(To Resolve Conflicts)

B-Engrossed
House Bill 2341

Ordered by the Senate May 9
Including House Amendments dated March 20 and Senate Amendments
dated May 9 to resolve conflicts

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor Kate Brown for Department of Consumer and Business Services)

SUMMARY

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

Updates Insurance Code provisions applicable to health insurance in accordance with federal requirements.

Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 192.556, 743.551, 743A.100, 743A.104, 743A.105, 743A.108, 743B.005, 743B.011, 743B.120, 743B.250, 743B.252, 743B.505, 743B.800 and 746.600; repealing section 1, chapter ___, Oregon Laws 2017 (Enrolled Senate Bill 271); and declaring an emergency.

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

SECTION 1. ORS 192.556 is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

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

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; or

(d) A health care clearinghouse.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage

therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means:

(a) An insurer as defined in ORS 731.106 who offers:

(A) A health benefit plan as defined in ORS 743B.005;

(B) A short term health insurance policy, the duration of which does not exceed [*six*] **three** months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual,

or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; or

(c) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 2. ORS 192.556, as amended by section 30, chapter 698, Oregon Laws 2013, is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; or

(d) A health care clearinghouse.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means an insurer as defined in ORS 731.106 who offers:

(a) A health benefit plan as defined in ORS 743B.005;

(b) A short term health insurance policy, the duration of which does not exceed [*six*] **three** months including renewals;

(c) A student health insurance policy;

(d) A Medicare supplemental policy; or

(e) A dental only policy.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; or

(c) Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 3. ORS 743.551 is amended to read:

743.551. (1) As used in this section, "student health benefit plan" means a plan that is subject to rules adopted by the United States Department of Health and Human Services under 42 U.S.C. 18118(c).

(2) Notwithstanding any other provision of law, the Department of Consumer and Business Services shall by rule and in a manner consistent with federal law **in effect on January 1, 2017**, adopt requirements for student health benefit plans.

SECTION 4. ORS 743A.100 is amended to read:

743A.100. (1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage of mammograms as follows:

(a) Mammograms for the purpose of diagnosis in symptomatic or high-risk [*women*] **individuals** at any time upon referral of [*the woman's*] **an individual's** health care provider; and

(b) An annual mammogram for the purpose of early detection for [*a woman*] **an individual** 40 years of age or older, with or without referral from the [*woman's*] **individual's** health care provider.

(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the [*woman*] **individual** is determined by [*her*] **the individual's** health care provider to be at high risk for breast cancer.

SECTION 5. ORS 743A.104 is amended to read:

743A.104. All policies providing health insurance, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:

(1) Annually for [*women*] **individuals** 18 to 64 years of age; and

(2) At any time upon referral of [*the woman's*] **an individual's** health care provider.

SECTION 6. ORS 743A.105 is amended to read:

743A.105. (1) All health benefit plans, as defined in ORS 743B.005, shall include coverage of the human papillomavirus vaccine for [*female*] beneficiaries under the health benefit plan who are at least 11 years of age but no older than 26 years of age.

(2) ORS 743A.001 does not apply to this section.

SECTION 7. ORS 743A.108 is amended to read:

743A.108. (1) A health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for a complete and thorough physical examination of the breast, including but not limited to a clinical breast examination, performed by a health care provider to check for lumps and other changes for the purpose of early detection and prevention of breast cancer as follows:

(a) Annually for [*women*] **individuals** 18 years of age and older; and

(b) At any time at the recommendation of [*the woman's*] **an individual's** health care provider.

(2) An insurance policy must provide coverage of physical examinations of the breast as described in subsection (1) of this section regardless of whether a health care provider performs other preventative [*women's*] health examinations or makes a referral for other preventative [*women's*] health examinations at the same time the health care provider performs the breast examination.

(3) This section applies to health care service contractors, as defined in ORS 750.005, and trusts carrying out a multiple employer welfare arrangement, as defined in ORS 750.301.

SECTION 8. ORS 743B.005 is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

(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 743B.012 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 743B.010 to 743B.013; or

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

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

(7) "Eligible employee" means an employee who is eligible for coverage under a group health

benefit plan.

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

(9) "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.

(10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

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

(12) "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.

(13)(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.

(14) "Grandfathered health plan" has the meaning prescribed by **rule by** the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) **that is in effect on January 1, 2017**.

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

(16)(a) "Health benefit plan" means any:

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

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; 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*] **three** 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.

(17) "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.

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

(19) "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.

(20) "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.

(21) "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 treat-

ment 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.

(22) "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.

