

**A-Engrossed**  
**Senate Bill 250**

Ordered by the Senate April 15  
Including Senate Amendments dated April 15

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**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.

*[Adopts Fry Graph Readability Formula for health insurance policies and materials approved by Department of Consumer and Business Services. Repeals mandatory terms for certain policy provisions and requires department to prescribe or approve terms.]*

**Prohibits individual from being excluded from participation in or denied benefits under health benefit plan issued or delivered in this state based on actual or perceived race, color, national origin, sex, sexual orientation, gender identity, age or disability.**

**Allows Oregon residents to be insured under master group policies issued outside of Oregon.**

**Authorizes Director of Department of Consumer and Business Services to assess fee on insurer that is exempt from covering benefit required under ORS chapter 743A or other Insurance Code provision to prevent insurer from gaining market advantage due to exemption.**

**Applies requirements for mental health parity to individual health benefit plans, other than grandfathered health plans.**

**Exempts, from requirements applicable to health benefit plans issued to small employers, individual health benefit plans for which employee of small employer pays premiums from funds in health reimbursement arrangement established by employer.**

**Requires individual health benefit plans to be offered on guaranteed issue basis without preexisting condition exclusions. Specifies exception.**

**Allows Department of Consumer and Business Services to certify more than one bronze plan and silver plan.**

**A BILL FOR AN ACT**

1  
2 Relating to health insurance; creating new provisions; and amending ORS 731.146, 731.804, 743A.168,  
3 743B.011, 743B.125, 743B.126, 743B.130 and 743B.800.

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

5 **SECTION 1. Section 2 of this 2019 Act is added to and made a part of the Insurance Code.**

6 **SECTION 2. Except as otherwise provided for in the Insurance Code, an individual may**  
7 **not, on the basis of actual or perceived race, color, national origin, sex, sexual orientation,**  
8 **gender identity, age or disability, be excluded from participation in, be denied the benefits**  
9 **of or otherwise be subjected to discrimination under any health benefit plan issued or deliv-**  
10 **ered in this state.**

11 **SECTION 3. ORS 731.146 is amended to read:**

12 731.146. (1) "Transact insurance" means one or more of the following acts effected by mail or  
13 otherwise:

14 (a) Making or proposing to make an insurance contract.

15 (b) Taking or receiving any application for insurance.

16 (c) Receiving or collecting any premium, commission, membership fee, assessment, due or other

**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 consideration for any insurance or any part thereof.

2 (d) Issuing or delivering policies of insurance.

3 (e) Directly or indirectly acting as an insurance producer for, or otherwise representing or aid-  
4 ing on behalf of another, any person in the solicitation, negotiation, procurement or effectuation of  
5 insurance or renewals thereof, the dissemination of information as to coverage or rates, the for-  
6 warding of applications, the delivering of policies, the inspection of risks, the fixing of rates, the  
7 investigation or adjustment of claims or losses, the transaction of matters subsequent to effectuation  
8 of the policy and arising out of it, or in any other manner representing or assisting a person with  
9 respect to insurance.

10 (f) Advertising locally or circularizing therein without regard for the source of such  
11 circularization, whenever such advertising or circularization is for the purpose of solicitation of in-  
12 surance business.

13 (g) Doing any other kind of business specifically recognized as constituting the doing of an in-  
14 surance business within the meaning of the Insurance Code.

15 (h) Offering a multistate qualified health plan to individuals or small employers through the  
16 program administered by the United States Office of Personnel Management pursuant to 42 U.S.C.  
17 18054.

18 (i) Doing or proposing to do any insurance business in substance equivalent to any of para-  
19 graphs (a) to (h) of this subsection in a manner designed to evade the provisions of the Insurance  
20 Code.

21 (2) Subsection (1) of this section does not include, apply to or affect the following:

22 (a) Making investments within a state by an insurer not admitted or authorized to do business  
23 within such state.

