Senate Bill 89

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SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Authorizes Department of Consumer and Business Services to enforce health insurance requirements of federal law. Modifies definition of "health benefit plan" and includes student health insurance within definition. Prohibits health insurer from canceling, rescinding or refusing to renew policy on or after September 23, 2010, except for fraud or intentional misrepresentation of material fact. Requires health insurers to notify covered persons and department regarding rescinded policies on or after September 23, 2010. Prohibits preexisting condition exclusion for insureds under 19 years of age who are enrolled in certain types of health insurance. Requires coverage of federally specified preventive health services and limited cost-sharing for preventive services in health benefit plans issued on or after September 23, 2010. Prohibits health insurers from offering rate differentials for highly compensated employees. Removes exception for association health plans from specified provisions of Insurance Code. Prohibits lifetime dollar limits on essential health benefits covered by health insurance. Imposes new requirements for internal and external review of adverse benefit determinations in health benefit plans offered or renewed on or after September 23, 2010. Allows enrollee to seek external review through Director of Department of Consumer and Business Services. Requires insurers to allow female enrollee access to obstetrical or gynecological care without referral or prior authorization.

Abolishes Health Insurance Reform Advisory Committee.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 243.252, 413.032, 731.146, 731.232, 731.236, 731.244, 731.248, 731.252, 731.256, 731.264, 731.300, 731.302, 731.358, 731.362, 731.402, 731.418, 731.426, 731.988, 732.543, 733.170, 734.043, 737.245, 742.021, 743.101, 743.405, 743.683, 743.730, 743.731, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 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, 743.913, 743A.080, 743A.090, 743A.110, 744.718, 746.650, 750.055, 750.313 and 750.333 and section 13, chapter 752, Oregon Laws 2007, and section 4, chapter 75, Oregon Laws 2010; repealing section 12, chapter 752, Oregon Laws 2007; and declaring an emergency.

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

SECTION 1. As used in ORS 743.730 to 743.773, "grandfathered health plan" has the meaning given that term in 29 C.F.R. 2590.715-1251.

SECTION 2. Section 3 of this 2011 Act is added to and made a part of ORS 743.730 to 743.773.

SECTION 3. (1) Notwithstanding any other provision of law, a health benefit plan 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.

(2) A health benefit plan may not impose cost-sharing requirements on an enrollee for preventive health services unless the preventive health services are provided by out-of-network providers according to criteria prescribed by the Department of Consumer and

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Business Services in rules adopted consistent with 45 C.F.R. 147.130.

SECTION 4. Section 5 of this 2011 Act is added to and made a part of the Insurance Code.

SECTION 5. (1) An insurer may not rescind a health benefit plan or the coverage of any individual under a group or individual health insurance policy unless:

(a)(A) The individual or a person seeking coverage on behalf of the individual performs an act, practice or omission that constitutes fraud; or

(B) The individual 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 each plan enrollee or primary subscriber who would be affected by the rescission of coverage.

(2) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form and manner prescribed by the department no later than 30 days after the date that the rescission takes effect.

(3) As used in this section, "a person seeking coverage on behalf of the individual" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

SECTION 6. ORS 243.252 is amended to read:

243.252. (1) The state may pay none of the cost of making health benefit plan coverage available to a retired state employee who is an eligible employee and to family members or may agree, by collective bargaining agreement or otherwise, to pay part or all of that cost.

(2) Nothing in subsection (1) of this section or other law, except ORS 243.886, prohibits a collective bargaining unit from agreeing with an employer that is a public body, as defined in ORS 174.109, to establish a retiree medical trust, voluntary employees' beneficiary association, health reimbursement arrangement or other agreement for health care expenses of employees or retirees if the provisions of the trust, association, arrangement or other agreement comply with the requirements of the Insurance Code **and federal health insurance law**.

SECTION 7. 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 8. ORS 731.146 is amended to read:

731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or otherwise:

(a) Making or proposing to make an insurance contract.

(b) Taking or receiving any application for insurance.

(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other consideration for any insurance or any part thereof.

(d) Issuing or delivering policies of insurance.

(e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aiding on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof, the dissemination of information as to coverage or rates, the forwarding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the

investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation of the policy and arising out of it, or in any other manner representing or assisting a person with respect to insurance.

(f) Advertising locally or circularizing therein without regard for the source of such circularization, whenever such advertising or circularization is for the purpose of solicitation of insurance business.

(g) Doing any other kind of business specifically recognized **under the Insurance Code or federal health insurance laws** as constituting the doing of an insurance business [*within the meaning of the Insurance Code*].

(h) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (g) of this subsection in a manner designed to evade [*the provisions of*] **any requirements for insurers under** the Insurance Code **or federal health insurance laws**.

(2) Subsection (1) of this section does not include, apply to or affect the following:

(a) Making investments within a state by an insurer not admitted or authorized to do business within such state.

(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group life insurance or a policy of blanket health insurance, if the master policy was validly issued to cover a group organized primarily for purposes other than the procurement of insurance and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business;

(B) The policyholder is domiciled or otherwise has a bona fide situs; and

(C) With respect to a policy of blanket health insurance, the policy was approved by the director of such state.

(c) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group health insurance, if the master policy was validly issued to cover an employer group other than an association, trust or multiple employer welfare arrangement and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business; and

(B) The policyholder is domiciled or otherwise has a bona fide situs.

(d) Investigating, settling, or litigating claims under policies lawfully written within a state, or liquidating assets and liabilities, all resulting from the insurer's former authorized operations within such state.

(e) Transactions within a state under a policy subsequent to its issuance if the policy was lawfully solicited, written and delivered outside the state and did not cover a subject of insurance resident, located or to be performed in the state when issued.

(f) The continuation and servicing of life or health insurance policies remaining in force on residents of a state if the insurer has withdrawn from such state and is not transacting new insurance therein.

(3) If mail is used, an act shall be deemed to take place at the point where the matter transmitted by mail is delivered and takes effect.

SECTION 9. ORS 731.146, as amended by section 6, chapter 752, Oregon Laws 2007, is amended to read:

731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or otherwise:

(a) Making or proposing to make an insurance contract.

