HB 2240-2
(LC 326)
3/8/13 (LHF/ps)

PROPOSED AMENDMENTS TO
HOUSE BILL 2240

On page 1 of the printed bill, line 2, after "ORS" delete the rest of the line and delete lines 3 through 13 and insert "192.556, 410.080, 413.011, 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839, 433.443, 731.036, 731.146, 735.625, 741.300, 743.018, 743.019, 743.405, 743.417, 743.420, 743.522, 743.524, 743.526, 743.528, 743.550, 743.552, 743.560, 743.610, 743.730, 743.731, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.757, 743.766, 743.767, 743.769, 743.777, 743.804, 743.822, 743.894, 743A.090, 743A.168, 743A.192, 746.015 and 746.045 and section 1, chapter 867, Oregon Laws 2009; repealing ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761; and declaring an emergency.".

In line 18, delete ", 6, 7 and 8" and insert "and 7".

In line 22, delete "but not limited to".

On page 2, delete lines 9 through 45.

On page 3, delete lines 1 through 28 and insert:

"SECTION 3. (1) As used in this section, 'health benefit plan' means a health benefit plan, as defined in ORS 743.730, that is offered in the individual or small group market.

"(2) The Department of Consumer and Business Services may establish by rule a procedure for adjusting risk between insurers. If a

procedure is established, the procedure may include:

"(a) An assessment imposed on an insurer if the actuarial risk of the enrollees in the insurer's health benefit plans is less than the average actuarial risk of all enrollees in all health benefit plans in this state; and

"(b) Payments to insurers if the actuarial risk of the enrollees in the insurer's health benefit plans is greater than the average actuarial risk of all enrollees in all health benefit plans in this state.

"(3) A procedure established under this section must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063.".

In line 29, delete "5" and insert "4".

In line 35, delete "6" and insert "5".

In line 43, after the period insert "Any requirements must be designed to minimize the administrative burden on insurers, including by allowing notices to be combined into one notice, as appropriate.".

Delete lines 44 and 45.

On page 4, delete lines 1 through 9 and insert:

"SECTION 6. (1) The Department of Consumer and Business Services shall adopt rules defining "network adequacy" consistent with the requirements of 45 C.F.R. 156.230.

"(2) The Oregon Health Authority shall recommend to the department a standard for network adequacy. The recommendation must be based on a consideration of:

"(a) The health plan accreditation standards of the National Committee for Quality Assurance;

"(b) The network accreditation standards of URAC or the American Accreditation HealthCare Commission, Incorporated;

"(c) Network adequacy standards adopted by the National Associ-

ation of Insurance Commissioners; and

"(d) Input from health insurers.

"(3) Not later than January 1, 2016, the department shall adopt rules establishing standards for network adequacy that take into account public comments and the recommendation of the authority under subsection (2) of this section.

"SECTION 7. Notwithstanding ORS 743.737 (8)(d) and 743.767 (3), at one time during the 2014 calendar year, insurers may increase their rates by an amount that reflects the health insurance providers fee imposed under section 9010 of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by section 10905 of the Patient Protection and Affordable Care Act, and as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). To the extent the existing rate was approved by the Department of Consumer and Business Services, the resulting rate, including the additional amount reflecting the health insurance providers fee, shall be considered an approved rate.

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

On page 6, lines 5 through 11, restore the bracketed material and delete the boldfaced material.

On page 7, delete lines 31 through 44 and insert:

"SECTION 13. ORS 743.417 is amended to read:

"743.417. (1) An individual health insurance policy shall [*contain a provision as follows: 'GRACE PERIOD:*] **specify** a minimum grace period of **at least** 10 days after the premium due date [*will be granted*] for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.[']

"(2) A policy that contains a cancellation provision may add the following clause at the end of the provision [*set forth*] **described** in subsection (1) of

this section: 'subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.'

"(3) A policy in which the insurer reserves the right to refuse renewal shall have the following clause at the beginning of the provision [*set forth*] **described** in subsection (1) of this section: 'Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. The insurer shall state in the notice the reason for its refusal to renew this policy.'

"SECTION 13a. ORS 743.420 is amended to read:

"743.420. (1) A health insurance policy**, other than a health benefit plan as defined in ORS 743.730,** shall contain a provision as follows: 'REINSTATEMENT: If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection

with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.'