24 (b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising  
25 out of a policy of group life insurance or a policy of blanket health insurance, if the master policy  
26 was validly issued to cover a group organized primarily for purposes other than the procurement  
27 of insurance and was delivered in and pursuant to the laws of another state in which:

28 (A) The insurer was authorized to do an insurance business;

29 (B) The policyholder is domiciled or otherwise has a bona fide situs; and

30 (C) With respect to a policy of blanket health insurance, the policy was approved by the director  
31 of such state.

32 (c) **Except as provided in ORS 743.015, doing or proposing to do any insurance business**  
33 **arising out of a policy of group health insurance, if the master policy was validly issued to**  
34 **cover an employer group other than an association, trust or multiple employer welfare ar-**  
35 **rangement and was delivered in and pursuant to the laws of another state in which:**

36 (A) **The insurer was authorized to do an insurance business; and**

37 (B) **The policyholder is domiciled or otherwise has a bona fide situs.**

38 [(c)] (d) Investigating, settling, or litigating claims under policies lawfully written within a state,  
39 or liquidating assets and liabilities, all resulting from the insurer's former authorized operations  
40 within such state.

41 [(d)] (e) Transactions within a state under a policy subsequent to its issuance if the policy was  
42 lawfully solicited, written and delivered outside the state and did not cover a subject of insurance  
43 resident, located or to be performed in the state when issued.

44 [(e)] (f) The continuation and servicing of life or health insurance policies remaining in force  
45 on residents of a state if the insurer has withdrawn from such state and is not transacting new in-

1 surance therein.

2 (3) If mail is used, an act shall be deemed to take place at the point where the matter trans-  
3 mitted by mail is delivered and takes effect.

4 **SECTION 4.** ORS 731.804 is amended to read:

5 731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business  
6 in this state shall pay assessments that the Director of the Department of Consumer and Business  
7 Services determines are necessary to support the legislatively authorized budget of the Department  
8 of Consumer and Business Services with respect to functions of the department under the Insurance  
9 Code. The director shall determine the assessments according to one or more percentage rates es-  
10 tablished by the director by rule. The director shall specify in the rule when assessments shall be  
11 made and payments shall be due. The premium-weighted average of the percentage rates may not  
12 exceed nine-hundredths of one percent of the gross amount of premiums received by an insurer or  
13 the insurer's insurance producers from and under the insurer's policies covering direct domestic  
14 risks, after deducting the amount of return premiums paid and the amount of dividend payments  
15 made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount  
16 of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount  
17 of premiums. In establishing the percentage rate or rates, the director shall use the most recent  
18 premium data approved by the director. In establishing the amounts to be collected under this sub-  
19 section, the director shall take into consideration the expenses of the department for administering  
20 the Insurance Code and the fees collected under subsection (2) of this section. When the director  
21 establishes two or more percentage rates:

22 (a) Each rate shall be based on such expenses of the department ascribed by the director to the  
23 line of insurance for which the rate is established.

24 (b) Each rate shall be applied to the gross amount of premium received by an insurer or its in-  
25 surance producers for the applicable line of insurance as provided in this subsection.

26 (2) The director may collect fees for specific services provided by the department under the In-  
27 surance Code according to a schedule of fees established by the director by rule. The director may  
28 collect such fees in advance. In establishing the schedule for fees, the director shall take into con-  
29 sideration the cost of each service for which a fee is imposed.

30 **(3)(a) Notwithstanding the provisions of ORS 743A.067 (7)(e) and 743A.067 (9), for the**  
31 **purpose of mitigating inequity in the health insurance market, the director may assess a fee**  
32 **on any insurer that offers a health benefit plan, as defined in ORS 743B.005, that is exempt**  
33 **from a provision of ORS chapter 743A or other provision of the Insurance Code that requires**  
34 **specified coverage by health benefit plans.**

35 **(b) Any fees collected under paragraph (a) of this subsection must be the actuarial**  
36 **equivalent of costs attributed to the provision and administration of the required coverage**  
37 **by an insurer that is not exempt.**

38 **(c) Nothing in this section limits the authority of the director to enforce the provisions**  
39 **of ORS chapter 743A if an insurer unlawfully fails to comply.**

40 **(d) Notwithstanding ORS 646A.628, fees paid in accordance with paragraph (a) of this**  
41 **subsection shall be deposited in the General Fund to become available for general govern-**  
42 **mental expenses.**

43 [(3)] (4) Establishment and amendment of the schedule of fees under subsection (2) of this section  
44 are subject to prior approval of the Oregon Department of Administrative Services and a report to  
45 the Emergency Board prior to adopting the fees and shall be within the budget authorized by the

1 Legislative Assembly as that budget may be modified by the Emergency Board.

2 [(4)] (5) The director may not collect an assessment under subsection (1) of this section from any  
3 of the following persons:

4 (a) A fraternal benefit society complying with ORS chapter 748.

