Rep. Nathanson

FULL COMMITTEE PONY

HB 2240
Relating to coverage of health care services

HB 2240 aligns Oregon health insurance law with the Affordable Care Act, adding market reforms and federal requirements to the Insurance Code. The bill also abolishes the Office of Private Health Partnerships within the Oregon Health Authority, and ends the Family Health Insurance Assistance Program (FHIAP).

The proposed amendment includes technical fixes that came up after the final amendments were adopted in the policy committee.

This bill results in a General Fund savings of $237,093 for the Oregon Health Authority in the 2013-15, and an increase in Total Funds of $40.1 million. This fiscal results from the transition of current FHIAP clients to the Oregon Health Plan and CoverOregon, the Oregon Health Insurance Exchange. These adjustments will be included in HB 5030, the budget bill for the Oregon Health Authority.

The Human Services Subcommittee recommends HB 2240 be amended and reported out do pass, as amended.

77th OREGON LEGISLATIVE ASSEMBLY – 2013 Session **MEASURE: HB 2240-B**
STAFF MEASURE SUMMARY

Joint Committee on Ways and Means **Carrier – House: Rep. Gallegos**
Carrier – Senate: Sen. Steiner Hayward

Revenue:
Fiscal: Fiscal statement issued

Action: Do Pass the A-Engrossed Measure as Amended and be Printed B-Engrossed
Vote:
House
Yeas:
Nays:
Exc:
Senate
Yeas:
Nays:
Exc:
Prepared By: Linda Ames, Legislative Fiscal Office
Meeting Date: May 17, 2013

WHAT THE MEASURE DOES Aligns Oregon health insurance law with Affordable Care Act. Establishes requirements for health benefit plan. Abolishes Office of Private Health Partnerships and ends Family Health Insurance Assistance Program. Modifies Health Care for All Oregon Children program to terminate eligibility at 19 years of age, allows Department of Human Services or Oregon Health Authority to specify eligibility requirements for private health option different from requirements for other medical assistance, allows purchase of insurance through Oregon Health Insurance Exchange (Cover Oregon) for private health option and prohibits child from qualifying for both private health option and other medical assistance programs. Allows Department of Consumer and Business Services (DCBS) to adopt rules for adjusting risk between insurers. Allows insurers to increase rates in 2014 to reflect taxes and fees. Requires DCBS to adopt rules defining network adequacy. Raises the definition of small employer from 50 to 100 employees. Declares an emergency, effective on passage.

ISSUES DISCUSSED:
- Proposed amendments
- Fiscal impact

EFFECT OF COMMITTEE AMENDMENT: (1) Restores the definition of "group health insurance" because the term is necessary for other provisions of the Insurance Code; (2) Clarifies that a carrier may not deny a small employer coverage under a health benefit plan if they fail to meet participation and contribution requirements, but may require small employers that do not meet those requirements to enroll during the open enrollment period beginning November 15 and ending December 15; (3) Adds language to ensure that premium rating factors are consistent with the Affordable Care Act; (4) Clarifies that carriers may request medical underwriting-type information in connection with the application for coverage in the individual, small group, and large group market. (5) Specifies that the term "applicant" is meant to refer to all persons seeking coverage under a health benefit plan, including children, spouses, and other dependents.

BACKGROUND: In 2010, the federal government enacted the Affordable Care Act (ACA). The ACA aims to decrease the number of uninsured Americans and reduce the overall costs of health care. The ACA creates mandates, subsidies and tax credits to employers and individuals to in order to increase the coverage rate.

Four key pieces of legislation bring Oregon into compliance with the provisions of the ACA and update related programs:

- House Bill 2240-A implements federal requirements in the Oregon insurance code and abolishes programs which become obsolete with the provisions of the ACA.
- House Bill 3458-A establishes the Oregon Reinsurance Program in the Oregon Health Authority. The program will help to stabilize rates and premiums for the market by providing supplemental reinsurance payments to insurers.
- House Bill 2859-A updates Oregon's medical assistance programs to reflect federal Medicaid and Children's Health Insurance Program changes.
- House Bill 2091-A updates the Health Care for All Oregon Children Program to reflect federal requirements.

FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: HB 2240 - A6**

Seventy-Seventh Oregon Legislative Assembly – 2013 Regular Session
Legislative Fiscal Office

Only Impacts on Original or Engrossed Versions are Considered Official

Prepared by: Kim To
Reviewed by: Linda Ames, Susie Jordan
Date: 4/24/2013

Measure Description:
Aligns Oregon health insurance law with changes in federal law.

Government Unit(s) Affected:
Department of Consumer and Business Services (DCBS), Oregon Health Authority (OHA)

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Summary of Net Expenditure Impact – Oregon Health Authority

	2013-15 Biennium
General Fund	(237,093)
Other Funds	(65,778)
Federal Funds	40,416,280
Total Funds	**$40,113,409**
Positions	0
FTE	(22.50)

Analysis:
House Bill 2240 amends Oregon health insurance law to align with the Affordable Care Act (ACA), the health care reform legislation, and adds market reforms and federal requirements to the Insurance Code. The – A6 amendment to HB 2240 make several technical and clarifying changes, including:

- Restoring the definition of "group health insurance" because the term is necessary for other provisions of the Insurance Code.
- Clarifying that a carrier may not deny a small employer coverage under a health benefit plan if the employer fail to meet participation and contribution requirements, but may require small employers that do not meet those requirements to enroll during the open enrollment period beginning November 15 and ending December 15.
- Adding language to ensure that premium rating factors are consistent with the Affordable Care Act.
- Stipulating that carriers may request medical underwriting-type information in connection with the application for coverage in the individual, small group, and large group market.
- Specifying that the term "applicant" is meant to refer to all persons seeking coverage under a health benefit plan, including children, spouses, and other dependents.

The – A6 amendment does not change the fiscal determination of the bill.

Oregon Health Authority (OHA)
House Bill 2240 abolishes the Office of Private Health Partnership (OPHP) and the Family Health Insurance Assistance Program (FHIAP). OHA reports that currently FHIAP supports approximately 5,333 total lives, approximately 82% will be eligible for direct transfer from FHIAP into the Oregon Health Plan (OHP), and approximately 18% will be directed toward CoverOregon. Planning for client transition has been underway since 2012. Provisions of this bill were anticipated in the 2013-15 Governor's

Budget (Policy Option Package 090). Reductions in Personal Services were not included in Package 090. Calculations in this fiscal have been adjusted to reflect the phase out of 31 positions by January 2014.

Expenditure Impact – Abolishing OPHP, and FHIAP

	2013-15 Biennium
General Fund	(2,514,368)
Other Funds	(65,778)
Federal Funds	(2,543,507)
Total Funds	**($5,123,653)**
Positions	0
FTE	(22.50)

Passage of this bill will result in an increase in the population for whom MAP administers benefits. OHA estimates the cost of the population increase to be approximately $45,237,062 Total Funds for the 2013-15 biennium.

Expenditure Impact – Medical Assistance Programs (MAP)

	2013-15 Biennium
General Fund	2,277,275
Other Funds	0
Federal Funds	42,959,787
Total Funds	**$45,237,062**
Positions	0
FTE	0.00

These adjustments will be included in House Bill 5030, the Oregon Health Authority budget appropriation bill.

Department of Consumer and Business Services (DCBS)

Passage of this bill is anticipated to have minimal fiscal impact on the Department of Consumer and Business Services. HB 2240 allows an insurer a one-time opportunity to adjust rates without review by DCBS to reflect new state and federal fees. The bill specifies that DCBS may establish by administrative rule, a procedure for adjusting risk between insurers. DCBS anticipates using existing staff and resources to carry out the rulemaking work required by this bill.

HB 2240-A6
(LC 326)
4/19/13 (LHF/ps)

PROPOSED AMENDMENTS TO A-ENGROSSED HOUSE BILL 2240

On page 1 of the printed A-engrossed bill, line 6, after "743.777," insert "743.801,".

In line 16, delete "and 6" and insert ", 6 and 7".