"(2) The last sentence of the provision set forth in subsection (1) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue.".

On page 10, line 22, delete "743.549" and insert "743.552".

On page 11, line 23, delete "5" and insert "4".

After line 23, insert:

"SECTION 15a. ORS 743.552 is amended to read:

"743.552. The Director of the Department of Consumer and Business Services shall by rule establish guidelines for the [*application of ORS 743.549,*] **coordination of benefits for individual and small group health insurance,** including:

"(1) The procedures by which persons insured under [*such*] **the** policies are to be made aware of the existence of [*such*] a **coordination of benefits** provision;

"(2) The benefits which may be subject to such a provision;

"(3) The effect of such a provision on the benefits provided;

"(4) Establishment of the order of benefit determination; and

"(5) Reasonable claim administration procedures to expedite claim payments**.** [*under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision.*]".

On page 13, delete lines 12 through 45 and delete pages 14 through 16.

On page 17, delete lines 1 through 35 and insert:

"SECTION 17. ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, and section 20, chapter 38, Oregon Laws 2012, is amended

to read:

"743.730. For purposes of ORS 743.730 to 743.773:

"(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736[*, 743.760 or 743.761,*] based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer [*and portability*] health benefit plans.

"(2) 'Affiliate' of, or person 'affiliated' with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, 'control' has the meaning given that term in ORS 732.548.

"(3) 'Affiliation period' means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

"(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee [*in lieu of a preexisting condition exclusion*];

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

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

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

"[*(4) 'Basic health benefit plan' means a health benefit plan that provides bronze plan coverage and that is approved by the Department of Consumer and Business Services under ORS 743.736.*]

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

"(a) Has been in active existence for at least five years;

"(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

"(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

"(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

"(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

"(f) Has a constitution and bylaws; and

"(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

"[*(6) 'Bronze plan' means a health benefit plan that meets the criteria for a bronze plan prescribed by the director by rule pursuant to ORS 743.822 (2).*]

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

"(a) A licensed insurance company;

"(b) A health care service contractor;

"(c) A health maintenance organization;

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

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

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

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

"[*(8)*] **(6)** '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.

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

"[*(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)*] **(9)** 'Eligible employee' means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. 'Eligible employee' does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

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

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

"[*(14)*] **(12)** 'Exchange' means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

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

"[*(16)*] **(14)** 'Financial impairment' means that a carrier is not insolvent and is:

"(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

"[*(17)(a)*] **(15)(a)** 'Geographic average rate' means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

"(A) Group health benefit plans offered to small employers; **or**

"(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**, age, tobacco use** or family composition.

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

"[*(19)*] **(17)** '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.

"[*(20)(a)*] **(18)(a)** 'Health benefit plan' means any:

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

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

"(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject

to state regulation.

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

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

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

"(C) Medicare supplement insurance policies;

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

"(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

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

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

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

"(I) Dental only coverage;

"(J) Vision only coverage;

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

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

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

"(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

"(O) Any employee welfare benefit plan that is exempt from state regu-

lation because of the federal Employee Retirement Income Security Act of 1974, as amended.

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

"[*(21) 'Health statement' means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. 'Health statement' includes the standard health statement approved by the director under ORS 743.745.*]

"[*(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.

"**(20) 'Individual health benefit plan' means a health benefit plan:**

"(a) That is issued to an individual policyholder; or

"(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

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

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

"(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg [*as amended and in effect on February 17, 2009*] **or as prescribed by rule by the Department of Consumer and Business Services**;

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

"(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored health benefit plan and

request for enrollment is made within 30 days after issuance of the court order;

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

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

"[*(25)*] **(23)** 'Minimal essential coverage' has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

"[*(26)*] **(24)** '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.

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

"[*(28) 'Preexisting condition exclusion' means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:*]

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

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

"[*(c) Except for coverage under an individual grandfathered health plan, a preexisting condition exclusion may not exclude coverage for services,*

charges or expenses incurred by an individual who is under 19 years of age.]

"**(26) 'Preexisting condition exclusion' means:**

"(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

"(b) With respect to a grandfathered health plan, a 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 this paragraph pregnancy and genetic information do not constitute preexisting conditions.