5 (b) Any person or class of persons designated by the director by rule.

6 [(5)] (6) The director may not collect an assessment under subsection (1) of this section with  
7 respect to premiums received from any of the following policies:

8 (a) Workers' compensation insurance policies.

9 (b) Wet marine and transportation insurance policies.

10 (c) Any category of policies designated by the director by rule.

11 **SECTION 5.** ORS 743A.168 is amended to read:

12 743A.168. (1) As used in this section:

13 (a) "Behavioral health assessment" means an evaluation by a provider, in person or using tele-  
14 medicine, to determine a patient's need for behavioral health treatment.

15 (b) "Behavioral health crisis" means a disruption in an individual's mental or emotional stability  
16 or functioning resulting in an urgent need for immediate outpatient treatment in an emergency de-  
17 partment or admission to a hospital to prevent a serious deterioration in the individual's mental or  
18 physical health.

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

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

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

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

30 (g) "Provider" means:

31 (A) An individual who has met the credentialing requirement of a group health insurer **or an**  
32 **issuer of an individual health benefit plan that is not a grandfathered health plan as defined**  
33 **in ORS 743B.005**, is otherwise eligible to receive reimbursement for coverage under the policy and  
34 is a behavioral health professional or a medical professional licensed or certified in this state;

35 (B) A health care facility as defined in ORS 433.060;

36 (C) A residential facility as defined in ORS 430.010;

37 (D) A day or partial hospitalization program;

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

39 (F) A provider organization certified by the Oregon Health Authority under subsection (7) of this  
40 section.

41 (2) A group health insurance policy **or an individual health benefit plan that is not a**  
42 **grandfathered health plan** providing coverage for hospital or medical expenses, other than limited  
43 benefit coverage, shall provide coverage for expenses arising from the diagnosis of and treatment for  
44 chemical dependency, including alcoholism, and for mental or nervous conditions at the same level  
45 as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement

1 of expenses arising from treatment for other medical conditions. The following apply to coverage for  
2 chemical dependency and for mental or nervous conditions:

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

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

14 (c) The coverage must include:

15 (A) A behavioral health assessment;

16 (B) No less than the level of services determined to be medically necessary in a behavioral  
17 health assessment of a patient or in a patient's care plan:

18 (i) To treat the patient's behavioral health condition; and

19 (ii) For care following a behavioral health crisis, to transition the patient to a lower level of  
20 care; and

21 (C) Coordinated care and case management as defined by the Department of Consumer and  
22 Business Services by rule.

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

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

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

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

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

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

33 (f)(A) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physi-  
34 cians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250  
35 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed profes-  
36 sional counselors and licensed marriage and family therapists, a group health insurer **or issuer of**  
37 **an individual health benefit plan** may provide for review for level of treatment of admissions and  
38 continued stays for treatment in health facilities, residential facilities, day or partial hospitalization  
39 programs and outpatient services by either **staff of a** group health insurer **or issuer of an indi-**  
40 **vidual health benefit plan** [*staff*] or personnel under contract to the group health insurer **or issuer**  
41 **of an individual health benefit plan that is not a grandfathered health plan**, or by a utilization  
42 review contractor, who shall have the authority to certify for or deny level of payment.

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

45 (C) Review shall be performed by or under the direction of a physician licensed under ORS

1 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social  
2 worker licensed by the State Board of Licensed Social Workers or a professional counselor or mar-  
3 riage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and  
4 Therapists, in accordance with standards of the National Committee for Quality Assurance or  
5 Medicare review standards of the Centers for Medicare and Medicaid Services.

