HB 4156-2
(LC 102)
2/6/18 (LHF/ps)

Requested by Representative MALSTROM

PROPOSED AMENDMENTS TO
HOUSE BILL 4156

On page 1 of the printed bill, line 2, after the semicolon delete the rest of the line and line 3 and insert "creating new provisions; and amending ORS 743B.005, 743B.013, 743B.105, 743B.125, 750.055 and 750.333.".

After line 4, insert:

"SECTION 1. Section 2 of this 2018 Act is added to and made a part of the Insurance Code.

"SECTION 2. (1)(a) There may be no deductible or other cost-sharing requirements, other than a flat dollar copayment, applied to prescription drugs covered as a pharmacy benefit or as a medical benefit in at least 25 percent of all individual, small employer and group health benefit plans that are offered by a carrier in each geographic area served by the carrier. Any flat dollar copayment must be:

"(A) Reasonably graduated from one cost tier to the next higher cost tier; and

"(B) Proportional across all tiers.

"(b) As used in this subsection, 'tier' means a group of prescription drugs, within a drug formulary, to which defined cost-sharing requirements apply.

"(2) A health benefit plan is excluded from the count of individual, small employer and group health benefit plans offered by a carrier in

a geographic region served by the carrier if the health benefit plan is:

"(a) Offered by a carrier as a plan that qualifies for a health savings account and that requires a deductible on prescription drugs to qualify for a health savings account; or

"(b) A catastrophic plan as defined in ORS 743.826.

"SECTION 3. ORS 743B.005 is amended to read:

"743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003 to 743B.127 and 743B.128 **and section 2 of this 2018 Act**:

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

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

"(3) 'Affiliation period' means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

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

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

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

"(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under

the plan.

"(4) 'Bona fide association' means an association that:

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

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

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

"(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

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

"(f) Has a constitution and bylaws; and

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

"(5) 'Carrier' means any person who provides health benefit plans in this state, including:

"(a) A licensed insurance company;

"(b) A health care service contractor;

"(c) A health maintenance organization;

"(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

"(A) Is subject to ORS 750.301 to 750.341; or

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

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

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

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

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

"(9) 'Enrollee' means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

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

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

"(12) 'Financial impairment' means that a carrier is not insolvent and is:

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

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

"(13)(a) 'Geographic average rate' means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

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

"(B) Individual health benefit plans.

"(b) 'Geographic average rate' does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

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

"(15) 'Group eligibility waiting period' means, with respect to a group health benefit plan, the period of employment or membership with the group

that a prospective enrollee must complete before plan coverage begins.

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

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

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

"(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

"(b) 'Health benefit plan' does not include:

"(A) Coverage for accident only, specific disease or condition only, credit or disability income;

"(B) Coverage of Medicare services pursuant to contracts with the federal government;

"(C) Medicare supplement insurance policies;

"(D) Coverage of TRICARE services pursuant to contracts with the federal government;

"(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;

"(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

"(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

"(H) Short term health insurance policies that are in effect for periods of three months or less, including the term of a renewal of the policy;

"(I) Dental only coverage;

"(J) Vision only coverage;

"(K) Stop-loss coverage that meets the requirements of ORS 742.065;

"(L) Coverage issued as a supplement to liability insurance;

"(M) Insurance arising out of a workers' compensation or similar law;

"(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

"(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

"(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

"(17) 'Individual health benefit plan' means a health benefit plan:

"(a) That is issued to an individual policyholder; or

"(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

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

"(19) 'Late enrollee' means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

"(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer and Business Services;

"(b) The individual applies for coverage during an open enrollment period;

"(c) A court issues an order that coverage be provided for a spouse or

minor child under an employee's employer sponsored health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

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

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

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

"(21) 'Preexisting condition exclusion' means:

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

"(b) With respect to a grandfathered health plan, a provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

"(22) 'Premium' includes insurance premiums or other fees charged for a

health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

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

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

"(25) 'Small employer' means an employer who employed an average of at least one but not more than 50 full-time equivalent employees on business days during the preceding calendar year and who employs at least one full-time equivalent employee on the first day of the plan year, determined in accordance with a methodology prescribed by the Department of Consumer and Business Services by rule.".

In line 5, delete "1" and insert "4".

On page 5, delete lines 28 through 37 and insert "a prescription drug; or

"(c) Impose new utilization controls on a prescription drug, including but not limited to prior authorization or step therapy.