On page 3, delete line 7 and insert:

"SECTION 7. 'Group health insurance' means that form of health insurance covering groups of persons described in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

"(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. As used in this subsection, 'employees' includes:

"(a) The officers, managers and employees of the employer;

"(b) The individual proprietor or partners if the employer is an individual proprietor or partnership;

"(c) The officers, managers and employees of subsidiary or affiliated corporations;

"(d) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or

otherwise;

"(e) The trustees or their employees, or both, if their duties are principally connected with such trusteeship;

"(f) The leased workers of a client employer; and

"(g) Elected or appointed officials if a policy issued to insure employees of a public body provides that the term 'employees' includes elected or appointed officials.

"(2) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employees or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

"(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as described in subsection (2) of this section, insuring employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. As used in this subsection, 'employees' may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term 'employees' includes the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

"(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be in-

sured under such group life policy.

"**NOTE:** Section 8 was deleted by amendment. Subsequent sections were not renumbered.".

On page 6, line 1, delete "ORS 743.522 (3)" and insert "section 7 of this 2013 Act".

On page 7, delete lines 15 through 45 and delete page 8.

On page 9, delete lines 1 through 20 and insert:

"SECTION 14. ORS 743.522 is amended to read:

"743.522. [*(1) 'Group health insurance' means that form of health insurance covering groups of persons described in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:*]

"[*(a) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. As used in this paragraph, 'employees' includes:*]

"[*(A) The officers, managers and employees of the employer;*]

"[*(B) The individual proprietor or partners if the employer is an individual proprietor or partnership;*]

"[*(C) The officers, managers and employees of subsidiary or affiliated corporations;*]

"[*(D) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise;*]

"[*(E) The trustees or their employees, or both, if their duties are principally connected with such trusteeship;*]

"[*(F) The leased workers of a client employer; and*]

"[*(G) Elected or appointed officials if a policy issued to insure employees of a public body provides that the term 'employees' includes elected or ap-*

pointed officials.]

"[*(b) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employees or employees of members of the association for the benefit of persons other than the association or its officers or trustees.*]

"[*(c) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as described in paragraph (b) of this subsection, insuring employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. As used in this paragraph, 'employees' may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term 'employees' includes the trustees or their employees, or both, if their duties are principally connected with such trusteeship.*]

"[*(d) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.*]

"**(1) As used in this section and ORS 743.533:**

"(a) 'Client employer' means an employer to whom workers are provided under contract and for a fee on a leased basis by a worker leasing company licensed under ORS 656.850.

"(b) 'Employee' may include a retired employee.

"(c) 'Leased worker' means a worker provided by a worker leasing

company licensed under ORS 656.850.

"(2) Group health insurance **may be** offered to a resident of this state under a group health insurance policy issued to a group other than one **of the groups** described in [*subsection (1) of this section may be delivered*] **section 7 of this 2013 Act** if:

"(a) The Director of the Department of Consumer and Business Services finds that:

"(A) The issuance of the policy is in the best interest of the public;

"(B) The issuance of the policy would result in economies of acquisition or administration; and

"(C) The benefits are reasonable in relation to the premiums charged; and

"(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both.

"[*(3) As used in this section and ORS 743.533:*]

"[*(a) 'Client employer' means an employer to whom workers are provided under contract and for a fee on a leased basis by a worker leasing company licensed under ORS 656.850.*]

"[*(b) 'Employee' may include a retired employee.*]

"[*(c) 'Leased worker' means a worker provided by a worker leasing company licensed under ORS 656.850.*]".

In line 25, delete "ORS 743.522 (3)(b)" and insert "section 7 (2) of this 2013 Act".

In line 27, delete "ORS 743.522 (3)(b)" and insert "section 7 (2) of this 2013 Act".

In line 32, delete "ORS 743.522".

In line 33, delete "(3)(b)" and insert "section 7 (2) of this 2013 Act".

On page 11, delete lines 6 through 45.

On page 12, delete lines 1 through 38 and insert:

"SECTION 16. ORS 743.610, as amended by section 3, chapter 24, Oregon Laws 2012, is amended to read:

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

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

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

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

"(b) 'Qualified beneficiary' means:

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

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

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

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

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

"(C) A covered person becoming eligible for Medicare;

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

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

"(F) The death of a covered person.