"[*(29)*] **(27)** '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.

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

"[*(31)*] **(29)** 'Representative' does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

"[*(32) 'Silver plan' means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to ORS 743.822 (2).*]

"[*(33)(a)*] **(30)(a)** 'Small employer' means an employer that employed an average of at least [*two*] **one** but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed

within this state, and that employs at least [*two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer*] **one eligible employee on the first day of the plan year**.

"(b) Any person that is treated as a single employer under [*subsection (b), (c), (m) or (o) of*] section 414 **(b), (c), (m) or (o)** 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.".

In line 37, delete "sections 3 and 4" and insert "section 3".

On page 18, delete line 1.

In line 2, delete "(6)" and insert "(5)".

In line 4, delete "(7)" and insert "(6)".

In line 5, delete "(8)" and insert "(7)".

In line 6, delete "(9)" and insert "(8)".

In line 29, before the period insert "and is no longer a small employer".

Delete lines 30 through 45.

On page 19, delete lines 1 through 29 and insert:

"SECTION 20. ORS 743.734, as amended by section 13, chapter 500, Oregon Laws 2011, is amended to read:

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

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

"(b) The health benefit plan is treated by the employer or any of the eli-

gible 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, 743.764 and 743A.012, 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)*] **(2)** Except as otherwise provided by ORS 743.733 to 743.737 or other law, no health benefit plan offered to a small employer shall:

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

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

"[*(4) Except to determine the application of a preexisting condition exclusion for a late enrollee who is 19 years of age or older, a carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.*]

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

"[*(6)(a)*] **(3)(a)** A carrier may provide different health benefit plans to different categories of employees of a small employer that has [*at least 26 but no more than 50*] **no more than 25** eligible employees when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or

their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

"(b) Except as provided in ORS 743.736 [*(9)*] **(8)**, a carrier that offers coverage to a small employer with no more than 25 eligible employees shall offer coverage to all eligible employees of the small employer[*, without regard to the actual or expected health status of any eligible employee*].

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

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

In line 33, after "plans" insert a comma.

In line 34, before the period insert ", for which the small employer is eligible".

On page 21, line 35, delete "all" and delete "unless it is a grandfathered health plan" and insert "consistent with 42 U.S.C. 300gg-11".

On page 25, line 35, after the period insert "A carrier is not required to file the actuarial certification under this subsection if the department has approved the carrier's rate filing within the preceding 12-month period.".

On page 28, delete lines 11 through 14 and insert:

"(1) A carrier may require an individual applying for coverage under an individual or small group health benefit plan to respond to health-related questions only for the purpose of managing the individual's health care and may not use the information to deny coverage.

"(2) If a carrier requires an individual to respond to health-related

questions, the carrier must also notify the individual, in the form and manner prescribed by the Department of Consumer and Business Services, that the responses may not be used to deny coverage.".

On page 32, delete lines 2 through 45 and delete page 33.

On page 34, delete lines 1 through 34 and insert:

"SECTION 28. ORS 743.766, as amended by section 4, chapter 24, Oregon Laws 2012, is amended to read:

"743.766. [*(1) All carriers that offer an individual health benefit plan and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established 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)*] **(1)(a)** [*If an individual is accepted for*] **With respect to** coverage under an individual health benefit plan, [*the*] **a** carrier [*shall not impose exclusions or limitations other than*] **may not impose**:

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

"[*(i) The 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;*]

"[*(ii) The exclusion expires no later than six months 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)*] **(A)** An individual coverage waiting period [*of*] **that exceeds** 90 days; or

"[*(C)*] **(B)** An exclusion period for specified covered services applicable to

all individuals enrolling for the first time in the individual health benefit plan.

"[*(b) Except for grandfathered health plans, pregnancy of individuals who are under 19 years of age may not constitute a preexisting condition for purposes of this section.*]

"**(b) With respect to individual coverage under a grandfathered health plan, a carrier may not impose exclusions or limitations other than a preexisting condition exclusion that complies with the following requirements:**

"(A) The 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

"(B) The exclusion expires no later than six months after the individual's effective date of coverage.