(b) Taking or receiving any application for insurance.

(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other consideration for any insurance or any part thereof.

(d) Issuing or delivering policies of insurance.

(e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aiding on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof, the dissemination of information as to coverage or rates, the forwarding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation of the policy and arising out of it, or in any other manner representing or assisting a person with respect to insurance.

(f) Advertising locally or circularizing therein without regard for the source of such circularization, whenever such advertising or circularization is for the purpose of solicitation of insurance business.

(g) Doing any other kind of business specifically recognized **under the Insurance Code or federal health insurance laws** as constituting the doing of an insurance business [*within the meaning of the Insurance Code*].

(h) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (g) of this subsection in a manner designed to evade [*the provisions of*] **any requirements for insurers under** the Insurance Code **or federal health insurance laws**.

(2) Subsection (1) of this section does not include, apply to or affect the following:

(a) Making investments within a state by an insurer not admitted or authorized to do business within such state.

(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out of a policy of group life insurance or group health insurance, or both, or a policy of blanket health insurance, if the master policy was validly issued to cover a group organized primarily for purposes other than the procurement of insurance and was delivered in and pursuant to the laws of another state in which:

(A) The insurer was authorized to do an insurance business;

(B) The policyholder is domiciled or otherwise has a bona fide situs; and

(C) With respect to a policy of blanket health insurance, the policy was approved by the director of such state.

(c) Investigating, settling, or litigating claims under policies lawfully written within a state, or liquidating assets and liabilities, all resulting from the insurer's former authorized operations within such state.

(d) Transactions within a state under a policy subsequent to its issuance if the policy was lawfully solicited, written and delivered outside the state and did not cover a subject of insurance resident, located or to be performed in the state when issued.

(e) The continuation and servicing of life or health insurance policies remaining in force on residents of a state if the insurer has withdrawn from such state and is not transacting new insurance therein.

(3) If mail is used, an act shall be deemed to take place at the point where the matter transmitted by mail is delivered and takes effect.

SECTION 10. ORS 731.232 is amended to read:

731.232. (1) For the purpose of an investigation or proceeding under the Insurance Code **or**

pursuant to federal health insurance laws, the Director of the Department of Consumer and Business Services may administer oaths and affirmations, subpoena witnesses, compel their attendance, take evidence and require the production of books, papers, correspondence, memoranda, agreements or other documents or records which the director considers relevant or material to the inquiry. Each witness who appears before the director under a subpoena shall receive the fees and mileage provided for witnesses in ORS 44.415 (2).

(2) If a person fails to comply with a subpoena so issued or a party or witness refuses to testify on any matters, the judge of the circuit court for any county, on the application of the director, shall compel obedience by proceedings for contempt as in the case of disobedience of the requirements of a subpoena issued from such court or a refusal to testify therein.

SECTION 11. ORS 731.236 is amended to read:

731.236. (1) The Director of the Department of Consumer and Business Services shall enforce the provisions of the Insurance Code **and federal health insurance laws** for the public good, and shall execute the duties imposed by the code.

(2) The director has the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code **and federal health insurance laws**.

(3) The director may conduct such examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the director considers proper to determine whether any person has violated any provision of the Insurance Code **or federal health insurance laws,** or to secure information useful in the lawful administration of any such provision. The cost of such additional examinations and investigations shall be borne by the state.

(4) The director has such additional powers and duties as may be provided by other laws of this state.

SECTION 12. ORS 731.244 is amended to read:

731.244. In accordance with the applicable provisions of ORS chapter 183, the Director of the Department of Consumer and Business Services may make reasonable rules necessary for or as an aid to the effectuation of the Insurance Code **and federal health insurance laws**. No such rule shall extend, modify or conflict with the Insurance Code**, federal health insurance laws** or the reasonable implications thereof.

SECTION 13. ORS 731.248 is amended to read:

731.248. (1) Orders of the Director of the Department of Consumer and Business Services shall be effective only when in writing and signed by the director or by the authority of the director. Orders shall be filed in the Department of Consumer and Business Services.

(2) Every such order shall state:

(a) Its effective date;

(b) Its intent or purpose;

(c) The grounds on which based; and

(d) The provisions of the Insurance Code **or federal health insurance laws** pursuant to which action is taken or proposed to be taken.

(3) Except as may be provided in the Insurance Code respecting particular procedures, an order or notice may be given by delivery to the person to be ordered or notified or by mailing it by certified or registered mail, return receipt requested, postage prepaid, addressed to the person at the residence or principal place of business of the person as last of record in the department. Notice so mailed shall be deemed to have been given when deposited in a letter depository of a United States post office.

SECTION 14. ORS 731.252 is amended to read:

731.252. (1) Whenever the Director of the Department of Consumer and Business Services has reason to believe that any person has been engaged or is engaging or is about to engage in any violation of the Insurance Code **or federal health insurance laws**, the director may issue an order, directed to such person, to discontinue or desist from such violation or threatened violation. The copy of the order forwarded to the person involved shall set forth a statement of the specific charges and the fact that the person may request a hearing within 20 days of the date of mailing. Where a hearing is requested, the director shall set a date for the hearing to be held within 30 days after receipt of the request, and shall give the person involved written notice of the hearing date at least seven days prior thereto. The person requesting the hearing must establish to the satisfaction of the director that such order should not be complied with. The order shall become final 20 days after the date of mailing unless within such 20-day period the person to whom it is directed files with the director a written request for a hearing. To the extent applicable and not inconsistent with the foregoing, the provisions of ORS chapter 183 shall govern the hearing procedure and any judicial review thereof. Where the hearing has been requested, the director's order shall become final at such time as the right to further hearing or review has expired or been exhausted.

(2) No order of the director under this section or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

(3) The powers vested in the director pursuant to this section are supplementary and not in lieu of any other powers to suspend or revoke certificates of authority or licenses or to enforce any penalties, fines or forfeitures, authorized by law with respect to any violation for which an order of discontinuance has been issued.

SECTION 15. ORS 731.256 is amended to read:

731.256. (1) The Director of the Department of Consumer and Business Services may institute such actions or other lawful proceedings as the director may deem necessary for the enforcement of any provision of the Insurance Code **or other law applicable to insurance operations** or **of** any order or action made or taken by the director in pursuance of law.

