011 Act.

(2) Section 4a of this 2011 Act applies to health benefit plans issued or renewed on or after the effective date of this 2011 Act.

(3) The amendments to ORS 743.610 by sections 6b and 6c of this 2011 Act apply to group health insurance policies issued or renewed before, on or after the effective date of this 2011 Act.

SECTION 48. (1) Section 5, chapter 73, Oregon Laws 2009, is repealed.

(2) Section 2, chapter 73, Oregon Laws 2009, as amended by section 6d of this 2011 Act, is repealed on January 2, 2012.

SECTION 49. If Senate Bill 91 becomes law, section 5, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91) (amending ORS 743.730), is repealed and ORS 743.730, as amended by section 7 of this 2011 Act, 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.

(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 condition exclusion;

(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 **that provides bronze plan coverage and that is** approved by the Department of Consumer and Business Services under ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-91 as amended and in effect on March 23, 2010.

(6) "Bronze plan" means a health benefit plan that meets the criteria for a bronze plan prescribed by the director by rule pursuant to section 2, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91).

[*(6)*] **(7)** "Carrier," except as provided in ORS 743.760, means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) 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.

[*(7)*] **(9)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

[*(8)*] **(10)** "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

[*(9)*] **(11)** "Eligible employee" means an employee 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 employer for fewer than 90 days are not eligible employees unless the employer so allows.

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

[*(11)*] **(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.

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

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

(a) Considered by the director 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.

[*(14)(a)*] **(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) 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.

[*(15)*] **(18)** "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

[*(16)*] **(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.

[*(17)(a)*] **(20)(a)** "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) 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, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) 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;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) 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; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

[*(18)*] **(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 approved by the director under ORS 743.745.

[*(19)*] **(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.

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

[*(21)*] **(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 February 17, 2009;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored 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 that 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, TRICARE, 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 after 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.

[*(22)*] **(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.

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

[*(24)*] **(28)** "Preexisting condition exclusion" 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) Except for coverage under an individual grandfathered health plan, a preexisting condition exclusion may not exclude coverage for services, charges or expenses incurred by an individual who is under 19 years of age.

[*(25)*] **(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.

[*(26)*] **(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.

[*(27)*] **(31)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(32) "Silver plan" means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to section 2, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91).

[*(28)(a)*] **(33)** "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 offered by the employer.

(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.

SECTION 50. If Senate Bill 91 becomes law, section 6, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91), is amended to read:

Sec. 6. Sections 2, 3 and 4**, chapter ___, Oregon Laws 2011 (Enrolled Senate Bill 91),** [*of this 2011 Act*] and the amendments to ORS 743.730 by [*section 5 of this 2011 Act*] **section 49 of this 2011 Act** become operative on January 2, 2014.

SECTION 51. This 2011 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2011 Act takes effect on its passage.

Passed by Senate May 3, 2011

Repassed by Senate June 13, 2011

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Robert Taylor, Secretary of Senate

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Peter Courtney, President of Senate

Passed by House June 7, 2011

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Bruce Hanna, Speaker of House

.....
Arnie Roblan, Speaker of House

Received by Governor:

.....M.,....., 2011

Approved:

.....M.,....., 2011

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John Kitzhaber, Governor

Filed in Office of Secretary of State:

.....M.,....., 2011

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Kate Brown, Secretary of State