6 (D) Review may involve prior approval, concurrent review of the continuation of treatment,  
7 post-treatment review or any combination of these. However, if prior approval is required, provision  
8 shall be made to allow for payment of urgent or emergency admissions, subject to subsequent re-  
9 view. If prior approval is not required, group health insurers **and issuers of individual health**  
10 **benefit plans that are not grandfathered health plans** shall permit providers, policyholders or  
11 persons acting on their behalf to make advance inquiries regarding the appropriateness of a partic-  
12 ular admission to a treatment program. Group health insurers **and issuers of individual health**  
13 **benefit plans that are not grandfathered health plans** shall provide a timely response to such  
14 inquiries. Noncontracting providers must cooperate with these procedures to the same extent as  
15 contracting providers to be eligible for reimbursement.

16 (g) Health maintenance organizations may limit the receipt of covered services by enrollees to  
17 services provided by or upon referral by providers contracting with the health maintenance organ-  
18 ization. Health maintenance organizations and health care service contractors may create substan-  
19 tive plan benefit and reimbursement differentials at the same level as, and subject to limitations no  
20 more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other  
21 medical conditions and apply them to contracting and noncontracting providers.

22 (3) This section does not prohibit a group health insurer **or issuer of an individual health**  
23 **benefit plan that is not a grandfathered health plan** from managing the provision of benefits  
24 through common methods, including but not limited to selectively contracted panels, health plan  
25 benefit differential designs, preadmission screening, prior authorization of services, utilization re-  
26 view or other mechanisms designed to limit eligible expenses to those described in subsection (2)(b)  
27 of this section.

28 (4) The Legislative Assembly finds that health care cost containment is necessary and intends  
29 to encourage health insurance plans designed to achieve cost containment by ensuring that re-  
30 bursement is limited to appropriate utilization under criteria incorporated into the insurance, ei-  
31 ther directly or by reference.

32 (5) This section does not prevent a group health insurer **or issuer of an individual health**  
33 **benefit plan that is not a grandfathered health plan** from contracting with providers of health  
34 care services to furnish services to policyholders or certificate holders according to ORS 743B.460  
35 or 750.005, subject to the following conditions:

36 (a) A group health insurer **or issuer of an individual health benefit plan that is not a**  
37 **grandfathered health plan** is not required to contract with all providers that are eligible for re-  
38 bursement under this section.

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

1 (6)(a) This section does not require coverage for:

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

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

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

7 (D) A court-ordered sex offender treatment program; or

8 (E) Support groups.

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

12 (7) The Oregon Health Authority shall establish a process for the certification of an organiza-  
13 tion described in subsection (1)(g)(F) of this section that:

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

15 (b) Does not contract with the authority, a subcontractor of the authority or a community  
16 mental health program.

17 (8) The Oregon Health Authority shall adopt by rule standards for the certification provided  
18 under subsection (7) of this section to ensure that a certified provider organization offers a distinct  
19 and specialized program for the treatment of mental or nervous conditions.

20 (9) The Oregon Health Authority may adopt by rule an application fee or a certification fee, or  
21 both, to be imposed on any provider organization that applies for certification under subsection (7)  
22 of this section. Any fees collected shall be paid into the Oregon Health Authority Fund established  
23 in ORS 413.101 and shall be used only for carrying out the provisions of subsection (7) of this sec-  
24 tion.

25 (10) The intent of the Legislative Assembly in adopting this section is to reserve benefits for  
26 different types of care to encourage cost effective care and to ensure continuing access to levels  
27 of care most appropriate for the insured's condition and progress. This section does not prohibit an  
28 insurer from requiring a provider organization certified by the Oregon Health Authority under sub-  
29 section (7) of this section to meet the insurer's credentialing requirements as a condition of entering  
30 into a contract.

