

# House Bill 2799

Sponsored by Representative SCHOUTEN; Representatives ALONSO LEON, NOSSE, PRUSAK, Senator BOQUIST

## 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**.

Requires carrier to offer, in at least 25 percent of carrier's health benefit plans at each coverage level, flat dollar copayments that meet specified criteria for prescription drug coverage. Requires carriers to report annually to Department of Consumer and Business Services specified information about changes to formulary, cost sharing and utilization controls for prescription drugs.

## A BILL FOR AN ACT

1  
2 Relating to health benefit plan coverage of prescription drugs; creating new provisions; and amend-  
3 ing ORS 743B.013, 743B.105 and 743B.125.

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

5 **SECTION 1.** ORS 743B.013 is amended to read:

6 743B.013. (1) A health benefit plan issued to a small employer:

7 (a) Other than a grandfathered health plan, must cover essential health benefits consistent with  
8 42 U.S.C. 300gg-11.

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

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

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

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

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

17 (b) The policyholder, small employer or contract holder or, with respect to coverage of individ-  
18 ual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an inten-  
19 tional misrepresentation of a material fact as prohibited by the terms of the plan.

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

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

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

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

29 (B) May not cancel coverage under the plans for 180 days after the date of the notice required  
30 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a

**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.

1 specified service area, except that:

2 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if  
 3 the cancellation is for a specified service area in the circumstances described in subparagraph (C)  
 4 of this paragraph; and

5 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-  
 6 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to  
 7 a delinquency proceeding, as defined in ORS 734.014; and

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

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

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

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

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

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

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

29 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-  
 30 section, the carrier must:

31 (A) Offer in writing to each small employer covered by the plan, all other health benefit plans  
 32 that the carrier offers to small employers in the specified service area.

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

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

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

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

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

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

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

45 (L) In the case of a health benefit plan that is offered in the small employer market only to one

1 or more bona fide associations, the membership of an employer in the association ceases and the  
2 termination of coverage is not related to the health status of any enrollee.

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

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

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

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

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

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

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

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

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

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

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

22 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-  
23 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-  
24 age; and

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

27 (7)(a) A carrier may continue to enforce reasonable employer participation and contribution re-  
28 quirements on small employers. However, participation and contribution requirements shall be ap-  
29 plied uniformly among all small employer groups with the same number of eligible employees  
30 applying for coverage or receiving coverage from the carrier. In determining minimum participation  
31 requirements, a carrier shall count only those employees who are not covered by an existing group  
32 health benefit plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly sponsored  
33 or subsidized health plan, including but not limited to the medical assistance program under ORS  
34 chapter 414.

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

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

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

44 (b)(A) The variations in premium rates charged during a rating period for health benefit plans  
45 issued to small employers must be based solely on the factors specified in subparagraph (B) of this

1 paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph  
2 apply to premium rates for health benefit plans for small employers. All other factors must be ap-  
3 plied in the same actuarially sound way to all small employer health benefit plans.

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

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

8 (ii) The level at which enrolled employees and dependents of enrolled employees engage in to-  
9 bacco use, except that the rate may not vary by more than 1.5 to one; and

10 (iii) Adjustments to reflect differences in family composition.

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

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

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

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

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

27 (9) Premium rates for grandfathered health plans are subject to requirements prescribed by the  
28 department by rule.

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

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

33 (b) The authority of the carrier to adjust rates and premiums, and the extent to which the car-  
34 rier considers age, tobacco use, family composition and geographic factors in establishing and ad-  
35 justing rates and premiums; and

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

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

43 (b) A carrier offering a small employer health benefit plan shall file with the department at least  
44 once every 12 months an actuarial certification that the carrier is in compliance with ORS 743B.010  
45 to 743B.013 and that the rating methods of the carrier are actuarially sound. Each certification must

1 be in a uniform form and manner and must contain such information as specified by the department.  
 2 The carrier shall retain a copy of each certification at the carrier's principal place of business. A  
 3 carrier is not required to file the actuarial certification under this paragraph if the department has  
 4 approved the carrier's rate filing within the preceding 12-month period.

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

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

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

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

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

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

23 **(17)(a) In at least 25 percent of the small employer health benefit plans offered at each**  
 24 **level of coverage in each geographic region served by a carrier, there may be no deductible**  
 25 **or other cost-sharing requirement, other than a flat dollar copayment, for prescription drugs**  
 26 **that are covered as a pharmacy benefit or as a medical benefit.**

27 **(b) Any flat dollar copayment under paragraph (a) of this subsection must be:**

28 **(A) Reasonably graduated from one tier to the next higher tier; and**

29 **(B) Proportional across all tiers.**

30 **(c) A small employer health benefit plan is excluded from the count of small employer**  
 31 **health benefit plans described in paragraph (a) of this subsection if the health benefit plan**  
 32 **is:**

