House Bill 2897

Sponsored by COMMITTEE ON HEALTH CARE

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 **as introduced.**

Prohibits insurer that offers health benefit plan in state from restricting covered services to in-network providers, imposing higher deductible, copayment or out-of-pocket maximum for out-of-network physicians than for in-network physicians, requiring prior authorization for physician ordered prescription drugs, laboratory tests or physician referrals, requiring generic drugs, except for controlled substances, to be filled at in-network pharmacies and requiring physicians licensed by Oregon Medical Board to be credentialed. Requires insurer that offers health benefit plan to reimburse immunization at same rate across all providers and to reimburse all drugs within same class in same amount.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 743A.012, 743A.063, 743A.082, 743A.168, 743A.260, 743B.001, 743B.012, 743B.013, 743B.105, 743B.125, 743B.126, 743B.225, 743B.250, 743B.505, 750.055 and 750.333 and section 2, chapter 94, Oregon Laws 2016; and repealing ORS 743.035 and 743B.227 and section 4, chapter 43, Oregon Laws 2016.

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

SECTION 1. Section 2 of this 2017 Act is added to and made a part of the Insurance Code.

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

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "In-network" means a health care provider who contracts with an insurer to provide health care services to enrollees in a health benefit plan offered by the insurer.

(c) "Out-of-network" means a health care provider who has not contracted with an insurer to provide health care services to enrollees in a health benefit plan offered by the insurer.

(d) "Pharmacy" has the meaning given that term in ORS 689.005.

(e) "Physician" means an individual licensed to practice medicine under ORS chapter 677.

(f) "Provider" means a physician and any other individual licensed or certified to provide health services in this state.

(2) A health benefit plan offered to residents of this state may not contain terms that:

(a) Deny reimbursement for covered services because the services are provided by an out-of-network provider;

(b) Require prior authorization for:

(A) Drugs that are covered by the health benefit plan if prescribed by a physician;

(B) Laboratory tests covered by the health benefit plan if ordered by a physician; or

(C) Referrals to in-network or out-of-network physicians for covered services;

(c) Require generic prescription drugs to be provided by an in-network pharmacy, except for controlled substances; or

(d) Require a physician to meet credentialing requirements in addition to requirements

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.

imposed by the Oregon Medical Board for licensure.

(3) The terms of a health benefit plan offered to residents of this state must:

(a) Impose the same deductible, copayment, coinsurance and out-of-pocket maximum on:

(A) All drugs in the same class; and

(B) A covered service provided by an in-network and out-of-network physician if the service is within the physician's scope of practice;

(b) Reimburse the cost of an immunization at the same rate regardless of the type of provider that is administering the immunization; and

(c) Reimburse all pharmacies for the cost of a 90-day or less supply of a prescription drug at the same rate.

SECTION 3. ORS 743A.012 is amended to read:

743A.012. (1) As used in this section:

(a) "Emergency medical condition" means a medical condition:

(A) That manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would:

(i) Place the health of a person, or an unborn child in the case of a pregnant woman, in serious jeopardy;

(ii) Result in serious impairment to bodily functions; or

(iii) Result in serious dysfunction of any bodily organ or part; or

(B) With respect to a pregnant woman who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of the woman or the unborn child.

(b) "Emergency medical screening exam" means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(c) "Emergency services" means, with respect to an emergency medical condition:

(A) An emergency medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment as are required under 42 U.S.C. 1395dd to stabilize a patient, to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital.

(d) "Grandfathered health plan" has the meaning given that term in ORS 743B.005.

(e) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(f) "Prior authorization" has the meaning given that term in ORS 743B.001.

(g) "Stabilize" means to provide medical treatment as necessary to:

(A) Ensure that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur during or to result from the transfer of the patient from a facility; and

(B) With respect to a pregnant woman who is in active labor, to perform the delivery, including the delivery of the placenta.

(2) All insurers offering a health benefit plan shall provide coverage without prior authorization for emergency services.

