

SENATE AMENDMENTS TO RESOLVE CONFLICTS TO A-ENGROSSED HOUSE BILL 2341

By COMMITTEE ON HEALTH CARE

May 9

1 On page 1 of the printed A-engrossed bill, line 2, after “insurance;” insert “creating new pro-
2 visions;”.

3 In line 3, after “746.600;” insert “repealing section 1, chapter ___, Oregon Laws 2017 (Enrolled
4 Senate Bill 271);”.

5 On page 12, after line 11, insert:

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7 **(Enrolled Senate Bill 271) (amending ORS 743B.005), is repealed and ORS 743B.005, as**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

9 “743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and
10 743B.128:

11 “(1) ‘Actuarial certification’ means a written statement by a member of the American Academy
12 of Actuaries or other individual acceptable to the Director of the Department of Consumer and
13 Business Services that a carrier is in compliance with the provisions of ORS 743B.012 based upon
14 the person’s examination, including a review of the appropriate records and of the actuarial as-
15 sumptions and methods used by the carrier in establishing premium rates for small employer health
16 benefit plans.

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

21 “(3) ‘Affiliation period’ means, under the terms of a group health benefit plan issued by a health
22 care service contractor, a period:

23 “(a) That is applied uniformly and without regard to any health status related factors to an
24 enrollee or late enrollee;

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

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

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

30 “(4) ‘Bona fide association’ means an association that:

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

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

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

35 “(d) Makes health insurance coverage that is offered through the association available to all

1 members of the association regardless of the health status of the member or individuals who are
2 eligible for coverage through the member;

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

5 “(f) Has a constitution and bylaws; and

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

7 “(5) ‘Carrier’ means any person who provides health benefit plans in this state, including:

8 “(a) A licensed insurance company;

9 “(b) A health care service contractor;

10 “(c) A health maintenance organization;

11 “(d) An association or group of employers that provides benefits by means of a multiple em-
12 ployer welfare arrangement and that:

13 “(A) Is subject to ORS 750.301 to 750.341; or

14 “(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by
15 ORS 743B.010 to 743B.013; or

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

18 “(6) ‘Dependent’ means the spouse or child of an eligible employee, subject to applicable terms
19 of the health benefit plan covering the employee.

20 “(7) ‘Eligible employee’ means an employee who is eligible for coverage under a group health
21 benefit plan.

22 “(8) ‘Employee’ means any individual employed by an employer.

23 “(9) ‘Enrollee’ means an employee, dependent of the employee or an individual otherwise eligible
24 for a group or individual health benefit plan who has enrolled for coverage under the terms of the
25 plan.

26 “(10) ‘Exchange’ means an American Health Benefit Exchange described in 42 U.S.C. 18031,
27 18032, 18033 and 18041.

28 “(11) ‘Exclusion period’ means a period during which specified treatments or services are ex-
29 cluded from coverage.

30 “(12) ‘Financial impairment’ means that a carrier is not insolvent and is:

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

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

33 “(13)(a) ‘Geographic average rate’ means the arithmetical average of the lowest premium and the
34 corresponding highest premium to be charged by a carrier in a geographic area established by the
35 director for the carrier’s:

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

37 “(B) Individual health benefit plans.

38 “(b) ‘Geographic average rate’ does not include premium differences that are due to differences
39 in benefit design, age, tobacco use or family composition.

40 “(14) ‘Grandfathered health plan’ has the meaning prescribed by rule by the United States Sec-
41 retaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e) that
42 is in effect on January 1, 2017.

43 “(15) ‘Group eligibility waiting period’ means, with respect to a group health benefit plan, the
44 period of employment or membership with the group that a prospective enrollee must complete be-
45 fore plan coverage begins.

1 “(16)(a) ‘Health benefit plan’ means any:
2 “(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
3 “(B) Subscriber contract of a health care service contractor as defined in ORS 750.005; or
4 “(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrange-
5 ment defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the
6 extent that the plan is subject to state regulation.
7 “(b) ‘Health benefit plan’ does not include:
8 “(A) Coverage for accident only, specific disease or condition only, credit or disability income;
9 “(B) Coverage of Medicare services pursuant to contracts with the federal government;
10 “(C) Medicare supplement insurance policies;
11 “(D) Coverage of TRICARE services pursuant to contracts with the federal government;
12 “(E) Benefits delivered through a flexible spending arrangement established pursuant to section
13 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition
14 to a group health benefit plan;
15 “(F) Separately offered long term care insurance, including, but not limited to, coverage of
16 nursing home care, home health care and community-based care;
17 “(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity
18 insurance;
19 “(H) Short term health insurance policies that are in effect for periods of three months or less,
20 including the term of a renewal of the policy;
21 “(I) Dental only coverage;
22 “(J) Vision only coverage;
23 “(K) Stop-loss coverage that meets the requirements of ORS 742.065;
24 “(L) Coverage issued as a supplement to liability insurance;
25 “(M) Insurance arising out of a workers’ compensation or similar law;
26 “(N) Automobile medical payment insurance or insurance under which benefits are payable with
27 or without regard to fault and that is statutorily required to be contained in any liability insurance
28 policy or equivalent self-insurance; or
29 “(O) Any employee welfare benefit plan that is exempt from state regulation because of the
30 federal Employee Retirement Income Security Act of 1974, as amended.
31 “(c) For purposes of this subsection, renewal of a short term health insurance policy includes
32 the issuance of a new short term health insurance policy by an insurer to a policyholder within 60
33 days after the expiration of a policy previously issued by the insurer to the policyholder.
34 “(17) ‘Individual health benefit plan’ means a health benefit plan:
35 “(a) That is issued to an individual policyholder; or
36 “(b) That provides individual coverage through a trust, association or similar group, regardless
37 of the situs of the policy or contract.
38 “(18) ‘Initial enrollment period’ means a period of at least 30 days following commencement of
39 the first eligibility period for an individual.
40 “(19) ‘Late enrollee’ means an individual who enrolls in a group health benefit plan subsequent
41 to the initial enrollment period during which the individual was eligible for coverage but declined
42 to enroll. However, an eligible individual shall not be considered a late enrollee if:
43 “(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg
44 or as prescribed by rule by the Department of Consumer and Business Services;
45 “(b) The individual applies for coverage during an open enrollment period;

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

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

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

10 “(20) ‘Multiple employer welfare arrangement’ means a multiple employer welfare arrangement
11 as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended,
12 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

13 “(21) ‘Preexisting condition exclusion’ means:

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

18 “(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late
19 enrollee that excludes coverage for services, charges or expenses incurred during a specified period
20 immediately following enrollment for a condition for which medical advice, diagnosis, care or treat-
21 ment was recommended or received during a specified period immediately preceding enrollment. For
22 purposes of this paragraph pregnancy and genetic information do not constitute preexisting condi-
23 tions.

24 “(22) ‘Premium’ includes insurance premiums or other fees charged for a health benefit plan,
25 including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by
26 the plan.

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

29 “(24) ‘Representative’ does not include an insurance producer or an employee or authorized
30 representative of an insurance producer or carrier.

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

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