(2) If the director has reason to believe that any person has violated any provision of the Insurance Code or other law applicable to insurance operations, for which criminal prosecution is provided and in the opinion of the director would be in order, the director shall give the information relative thereto to the Attorney General or district attorney having jurisdiction of any such violation. The Attorney General or district attorney promptly shall institute such action or proceedings against such person as the information requires or justifies.

SECTION 16. ORS 731.264 is amended to read:

731.264. (1) A complaint made to the Director of the Department of Consumer and Business Services against any person regulated by the Insurance Code **or federal health insurance laws**, and the record thereof, shall be confidential and may not be disclosed except as provided in ORS 705.137. No such complaint, or the record thereof, shall be used in any action, suit or proceeding except to the extent considered necessary by the director in the prosecution of apparent violations of the Insurance Code or other law.

(2) Data gathered pursuant to an investigation by the director of a complaint shall be confidential, may not be disclosed except as provided in ORS 705.137 and may not be used in any action, suit or proceeding except to the extent considered necessary by the director in the investigation or prosecution of apparent violations of the Insurance Code or other law.

(3) Notwithstanding subsections (1) and (2) of this section, the director shall establish by rule a method for publishing an annual statistical report containing the insurer's name and the number, percentage, type and disposition of complaints received by the Department of Consumer and Business Services against each insurer transacting insurance within this state.

SECTION 17. ORS 731.300 is amended to read:

731.300. (1) The Director of the Department of Consumer and Business Services shall examine every authorized insurer, including an audit of the financial affairs of such insurer, as often as the director determines an examination to be necessary but at least once each five years. An examination shall be conducted for the purpose of determining the financial condition of the insurer, its ability to fulfill its obligations and its manner of fulfillment, the nature of its operations and its compliance with the Insurance Code **and federal health insurance laws**. The director may also make such an examination of any surplus lines insurance producer or any person holding the capital stock of an authorized insurer or surplus lines insurance producer for the purpose of controlling the management thereof as a voting trustee or otherwise, or both.

(2) Instead of conducting an examination of an authorized foreign or alien insurer, the director may accept an examination report on the insurer that is prepared by the insurance department for the state of domicile or state of entry of the insurer if:

(a) At the time of the examination the insurance department of the state was accredited under the Financial Regulation Standards and Accreditation Program or successor program of the National Association of Insurance Commissioners; or

(b) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(3) Examination of an alien insurer shall be limited to its insurance transactions, assets, trust deposits and affairs in the United States except as otherwise required by the director.

SECTION 18. ORS 731.302 is amended to read:

731.302. (1) When the Director of the Department of Consumer and Business Services determines that an examination should be conducted, the director shall appoint one or more examiners to perform the examination and instruct them as to the scope of the examination. In conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners. The director may prescribe the examiner handbook or its successor publication and employ other guidelines and procedures that the director determines to be appropriate.

(2) When making an examination, the director may retain appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as needed. The cost of retaining such professionals and specialists shall be borne by the person that is the subject of the examination.

(3) At any time during the course of an examination, the director may take other action pursuant to the Insurance Code **or federal health insurance laws**.

(4) Facts determined [*and conclusions made*] pursuant to an examination shall be presumptive evidence of the relevant facts [*and conclusions*] in any judicial or administrative action.

SECTION 19. ORS 731.358 is amended to read:

731.358. Upon application**,** a domestic insurer shall be granted a certificate of authority to

transact any class of insurance permitted by the Insurance Code and provided for in its articles of incorporation upon its compliance with all the laws of this state [*and*]**,** the rules of the Department of Consumer and Business Services relating to such insurers **and federal health insurance laws**.

SECTION 20. ORS 731.362 is amended to read:

731.362. (1) A foreign or alien insurer may be authorized to transact insurance in this state when it has complied with the following requirements:

(a) It shall file with the Director of the Department of Consumer and Business Services a certified copy of its charter, articles of incorporation or deed of settlement and a statement of its financial condition and business in all states in such form and detail as the director may require, signed and sworn to by at least two of its executive officers or the United States manager.

(b) It shall satisfy the director that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact.

(c) It shall satisfy the director that it is possessed of and will maintain at all times its required capitalization.

(d) It shall make such deposits with the Department of Consumer and Business Services as are required by the provisions of the Insurance Code.

(2) Upon compliance with the requirements of this section and all other requirements imposed on such insurer by the Insurance Code **and federal health insurance laws**, the director shall issue to it a certificate of authority.

SECTION 21. ORS 731.402 is amended to read:

731.402. (1) The Director of the Department of Consumer and Business Services shall issue to an insurer a certificate of authority if upon completion of the application for a certificate of authority by the insurer the director finds, from the application and such other investigation and information the director may acquire, that the insurer is fully qualified and entitled thereto under the Insurance Code **and federal health insurance laws**.

(2) The director shall take all necessary action and shall either issue or refuse to issue a certificate of authority within a reasonable time after the completion of the application for such authority.

(3) The certificate of authority, if issued, shall specify the class or classes of insurance the insurer is authorized to transact in this state. The director may issue authority limited to particular subclasses of insurance or types of insurance coverages within the scope of a class of insurance.

SECTION 22. ORS 731.418 is amended to read:

731.418. (1) The Director of the Department of Consumer and Business Services may refuse to continue or may suspend or revoke an insurer's certificate of authority if the director finds after **notice and an opportunity for** a hearing that:

(a) The insurer has violated or failed to comply with any lawful order of the director, [*or any provision of*] the Insurance Code **or federal health insurance laws** other than those for which suspension or revocation is mandatory.

(b) The insurer is in unsound condition, or in such condition or using such methods and practices in the conduct of its business, as to render its further transaction of insurance in this state hazardous or injurious to its policyholders or to the public.

(c) The insurer has failed, after written request by the director, to remove or discharge an officer or director who has been convicted in any jurisdiction of an offense which, if committed in this state, constitutes a misdemeanor involving moral turpitude or a felony, or is punishable by death or imprisonment under the laws of the United States, in any of which cases the record of the con-

viction shall be conclusive evidence.