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

35 **(B) A catastrophic plan as defined in ORS 743.826.**

36 **(d) As used in this subsection:**

37 **(A) "Level of coverage" means the bronze, silver, gold and platinum levels of coverage**  
 38 **as defined in 42 U.S.C. 18022(d).**

39 **(B) "Tier" means a group of prescription drugs, within a drug formulary, to which de-**  
 40 **defined cost sharing requirements apply.**

41 **(18) A carrier that offers a small employer health benefit plan that reimburses the costs**  
 42 **of prescription drugs sold by a retail pharmacy or administered by a health care provider**  
 43 **shall report annually to the department, in the form and manner prescribed by the depart-**  
 44 **ment:**

45 **(a) The number of times the carrier removed a prescription drug from a prescription**

1 **drug formulary in the prior 12-month period, other than in response to an alert issued by the**  
 2 **United States Food and Drug Administration, and why each drug was removed from the**  
 3 **formulary;**

4 **(b) The number of times the carrier increased the deductible, copayment, coinsurance**  
 5 **or other cost sharing applicable to a prescription drug in the prior 12-month period, except**  
 6 **when an A-rated generic for the drug was added to the formulary before the increase became**  
 7 **effective, and why the cost sharing was increased; and**

8 **(c) The number of times the carrier imposed new utilization controls on a prescription**  
 9 **drug in the prior 12-month period, including but not limited to prior authorization or step**  
 10 **therapy, and why the new utilization control was imposed on each drug.**

11 **SECTION 2.** ORS 743B.105 is amended to read:

12 743B.105. The following requirements apply to all group health benefit plans other than small  
 13 employer health benefit plans covering two or more certificate holders:

14 (1) A carrier offering a group health benefit plan may not decline to offer coverage to any eli-  
 15 gible prospective enrollee and may not impose different terms or conditions on the coverage, pre-  
 16 miums or contributions of any enrollee in the group that are based on the actual or expected health  
 17 status of the enrollee.

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

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

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

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

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

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

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

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

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

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

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

41 (e) The carrier discontinues both offering and renewing, all of the carrier's group health benefit  
 42 plans in this state or in a specified service area within this state. In order to discontinue plans un-  
 43 der this paragraph, the carrier:

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

1 (B) May not cancel coverage under the plans for 180 days after the date of the notice required  
 2 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a  
 3 specified service area, except that:

4 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if  
 5 the cancellation is for a specified service area in the circumstances described in subparagraph (C)  
 6 of this paragraph; and

7 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-  
 8 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to  
 9 a delinquency proceeding, as defined in ORS 734.014; and

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

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

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

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

22 (C) Must offer in writing to each policyholder covered by the plan, all other group health benefit  
 23 plans that the carrier offers in the specified service area. The carrier shall offer the plans at least  
 24 90 days prior to discontinuation.

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

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

31 (i) With respect to plans that are being discontinued under paragraph (g) or (h) of this sub-  
 32 section, the carrier must:

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

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

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

38 (j) The director orders the carrier to discontinue coverage in accordance with procedures spec-  
 39 ified or approved by the director upon finding that the continuation of the coverage would:

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

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

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

45 (L) In the case of a health benefit plan that is offered in the group market only to one or more

1 bona fide associations, the membership of an employer in the association ceases and the termination  
 2 of coverage is not related to the health status of any enrollee.

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

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

7 (a) The enrollee:

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

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

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

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

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

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

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

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

21 (b) The carrier provides at least 30 days' advance written notice, in the form and manner pre-  
 22 scribed by the department, to each plan enrollee who would be affected by the rescission of cover-  
 23 age; and

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

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

28 **(10)(a) In at least 25 percent of the group health benefit plans offered at each level of**  
 29 **coverage in each geographic region served by a carrier, there may be no deductible or other**  
 30 **cost-sharing requirement, other than a flat dollar copayment, for prescription drugs that are**  
 31 **covered as a pharmacy benefit or as a medical benefit.**

32 **(b) Any flat dollar copayment under paragraph (a) of this subsection must be:**

33 **(A) Reasonably graduated from one tier to the next higher tier; and**

34 **(B) Proportional across all tiers.**

35 **(c) A group health benefit plan is excluded from the count of group health benefit plans**  
 36 **described in paragraph (a) of this subsection if the health benefit plan is:**

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

39 **(B) A catastrophic plan as defined in ORS 743.826.**

40 **(d) As used in this subsection:**

41 **(A) "Level of coverage" means the bronze, silver, gold and platinum levels of coverage**  
 42 **as defined in 42 U.S.C. 18022(d).**

43 **(B) "Tier" means a group of prescription drugs, within a drug formulary, to which de-**  
 44 **defined cost-sharing requirements apply.**

45 **(11) A carrier that offers a group health benefit plan that reimburses the costs of pre-**