"[*(3)*] **(2)** If the carrier elects to restrict coverage [*through the application of a preexisting condition exclusion or an individual coverage waiting period provision*] **as described in subsection (1) of this section**, the carrier shall reduce the duration of the [*provision*] **period during which the restriction is imposed** 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 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.*]

"**(3) An individual health benefit plan must cover, at a minimum, all essential health benefits consistent with 42 U.S.C. 300gg-11.**

"[*(5)*] **(4)** [*If a carrier accepts an individual for coverage under*] **A carrier shall renew** an individual health benefit plan, **including a health benefit plan issued through a bona fide association,** [*the carrier shall renew the policy*] unless:

"(a) The policyholder fails to pay the required premiums.

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

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

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

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

"(e) The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan, other than a grandfathered health plan, for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection.

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

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

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

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

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

"(h) 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.

"(i) 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.

"(j) 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.

"[*(6)*] **(5)** 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 subsection [*(5)(c)*] **(4)(c)**, (e) and (f) of this section.

"[*(7)*] **(6)** Notwithstanding any other provision of this section, and subject to the provisions of ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

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

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

"[*(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.*]

"[*(9)*] **(7)** 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)*] **(4)** of this section.

"[*(10)*] **(8)** An individual 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*].

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

In line 45, delete "ac-".

On page 35, delete line 1.

On page 36, delete lines 27 through 45 and delete page 37.

On page 38, delete lines 1 through 14.

In line 15, delete "32" and insert "31".

After line 36, insert:

"SECTION 32. ORS 743.894 is amended to read:

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

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

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

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

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

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

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

"(a) The plan sponsor:

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

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

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

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

"(5) This section does not apply to long term care insurance that is subject to ORS 743.650 to 743.665.".

On page 39, line 22, delete "special" and insert "additional".

In line 28, delete "within the".

In line 29, delete "scope of" and insert "consistent with the".

On page 41, after line 37, insert:

"SECTION 35a. ORS 746.045 is amended to read:

"746.045. **(1)** No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the insurance producer's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy.

"(2) A premium discount or rebate is not prohibited by this section if the discount or rebate is:

"(a) Offered in connection with a program of health promotion or disease prevention, as described in 42 U.S.C. 300gg-4;

"(b) Paid for participation in a program to promote healthy behaviors under ORS 743.824; or

"(c) Offered in connection with a wellness program defined by the Department of Consumer and Business Services by rule.".

On page 44, after line 37, insert:

"SECTION 37a. (1) A carrier may not offer a portability health benefit plan in this state after December 31, 2013.

"(2) A carrier discontinuing a portability health benefit plan in accordance with this section must comply with the requirements of ORS 743.737 (3)(e), 743.766 (4)(c) and 743.769.".

In line 39, delete "82" and insert "64".

In line 41, delete "82" and insert "64".

On page 46, line 6, delete "83" and insert "65".

In line 29, delete "82" and insert "64".

On page 54, line 38, delete "shall" and insert "may".

On page 58, delete lines 33 through 45 and delete pages 59 through 87.

On page 88, delete lines 1 through 42.

After line 44, insert:

"SECTION 54. ORS 731.036 is amended to read:

"731.036. Except as provided in ORS 743.061 or as specifically provided by law, the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

"(1) A bail bondsman, other than a corporate surety and its agents.

"(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

"(3) A religious organization providing insurance benefits only to its employees, if the organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

"(4) Public bodies, as defined in ORS 30.260, that either individually or

jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

"(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

"(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

"(a) The individual or jointly self-insured program meets the following minimum requirements:

"(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

"(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

"(C) In the case of a joint program of two or more public bodies, the number of covered employees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

"(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

"(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

"(d) Enrollees must be provided copies of summary plan descriptions including:

"(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

"(B) The program's grievance and appeal process; and

"(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

"(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

"(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

"(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

"(i) Known claims, paid and outstanding;

"(ii) A history of incurred but not reported claims;

"(iii) Claims handling expenses;

"(iv) Unearned contributions; and

"(v) A claims trend factor; and

"(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

"(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

"(g) The individual or jointly self-insured program shall be subject to as-

sessment in accordance with ORS 735.614 [*and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616*];

"(h) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Consumer and Business Services copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

"(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

"(7) All ambulance services.