(d) The insurer is affiliated with and under the same general management, interlocking directorate or ownership as another insurer that transacts direct insurance in this state without having a certificate of authority [*therefor*], except as permitted under the Insurance Code **or federal law**.

(e) The insurer or an affiliate or holding company of the insurer refuses to be examined or any director, officer, employee or representative of the insurer, affiliate or holding company refuses to submit to examination relative to the affairs of the insurer, or to produce its accounts, records, and files for examination when required by the director or an examiner of the Department of Consumer and Business Services, or refuse to perform any legal obligation relative to the examination.

(f) The insurer has failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking issued or guaranteed by it, within 30 days after the judgment became final, or within 30 days after time for taking an appeal has expired, or within 30 days after dismissal of an appeal before final determination, whichever date is the later.

(g) The insurer [*fails*] **has failed** to comply with ORS 742.534 (1).

(h) The insurer has failed to comply with ORS 476.270 (1), (2) or (3) or 654.097 (1).

[*(2) Without advance notice or a hearing thereon, the director may suspend immediately the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings, have been commenced in any state by the public insurance supervisory official of such state.*]

(2) If an insurance official of any state commences receivership, conservatorship, rehabilitation or other delinquency proceedings against any insurer, the director may immediately suspend the insurer's certificate of authority without advance notice or an opportunity for a hearing.

SECTION 23. ORS 731.426 is amended to read:

731.426. (1) In an order suspending the certificate of authority of an insurer, the Director of the Department of Consumer and Business Services may provide that the suspension expires at the end of a specified period or when the director determines that the cause or causes of the suspension have terminated. During the suspension the director may rescind or shorten the suspension by further order.

(2) During the suspension period the insurer shall not solicit or write any new business in this state, but shall file its annual statement and pay fees, licenses and taxes as required under the Insurance Code, and may service its business already in force in this state, as if the certificate of authority had continued in full force.

(3) Upon expiration of a specific suspension period, if within such period the certificate of authority has not terminated, the insurer's certificate of authority automatically shall reinstate unless the director finds that the cause or causes of the suspension have not terminated, or that the insurer is otherwise not in compliance with the requirements of the Insurance Code **or federal health insurance laws**, and of which the director shall give the insurer notice not less than 30 days in advance of the expiration of the suspension period.

(4) When the director determines that a suspension should expire because the cause or causes have terminated, the director shall reinstate the certificate of authority of the insurer unless the certificate of authority has expired within the suspension period.

(5) Upon reinstatement of the insurer's certificate of authority, the authority of its insurance producers in this state to represent the insurer shall likewise reinstate. The director promptly shall

notify the insurer and its insurance producers in this state of record in the Department of Consumer and Business Services, of such reinstatement. If pursuant to ORS 731.422 the director has published notice of suspension, in like manner the director shall publish notice of the reinstatement.

SECTION 24. ORS 731.988 is amended to read:

731.988. (1) Any person who violates any provision of the Insurance Code, any lawful rule or final order of the Director of the Department of Consumer and Business Services or any judgment made by any court upon application of the director, shall forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director of not more than $10,000 for each offense. In the case of individual insurance producers, adjusters or insurance consultants, the civil penalty shall be not more than $1,000 for each offense. Each violation shall be deemed a separate offense.

(2) In addition to the civil penalty set forth in subsection (1) of this section, any person who violates any provision of the Insurance Code, any lawful rule or final order of the director or any judgment made by any court upon application of the director, may be required to forfeit and pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed the amount by which such person profited in any transaction which violates any such provision, rule, order or judgment.

(3) In addition to the civil penalties set forth in subsections (1) and (2) of this section, any insurer that is required to make a report under ORS 742.400 and that fails to do so within the specified time may be required to pay to the General Fund of the State Treasury a civil penalty in an amount determined by the director but not to exceed $10,000.

(4) A civil penalty imposed under this section may be recovered either as provided in subsection (5) of this section or in an action brought in the name of the State of Oregon in any court of appropriate jurisdiction.

(5) Civil penalties under this section shall be imposed and enforced in the manner provided by ORS 183.745.

(6) The provisions of this section are in addition to and not in lieu of any other enforcement provisions contained in the Insurance Code **or federal health insurance laws**.

SECTION 25. ORS 732.543 is amended to read:

732.543. (1) Whenever it appears to the Director of the Department of Consumer and Business Services that any person has committed or is about to commit a violation of any provision of ORS 732.517 to 732.546 or of any rule or order issued by the director under ORS 732.517 to 732.546, the director may apply to the Circuit Court for Marion County for an order enjoining the person, and any director, officer, employee or agent of the person, from the violation, and for such other equitable relief as the nature of the case and the interests of the policyholders, creditors and shareholders of any insurer or the public may require.

(2) No security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of ORS 732.517 to 732.546 or of any rule or order issued by the director under ORS 732.517 to 732.546, may be voted at any shareholder's meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding. However, no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the director has reason to believe that any security of the insurer has been or is about to be acquired in contravention of ORS 732.517 to 732.546 or any rule or order

issued by the director under ORS 732.517 to 732.546, the insurer or the director may apply to the Circuit Court for Marion County, or to the circuit court for the county in which the insurer has its principal place of business in this state, if any, to enjoin the violation, to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

(3) In any case in which a person has acquired or is proposing to acquire any voting securities of an insurer in violation of ORS 732.517 to 732.546 or any rule or order issued by the director under ORS 732.517 to 732.546, the Circuit Court for Marion County, or the circuit court for the county in which the insurer has its principal place of business in this state, if any, upon the application of the insurer or the director and on such notice as the court deems appropriate, may seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue any order with respect to the voting securities as may be appropriate to effect the provisions of ORS 732.517 to 732.546. Notwithstanding any other provision of law, for the purposes of this section, the situs of the ownership of the securities of domestic insurers is located in this state.

(4) The director may exercise remedies available under this section in addition to or in lieu of any other remedy or administrative action available to the director under the Insurance Code **or federal health insurance laws**.