"(18)(a) Subsection (17) of this section does not prohibit a carrier, during a plan year, from:

"(A) Adding to a prescription drug formulary a prescription drug newly approved by the United States Food and Drug Administration;

"(B) Reducing a deductible, copayment, coinsurance or other cost sharing applicable to a prescription drug; or

"(C) Eliminating one or more utilization controls applicable to a prescription drug.

"(b) Subsection (17) of this section does not prohibit a pharmacist, when dispensing a prescription drug, from substituting a generic equivalent drug or an interchangeable biological product for the prescribed drug or product in accordance with ORS 689.515 or 689.522.

"(19) A carrier that offers a small employer health benefit plan that re-

imburses the costs of prescription drugs sold by a retail pharmacy or administered by a health care provider shall make publicly available on the carrier's website, without the necessity of entering a password, a user name or personally identifying information, all of the following:

"(a) The prescription drug formulary for each health benefit plan, electronically searchable by drug name.

"(b) Notice of any change to the prescription drug formulary due to the deletion or addition of a drug, no later than 72 hours after the effective date of the change.

"(c) Notice of any change to the prescription drug formulary other than changes described in paragraph (b) of this subsection, such as changes to drug strength or form, no later than 14 calendar days after the effective date of the change.

"(d) The cost sharing typically paid by an enrollee for each drug on the prescription drug formulary, indicated by the following dollar ranges:

"(A) $100 or less.

"(B) More than $100 but not more than $250.

"(C) More than $250 but not more than $500.

"(D) More than $500 but not more than $1,000.

"(E) More than $1,000.

"(e) Any prior authorization, step therapy or other utilization control applicable to each drug on the prescription drug formulary.".

In line 38, delete "2" and insert "5".

On page 8, delete lines 16 through 25 and insert "a prescription drug; or

"(c) Impose new utilization controls on a prescription drug, including but not limited to prior authorization or step therapy.

"(11)(a) Subsection (10) of this section does not prohibit a carrier, during a plan year, from:

"(A) Adding to a prescription drug formulary a prescription drug newly approved by the United States Food and Drug Administration;

"(B) Reducing a deductible, copayment, coinsurance or other cost sharing applicable to a prescription drug; or

"(C) Eliminating one or more utilization controls applicable to a prescription drug.

"(b) Subsection (10) of this section does not prohibit a pharmacist, when dispensing a prescription drug, from substituting a generic equivalent drug or an interchangeable biological product for the prescribed drug or product in accordance with ORS 689.515 or 689.522.

"(12) A carrier that offers a group health benefit plan that reimburses the costs of prescription drugs sold by a retail pharmacy or administered by a health care provider shall make publicly available on the carrier's website, without the necessity of entering a password, a user name or personally identifying information, all of the following:

"(a) The prescription drug formulary for each health benefit plan, electronically searchable by drug name.

"(b) Notice of any change to the prescription drug formulary due to the deletion or addition of a drug, no later than 72 hours after the effective date of the change.

"(c) Notice of any change to the prescription drug formulary other than changes described in paragraph (b) of this subsection, such as changes to drug strength or form, no later than 14 calendar days after the effective date of the change.

"(d) The cost sharing typically paid by an enrollee for each drug on the prescription drug formulary, indicated by the following dollar ranges:

"(A) $100 or less.

"(B) More than $100 but not more than $250.

"(C) More than $250 but not more than $500.

"(D) More than $500 but not more than $1,000.

"(E) More than $1,000.

"(e) Any prior authorization, step therapy or other utilization control

applicable to each drug on the prescription drug formulary.".

In line 26, delete "3" and insert "6".

On page 10, delete lines 39 through 45 and delete page 11 and insert "a prescription drug; or

"(c) Impose new utilization controls on a prescription drug, including but not limited to prior authorization or step therapy.

"(12)(a) Subsection (11) of this section does not prohibit a carrier, during a plan year, from:

"(A) Adding to a prescription drug formulary a prescription drug newly approved by the United States Food and Drug Administration;

"(B) Reducing a deductible, copayment, coinsurance or other cost sharing applicable to a prescription drug; or

"(C) Eliminating one or more utilization controls applicable to a prescription drug.

"(b) Subsection (11) of this section does not prohibit a pharmacist, when dispensing a prescription drug, from substituting a generic equivalent drug or an interchangeable biological product for the prescribed drug or product in accordance with ORS 689.515 or 689.522.

