Senate Bill 526

Sponsored by Senators KRUSE, FREDERICK (Presession filed.)

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.**

Modifies requirements applicable to step therapy protocol imposed by insurer. Allows patient to appeal insurer's denial of step therapy override.

A BILL FOR AN ACT

Relating to prescription drugs; creating new provisions; and amending ORS 743B.001, 743B.250, 743B.602, 750.055 and 750.333.

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

SECTION 1. ORS 743B.602 is amended to read:

743B.602. [*(1) As used in this section:*]

[*(a) "Health care coverage plan" includes:*]

[*(A) A health benefit plan, as defined in ORS 743B.005;*]

[*(B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies;*]

[*(C) A medical services contract, as defined in ORS 743B.001;*]

[*(D) A multiple employer welfare arrangement, as defined in ORS 750.301;*]

[*(E) A contract or agreement with a health care service contractor, as defined in ORS 750.005, or a preferred provider organization;*]

[*(F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator that pays prescription drug claims; and*]

[*(G) An accident insurance policy or any other insurance contract providing reimbursement for the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies.*]

[*(b) "Step therapy" means a drug protocol in which a health care coverage plan will reimburse the cost of a prescribed drug only if the patient has first tried a specified drug or series of drugs.*]

[*(2) A health care coverage plan that requires step therapy shall make easily accessible to prescribing practitioners, clear explanations of:*]

[*(a) The clinical criteria for each step therapy protocol;*]

[*(b) The procedure by which a practitioner may submit to the plan the practitioner's medical rationale for determining that a particular step therapy protocol is not appropriate for a particular patient based on the patient's medical condition and history; and*]

[*(c) The documentation, if any, that a practitioner must submit to the plan for the plan to determine the appropriateness of step therapy for a specific patient.*]

(1) As used in this section:

(a) "Insurer" includes any entity authorized in this state to offer:

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.

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

(B) An insurance policy or certificate covering the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies;

(C) A medical services contract, as defined in ORS 743B.001;

(D) A multiple employer welfare arrangement, as defined in ORS 750.301;

(E) A contract or agreement with a health care service contractor, as defined in ORS 750.005, or a preferred provider organization;

(F) A pharmacy benefit manager, as defined in ORS 735.530, or other third party administrator that pays prescription drug claims; and

(G) An accident insurance policy or any other insurance contract providing reimbursement for the cost of prescription drugs, hospital expenses, health care services and medical expenses, equipment and supplies other than limited benefit coverage.

(b) "Patient" means an individual covered under a policy, certificate or contract issued by an insurer who has requested, or whose prescribing practitioner has requested, a step therapy override.

(c) "Step therapy" means a prescription drug protocol in which an insurer will not reimburse the cost of a prescribed drug unless the patient has first tried a drug or series of drugs specified by the insurer.

(d) "Step therapy override" means a determination by an insurer to override a step therapy protocol and permit reimbursement for a prescription drug ordered by a prescribing practitioner.

(2) An insurer that controls utilization of prescription drugs using step therapy shall:

(a) Develop the step therapy protocol using recognized evidence-based, peer-reviewed clinical review criteria that take into account the needs of atypical patients and diagnoses;

(b) Provide a clear and convenient process for a prescribing practitioner to obtain an override of the step therapy protocol not later than 72 hours, or 24 hours in the case of a patient whose condition is in serious jeopardy without the prescribed drug or drugs, after the prescribing practitioner submits documentation to the insurer that one or more criteria listed in paragraph (c) of this subsection have been met; and

(c) Provide a step therapy override if:

(A) The treatment required under the step therapy protocol:

(i) Is contraindicated;

(ii) Has been ineffective in the treatment of the disease or medical condition of the patient;

(iii) Is expected to be ineffective based on the known clinical history and condition of the patient and the patient's prescription drug regimen; or

(iv) Is likely to cause an adverse effect or physical or mental harm to the patient;

(B) The patient has tried the prescription drug or drugs required by the step therapy, or another prescription drug or drugs in the same pharmacologic class or with the same mechanism of action, while covered by a current or previous insurer, and the drug or drugs were discontinued due to lack of effectiveness, diminished effect or adverse effect;

(C) Except as provided in subsection (4) of this section, the patient's condition is stable on a prescription drug or drugs ordered by the prescribing practitioner for the medical condition for which the drug or drugs are prescribed; or

(D) The required prescription drug or drugs are not in the best interest of the patient

because the drug or drugs will likely create a significant barrier to the patient's compliance with the treatment plan, worsen a comorbid condition of the patient or decrease the patient's ability to achieve or maintain the functional ability to perform activities of daily living.

(3) An insurer that does not make a determination on a request for a step therapy override within the number of hours specified in subsection (2) of this section shall be deemed to have approved the step therapy override and shall immediately authorize payment for the prescribed drug or drugs.

(4) Subsection (2)(c)(C) of this section does not prohibit an insurer from requiring that a patient first try a generic drug rated by the United States Food and Drug Administration as an AB-rated generic drug equivalent before the insurer will reimburse the cost of an equivalent brand name drug.

SECTION 2. 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**, step therapy protocol** 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 a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits 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;

(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) "Step therapy" has the meaning given that term in ORS 743B.602.

[*(17)*] **(18)** "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 3. 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 **or may obtain a step therapy override as provided in ORS 743B.602**;

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

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

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

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

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

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

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

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

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

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

(2) Establish procedures 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 4. 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**,** **743B.602** 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 5. 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**,** **743B.602** 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 6. 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**,** **743B.602** 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 7. 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 **and 743B.602**.

(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 8. The amendments to ORS 743B.001 and 743B.602 by sections 1 and 2 of this 2017 Act apply to policies, certificates and contracts issued, renewed or extended by insurers on or after the effective date of this 2017 Act.

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