"(8) A person providing any of the services described in this subsection. The exemption under this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

"(a) Towing service.

"(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

"(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

"(9)(a) A person described in this subsection who, in an agreement to

lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

"(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

"(B) The lessor of the motor vehicle.

"(C) The lender who finances the purchase of the motor vehicle.

"(D) The assignee of a person described in this paragraph.

"(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

"(10) A self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

"(a) 'Affordable housing' means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

"(b) 'Affordable housing entity' means any of the following:

"(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

"(B) A nonprofit corporation that is engaged in providing affordable housing.

"(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority de-

scribed in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

"(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

"(ii) Has the power to direct the management or policies of the partnership or limited liability company;

"(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

"(iv) Has any other material relationship with the partnership or limited liability company.

"(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

"(12) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of Consumer and Business Services to operate a retainer medical practice.

"SECTION 55. ORS 735.625 is amended to read:

"735.625. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person.

"(2) The coverage to be issued by the board, its schedule of benefits, exclusions and other limitations, shall be established through rules adopted by the board, taking into consideration the advice and recommendations of the pool members. In the absence of such rules, the pool shall adopt by rule the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

"(3)(a) In establishing portability coverage under the pool, the board shall

consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to the portability health benefit plans established under ORS 743.760.

"(b) In establishing medical insurance coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to those found in the commercial group or employer-based medical insurance market.

"(c) The board may provide a separate Medicare supplement policy for individuals under the age of 65 who are receiving Medicare disability benefits. The board shall adopt rules to establish benefits, deductibles, coinsurance, exclusions and limitations, premiums and eligibility requirements for the Medicare supplement policy.

"(d) In establishing medical insurance coverage for persons eligible for coverage under ORS 735.615 (1)(d), the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations to create benefit plans that qualify the person for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

"(4)(a) Premiums charged for coverages issued by the board may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

"(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

"(c) The board shall determine the applicable medical and portability risk

rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

"(d) The board shall annually determine adjusted benefits and premiums. The adjustments shall be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

"(5)(a) The board may apply:

"(A) A waiting period of not more than 90 days during which the person has no available coverage; or

"(B) Except as provided in paragraph (c) of this subsection, a preexisting conditions provision of not more than six months from the effective date of coverage under the pool.

"(b) In determining whether a preexisting conditions provision applies to an eligible enrollee, except as provided in this subsection, the board shall credit the time the eligible enrollee was covered under a previous health benefit plan if the previous health benefit plan was continuous to a date not more than 63 days prior to the effective date of the new coverage under the Oregon Medical Insurance Pool, exclusive of any applicable waiting period.

The Oregon Medical Insurance Pool Board need not credit the time for previous coverage to which the insured or dependent is otherwise entitled under this subsection with respect to benefits and services covered in the pool coverage that were not covered in the previous coverage.

"(c) The board may adopt rules applying a preexisting conditions provision to a person who is eligible for coverage under ORS 735.615 (1)(d).

"(d) For purposes of this subsection, a 'preexisting conditions provision' means a provision that excludes coverage for services, charges or expenses incurred during a specified period not to exceed six months following the insured's effective date of coverage, for a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the insured's effective date of coverage.

"(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except the Medicaid portion of the medical assistance program offering a level of health services described in ORS 414.707.

"(b) The board shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

"(7) [*Except as provided in ORS 735.616,*] No mandated benefit statutes apply to pool coverage under ORS 735.600 to 735.650.

"(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.".

In line 45, delete "75" and insert "56".

On page 89, line 23, delete "76" and insert "57".

In line 39, delete "77" and insert "58".

On page 90, delete lines 24 through 45 and delete pages 91 through 93.

On page 94, delete lines 1 through 17 and insert:

"**SECTION 59.** ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, section 20, chapter 38, Oregon Laws 2012, and section 17 of this 2013 Act, is amended to read:

"743.730. For purposes of ORS 743.730 to 743.773:

"(1) 'Actuarial certification' means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736 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 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;

"(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) 'Bona fide association' means an association that:

"(a) Has been in active existence for at least five years;

"(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

"(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

"(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

"(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

"(f) Has a constitution and bylaws; and

"(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

"(5) 'Carrier' means any person who provides health benefit plans in this state, including:

"(a) A licensed insurance company;

"(b) A health care service contractor;

"(c) A health maintenance organization;

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

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

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

"(e) Any other person or corporation responsible for the payment of ben-

efits or provision of services.