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

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

(25) "Small employer" has the meaning given that term in 42 U.S.C. 18024 [*unless otherwise prescribed by the department by rule in accordance with guidance issued by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury*] **as amended and in effect on January 1, 2017**.

SECTION 8a. If Senate Bill 271 becomes law, section 1, chapter ___, Oregon Laws 2017 (Enrolled Senate Bill 271) (amending ORS 743B.005), is repealed and ORS 743B.005, as amended by section 8 of this 2017 Act, is amended to read:

743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128:

(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 743B.012 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 743B.010 to 743B.013; or

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

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

(7) "Eligible employee" means an employee who is eligible for coverage under a group health benefit plan.

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

(9) "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.

(10) "Exchange" means an American Health Benefit Exchange described in 42 U.S.C. 18031, 18032, 18033 and 18041.

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

(12) "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.

(13)(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.

(14) "Grandfathered health plan" has the meaning prescribed by rule by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.

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

(16)(a) "Health benefit plan" means any:

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

(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; 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 three 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.

(17) "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.

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

(19) "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.

(20) "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.

(21) "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.

(22) "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.

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

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

(25) "Small employer" [*has the meaning given that term in 42 U.S.C. 18024 as amended and in effect on January 1, 2017*] **means an employer who employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and who employs at least one full-time equivalent employee on the first day of the plan year, determined in accordance with a methodology prescribed by the Department of Consumer and Business Services by rule**.

SECTION 8b. The amendments to ORS 743B.005 by section 8a of this 2017 Act become operative on January 1, 2018.

SECTION 9. ORS 743B.011 is amended to read:

743B.011. (1) Every health benefit plan shall be subject to the provisions of ORS 743B.010 to 743B.013, 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 employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium **unless the reimbursement is made through a qualified small employer health reimbursement arrangement, as defined in section 9831 of the Internal Re-**

venue Code; or

(b) The health benefit plan is treated by the employer or any of the 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 otherwise provided by ORS 743B.010 to 743B.013 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.

(3)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer 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 743B.012 (7), a carrier that offers coverage to a small employer shall offer coverage to all eligible employees of the small employer.

(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.

(4) 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.

SECTION 10. ORS 743B.120 is amended to read:

743B.120. Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services as prescribed by the United States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13 **in rules adopted and in effect on January 1, 2017**; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by federal law.

SECTION 11. ORS 743B.250, as amended by section 5, chapter 59, Oregon Laws 2015, is amended to read:

743B.250. All insurers offering a health benefit plan in this state shall:

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

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

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the department by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe **clinically appropriate** drugs not included on the formulary;

(E) Procedures for the coverage of **clinically appropriate** prescription drugs not included on the formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks. The list must be available online and upon request in printed format.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743B.225.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information and the requirement under ORS 743B.555 that a carrier or third party administrator send communications containing protected health information only to the enrollee who is the subject of the protected health information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743B.200, 743B.202 and 743B.423.

(2) Establish procedures**, in accordance with requirements adopted by the department,** for

making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations [*in a form and manner approved by the department or prescribed by the department by rule*].

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions [*meeting criteria established by the Director of the Department of Consumer and Business Services by rule*].

(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans **and for any denial of an exception to a prescription drug formulary**. If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255 [*and is conducted in a manner approved by the department or prescribed by the department by rule*], after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

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

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

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

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) Provide, upon the request of an enrollee, a written summary of information that the insurer

may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743B.001 (7)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

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

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

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

(9) Allow the exercise of any rights described in this section by an authorized representative.

SECTION 12. ORS 743B.252 is amended to read:

743B.252. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743B.255 and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS **743B.250 and** 743B.255. Each insurer shall provide the external review through an independent review organization that is under contract with the director to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer or the director, to obtain review by an independent review organization of a dispute relating to an adverse benefit determination by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(e) Whether an exception to the health benefit plan's prescription drug formulary should be granted.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the director shall appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization no later than five business days after the appointment. The insurer shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. An independent review organization may reverse the adverse benefit de-

termination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

(b) If a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION 13. ORS 743B.505 is amended to read:

743B.505. (1) An insurer offering a health benefit plan in this state that provides coverage to individuals or to small employers, as defined in ORS 743B.005, through a specified network of health care providers shall:

(a) Contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure that all covered services under the health benefit plan, including mental health and substance abuse treatment, are accessible to enrollees without unreasonable delay.

