HB 2466-A7
(LC 632)
6/1/15 (LHF/ps)

PROPOSED AMENDMENTS TO
A-ENGROSSED HOUSE BILL 2466

On page 1 of the printed A-engrossed bill, line 3, delete "743.748,".

In line 5, after "2013" insert ", and section 5, chapter 80, Oregon Laws 2014".

Delete lines 9 through 28.

On page 2, delete lines 1 through 14 and insert:

"SECTION 2. (1) As used in this section:

"(a) 'Grandfathered health plan' has the meaning given that term in ORS 743.730.

"(b) 'Transitional grandfathered health benefit plan' means a grandfathered health plan that is issued or renewed by an employer with 51 to 100 employees.

"(2) A transitional grandfathered health benefit plan is not subject to the requirements:

"(a) In ORS 742.005 (6) unless otherwise required by rule by the Department of Consumer and Business Services;

"(b) In ORS 743.736;

"(c) In ORS 743.737 (1)(a), (8), (10) and (11); and

"(d) Imposing limitations on participation and contribution rates contained in ORS 743.737.

"(3) No later than September 1, 2018, the department shall report to the appropriate interim committees of the Legislative Assembly on whether the repeal of this section by section 33 of this 2015 Act should

be extended to a later date.".

On page 7, line 19, after "(B)" insert "Subscriber contract of a".

On page 9, line 16, after "18024" insert "unless otherwise prescribed by the department by rule in accordance with regulations adopted by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury".

On page 11, line 11, after "(B)" insert "Subscriber contract of a".

On page 13, line 9, delete "guidance issued" and insert "regulations adopted".

On page 15, delete lines 44 and 45 and delete pages 16 through 19 and insert:

"**SECTION 14.** ORS 743.737 is amended to read:

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

"(a) **Other than a grandfathered health plan,** must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

"(b) May[*:*]

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

"[*(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*]

"[*(C)*] **(c) May** not apply a preexisting condition exclusion to any enrollee.

"(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

"(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*] **both** 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; **and**

"(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 **both** 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*] **both** 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*] **both** 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 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.

"(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 (3)(e), (g) and (h) of this section.

"(5) Notwithstanding any provision of subsection (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.

"(6) Notwithstanding any provision of subsection (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.

"(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. 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.

"(8) Premium rates for small employer health benefit plans**, except grandfathered health 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 variations in premium rates charged during a rating period for health benefit plans issued to small employers shall be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

"(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 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

"(iii) Adjustments to reflect differences in family composition.

"(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 and differences in family composition.

"[*(e) Premium rates for small employer health benefit plans shall comply with the requirements of this section.*]

"**(9) Premium rates for grandfathered health plans shall be subject to requirements prescribed by the department by rule.**

"[*(9)*] **(10)** 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*] **considers** 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.

"[*(10)(a)*] **(11)(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.

"[*(11)*] **(12)** 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.

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

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

"[*(14)*] **(15)** All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the department.

"[*(15)*] **(16)** A small employer health benefit plan may not impose annual

or lifetime limits on the dollar amount of essential health benefits.

"[*(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.*]".

On page 20, delete lines 1 through 4.

In line 15, delete "marketed" and insert "sold".

In line 18, delete "marketing" and insert "selling".

Delete lines 26 through 45 and delete page 21.

On page 22, delete lines 1 through 11 and insert:

"**NOTE:** Sections 16 and 17 were deleted by amendment. Subsequent sections were not renumbered.".

Delete lines 38 through 45 and delete pages 23 through 29.

On page 30, delete lines 1 through 11 and insert:

"SECTION 19. ORS 743.754 is amended to read:

"743.754. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

"(1) [*Except in the case of a late enrollee and except as otherwise provided in this section,*] A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

"(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

"(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

"[*(b) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the plan.*]

"[*(3) Late enrollees may be subjected to*]

"**(b)** A group eligibility waiting period **for late enrollees** that does not exceed 90 days.

"[*(4)*] **(3)** Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

"**(4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by the carrier for which the group is eligible, if the group applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.**

"(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

"(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

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

"(b) The policyholder 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 policyholder fails to comply with the contribution requirements under the plan.

"(e) The carrier discontinues [*offering or renewing, or*] **both** offering and renewing, all of its group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this par-

agraph, the carrier:

"(A) Must give notice of the decision to the department 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; **and**

"(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area[*; and*]**.**

"[*(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the group market in this state or in the specified service area.*]

"(f) The carrier discontinues **both** offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

"(A) Must give notice of the decision to the department and to all policyholders covered by the plan;

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

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

"(g) The carrier discontinues [*offering or renewing, or*] **both** offering and

renewing[,] a group health benefit plan, other than a grandfathered health plan, for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection.

"(h) The carrier discontinues [*renewing or*] **both** offering and renewing a grandfathered health plan for all groups in this state or in a specified service are 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 policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups 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.

"(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 group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

"(L) In the case of a health benefit plan that is offered in the group market only 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.