"(2)**(a)** A [*group health insurance policy*] **grandfathered health plan, as defined in ORS 743.730,** providing coverage **under a group health insurance policy** for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that a covered person and any qualified beneficiary may continue coverage under

the policy as provided in this section.

"(b) A group health insurance policy that provides coverage for one or more of the essential health benefits, other than a grandfathered health plan, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

"(3) Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for:

"(a) Medicare; or

"(b) **The same** coverage [*for hospital or medical expenses*] under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

"(4) The continued coverage [*need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy other than hospital and medical expense benefits*] **must be offered in the same manner as it is provided to other certificate holders under the group health insurance policy**.

"(5) A covered person or qualified beneficiary [*who wishes to continue coverage must provide the insurer with a written request for continuation no later than 10 days after the later of the date of a qualifying event or*] **must submit a written request for continuation of coverage to the insurer within the time prescribed by the insurer, except that an insurer may not require a request to be submitted less than 10 days after the later of:**

"(a) The date of a qualifying event; or

"(b) The date the insurer provides the notice required by subsection (10) of this section.

"(6) A covered person or qualified beneficiary who requests continuation of coverage shall pay the premium on a monthly basis and in advance to the insurer or to the employer or policyholder, whichever the group policy pro-

vides. The required premium payment may not exceed the group premium rate for the insurance being continued under the group policy as of the date the premium payment is due.

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

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

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

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

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

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

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

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

"(9) A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer may not be subjected to a waiting period for coverage under the employer's group health insurance

policy if the covered person was eligible for coverage at the time of the layoff, regardless of whether the covered person continued coverage during the layoff.

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

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

On page 18, line 45, delete "with no more than 25 eligible employees".

On page 20, line 27, delete "(3)(c)" and insert "(3)(e)".

In line 30, delete "(3)(c)" and insert "(3)(e)".

Delete lines 38 through 45 and delete pages 21 through 25.

On page 26, delete line 1 and insert:

"**SECTION 22.** ORS 743.737 is amended to read:

"743.737. [*(1) A preexisting 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 condition exclusion in a small employer health benefit*

plan shall expire as follows:]

"[*(a) For an enrollee, on the earlier of the following dates:*]

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

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

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

"[*(3) In applying a preexisting 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 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:*]

"**(1) A health benefit plan issued to a small employer:**

"(a) Must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

"(b) May:

"[*(a)*] **(A) Require** an affiliation period that does not exceed two months for an enrollee or [*three months*] **90 days** for a late enrollee; [*or*]

"[*(b)*] **(B) Impose** an exclusion period for specified covered services, as established under ORS 743.745, applicable to all individuals enrolling for the first time in the small employer health benefit plan[.]**; or**

"[*(4)*] **(C)** [*A health benefit plan issued to a small employer may*] Not apply a preexisting condition exclusion to [*a person under 19 years of age*] **any enrollee**.

"[*(5)*] **(2)** Late enrollees in a small employer health benefit plan may be

subjected to a group eligibility waiting period [*of up to 12 months or, if 19 years of age or older, may be subjected to a preexisting condition exclusion for up to 12 months. If both a waiting period and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 12 months*] **that does not exceed 90 days**.

"[*(6)*] **(3)** 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 unless:

"(a) The policyholder, small employer or contract holder fails to pay the required premiums.

"(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, 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) 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) The small employer fails to comply with the contribution requirements under the health benefit plan.

"(e) 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 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) 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 department and to all policyholders covered by the plan;

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

"(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

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

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

"(i) With respect to plans that are being discontinued under paragraph (g)

or (h) of this subsection, the carrier must:

"(A) Offer in writing to each small employer covered by the plan, all other health benefit plans that the carrier offers to small employers in the specified service area.

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

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

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

"(j) 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.

"(k) 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.

"(L) In the case of a health benefit plan that is offered in the small employer market only [*through*] **to** 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.

"[*(7)*] **(4)** A 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 subsection [*(6)(e)*] **(3)(e)**, (g) and (h) of this section.