(b)(A) With respect to health benefit plans offered through the health insurance exchange under ORS 741.310, contract with a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of essential community providers for low-income, medically underserved individuals in the plan's service area in accordance with the network adequacy standards established by the Department of Consumer and Business Services;

(B) If the health benefit plan offered through the health insurance exchange offers a majority of the covered services through physicians employed by the insurer or through a single contracted medical group, have a sufficient number and geographic distribution of employed or contracted providers and hospital facilities to ensure reasonable and timely access for low-income, medically underserved enrollees in the plan's service area, in accordance with network adequacy standards adopted by the Department of Consumer and Business Services; or

(C) With respect to health benefit plans offered outside of the health insurance exchange, contract with or employ a network of providers that is sufficient in number, geographic distribution and types of providers to ensure access to care by enrollees who reside in locations within the health benefit plan's service area that are designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as health professional shortage areas or low-income zip codes.

(c) Annually report to the Department of Consumer and Business Services, in the format prescribed by the department, the insurer's plan for ensuring that the network of providers for each health benefit plan meets the requirements of this section.

(2)(a) An insurer may not discriminate with respect to participation under a health benefit plan or coverage under the plan against any health care provider who is acting within the scope of the provider's license or certification in this state.

(b) This subsection does not require an insurer to contract with any health care provider who is willing to abide by the insurer's terms and conditions for participation established by the insurer.

(c) This subsection does not prevent an insurer from establishing varying reimbursement rates based on quality or performance measures.

(d) Rules adopted by the Department of Consumer and Business Services to implement this section shall be consistent with the provisions of 42 U.S.C. 300gg-5 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 300gg-5 **that are in effect on January 1, 2017**.

(3) The Department of Consumer and Business Services shall use one of the following methods in evaluating whether the network of providers available to enrollees in a health benefit plan meets the requirements of this section:

(a) An approach by which an insurer submits evidence that the insurer is complying with at least one of the factors prescribed by the department by rule from each of the following categories:

(A) Access to care consistent with the needs of the enrollees served by the network;

(B) Consumer satisfaction;

(C) Transparency; and

(D) Quality of care and cost containment; or

(b) A nationally recognized standard adopted by the department and adjusted, as necessary, to reflect the age demographics of the enrollees in the plan.

(4) This section does not require an insurer to contract with an essential community provider that refuses to accept the insurer's generally applicable payment rates for services covered by the plan.

(5) This section does not require an insurer to submit provider contracts to the department for review.

SECTION 14. ORS 743B.800 is amended to read:

743B.800. (1) As used in this section, "health benefit plan" means a health benefit plan, as defined in ORS 743B.005, 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 **that are in effect on January 1, 2017**.

SECTION 15. ORS 746.600 is amended to read:

746.600. As used in ORS 746.600 to 746.690:

(1)(a) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that the insurance producer represents and that is requested by an applicant.

(D) In the case of life or health insurance coverage, an offer to insure at higher than standard rates.

(E) In the case of insurance coverage other than life or health insurance coverage:

(i) Placement by an insurer or insurance producer of a risk with a residual market mechanism, an unauthorized insurer or an insurer that specializes in substandard risks.

(ii) The charging of a higher rate on the basis of information that differs from that which the applicant or policyholder furnished.

(iii) An increase in any charge imposed by the insurer for any personal insurance in connection with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a service fee is not a charge.

(b) "Adverse underwriting decision" does not mean any of the following actions, but the insurer or insurance producer responsible for the occurrence of the action must nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

(A) The termination of an individual policy form on a class or statewide basis.

(B) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(C) The rescission of a policy.

(2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(3) "Applicant" means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage that is not individually underwritten.

(4) "Consumer" means an individual, or the personal representative of the individual, who seeks to obtain, obtains or has obtained one or more insurance products or services from a licensee that are to be used primarily for personal, family or household purposes, and about whom the licensee has personal information.

(5) "Consumer report" means any written, oral or other communication of information bearing on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used in connection with an insurance transaction.

(6) "Consumer reporting agency" means a person that, for monetary fees or dues, or on a cooperative or nonprofit basis:

(a) Regularly engages, in whole or in part, in assembling or preparing consumer reports;

(b) Obtains information primarily from sources other than insurers; and

(c) Furnishes consumer reports to other persons.

(7) "Control" means, and the terms "controlled by" or "under common control with" refer to, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power of the person is the result of a corporate office held in, or an official position held with, the controlled person.

(8) "Covered entity" means:

(a) A health insurer;

(b) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 746.607 or by rules adopted under ORS 746.608; or

(c) A health care clearinghouse.

(9) "Credit history" means any written or other communication of any information by a consumer reporting agency that:

(a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

(b) Is used or expected to be used, or collected in whole or in part, as a factor in determining eligibility, premiums or rates for personal insurance.