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

34 **SECTION 6.** ORS 743B.011 is amended to read:

35 743B.011. (1) **Except as provided in subsection (2) of this section**, every health benefit plan  
36 shall be subject to the provisions of ORS 743B.010 to 743B.013, if the plan provides health benefits  
37 covering one or more employees of a small employer and if any one of the following conditions is  
38 met:

39 (a) Any portion of the premium or benefits is paid by a small employer or any employee is re-  
40 imbursement, whether through wage adjustments or otherwise, by a small employer for any portion of  
41 the health benefit plan premium [*unless the reimbursement is made through a qualified small employer*  
42 *health reimbursement arrangement, as defined in section 9831 of the Internal Revenue Code*]; or

43 (b) The health benefit plan is treated by the employer or any of the employees as part of a plan  
44 or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code  
45 of 1986, as amended.

1       **(2) Subsection (1) of this section does not apply to:**

2       **(a) An individual health benefit plan for which a portion of the premium is reimbursed**  
3 **through a qualified small employer health reimbursement arrangement as defined in section**  
4 **9831 of the Internal Revenue Code; or**

5       **(b) An individual health benefit plan that is considered to be integrated with a health**  
6 **reimbursement arrangement or other account-based group health plan authorized by federal**  
7 **law.**

8       [(2)] **(3)** Except as otherwise provided by ORS 743B.010 to 743B.013 or other law, no health  
9 benefit plan offered to a small employer shall:

10       (a) Inhibit a carrier from contracting with providers or groups of providers with respect to  
11 health care services or benefits; or

12       (b) Impose any restriction on the ability of a carrier to negotiate with providers regarding the  
13 level or method of reimbursing care or services provided under health benefit plans.

14       [(3)(a)] **(4)(a)** A carrier may provide different health benefit plans to different categories of em-  
15 ployees of a small employer when the employer has chosen to establish different categories of em-  
16 ployees in a manner that does not relate to the actual or expected health status of such employees  
17 or their dependents. The categories must be based on bona fide employment-based classifications  
18 that are consistent with the employer's usual business practice.

19       (b) Except as provided in ORS 743B.012 (7), a carrier that offers coverage to a small employer  
20 shall offer coverage to all eligible employees of the small employer.

21       (c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier  
22 shall offer coverage to all dependents of eligible employees.

23       [(4)] **(5)** An insurer may not deny, delay or terminate participation of an individual in a group  
24 health benefit plan or exclude coverage otherwise provided to an individual under a group health  
25 benefit plan based on a preexisting condition of the individual.

26       **SECTION 7.** ORS 743B.125 is amended to read:

27       743B.125. (1) With respect to coverage under an individual health benefit plan **other than a**  
28 **grandfathered health plan**, a carrier may not impose **a preexisting condition exclusion or an**  
29 **individual coverage waiting period.**

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

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

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

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

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

40       (c) **May not impose a waiting period.**

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

43       **(4)(a) A carrier shall issue any individual health benefit plan offered by the carrier, other**  
44 **than a grandfathered health plan, to any individual who applies for the health benefit plan,**  
45 **if:**



1       **(A) The individual resides in the geographic area where the plan is offered;**

2       **(B) The individual agrees to make the required premium payments; and**

3       **(C) Issuance of the health benefit plan is not otherwise prohibited by law.**

4       **(b) The Department of Consumer and Business Services may allow a carrier to cap the**  
5 **number of individuals enrolled in an individual health benefit plan offered by the carrier if**  
6 **the department finds that issuing the health benefit plan to more individuals than are cur-**  
7 **rently enrolled in the plan would have a material adverse effect upon the carrier's ability to**  
8 **fulfill the carrier's contractual obligations or result in the financial impairment of the car-**  
9 **rier.**

10       **(c) Except as otherwise provided in this section and ORS 743.022, a carrier offering an**  
11 **individual health benefit plan may not impose different terms or conditions on the coverage**  
12 **provided or the premium charged based on the actual or expected health status of an**  
13 **enrollee or prospective enrollee.**

14       [(4)] (5) A carrier shall renew an individual health benefit plan, including a health benefit plan  
15 issued through a bona fide association, unless:

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

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

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

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

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

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

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

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

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

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

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

45       (C) Shall offer in writing to each policyholder covered by the plan, all other individual health

1 benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans  
2 at least 90 days prior to discontinuation.