SECTION 26. ORS 733.170 is amended to read:

733.170. An insurer shall keep its books, records, accounts and transaction source data in such manner that the Director of the Department of Consumer and Business Services may readily verify its statements of financial condition and ascertain whether the insurer is unimpaired, has given proper treatment to policyholders and has complied with the Insurance Code **and federal health insurance laws**.

SECTION 27. ORS 734.043 is amended to read:

734.043. (1) For any reason stated in subsection (2) of this section, the Director of the Department of Consumer and Business Services by order may place under supervision:

(a) A domestic insurer; or

(b) A foreign or alien insurer, if the insurance regulatory official of its state of domicile or entry has asked the director to apply this section and ORS 734.047, 734.051 and 734.055 to the insurer.

(2) The director may place an insurer under supervision if upon examination or at any other time the director determines that:

(a) The condition of the insurer renders the continuance of its business hazardous to the public or to its insureds.

(b) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the director or any deputy, examiner or employee representing the director.

(c) A domestic insurer has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the insurer.

(d) The insurer has failed to comply promptly with the applicable financial reporting statutes or rules and any request of the Department of Consumer and Business Services relating thereto.

(e) The insurer has failed to observe an order of the director to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus.

(f) The insurer is continuing to transact insurance or write business after its certificate of authority has been revoked or suspended by the director.

(g) The insurer, by contract or otherwise, has done any of the following unlawfully, in violation

of an order of the director or without first having obtained written approval of the director:

(A) Totally reinsured its entire outstanding business; or

(B) Merged or consolidated substantially its entire property or business with another insurer.

(h) The insurer has engaged in any transaction in which it is not authorized to engage under the laws of this state.

(i) The insurer has failed to comply with any other order of the director.

(j) The insurer has failed to comply with any other applicable provisions of the Insurance Code **or federal health insurance laws**.

(k) The business of the insurer is being conducted fraudulently.

(L) The insurer agrees to supervision.

(3) If the director determines that one or more conditions set forth in subsection (2) of this section exist, the director may do all of the following:

(a) Notify the insurer of the determination of the director.

(b) Furnish to the insurer a written list of the requirements to abate the condition or conditions determined to exist.

(c) Notify the insurer that it is under the supervision of the director and that the director is applying this section and ORS 734.047, 734.051 and 734.055.

(4) The director may act as the supervisor to conduct the supervision and otherwise carry out an order under subsection (1) of this section or may appoint another person as supervisor.

(5) The director or the appointed supervisor may prohibit any person from taking any of the following actions during the period of supervision without the prior approval of the director or supervisor:

(a) Disposing of, conveying or encumbering any of the insurer's assets or its business in force.

(b) Withdrawing from any of the insurer's bank accounts.

(c) Lending any of the insurer's funds.

(d) Investing any of the insurer's funds.

(e) Transferring any of the insurer's property.

(f) Incurring any debt, obligation or liability on behalf of the insurer.

(g) Merging or consolidating the insurer with another insurer or other person.

(h) Entering into any new reinsurance contract or treaty.

(i) Approving new premiums or renewing any policies.

(j) Terminating, surrendering, forfeiting, converting or lapsing any insurance policy, certificate or contract, except for nonpayment of premiums due.

(k) Releasing, paying or refunding premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate or contract.

(L) Making any material change in management.

(m) Increasing salaries and benefits of officers or directors.

(n) Making or increasing preferential payment of bonuses, dividends or other payments determined by the director to be preferential.

(o) Any other action affecting the business or condition of the insurer.

(6) The director may apply to any circuit court for any restraining order, preliminary and permanent injunctions and other orders necessary to enforce a supervision order.

(7) During the period of supervision, the insurer may file a written request for a hearing to review the supervision or any action taken or proposed to be taken. A request under this subsection shall not suspend the supervision. The insurer must specify in the request the manner in which the

action being complained of would not result in improving the condition of the insurer. The hearing shall be held within 30 days after the filing of the request. The director shall complete the review of the supervision or other action and shall take action under subsection (8) of this section if appropriate within 30 days after the record for the hearing is closed.

(8) The director shall release an insurer from supervision if the director determines upon hearing that none of the conditions giving rise to the supervision exist.

SECTION 28. ORS 737.245 is amended to read:

737.245. In the event any insurer shall in collusion with any other insurer conspire to fix, set or adhere to insurance rates except as expressly sanctioned by the Insurance Code **or federal health insurance laws**, such insurer shall be liable to any person damaged thereby for an amount equal to three times the amount of such damage together with the damaged party's attorney fees.

SECTION 29. ORS 742.021 is amended to read:

742.021. (1) Insurance policies shall contain such standard or uniform provisions as are required by the applicable provisions of the Insurance Code **and federal health insurance laws**. However, the insurer may at its option substitute for one or more of such provisions corresponding provisions of different wording approved by the Director of the Department of Consumer and Business Services [*which*] **that** are in each instance not less favorable in any respect to the insured or the beneficiary.

(2) If any standard or uniform provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy**,** the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision[,] and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(3) Except as provided in subsection (2) of this section, [*no*] **a** policy [*shall*] **may not** contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used.

SECTION 30. ORS 743.101 is amended to read:

743.101. (1) The purpose of the Life and Health Insurance Policy Language Simplification Act is to establish minimum standards for language used in policies and certificates of life insurance and health insurance delivered or issued for delivery in this state in order to facilitate ease of reading.

(2) ORS 743.100 to 743.109 is not intended to increase the risk assumed by insurers or to supersede their obligation to comply with the substance of other [*Insurance Code*] provisions **of the Insurance Code or federal law** applicable to insurance policies. ORS 743.100 to 743.109 is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content.

SECTION 31. 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, dependent 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 32. ORS 743.683 is amended to read:

743.683. (1) No Medicare supplement insurance policy, contract or certificate in force in [*the*] **this** state shall contain benefits [*which*] **that** duplicate benefits provided by Medicare.

(2) The Director of the Department of Consumer and Business Services shall adopt by rule specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable **state and federal** laws [*of this state*]. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in ORS 743.680 to 743.689, shall apply to Medicare supplement policies. The standards may cover, but not be limited to:

(a) Terms of renewability;

(b) Initial and subsequent conditions of eligibility;

(c) Nonduplication of coverage;

(d) Probationary periods;

(e) Benefit limitations, exceptions and reductions;

(f) Elimination periods;

(g) Requirements for replacement;

(h) Recurrent conditions; and

(i) Definitions of terms.