"(13) A carrier that offers an individual health benefit plan that reimburses the costs of prescription drugs sold by a retail pharmacy or administered by a health care provider shall make publicly available on the carrier's website, without the necessity of entering a password, a user name or personally identifying information, all of the following:

"(a) The prescription drug formulary for each health benefit plan, electronically searchable by drug name.

"(b) Notice of any change to the prescription drug formulary due to the deletion or addition of a drug, no later than 72 hours after the effective date of the change.

"(c) Notice of any change to the prescription drug formulary other than changes described in paragraph (b) of this subsection, such as changes to

drug strength or form, no later than 14 calendar days after the effective date of the change.

"(d) The cost sharing typically paid by an enrollee for each drug on the prescription drug formulary, indicated by the following dollar ranges:

"(A) $100 or less.

"(B) More than $100 but not more than $250.

"(C) More than $250 but not more than $500.

"(D) More than $500 but not more than $1,000.

"(E) More than $1,000.

"(e) Any prior authorization, step therapy or other utilization control applicable to each drug on the prescription drug formulary.

"SECTION 7. ORS 750.055 is amended to read:

"750.055. (1) The following provisions 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, 705.138 and 705.139.

"(b) ORS 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, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

"(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, 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 734.014 to 734.440.

"(f) ORS 735.600 to 735.650.

"(g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

"(h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020,

743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 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 and 743.790.

"(i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 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.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2, chapter 771, Oregon Laws 2013.

"(j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to 743B.204, 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.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 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 of this 2018 Act**.

"(k) The following provisions of ORS chapter 744:

"(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

"(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635, 744.650, 744.655 and 744.665, relating to the regulation of insurance consultants; and

"(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

"(L) 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.

"(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

"(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

"(b) ORS 743A.024, unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

"(3) For the purposes of this section, health care service contractors are insurers.

"(4) 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.

"(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

"(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

"(6) 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 necessary for the proper administration of these provisions.

"SECTION 8. 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, section 30, chapter 515, Oregon laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, and section 22, chapter 479, Oregon Laws 2017, is amended to read:

"750.055. (1) The following provisions 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, 705.138 and 705.139.

"(b) ORS 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, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

"(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, 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 734.014 to 734.440.

"(f) ORS 735.600 to 735.650.

"(g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to 742.542.

"(h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020, 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 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 and 743.790.

"(i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 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.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260.

"(j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to 743B.204, 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.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 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 of this 2018 Act**.

"(k) The following provisions of ORS chapter 744:

"(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

"(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635, 744.650, 744.655 and 744.665, relating to the regulation of insurance consultants; and

"(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

"(L) 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.

"(2) The following provisions of the Insurance Code apply to health care service contractors except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act:

"(a) ORS 731.485, if the group practice health maintenance organization wholly owns and operates an in-house drug outlet.

"(b) ORS 743A.024, unless the patient is referred by a physician, physician

assistant or nurse practitioner associated with a group practice health maintenance organization.

"(3) For the purposes of this section, health care service contractors are insurers.

"(4) 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.

"(5)(a) A health care service contractor is a domestic insurance company for the purpose of determining whether the health care service contractor is a debtor, as defined in 11 U.S.C. 109.

"(b) A health care service contractor's classification as a domestic insurance company under paragraph (a) of this subsection does not subject the health care service contractor to ORS 734.510 to 734.710.

"(6) 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 necessary for the proper administration of these provisions.

"SECTION 9. ORS 750.333 is amended to read:

"750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare arrangement:

"(a) ORS 705.137, 705.138 and 705.139.

"(b) 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, 731.808 and 731.844 to 731.992.

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

"(d) ORS 734.014 to 734.440.

"(e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.

"(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023,

743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526 and 743.535.

"(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 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.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260.

"(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195 to 743B.204, 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 section 2 of this 2018 Act**.

"(i) The following provisions of ORS chapter 744:

"(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

"(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635, 744.650, 744.655 and 744.665, relating to the regulation of insurance consultants; and

"(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.

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

"(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.

"(4) The Department of Consumer and Business Services may adopt rules that are necessary to implement the provisions of ORS 750.301 to 750.341.

"SECTION 10. Section 2 of this 2018 Act and the amendments to ORS 743B.005, 743B.013, 743B.105, 743B.125, 750.055 and 750.333 by sections 3 to 9 of this 2018 Act apply to health benefit plans for which the Department of Consumer and Business Services has not approved rates on the effective date of this 2018 Act.".