(3) A health benefit plan, other than a grandfathered health plan, must provide coverage re-

quired by subsection (2) of this section:

(a) For the services of participating providers, without regard to any term or condition of coverage other than:

(A) The coordination of benefits;

(B) An affiliation period or waiting period permitted under part 7 of the Employee Retirement Income Security Act, part A of Title XXVII of the Public Health Service Act or chapter 100 of the Internal Revenue Code;

(C) An exclusion other than an exclusion of emergency services; or

(D) Applicable cost-sharing; and

(b) For the services of a nonparticipating provider:

(A) Without imposing any administrative requirement or limitation on coverage that is more restrictive than requirements or limitations that apply to participating providers;

(B) Without imposing a copayment amount or coinsurance rate that exceeds the amount or rate for participating providers;

(C) Without imposing a deductible[*, unless the deductible applies generally to nonparticipating providers*]; and

(D) Subject only to an out-of-pocket maximum that applies to [*all*] services from [*nonparticipating*] **participating** providers.

(4) All insurers offering a health benefit plan shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(5) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and may not deny coverage for emergency services solely because 9-1-1 was used.

(6) This section is exempt from ORS 743A.001.

SECTION 4. ORS 743A.063 is amended to read:

743A.063. (1) A prescription drug benefit program, or a prescription drug benefit offered under a health benefit plan as defined in ORS 743B.005, must provide for reimbursement for up to a 90-day supply of a prescription drug dispensed by a pharmacy, as defined in ORS 689.005, if:

(a) The prescription drug is covered by the program or plan;

(b) An initial 30-day supply of the prescription drug has been previously dispensed to the program or plan member; and

(c) The quantity of the prescription drug dispensed does not exceed the total remaining quantity of the prescription drug that the prescribing practitioner authorized to be dispensed through refills.

(2) **Except as provided in section 2 of this 2017 Act,** the coverage required by subsection (1) of this section may be limited by the terms and conditions of a pharmacy network contract, or a prescription drug benefit program or health benefit plan, that are related to the reimbursement rate of the prescription drug.

(3) The coverage required by subsection (1) of this section may be limited by formulary restrictions that are related to the prescription drug.

(4) This section does not apply to the reimbursement of prescription drugs classified as a controlled substance in Schedule II.

(5) This section is exempt from ORS 743A.001.

SECTION 5. ORS 743A.082 is amended to read:

743A.082. (1) Except as provided in subsections (2) and (3) of this section, a health benefit plan, as defined in ORS 743B.005, may not require a copayment or impose a coinsurance requirement or a deductible on the covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes during the period of each pregnancy, beginning with conception and ending six weeks postpartum.

(2) Subsection (1) of this section does not apply to a high deductible health plan described in 26 U.S.C. 223.

(3) The coverage required by subsection (1) of this section may be limited by [*network and*] formulary restrictions that apply to other benefits under the plan. Subsection (1) of this section does not apply to services, medications, test strips and syringes that are not covered due to the [*network or*] formulary restrictions.

(4) An insurer may require an enrollee or the enrollee's health care provider to notify the insurer orally, in a timely manner, that the enrollee is diabetic and is pregnant or has given birth and is within six weeks postpartum.

SECTION 6. ORS 743A.168, as amended by section 7, chapter 11, Oregon Laws 2016, is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses, other than limited benefit coverage, shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that:

(A) Has met the credentialing requirement**, if applicable,** of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(i) A health facility as defined in ORS 430.010;

(ii) A residential facility as defined in ORS 430.010;

(iii) A day or partial hospitalization program as defined in ORS 430.010;

(iv) An outpatient service as defined in ORS 430.010; or

(v) An individual behavioral health or medical professional licensed or certified under Oregon law; or

(B) Is a provider organization certified by the Oregon Health Authority under subsection (13)

of this section.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present; or

(D) A court-ordered sex offender treatment program.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved or certified by the Oregon Health Authority;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250

and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health facilities, residential facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743B.460 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all providers that are eligible for reimbursement under this section.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(e)(B) of this section that:

(a) Is not otherwise subject to licensing or certification by the authority; and

(b) Does not contract with the authority, a subcontractor of the authority or a community

mental health program.

(14) The Oregon Health Authority shall adopt by rule standards for the certification provided under subsection (13) of this section to ensure that a certified provider organization offers a distinct and specialized program for the treatment of mental or nervous conditions.

(15) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or both, to be imposed on any provider organization that applies for certification under subsection (13) of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established in ORS 413.101 and shall be used only for carrying out the provisions of subsection (13) of this section.

(16) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress. This section does not prohibit an insurer from requiring a provider organization certified by the Oregon Health Authority under subsection (13) of this section to meet the insurer's credentialing requirements as a condition of entering into a contract.