(3) Provisions established by the director governing eligibility for Medicare supplement insurance shall not be limited to persons qualifying for Medicare by reason of age.

(4) The director may adopt by rule standards that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supple-

ment policy.

(5) Notwithstanding any other provision of law of this state, a Medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(6) The director shall adopt by rule standards for benefits and claims payment under Medicare supplement policies.

SECTION 33. 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 director 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.

[*(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.

[*(18)*] **(15)** "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)*] **(16)(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*]**;**

(C) Student health insurance policy; or

(D) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

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

(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 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, a short term health insurance policy is renewed if an insurer issues a new short term health insurance policy to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

[*(20)*] **(17)** "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**.

(18) "Highly compensated individual" means a highly compensated individual as defined in 26 U.S.C. 105 or as otherwise defined, in a manner consistent with federal law, by the director by rule.

[*(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 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, 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) **Notwithstanding any other provision of law, except for grandfathered health plan coverage of individuals,** a preexisting [*conditions provision shall*] **condition exclusion may** not be applied to [*a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090*] **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.

[*(30)(a)*] **(27)(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)*] **(b)** 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 34. 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 35. 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 36. 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**, chapter 81, Oregon Laws 2010, and sections 9, 39 and 44 of this 2011 Act** [*of this 2010 Act*] become operative on January 2, 2014.

SECTION 37. Section 12, chapter 752, Oregon Laws 2007, is repealed.

SECTION 38. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, and section 2, chapter 81, Oregon Laws 2010, is amended to read:

743.734. (1) Every [*group*] health benefit plan shall be subject to the provisions of ORS 743.733

to 743.737, 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 section 3 of this 2011 Act**, no **state** law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

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

(a) 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 **and may not discriminate in favor of highly compensated individuals**. [*Except as provided in ORS 743.736 (10):*]

[*(a)*] **(b)** [*When*] **Except as provided in ORS 743.736 (8),** 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 in subsection (7) of this section does not include 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 health benefit plan or exclude coverage otherwise provided to an individual under a plan, other than a grandfathered health plan, based on a preexisting condition of the individual if the individual is under 19 years of age.

SECTION 39. ORS 743.734, as amended by section 9, chapter 752, Oregon Laws 2007, sections 2 and 3, chapter 81, Oregon Laws 2010, and section 38 of this 2011 Act, 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 section 3 of this 2011 Act**, no **state** law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

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

(a) 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 **and may not discriminate in favor of highly compensated individuals**. [*Except as provided in ORS 743.736 (10):*]

[*(a)*] **(b)** [*When*] **Except as provided in ORS 743.736 (8),** 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) Notwithstanding any other provision of law, an insurer may not deny, delay or ter-

minate participation of an individual in a health benefit plan or exclude coverage otherwise provided to an individual under a plan, other than a grandfathered health plan, based on a preexisting condition of the individual if the individual is under 19 years of age.

SECTION 40. ORS 743.736 is amended to read:

743.736. [*(1) In order to improve the availability and affordability of health benefit coverage for small employers, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the Director of the Department of Consumer and Business Services two basic health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. 300e et seq.*]

[*(2)(a) The director shall approve the basic health benefit plans following a determination that the plans provide for maximum accessibility and affordability of needed health care services and following a determination that the basic health benefit plans substantially meet the social values that underlie the ranking of benefits by the Health Services Commission and that the basic health benefit plans are substantially similar to the Medicaid reform program under chapter 836, Oregon Laws 1989, funded by the Legislative Assembly.*]

[*(b) The basic health benefit plans shall include benefits mandated under ORS 743A.168 until mental health, alcohol and chemical dependency services are fully integrated into the Health Services Commission's priority list, and as funded by the Legislative Assembly, and chapter 836, Oregon Laws 1989, is implemented.*]

[*(c) The commission shall aid the director by reviewing the basic health benefit plans and commenting on the extent to which the plans meet these criteria.*]

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

[*(4)(a) As a condition of transacting business in the small employer health insurance market in this state, every small employer carrier shall offer small employers an approved basic health benefit plan and any other plans that have been submitted by the small employer carrier for use in the small employer market and approved by the director.*]

[*(b) Nothing in this subsection shall require a small employer carrier to resubmit small employer health benefit plans that were approved by the director prior to October 1, 1996, nor shall small employer carriers be required to reinitiate new plan selection procedures for currently enrolled small employers prior to the small employer's next health benefit plan coverage anniversary date.*]

[*(c)*] **(2)** A carrier that offers a health benefit plan in the small employer market only through one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

[*(5)*] **(3)** [*A small employer*] **A** carrier shall issue to a small employer any [*small employer*] health benefit plan**, including a basic health benefit plan, that is** offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

[*(6)*] **(4)** A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business,

profession or industry or their subsidiaries shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

[*(7)*] **(5)** [*A small employer*] **A** carrier shall, pursuant to [*subsections (4) and (5)*] **subsection (3)** of this section, [*offer coverage to or accept applications from a*] **accept applications from and offer coverage to a small employer** group covered under an existing [*small employer*] health benefit plan **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)*] **(6)** [*No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5)*] **A carrier is not required to accept applications from and offer coverage pursuant to subsection (3)** of this section if the director finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

[*(9)*] **(7)** [*Every small employer*] **A** carrier shall market fairly all [*small employer*] health benefit plans **in which a small employer is legally eligible to enroll and that are not grandfathered health plans, including basic health benefit plans, that are** offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

[*(10)(a)*] **(8)(a)** [*No small employer carrier shall be*] **A carrier is not** required to **accept applications from or** offer coverage [*or accept applications*] pursuant to [*subsections (4) and (5)*] **subsection (3)** of this section [*in the case of any of the following*]:

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

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

(C) Within an area where the carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection shall not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

[*(11)*] **(9)** For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in

this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

[*(12)*] **(10)** [*A small employer*] **A** carrier that[*, after September 29, 1991,*] elects to discontinue offering all of its [*small employer*] health benefit plans **to small employers** under ORS 743.737 [*(5)(e)*] **(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 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 provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering [*small employer*] health benefit plans **to small employers** in this state.