"(6) A carrier may modify a group health benefit plan at the time of

coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

"(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

"(a) The enrollee:

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

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

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

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

"(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

"(a) The plan sponsor or a representative of the plan sponsor:

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

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

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

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

"[*(9) A carrier that continues to offer coverage in the group market in this state is not required to offer coverage in all of the carrier's group health benefit plans. If a carrier, however, elects to continue a plan that is closed to new policyholders instead of offering alternative coverage in its other group health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.*]

"[*(10)*] **(9)** A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

"[*(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a group not eligible for coverage under such a plan.*]

"SECTION 20. ORS 743.766 is amended to read:

"743.766. (1) With respect to coverage under an individual health benefit plan, a carrier[*:*]

"[*(a)*] may not impose an individual coverage waiting period [*that exceeds 90 days*].

"[*(b) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.*]

"[*(c)*] **(2)** With respect to individual coverage under a grandfathered health plan, a carrier [*may*]**:**

"(a) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

"(b) May not impose a preexisting condition exclusion unless the exclusion 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.

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

"[*(2)*] **(3)** If the carrier elects to restrict coverage as described in subsection (1) **or (2)** of this section, the carrier shall reduce the duration of the period during which the restriction is imposed by an amount equal to the individual's aggregate periods of creditable coverage if the most recent pe-

riod 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.

"[*(3)*] **(4)** An individual health benefit plan other than a grandfathered health plan must cover, at a minimum, all essential health benefits.

"[*(4)*] **(5)** A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, 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*] **both** 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; **and**

"(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 **both** 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*] **both** 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*] **both** 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.

"[*(5)*] **(6)** A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection [*(4)(c)*] **(5)(c)**, (e) and (f) of this section.

"[*(6)*] **(7)** 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.

"[*(7)*] **(8)** 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 alter-

native coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection [*(4)*] **(5)** of this section.

"[*(8)*] **(9)** An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

"**(10) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.**

"[*(9)*] **(11)** 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*]**:**

"(a) A bona fide association health benefit plan from individuals who are not members of the bona fide association; or

"(b) A grandfathered health plan from individuals who are not eligible for coverage under the plan.

"SECTION 21. ORS 743.766, as amended by section 20 of this 2015 Act, is amended to read:

"743.766. (1) With respect to coverage under an individual health benefit plan, a carrier may not impose an individual coverage waiting period.

"(2) With respect to individual coverage under a grandfathered health plan, a carrier:

"(a) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

"(b) May not impose a preexisting condition exclusion unless the exclusion 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.

"(B) The exclusion expires no later than six months after the individual's

effective date of coverage.

"[*(3) If the carrier elects to restrict coverage as described in subsection (1) or (2) of this section, the carrier shall reduce the duration of the 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)*] **(3)** An individual health benefit plan other than a grandfathered health plan must cover, at a minimum, all essential health benefits.

"[*(5)*] **(4)** A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, 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 both 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; and

"(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.

"(d) The carrier discontinues both 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 both 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 both 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)*] **(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 alter-

native 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.

"[*(9)*] **(8)** An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

"[*(10)*] **(9)** A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.

"[*(11)*] **(10)** This section does not require a carrier to actively market, offer, issue or accept applications for:

"(a) A bona fide association health benefit plan from individuals who are not members of the bona fide association; or

"(b) A grandfathered health plan from individuals who are not eligible for coverage under the plan.

"SECTION 22. ORS 743.769 is amended to read:

"743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier that are not grandfathered health plans.

"(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 [*(4)(c)*] **(5)(c)** or to discontinue **both**

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 [*(4)(c)*] **(5)(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.

"SECTION 22a. ORS 743.769, as amended by section 22 of this 2015 Act, is amended to read:

"743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier that are not grandfathered health plans.

"(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 both 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.".

On page 31, line 13, restore the bracketed material and delete "a".

Delete line 14.

In lines 15 through 17, restore the bracketed material.

On page 35, after line 10, insert:

"SECTION 31. Section 5, chapter 80, Oregon Laws 2014, is amended to read:

"**Sec. 5.** (1) As used in this section:

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

"(b) 'Transitional health benefit plan' means a health benefit plan that:

"(A) Was issued to an individual or a small employer who elected to renew coverage under the plan in calendar year 2013 instead of obtaining coverage under a new health benefit plan;

"(B) Is in force on the effective date of this 2014 Act;

"(C) Does not comply with the requirements of the Insurance Code in effect on or after January 1, 2014; and

"(D) Complies with the requirements of the Insurance Code in effect on December 31, 2013.

"(2) If authorized by guidance from the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury, the Department of Consumer and Business Services shall permit a transitional health benefit plan to remain in force until [*the later of:*]

"[*(a)*] December 31, 2015[*; or*]

"[*(b) A later date specified by the Department of Consumer and Business Services by rule*].".

In line 11, delete "31" and insert "32".

In line 12, delete "32" and insert "33".

In line 13, delete "33" and insert "34".

Delete lines 19 through 33 and insert:

"(2) The amendments to ORS 743.106 by section 5 of this 2015 Act apply to health benefit plans issued or renewed on or after January 1, 2017.

"(3) The amendments to ORS 743.602, 743.730, 743.766, 743.769, 743.818 and 743A.141 and section 66, chapter 681, Oregon Laws 2013, by sections 7 to 10, 21, 22a, 23 and 26 of this 2015 Act apply to:

"(a) A health benefit plan issued or renewed on or after January 1, 2016; and

"(b) A health benefit plan that, according to its terms, would renew on or after January 1, 2016, but is renewed prior to January 1, 2016.".

In line 34, delete "34" and insert "35".

In line 36, delete "35" and insert "36".