(17) The Director of the Department of Consumer and Business Services and the Oregon Health Authority, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of this section.

SECTION 7. ORS 743A.260 is amended to read:

743A.260. (1) As used in this section:

(a) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(b) "Supervisory authority" has the meaning given that term in ORS 144.087.

(2) Except as provided in subsection (4) of this section, an insurer offering a health benefit plan may not deny reimbursement for any service or supply covered by the plan or cancel the coverage of an insured under the plan on the basis that:

(a) The insured is in the custody of a local supervisory authority, if the insured is in custody pending the disposition of charges;

(b) The insured receives publicly funded medical care while in the custody of a local supervisory authority; or

(c) The care was provided to the insured by an employee or contractor of a county or a local supervisory authority, if the employee or contractor meets the credentialing criteria of the health benefit plan.

(3) An insurer shall reimburse a county for the costs of covered services or supplies provided to an insured who is in the custody of the local supervisory authority, pending the disposition of charges, in an amount that is no less than 115 percent of the Medicare rate for the service or supply.

(4) An insurer offering a health benefit plan may:

(a) Deny coverage for the treatment of injuries resulting from a violation of law;

(b) Exclude from any requirements for reporting quality outcomes or performance, any covered services provided to an insured in the custody of a local supervisory authority;

[*(c) Impose utilization controls under the health benefit plan that apply to services provided to insureds who are not in custody by in-network providers, including a requirement for prior authorization;*]

[*(d)*] **(c)** Impose the requirements for billing and medical coding for covered services provided to an insured in the custody of a local supervisory authority that the insurer imposes on other

providers;

[*(e)*] **(d)** Deny coverage of diagnostic tests or health evaluations required, as a matter of course, for all individuals who are in the custody of the local supervisory authority pending the disposition of charges; **and**

[*(f) Limit coverage of hospital and ambulatory surgical center services provided to an insured in the custody of a local supervisory authority to services provided by in-network hospitals and ambulatory surgical centers; and*]

[*(g)*] **(e)** Reimburse an out-of-network renal dialysis facility at either the in-network or the out-of-network rate paid by the insurer for dialysis provided to an insured in the custody of a local supervisory authority.

(5)(a) An insurer may not refuse to credential a health care provider who is an employee or contractor of a county or a local supervisory authority on the basis that the employee or contractor provides the services in a facility operated by the local supervisory authority.

(b) If an insurer refuses to credential a health care provider who is an employee or contractor of a county or a local supervisory authority, the insurer must give written notice to the provider explaining the reasons for the refusal.

(6) This section does not:

(a) Impair any right of an employer to remove an employee from coverage under a health benefit plan;

(b) Release carriers from the requirement to coordinate benefits for persons who are insured by more than one carrier; or

(c) Limit an insurer's right to rescind coverage in accordance with ORS 743B.310.

(7) A public body, as defined in ORS 174.109, may not pay health benefit plan premiums on behalf of a person who is in the custody of a local supervisory authority.

SECTION 8. ORS 743B.001, as amended by sections 3 and 4, chapter 59, Oregon Laws 2015, is amended to read:

743B.001. As used in this section and ORS 743.008, [*743.035,*] 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.206, 743B.220, 743B.225, [*743B.227,*] 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550 and 743B.555:

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

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

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

(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury exclusion, [*network exclusion,*] annual benefit limit or other limitation on otherwise covered items or services;

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

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

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

(3) "Credit card" has the meaning given that term in 15 U.S.C. 1602.

(4) "Electronic funds transfer" has the meaning given that term in ORS 293.525.

(5) "Enrollee" has the meaning given that term in ORS 743B.005.

(6) "Essential community provider" has the meaning given that term in rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 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. 18031.

(7) "Grievance" means:

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

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

(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

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

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

(8) "Health benefit plan" has the meaning given that term in ORS 743B.005.

(9) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 731.098, to provide health care services to group members.

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) With respect to the statutes governing the billing for or payment of claims, "provider" also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

(17) "Utilization review" means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

SECTION 9. ORS 743B.012 is amended to read:

743B.012. (1) As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers all of the carrier's health benefit plans, approved by the Department of Consumer and Business Services for use in the small employer market, for which the small employer is eligible.