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

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

"(9) 'Eligible employee' means an employee who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. 'Eligible employee' does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

"(10) 'Employee' means any individual employed by an employer.

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

"(12) 'Exchange' means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

"(13) 'Exclusion period' means a period during which specified treatments or services are excluded from coverage.

"(14) 'Financial impairment' means that a carrier is not insolvent and is:

"(a) Considered by the director to be potentially unable to fulfill its contractual obligations; or

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

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

"(A) Group health benefit plans offered to small employers; or

"(B) Individual health benefit plans.

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

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

"(17) '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.

"(18)(a) 'Health benefit plan' means any:

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

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

"(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

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

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

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

"(C) Medicare supplement insurance policies;

"(D) Coverage of TRICARE services pursuant to contracts with the fed-

eral government;

"(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

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

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

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

"(I) Dental only coverage;

"(J) Vision only coverage;

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

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

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

"(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

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

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

"(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.

"(20) 'Individual health benefit plan' means a health benefit plan:

"(a) That is issued to an individual policyholder; or

"(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

"(21) 'Initial enrollment period' means a period of at least 30 days following commencement of the first eligibility period for an individual.

"(22) '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 or as prescribed by rule by the Department of Consumer and Business Services;

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

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

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

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

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

"(24) '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.

"(25) 'Oregon Medical Insurance Pool' means the pool created under ORS 735.610.

"(26) 'Preexisting condition exclusion' means:

"(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

"(b) With respect to a grandfathered health plan, a 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 this paragraph pregnancy and genetic information do not constitute preexisting conditions.

"(27) '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.

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

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

"(30)(a) 'Small employer' means an employer that employed an average of at least one but not more than [*50*] **100** employees on business days during the preceding calendar year, the majority of whom are employed within this

state, and that employs at least one eligible employee on the first day of the plan year.

"(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) 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.".

In line 18, delete "79" and insert "60".

On page 95, after line 3, insert:

"SECTION 61. ORS 743.769 is amended to read:

"743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier.

"(2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

"(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

"(4) Rejection by a carrier of an application for coverage shall be in writing and shall state the reason or reasons for the rejection.

"(5) The Director of the Department of Consumer and Business Services may establish by rule additional standards to provide for the fair marketing and broad availability of individual health benefit plans.

"(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743.766 [*(5)(c)*] **(4)(c)** or to discontinue offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five

years from the date of notice to the director pursuant to ORS 743.766 [*(5)(c)*] **(4)(c)** or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.".

In line 4, delete "80" and insert "62".

On page 97, line 37, delete "81" and insert "63".

Delete lines 43 through 45 and delete page 98 and insert:

"SECTION 64. Sections 2 to 5, 7 and 40 of this 2013 Act and the amendments to ORS 192.556, 410.080, 413.011, 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839, 433.443, 731.036, 735.625, 741.300, 743.018, 743.019, 743.405, 743.417, 743.420, 743.522, 743.524, 743.526, 743.528, 743.550, 743.552, 743.560, 743.610, 743.731, 743.733, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.757, 743.766, 743.767, 743.769, 743.777, 743.804, 743.894, 743A.090, 743A.192, 746.015 and 746.045 and section 1, chapter 867, Oregon Laws 2009, by sections 10 to 16, 18, 19, 21 to 30, 32 to 37, 42 to 58, 60 and 61 of this 2013 Act become operative January 1, 2014.

"SECTION 65. ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761 are repealed January 1, 2014.

"SECTION 66. (1) Section 6 of this 2013 Act is repealed January 2, 2016.

"(2)(a) The amendments to ORS 743.730 by section 17 of this 2013 Act become operative January 2, 2014.

"(b) The amendments to ORS 743.730 by section 59 of this 2013 Act

become operative January 2, 2016.

"(3) The amendments to ORS 731.146, 743.734 and 743.822 by sections 9, 20 and 31 of this 2013 Act become operative January 2, 2014.

"SECTION 67. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.".