SECTION 41. 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 who are 19 years of age or**

older may be [*excluded from coverage*] **denied enrollment** for up to 12 months or may be subjected to a preexisting [*conditions provision*] **condition exclusion** for up to 12 months. If both [*an exclusion from coverage period*] **a denial of enrollment** 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 a small employer is legally eligible to purchase and** that the carrier offers **to small employers** in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) [*When*] The carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection **or a grandfathered health**

plan. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all health benefit plans **that a small employer is legally eligible to purchase and** that the carrier offers **to small employers** in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

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

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

(h) [*When*] The Director **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) [*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) [*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)*] **(6)** 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 **(5)(e) and (g) of this section**.

[*(6)*] **(7)** Notwithstanding any provision of subsection [*(5)*] **(6)** of this section to the contrary, **a carrier may rescind** any small employer [*carrier*] health benefit plan**, or the coverage of an enrollee under a plan,** subject to the provisions of ORS 743.733 to 743.737 [*may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.*] **if the small employer or the enrollee:**

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

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

[*(7)*] **(8)** A [*small employer*] carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the [*small employer*] carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

[*(8)*] **(9)** Premium rates for small employer health benefit plans 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*] **department** at least once every 12 months.

(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers may not vary from the geographic average rate by more than 50 percent on or after January 1, 2008, except as provided in subparagraph (D) of this paragraph.

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on the factors specified in subparagraph (C) of this paragraph. A [*small employer*] carrier may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium rates for **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)*] **(10)** In connection with the offering for sale of any health benefit plan to a small employer, each [*small employer*] carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans 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)*] **(11)(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)*] **(12)** A [*small employer*] carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

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

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

[*(14)*] **(15)** 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**.

(16) A group health benefit plan may not impose lifetime dollar limits on the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11.

SECTION 42. 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 43. 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 44. 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 45. 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**, 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 46. ORS 743.752 is amended to read:

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

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

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

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

(3) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status of the employees or their dependents **and does not discriminate in favor of highly compensated individuals**.

(5) A multiple employer welfare arrangement, professional or trade association, or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry or their subsidiaries as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

SECTION 47. 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 **who are 19 years of age or older** may be [*excluded from coverage*] **denied enrollment** for up to 12 months or may be subjected to a preexisting [*conditions provision*] **condition exclusion** for up to 12 months. If both [*an exclusion from coverage period*] **a denial of enrollment** 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 policyholder is legally eligible to purchase and** that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) [*When*] The carrier discontinues offering or renewing, or offering and renewing, a [*health benefit*] plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans **that the policyholder is legally eligible to purchase and** 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) [*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) [*When,*] In the case of a [*group health benefit*] plan that delivers covered services through a

specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

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

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

[*(L)*] **(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) and (g) of this section**.

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

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

(10) A health benefit plan may not impose lifetime dollar limits on the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11.

SECTION 48. 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*] **do not preempt** any provision of Oregon law.

SECTION 49. 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 car-

rier 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.

(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 **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) A carrier may rescind a portability health benefit plan issued to a policyholder only if 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 50. 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 51. 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) Pregnancy may constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting [*conditions provision*] **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 **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 policyholder is legally eligible to purchase and** that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) [*When*] The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection. With respect to plans that are being discontinued, the carrier must:

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

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

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

(f) [*When*] The Director **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) [*When,*] In the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

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

[*(i) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the*

physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide service to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.]

[*(j)*] **(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) and (e) of this section**.

[*(6)*] **(7)** Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan [*for fraud, material misrepresentation or concealment by an enrollee.*] **if 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 other than a grandfathered health plan may not impose lifetime dollar limits on the essential health benefits prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11.

SECTION 52. 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 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 53. 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, 743.918**,** [*and*] 743A.012 **and 750.333 and section 5 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 or termination of enrollment of an individual 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 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.

[*(1)*] **(2)** "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)*] **(3)** "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)*] **(4)** "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.*]**, 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 to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

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

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

(a) Availability, delivery or quality of health care services, including a complaint regarding an

adverse **benefit** determination made pursuant to utilization review;

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

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

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

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

[*(9)*] **(10)** "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)*] **(11)** "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)*] **(12)(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)*] **(13)** "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)*] **(14)** "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)*] **(15)** "Stabilization" means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

[*(15)*] **(16)** "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 54. 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 re-*

quirements 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 voice grievances about the insurer or health care provided under the plan.

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

(b) An explanation that is culturally and linguistically appropriate of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances and appeals, including:

(A) The opportunity for expedited 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 or appeals; 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, the hours the providers are available 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 and appeals that provide for:

(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 and appeals, including the nature of the grievance or appeal and significant action taken;

(c) Written decisions that are culturally and linguistically appropriate explaining the basis for adverse benefit determinations, with references to relevant policies, procedures and contract terms, and that include:

(A) The date of service;

(B) The health care provider;

(C) The amount of the claim;

(D) The diagnosis code and the meaning of the code;

(E) The treatment code and the meaning of the code;

(F) The denial code and the meaning of the code; and

(G) A description of the standard used in denying a claim;

(d) Responding to grievances or appeals in a manner that accommodates the clinical urgency of the situation;

(e) Three levels of review for group health benefit plans, the second of which shall be by persons not previously involved in the dispute, and two levels of review for individual health benefit plans and portability health benefit plans, with the final level of review in all cases being 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; and

(f) The opportunity for the enrollee to receive continued coverage under the health benefit plan pending the outcome of the appeal and, at either the first or second level of internal review, for the enrollee and any representative chosen by the enrollee to:

(A) Submit for consideration by the reviewers 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 de-

termination.

(3) Establish procedures for notifying enrollees of:

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

(b) The 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.

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

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

(a) The insurer's annual report on grievances and 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 and appeals and make the written records available for examination by the department or by an enrollee or representative of an enrollee with respect to a grievance or appeal requested by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance or appeal.