(2) A carrier shall issue to a small employer any health benefit plan that is offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

(3) A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries may not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement may not include any requirements that relate to the actual or expected health status of the prospective enrollee.

(4) A carrier shall, pursuant to subsection (2) of this section, accept applications from and offer coverage to a small employer group covered under an existing health benefit plan regardless of whether a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a carrier accepts an application for a small employer group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the

prospective enrollee would have become eligible for coverage under that replaced plan.

(5) A carrier is not required to accept applications from and offer coverage pursuant to subsection (2) of this section if the department finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(6) A carrier shall actively market all health benefit plans that are offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(7)[*(a)*] Subsection (2) of this section does not require a carrier to offer coverage to or accept applications from:

[*(A)*] **(a)** A small employer if the small employer is not physically located in the carrier's approved service area; **or**

[*(B)*] **(b)** An employee of a small employer if the employee does not work or reside within the carrier's approved service areas[*; or*]

[*(C) Small employers located within an area where the carrier reasonably anticipates, and demonstrates to the department, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those small employer groups because of its obligations to existing small employer group contract holders and enrollees*].

[*(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection may not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.*]

(8) For purposes of ORS 743B.010 to 743B.013, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743B.010 to 743B.013 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(9) A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743B.013 (3)(e) or elects to discontinue renewing all such plans is prohibited from offering health benefit plans to small employers in this state for a period of five years from one of the following dates:

(a) The date of notice to the department pursuant to ORS 743B.013 (3)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the department provides notice to the carrier that the department has determined that the carrier has effectively discontinued offering health benefit plans to small employers in this state.

SECTION 10. ORS 743B.013 is amended to read:

743B.013. (1) A health benefit plan issued to a small employer:

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

(b) May require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee.

(c) May not apply a preexisting condition exclusion to any enrollee.

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

(3) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder unless:

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

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) The carrier discontinues both offering and renewing all of its small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area; and

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

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

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

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

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers to small employers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013. The carrier shall offer the plans at least 90 days prior to discontinuation.

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

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

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

(A) Offer in writing to each small employer covered by the plan, all other health benefit plans

that the carrier offers to small employers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743B.010 to 743B.013.

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

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

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

[*(k) In the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.*]

[*(L)*] **(k)** In the case of a health benefit plan that is offered in the small employer market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(4) A carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (3)(e), (g) and (h) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group

health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans, except grandfathered health plans, shall be subject to the following provisions:

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

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

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

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

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

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age and differences in family composition.

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

(10) In connection with the offering for sale of any health benefit plan to a small employer, each carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates and premiums, and the extent to which the carrier considers age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

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

(11)(a) Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its small employer health benefit plans, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification shall be in a uniform form and manner and shall contain such information as specified by the department. A copy of each certification shall be retained by the carrier at its principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743B.010 to 743B.013, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(12) A carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

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

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

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

(16) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

SECTION 11. ORS 743B.105 is amended to read:

743B.105. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) A carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

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

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

late enrollee; or

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

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

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

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

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

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

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) The number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

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

(e) The carrier discontinues both offering and renewing, all of its group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

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

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area; and

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

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

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

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

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

(g) The carrier discontinues both offering and renewing a group health benefit plan, other than a grandfathered health plan, for all groups in this state or in a specified service area within this

state, other than a plan discontinued under paragraph (f) of this subsection.

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

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

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups in the specified service area.

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

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

(j) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

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

[*(L)*] **(k)** In the case of a health benefit plan that is offered in the group market only to one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(6) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under subsection (5)(e), (g) and (h) of this section.

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

(a) The enrollee:

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

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

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

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

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

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

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

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

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

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

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

SECTION 12. ORS 743B.125 is amended to read:

743B.125. (1) With respect to coverage under an individual health benefit plan, a carrier may not impose an individual coverage waiting period.

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

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

(b) May not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

(A) The exclusion applies only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage.

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

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

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:

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

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

(c) The carrier discontinues both offering and renewing all of its individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area; and

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

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

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

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

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

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

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

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

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

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

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

(h) The Director of the Department of Consumer and Business Services orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet its contractual obligations.

[*(i) In the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.*]

[*(j)*] **(i)** In the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

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

(6) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

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

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

(7) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

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

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

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

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

fide association; or

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

SECTION 13. ORS 743B.126 is amended to read:

743B.126. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier that are not grandfathered health plans.