"[*(8)*] **(5)** Notwithstanding any provision of subsection [*(6)*] **(3)** of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

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

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

"(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

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

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

"[*(9)*] **(6)** Notwithstanding any provision of subsection [*(6)*] **(3)** of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

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

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

"(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

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

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

"[*(10)*] **(7)(a)** A 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 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

"**(b) A carrier may not deny a small employer's application for**

coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

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

"(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

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

"[*(B)*] **(b)(A)** The variations in premium rates [*described in subparagraph (A) of this paragraph*] **charged during a rating period for health benefit plans issued to small employers** shall be based solely on the factors specified in subparagraph [*(C)*] **(B)** of this paragraph. A carrier may elect which of the factors specified in subparagraph [*(C)*] **(B)** 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 employer health benefit plans.

"[*(C)*] **(B)** The variations in premium rates described in subparagraph (A) of this paragraph may be based **only** on one or more of the following factors **as prescribed by the department by rule**:

"(i) The ages of enrolled employees and their dependents**, except that the rate for adults may not vary by more than three to one**;

"[*(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)*] **(ii)** The level at which enrolled employees and their dependents **18 years of age and older** engage in tobacco use[*;*]**, except that the rate may not vary by more than 1.5 to one; and**

"[*(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 carrier; and*]

"[*(vii)*] **(iii)** 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 carrier to reflect the expected claims experience of 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) 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)*] **(C)** A carrier shall apply the carrier's schedule of premium rate variations as approved by the department 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 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 health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage**, age, tobacco use and family composition** and must not

include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

"(d) A 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.

"[*(12)*] **(9)** In connection with the offering for sale of any health benefit plan to a small employer, each 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 premiums**, and the extent to which the carrier will consider age, **tobacco use,** family composition and geographic factors in establishing and adjusting rates[*;*] **and premiums; and**

"(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

"[*(c) Provisions relating to renewability of policies and contracts; and*]

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

"[*(13)(a)*] **(10)(a)** Each 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) A carrier offering a small employer health benefit plan shall file with the 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 carrier are actuarially sound. Each certification shall be in a uniform form and manner and shall contain such information as specified by the department. A copy of each certification shall be retained by the carrier at its principal place of business. **A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.**

"(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the 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 to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

"[*(14)*] **(11)** A 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.

"[*(15)*] **(12)** 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.

"[*(16)*] **(13)** A 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.

"[*(17)*] **(14)** 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 February 17, 2009*] **by federal law and rules adopted by the department**.

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

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

On page 27, line 43, delete "individ-".

Delete lines 44 and 45 and insert "applicant for individual or small group health benefit plan coverage to provide health-related information only for the purpose of health care management and".

On page 28, delete lines 2 through 5 and insert:

"(2) Except for an individual grandfathered health plan, if a carrier requires an applicant to provide health-related information, the carrier must also notify the applicant, in the form and manner prescribed by the Department of Consumer and Business Services, that the information may not be used to deny coverage.".

On page 43, line 41, delete "(3)(e)".

On page 62, line 20, delete "ORS".

In line 21, delete "743.522 (3)(c)" and insert "section 7 (3) of this 2013

Act".

In line 23, delete "ORS".

In line 24, delete "743.522 (3)(c)" and insert "section 7 (3) of this 2013 Act".

In line 37, delete "ORS 743.522 (3)(c)" and insert "section 7 (3) of this 2013 Act".

On page 67, line 37, delete "ORS 743.522 (3)(b)" and insert "section 7 (2) of this 2013 Act".

On page 68, after line 42, insert:

"SECTION 61a. ORS 743.801, as amended by section 5, chapter 24, Oregon Laws 2012, is amended to read:

"743.801. As used in this section and ORS 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, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

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

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

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

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

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

"(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of

care under ORS 743.854.

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

"(3) 'Enrollee' has the meaning given that term in ORS 743.730.

"(4) 'Grievance' means:

"(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

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

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

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

"(A) Availability, delivery or quality of a health care service;

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

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

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

"(6) 'Independent practice association' means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in [*ORS 743.522*] **section 7 of this 2013 Act**, to provide health care services to group members.

"(7) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

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

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

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

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

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

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

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

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

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

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

services contracts.

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

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

"(14) '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.".

On page 71, line 41, after "743.777," insert "743.801,".

In line 43, delete "and 61" and insert ", 61 and 61a".
