HOUSE AMENDMENTS TO A-ENGROSSED SENATE BILL 89 (INCLUDING AMENDMENTS TO RESOLVE CONFLICTS)

By COMMITTEE ON HEALTH CARE

June 2

On page 1 of the printed A-engrossed bill, line 2, after "743.405," insert "743.601, 743.610,".

In line 5, after "743A.110," insert "743A.141,".

In line 6, delete the third "and" and insert "section 2, chapter 73, Oregon Laws 2009,".

In line 7, after "2010" insert ", 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)".

On page 2, line 9, delete "Section 4" and insert "Sections 4 and 4a" and delete "is" and insert "are".

In line 14, after "individual" delete the rest of the line.

In line 15, delete "vidual belongs".

Delete lines 17 through 20 and insert:

"(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".

In line 22, delete "of Consumer and Business Services".

In line 24, delete "(3)" and insert "(4)".

After line 25, insert:

"**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.".

On page 4, after line 19, insert:

"**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 member-*

ship] **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 con-**

tinuation 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 per-**

son 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 prereq-*

uisite 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.".

On page 5, line 3, after "including" insert a colon and delete the rest of the line and lines 4 through 6 and insert:

"(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.".

On page 8, lines 7 through 10, restore the bracketed material and delete the boldfaced material.

On page 17, line 41, after the comma delete the rest of the line and delete lines 42 through 45.

On page 18, delete lines 1 through 6 and insert "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.".

In line 7, delete "(9)" and insert "(10)".

In line 15, delete "(10)" and insert "(11)".

On page 19, line 29, delete "(11)" and insert "(12)".

In line 37, delete "(12)(a)" and insert "(13)(a)".

On page 20, line 9, delete "(13)" and insert "(14)".

In line 13, delete "(14)" and insert "(15)".

In line 15, delete "(15)" and insert "(16)".

In line 18, delete "(16)" and insert "(17)".

In line 21, delete "(17)" and insert "(18)" and delete "dollar".

In line 22, before "essential" insert "dollar amount of the".

In line 24, delete "(18)" and insert "(19)".

On page 26, line 7, after the comma delete the rest of the line and lines 8 through 15 and insert "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.".

In line 16, delete "(9)" and insert "(10)".

In line 23, delete "(10)" and insert "(11)" and delete "dollar" and after "the" insert "dollar amount of the".

In line 26, delete "(11)" and insert "(12)".

On page 29, line 29, delete "(3)" and insert "(4)".

On page 31, line 36, delete "one or more individual" and insert "all".

On page 32, line 17, delete "(3)" and insert "(4)".

In line 30, delete "dollar" and after "the" insert "dollar amount of the".

On page 33, delete line 30 and insert:

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

On page 34, line 12, delete "internal appeal" and insert "expedited response" and delete

"(2)(e)" and insert "(2)(d)".

In line 14, after "A" insert "written".

On page 38, delete lines 36 through 39 and insert:

"(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;".

On page 39, line 43, delete "Responding to grievances in a manner" and insert "An expedited response to a request for an internal appeal".

On page 40, line 44, delete "and internal appeals" and insert "described in ORS 743.801 (4)(a)".

On page 41, line 3, delete "and internal appeal".

In line 7, delete "grievance" and insert "appeal".

On page 46, line 13, after the second "condition" insert a colon and begin a new paragraph and insert "(A)".

In line 16, after "would" delete the rest of the line and insert ":

"(i) Place the health of a person, or an unborn child in the".

In line 17, delete the period and insert ";

"(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.".

On page 47, line 36, after "health" delete the rest of the line.

In line 37, delete "surgical expense benefits" and insert "benefit plans, as defined in ORS 743.730,".

On page 48, after line 16, insert:

"(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.".

In line 17, delete "(5)" and insert "(6)".

Delete lines 18 through 21 and insert:

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

On page 50, after line 43, insert:

"**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.".

On page 51, line 19, delete "and 4" and insert ", 4 and 4a".

On page 52, line 9, delete "and 4" and insert ", 4 and 4a".

In line 37, delete "(10)" and insert "(11)".

In line 39, after "47." insert "(1)" and delete the comma and insert "and".

In line 40, after "5" insert ", 6, 7".

After line 42, insert:

"(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.".

In line 43, delete "48" and insert "51".