1 **scription drugs sold by a retail pharmacy or administered by a health care provider shall**  
 2 **report annually to the department, in the form and manner prescribed by the department:**

3 **(a) The number of times the carrier removed a prescription drug from a prescription**  
 4 **drug formulary in the prior 12-month period, other than in response to an alert issued by the**  
 5 **United States Food and Drug Administration, and why each drug was removed from the**  
 6 **formulary;**

7 **(b) The number of times the carrier increased the deductible, copayment, coinsurance**  
 8 **or other cost sharing applicable to a prescription drug in the prior 12-month period, except**  
 9 **when an A-rated generic for the drug was added to the formulary before the increase became**  
 10 **effective, and why the cost sharing was increased; and**

11 **(c) The number of times the carrier imposed new utilization controls on a prescription**  
 12 **drug in the prior 12-month period, including but not limited to prior authorization or step**  
 13 **therapy, and why the new utilization control was imposed on each drug.**

14 **SECTION 3.** ORS 743B.125 is amended to read:

15 743B.125. (1) With respect to coverage under an individual health benefit plan, a carrier may  
 16 not impose an individual coverage waiting period.

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

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

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

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

25 (B) The exclusion expires no later than six months after the individual's effective date of cov-  
 26 erage.

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

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

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

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

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

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

39 (B) May not cancel coverage under the plans for 180 days after the date of the notice required  
 40 under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or in a  
 41 specified service area, except that:

42 (i) The carrier shall cancel coverage in accordance with subparagraph (C) of this paragraph if  
 43 the cancellation is for a specified service area in the circumstances described in subparagraph (C)  
 44 of this paragraph; and

45 (ii) The Director of the Department of Consumer and Business Services may specify a cancella-

1 tion date other than the cancellation date specified in this subparagraph if the carrier is subject to  
 2 a delinquency proceeding, as defined in ORS 734.014; and

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

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

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

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

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

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

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

24 (g) With respect to plans that are being discontinued under paragraph (e) or (f) of this sub-  
 25 section, the carrier shall:

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

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

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

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

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

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

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

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

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

45 (6) Notwithstanding any other provision of this section, and subject to the provisions of ORS

1 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or  
 2 a representative of the policyholder:

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

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

6 (7) A carrier that continues to offer coverage in the individual market in this state is not re-  
 7 quired to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
 8 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-  
 9 tive coverage in the carrier's other individual health benefit plans, the coverage for all existing  
 10 policyholders in the closed plan is renewable in accordance with subsection (4) of this section.

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

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

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

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

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

21 **(11)(a) In at least 25 percent of the individual health benefit plans offered at each level**  
 22 **of coverage in each geographic region served by a carrier, there may be no deductible or**  
 23 **other cost-sharing requirement, other than a flat dollar copayment, for prescription drugs**  
 24 **that are covered as a pharmacy benefit or as a medical benefit.**

25 **(b) Any flat dollar copayment under paragraph (a) of this subsection must be:**

26 **(A) Reasonably graduated from one tier to the next higher tier; and**

27 **(B) Proportional across all tiers.**

28 **(c) An individual health benefit plan is excluded from the count of individual health ben-**  
 29 **efit plans described in paragraph (a) of this subsection if the health benefit plan is:**

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

32 **(B) A catastrophic plan as defined in ORS 743.826.**

33 **(d) As used in this subsection:**

34 **(A) "Level of coverage" means the bronze, silver, gold and platinum levels of coverage**  
 35 **as defined in 42 U.S.C. 18022(d).**

36 **(B) "Tier" means a group of prescription drugs, within a drug formulary, to which de-**  
 37 **fin cost-sharing requirements apply.**

38 **(12) A carrier that offers an individual health benefit plan that reimburses the costs of**  
 39 **prescription drugs sold by a retail pharmacy or administered by a health care provider shall**  
 40 **report annually to the department, in the form and manner prescribed by the department:**

41 **(a) The number of times the carrier removed a prescription drug from a prescription**  
 42 **drug formulary in the prior 12-month period, other than in response to an alert issued by the**  
 43 **United States Food and Drug Administration, and why each drug was removed from the**  
 44 **formulary;**

45 **(b) The number of times the carrier increased the deductible, copayment, coinsurance**

1 or other cost sharing applicable to a prescription drug in the prior 12-month period, except  
2 when an A-rated generic for the drug was added to the formulary before the increase became  
3 effective, and why the cost sharing was increased; and

4 (c) The number of times the carrier imposed new utilization controls on a prescription  
5 drug in the prior 12-month period, including but not limited to prior authorization or step  
6 therapy, and why the new utilization control was imposed on each drug.

7 **SECTION 4.** The amendments to ORS 743B.013, 743B.105 and 743B.125 by sections 1 to 3  
8 of this 2019 Act apply to health benefit plans issued, extended or renewed on or after January  
9 1, 2021.

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