A-Engrossed
Senate Bill 91

Ordered by the Senate April 20
Including Senate Amendments dated April 20

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

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.

Requires health insurance [*carriers to offer*] **carrier to offer, in each individual and small group market in which carrier offers health benefit plan,** health benefit plan that provides bronze **and silver** plan coverage. Specifies requirements for catastrophic plan. [*Transfers responsibility for prescribing basic health plan coverage and terms from Health Insurance Reform Advisory Committee to Department of Consumer and Business Services and eliminates committee.*] Specifies operative date of January 2, 2014.

A BILL FOR AN ACT

Relating to health benefit plans; creating new provisions; and amending ORS 743.730.

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

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

SECTION 2. The Director of the Department of Consumer and Business Services shall prescribe by rule the:

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

(2) Requirements for a silver plan to ensure that a silver plan offered in this state is actuarially equivalent to 70 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).

(3) Form, level of coverage and benefit design for the bronze and silver plans to be used by carriers in the individual and small group market in this state.

SECTION 3. As a condition of transacting business in the health benefit plan market in this state, a carrier shall offer to residents of this state bronze and silver plans approved by the Department of Consumer and Business Services as meeting the requirements of section 2 of this 2011 Act in each individual and small group market in which the carrier offers a health benefit plan through the Oregon Health Insurance Exchange or outside of the exchange.

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

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.

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

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

SECTION 5. 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;

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

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

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

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

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

[*(6)*] **(7)** "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

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

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

[*(8)*] **(10)** "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 27, 2010**, 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)*] **(11)** "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) "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) "Employee" means any individual employed by an employer.

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

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

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

(a) Considered by the director [*of the Department of Consumer and Business Services*] to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

[*(17)(a)*] **(18)(a)** "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

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

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or family composition.

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

[*(19)(a)*] **(20)(a)** "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) "Health benefit plan" does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, 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, long term care insurance,

hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

[*(20)*] **(21)** "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement developed by the Health Insurance Reform Advisory Committee.

[*(21)*] **(22)** "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)*] **(23)** "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)*] **(24)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(24)*] **(25)** "Late enrollee" means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997;

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

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

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

[*(25)*] **(27)** "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)*] **(28)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(27)*] **(29)** "Preexisting conditions provision" means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred

during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743A.090.

[*(28)*] **(30)** "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)*] **(31)** "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(32) "Silver plan" means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to section 2 of this 2011 Act.

[*(30)(a)*] **(33)(a)** "Small employer" means an employer that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least two eligible employees on the date on which coverage takes effect under a health benefit plan issued by a small employer carrier.

(b) Any person that is treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

[*(31)*] **(34)** "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 6. Sections 2, 3 and 4 of this 2011 Act and the amendments to ORS 743.730 by section 5 of this 2011 Act become operative on January 2, 2014.

SECTION 7. The Director of the Department of Consumer and Business Services may take any action before the operative date specified in section 6 of this 2011 Act that is necessary to enable the director to exercise, on and after the operative date specified in section 6 of this 2011 Act, all of the duties, functions and powers conferred on the director by this 2011 Act.