(2) [*Except as provided in subsection (3) of this section, no*] **A** carrier or insurance producer [*shall*] **may not**, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

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

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

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

[*(6)*] **(5)** A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743B.125 (4)(c) or to discontinue both offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the director pursuant to ORS 743B.125 (4)(c) or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.

SECTION 14. ORS 743B.225 is amended to read:

743B.225. (1) As used in this section, "continuity of care" means the feature of a health benefit plan under which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider [*for a limited period of time*] after the medical services contract terminates.

(2) An insurer offering managed health insurance or preferred provider organization insurance in this state shall provide continuity of care to an enrollee under a health benefit plan if:

(a) A medical services contract or other contract for an individual provider's services is terminated;

(b) The provider no longer participates in the provider network; and

(c) The insurer does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level below the benefit level specified in the plan for out-of-network providers.

(3) In order to obtain continuity of care, an enrollee must request continuity of care from the insurer.

(4) An enrollee of a health benefit plan is entitled to continuity of care when the following conditions are met:

(a) The enrollee is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the enrollee, it is desirable to maintain continuity of care; and

(b) The contractual relationship between the individual provider and the insurer described in subsection (2) of this section with respect to the plan covering the enrollee has ended, except as provided in subsection (5) of this section.

(5) A health benefit plan is not required to provide continuity of care when the contractual relationship between the individual provider and the insurer described in subsection (2) of this section ends under one of the following circumstances:

(a) The contractual relationship between the individual provider and the insurer has ended because the individual provider:

(A) Has retired;

(B) Has died;

(C) No longer holds an active license;

[*(D) Has relocated out of the service area;*]

[*(E)*] **(D)** Has gone on sabbatical; or

[*(F)*] **(E)** Is prevented from continuing to care for patients because of other circumstances; or

(b) The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

(6) A health benefit plan is not required to provide continuity of care if the enrollee leaves a health benefit plan or if the policyholder discontinues the plan in which the enrollee is enrolled.

[*(7) Except as provided for pregnancy in subsection (8) of this section, an enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:*]

[*(a) The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or*]

[*(b) The 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider, as required by subsection (9) of this section.*]

[*(8) An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:*]

[*(a) The 45th day after the birth; or*]

[*(b) As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider as required by subsection (9) of this section.*]

[*(9)*] **(7)** An insurer shall give written notice of the termination of the contractual relationship between the insurer and the individual provider and of the right to obtain continuity of care to those enrollees that the insurer knows or reasonably should know are under the care of the individual provider. The notice may be given prior to the date on which the termination of the contractual relationship with the individual provider takes effect only if the insurer gives notice in a good faith belief that the termination will take effect as stated in the notice. In any event, the notice shall be given to those enrollees not later than the 10th day after the date on which the termination of the contractual relationship with the individual provider takes effect. If the insurer first learns the identity of an affected enrollee after the date of termination of the contractual relationship with the

individual provider or after the date on which the insurer gave notice to the other affected enrollees, then the insurer shall give a notice of termination to the affected enrollee not later than the 10th day after learning that enrollee's identity.

[*(10) For the purpose of notifying an enrollee under subsection (7)(b) or (8)(b) of this section:*]

[*(a) The date of notification by the insurer is the earlier of the date on which the enrollee receives the notice or the date on which the insurer receives or approves the request for continuity of care.*]

[*(b) If an individual provider belongs to a provider group, the provider group may deliver the notice if the insurer agrees that the provider group may do so and if the notice clearly provides the information that the plan is required to provide to the enrollee under subsection (9) of this section.*]

[*(11)*] **(8)** A health benefit plan may condition continuity of care upon the requirement that the individual provider adhere to the medical services contract between the provider and the insurer and accept the contractual reimbursement rate applicable at the time of contract termination or, if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.

SECTION 15. 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 drugs not included on the formulary;

(E) Procedures for the coverage of 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)*] **(h)** The availability of continuity of care as required by ORS 743B.225.

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

[*(k)*] **(j)** Cost-sharing requirements and other charges to enrollees.

[*(L)*] **(k)** Procedures, if any, for changing providers.

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

[*(n)*] **(m)** 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)*] **(n)** Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

[*(p)*] **(o)** 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)*] **(p)** An explanation of assistance provided to non-English-speaking enrollees.