(10) "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in part, by an insurer or insurance producer of an application for requested insurance coverage.

(12) "Health care" means care, services or supplies related to the health of an individual.

(13) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(14) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician or physician assistant licensed under ORS chapter 677, an acupuncturist licensed under ORS 677.759 or an employee of the physician, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.014;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743.694; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(15) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(16) "Health insurer" means an insurer who offers:

(a) A health benefit plan as defined in ORS 743B.005;

(b) A short term health insurance policy, the duration of which does not exceed [*six*] **three** months including renewals;

(c) A student health insurance policy;

(d) A Medicare supplemental policy; or

(e) A dental only policy.

(17) "Homeowner insurance" means insurance for residential property consisting of a combination of property insurance and casualty insurance that provides coverage for the risks of owning or occupying a dwelling and that is not intended to cover an owner's interest in rental property or commercial exposures.

(18) "Individual" means a natural person who:

(a) In the case of life or health insurance, is a past, present or proposed principal insured or certificate holder;

(b) In the case of other kinds of insurance, is a past, present or proposed named insured or certificate holder;

(c) Is a past, present or proposed policyowner;

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

(f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate that is subject to ORS 746.600 to 746.690.

(19) "Individually identifiable health information" means any oral or written health information that is:

(a) Created or received by a covered entity or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(20) "Institutional source" means a person or governmental entity that provides information about an individual to an insurer, insurance producer or insurance-support organization, other than:

(a) An insurance producer;

(b) The individual who is the subject of the information; or

(c) A natural person acting in a personal capacity rather than in a business or professional capacity.

(21) "Insurance producer" or "producer" means a person licensed by the Director of the Department of Consumer and Business Services as a resident or nonresident insurance producer.

(22) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit history.

(23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in part, in assembling or collecting information about natural persons for the primary purpose of providing the information to an insurer or insurance producer for insurance transactions, including:

(A) The furnishing of consumer reports to an insurer or insurance producer for use in connection with insurance transactions; and

(B) The collection of personal information from insurers, insurance producers or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) "Insurance-support organization" does not mean insurers, insurance producers, governmental institutions or health care providers.

(24) "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails:

(a) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

(b) The servicing of an insurance application, policy or certificate.

(25) "Insurer" has the meaning given that term in ORS 731.106.

(26) "Investigative consumer report" means a consumer report, or portion of a consumer report, for which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

(27) "Licensee" means an insurer, insurance producer or other person authorized or required to be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

(28) "Loss history report" means a report provided by, or a database maintained by, an insurance-support organization or consumer reporting agency that contains information regarding the claims history of the individual property that is the subject of the application for a homeowner insurance policy or the consumer applying for a homeowner insurance policy.

(29) "Nonaffiliated third party" means any person except:

(a) An affiliate of a licensee;

(b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the licensee; and

(c) As designated by the director by rule.

(30) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(31)(a) "Personal financial information" means:

(A) Information that is identifiable with an individual, gathered in connection with an insurance transaction from which judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit or any other personal characteristics; or

(B) An individual's name, address and policy number or similar form of access code for the individual's policy.

(b) "Personal financial information" does not mean information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law.

(32) "Personal information" means:

(a) Personal financial information;

(b) Individually identifiable health information; or

(c) Protected health information.

(33) "Personal insurance" means the following types of insurance products or services that are to be used primarily for personal, family or household purposes:

(a) Private passenger automobile coverage;

(b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and renters coverage;

(c) Personal dwelling property coverage;

(d) Personal liability and theft coverage, including excess personal liability and theft coverage;

and

(e) Personal inland marine coverage.

(34) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.372, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 746.611.

(35) "Policyholder" means a person who:

(a) In the case of individual policies of life or health insurance, is a current policyowner;

(b) In the case of individual policies of other kinds of insurance, is currently a named insured; or

(c) In the case of group policies of insurance under which coverage is individually underwritten, is a current certificate holder.

(36) "Pretext interview" means an interview wherein the interviewer, in an attempt to obtain personal information about a natural person, does one or more of the following:

(a) Pretends to be someone the interviewer is not.

(b) Pretends to represent a person the interviewer is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

(37) "Privileged information" means information that is identifiable with an individual and that:

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving the individual.

(38)(a) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(39) "Residual market mechanism" means an association, organization or other entity involved in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance Code relating to insurance applicants who are unable to procure insurance through normal insurance markets.

(40) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure of a premium to be paid as required by the policy.

(41) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 16. This 2017 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2017 Act takes effect

on its passage.