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

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

(d) The date the grievance or appeal was reviewed or the date of any review meeting held concerning the grievance or appeal.

(e) The resolution of the grievance or appeal at each level of review.

(f) The name of the covered person for whom the grievance or appeal was filed.

(8) Provide an annual summary to the department 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.

(9) Allow the exercise of any rights described in this section by a person with the consent of the enrollee or, if the enrollee is unable to provide informed consent, allow the exercise of any rights described in this section by a family member of the enrollee, the enrollee's health care provider or any person authorized by law to provide consent.

SECTION 55. 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 **or for review as provided in ORS 743.804, 743.857 and 743.861**.

(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 56. 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*] **enrollee** 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 **or for review as provided in ORS 743.804, 743.857 and 743.861**.

(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 57. 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 collab-

oration 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 58. 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. 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.*]

(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 six 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 insurer's failure to furnish records, information and materials to the independent review organization in a timely manner is grounds for an immediate reversal of the adverse benefit determination.**

(4) An enrollee may submit additional information to the independent review organization no later than five 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 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 59. 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 60. 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 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 procedures established pursuant to ORS 743.804 **or be considered to have exhausted the plan's internal grievance procedures according to rules adopted by the Department of Consumer and Business Services**. The insurer may waive the requirement of compliance with the internal grievance procedures and have a dispute referred directly to external review upon the enrollee's consent.

(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 61. 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 62. ORS 743.863 is amended to read:

743.863. (1) 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 of an independent review organization under ORS 743.862**, the Director of the Department of Consumer and Business Services shall 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 63. 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 64. 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 65. ORS 743.913 is amended to read:

743.913. (1) An insurer that fails to pay a claim to a provider within the timelines established in ORS 743.911 shall pay simple interest of 12 percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid. Interest on any overdue payment for a claim begins to accrue on the 31st day after:

(a) The date on which the insurer received the claim; or

(b) The date the insurer receives the requested additional information.

(2) The interest is payable with the payment of the claim. An insurer is not required to pay interest that is in the amount of $2 or less on any claim.

(3) The availability of interest under subsection (1) of this section is in addition to and not in lieu of administrative actions and penalties that may be imposed by the Director of the Department of Consumer and Business Services under the Insurance Code **or federal health insurance laws**.

SECTION 66. 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 67. ORS 743A.090 is amended to read:

743A.090. (1) All individual and group health insurance policies providing hospital, medical or surgical expense benefits 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 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 the insurer within 31 days after the date of birth or date of placement in order 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) 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*] **is under 18 years of age** as of the date of the adoption or placement for adoption **and who is under 26 years of age as of the date of the provision of a benefit under the policy**.

(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 68. 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 69. ORS 744.718 is amended to read:

744.718. (1) The Director of the Department of Consumer and Business Services shall suspend, revoke or refuse to renew a license of a third party administrator if the director finds that the third party administrator:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of business so as to render further transaction of business by the third party administrator in this state hazardous or injurious to insured persons or to the public; or

(c) Has failed to pay any judgment rendered against the third party administrator in this state within 60 days after the judgment has become final.

(2) The director may suspend, revoke, refuse to issue or refuse to renew a license of a third party administrator if the director finds one or more of the following with respect to a third party administrator or an applicant for a license therefor:

(a) Falsification by the applicant or licensee of an application for the license or renewal thereof, or engagement in any dishonest act in relation to the application;

(b) Dishonesty, fraud or gross negligence in the transaction of insurance or in the conduct of business as a third party administrator;

(c) Conduct resulting in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280;

(d) Conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States;

(e) Refusal to renew or cancellation, revocation or suspension of authority to transact insurance or business as a third party administrator or similar entity in another state;

(f) Failure to pay a civil penalty imposed by final order of the director or to carry out terms of probation set by the director;

(g) Refusal to be examined or to produce accounts, records or files for examination, refusal by any officers to give information with respect to the affairs of the third party administrator or refusal to perform any other legal obligation as to the examination when required by the director;

(h) Affiliation with or under the same general management or interlocking directorate or ownership as another administrator or insurer that unlawfully transacts business in this state;

(i) Failure at any time to meet any qualification for which issuance of the license could have been refused had the failure then existed and been known to the director; or

(j) Violation of any rule or order of the director or any provision of the Insurance Code **or federal health insurance laws**.

(3) The director may suspend or refuse to renew a license immediately and without hearing if the director determines that one or more of the following circumstances exist:

(a) The third party administrator is insolvent;

(b) A proceeding for receivership, conservatorship or rehabilitation or other delinquency proceeding regarding the third party administrator has been commenced in any state; or

(c) The financial condition or business practices of the third party administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(4) A third party administrator holding a license that has not been renewed or has been revoked shall surrender the license to the director at the director's request.

(5) The director may take any other administrative action authorized under the Insurance Code **or federal health insurance laws** in addition to or in lieu of the actions authorized under this section.

SECTION 70. 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 71. 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 section 5 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 72. ORS 750.313 is amended to read:

750.313. (1) The Director of the Department of Consumer and Business Services shall issue a certificate of multiple employer welfare arrangement to a multiple employer welfare arrangement by and through its board of trustees if, upon completion of the application for the certificate and upon investigation and review of all information acquired by the director, the director does all of the following:

(a) Approves the application for the certificate.

(b) Determines that the person applying for the certificate satisfies the requirements in ORS 750.305, 750.307 and 750.309 for qualifying for and holding a certificate of multiple employer welfare arrangement and satisfies all other applicable requirements in the Insurance Code **and federal health insurance laws**.

(2) The director shall take all necessary action and shall either issue or refuse to issue a certificate within a reasonable time after the completion of the application for the certificate.

SECTION 73. 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 section 5 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 74. 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)*] **(9)** or 743.767.

SECTION 75. Sections 1, 3 and 5 of this 2011 Act, the amendments to statutes and session laws by sections 6 to 36 and 38 to 74 of this 2011 Act and the repeal of section 12, chapter 752, Oregon Laws 2007, by section 37 of this 2011 Act apply to policies or certificates issued or renewed on or after September 23, 2010.

SECTION 76. The Health Insurance Reform Advisory Committee is abolished.

SECTION 77. 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.