[*(r)*] **(q)** 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 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. 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 16. ORS 743B.505 is amended to read:

743B.505. (1) An insurer offering [*a*] **an individual or small employer, as defined in ORS 743B.005,** health benefit plan in this state that [*provides coverage to individuals or to small employers, as defined in ORS 743B.005, through*] **contracts with** 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.

(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 17. Section 2, chapter 94, Oregon Laws 2016, is amended to read:

Sec. 2. As used in sections 1 to 5**, chapter 94, Oregon Laws 2016** [*of this 2016 Act*]:

(1) "Advance premium tax credit" means the premium assistance amount determined in accordance with 26 U.S.C. 36B.

(2) "COFA citizen" means an individual who is a citizen of:

(a) The Republic of the Marshall Islands;

(b) The Federated States of Micronesia; or

(c) The Republic of Palau.

(3) "Health insurance exchange" or "exchange" has the meaning given that term in ORS 741.300.

(4) "Income" means the modified adjusted gross income that is attributed to an individual in determining the individual's eligibility for advance premium tax credits.

[*(5) "In-network provider" means a health care provider or group of providers that directly contract with an insurer to provide health benefits covered by a health benefit plan offered by the insurer.*]

[*(6)*] **(5)** "Open enrollment period" means the period during which a person may enroll in a qualified health plan.

[*(7)*] **(6)** "Out-of-pocket costs" means copayments, coinsurance, deductibles and other cost-sharing requirements imposed under a qualified health plan for services, pharmaceuticals, devices and other health benefits that are covered by the plan [*and that are rendered by in-network providers*].

[*(8)*] **(7)** "Premium cost" means an individual's premium for a qualified health plan less the amount of the individual's advance premium tax credit.

[*(9)*] **(8)** "Qualified health plan" means a health benefit plan, as defined in ORS 743B.005, offered through the health insurance exchange.

[*(10)*] **(9)** "Resident" means a person who is domiciled in this state.

[*(11)*] **(10)** "Special enrollment period" means a period during which a person who has not done so during the open enrollment period may enroll in a qualified health plan through the exchange if the person meets specified requirements.

SECTION 18. ORS 750.055, as amended by section 7, chapter 59, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,

731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, [*743B.227,*] 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 19. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 6, chapter 25, Oregon Laws 2014, section 81, chapter 45, Oregon Laws 2014, section 8, chapter 59, Oregon Laws 2015, section 6, chapter 100, Oregon Laws 2015, section 6, chapter 224, Oregon Laws 2015, section 10, chapter 362, Oregon Laws 2015, section 9, chapter 470, Oregon Laws 2015, and section 29, chapter 515, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, [*743B.227,*] 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800 and section 2, chapter 771, Oregon Laws 2013.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 20. ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,

Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, and section 30, chapter 515, Oregon Laws 2015, is amended to read:

750.055. (1) The following provisions of the Insurance Code apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743A.252.

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(e) ORS chapter 734.

(f) ORS 735.600 to 735.650.

(g) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.004, 743.008, 743.010, 743.018, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788, 743.790, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.051, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743B.003 to 743B.127, 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, [*743B.227,*] 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601 and 743B.800.

(h) The provisions of ORS chapter 744 relating to the regulation of insurance producers and third party administrators.

(i) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(j) ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025

and 750.045 that are deemed necessary for the proper administration of these provisions.

SECTION 21. ORS 750.333, as amended by section 10, chapter 59, Oregon Laws 2015, is amended to read:

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992, 743.029 and 743A.252.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.004, 743.008, 743.028, 743.053, 743.406, 743.524, 743.526, 743.528, 743.535, 743A.012, 743A.020, 743A.034, 743A.051, 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150, 743A.170, 743A.175, 743A.184, 743A.192, 743A.250, 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195 to 743B.206, 743B.220, 743B.222, 743B.225, [*743B.227,*] 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601.

(f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048, 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141, 743A.148, 743A.168, 743A.180, 743A.185, 743A.188 and 743A.190. Multiple employer welfare arrangements to which ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.004, 743.022, 743.535 and 743B.003 to 743B.127.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(j) ORS 731.870.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

SECTION 22. ORS 743.035 and 743B.227 and section 4, chapter 43, Oregon Laws 2016, are repealed.