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

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

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

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

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

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

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

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

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

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

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

28 [(5)] (6) A carrier may modify an individual health benefit plan at the time of coverage renewal.  
29 The modification is not a discontinuation of the plan under subsection [(4)(c)] (5)(c), (e) and (f) of  
30 this section.

31 [(6)] (7) Notwithstanding any other provision of this section, and subject to the provisions of  
32 ORS 743B.310 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder  
33 or a representative of the policyholder:

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

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

37 [(7)] (8) A carrier that continues to offer coverage in the individual market in this state is not  
38 required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier  
39 elects to continue a plan that is closed to new individual policyholders instead of offering alterna-  
40 tive coverage in the carrier's other individual health benefit plans, the coverage for all existing  
41 policyholders in the closed plan is renewable in accordance with subsection [(4)] (5) of this section.

42 [(8)] (9) An individual health benefit plan may not impose annual or lifetime limits on the dollar  
43 amount of essential health benefits.

44 [(9)] (10) A grandfathered health plan may not impose lifetime limits on the dollar amount of  
45 essential health benefits.

1        [(10)] (11) This section does not require a carrier to actively market, offer, issue or accept ap-  
2 plications for:

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

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

7        **SECTION 8.** ORS 743B.126 is amended to read:

8        743B.126. (1) Each carrier shall actively market all individual health benefit plans sold by the  
9 carrier that are not grandfathered health plans.

10        (2) Except as provided in subsection (3) of this section, no carrier or insurance producer shall,  
11 directly or indirectly, discourage an individual from filing an application for coverage because of the  
12 health status, claims experience, occupation or geographic location of the individual.

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

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

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

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

31        (7) The Department of Consumer and Business Services may, in accordance with ORS 743B.129,  
32 shorten the period of prohibition described in subsection (6) of this section if necessary to ensure,  
33 in all geographic areas of this state, that:

34        (a) A competitive health insurance market exists;

35        (b) Consumers have a reasonable number of health insurance options available to them; and

36        (c) Consumers who purchase insurance are protected.

37        **SECTION 9.** ORS 743B.130 is amended to read:

38        743B.130. (1) In each individual or small group market, in which a carrier offers a health benefit  
39 plan through or outside of the health insurance exchange described in ORS 741.310, the carrier must  
40 offer to residents of this state [a] bronze and [a] silver [plan] **plans** certified by the Department of  
41 Consumer and Business Services as qualified health plans and meeting the requirements of sub-  
42 section (2) of this section.

43        (2) The department shall prescribe by rule, in accordance with federal requirements, the form,  
44 level of coverage and benefit design for the bronze and silver plans that must be offered under  
45 subsection (1) of this section.

1 (3) As used in this section, “health benefit plan” has the meaning given that term in ORS  
2 743B.005.

3 **SECTION 10.** ORS 743B.800 is amended to read:

4 743B.800. (1) As used in this section, “health benefit plan” means a health benefit plan, as de-  
5 fined in ORS 743B.005, that is offered in the individual or small group market.

6 (2) The Department of Consumer and Business Services may establish by rule a procedure for  
7 adjusting risk between insurers. If a procedure is established[,]:

8 (a) The procedure may include:

9 [(a)] (A) An assessment imposed on an insurer if the actuarial risk of the enrollees in the  
10 insurer’s health benefit plans is less than the average actuarial risk of all enrollees in all health  
11 benefit plans in this state; and

12 [(b)] (B) Payments to insurers if the actuarial risk of the enrollees in the insurer’s health benefit  
13 plans is greater than the average actuarial risk of all enrollees in all health benefit plans in this  
14 state.

15 [(3)] (b) [A procedure established under this section] **The methodology for adjusting risk be-**  
16 **tween insurers** must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary  
17 of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063 that  
18 are in effect on January 1, [2017] **2019**.

19 **SECTION 11. Section 2 of this 2019 Act and the amendments to ORS 731.146, 731.804,**  
20 **743A.168, 743B.011, 743B.125, 743B.126, 743B.130 and 743B.800 by sections 3 to 10 of this 2019**  
21 **Act apply to health insurance policies issued or renewed on or after the effective date of this**  
22 **2019 Act.**

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