Senate Bill 250

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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 **as introduced.**

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.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 743.010, 743.104, 743.106, 743.107, 743.408, 743.411, 743.414, 743.417, 743.420, 743.423, 743.426, 743.429, 743.432, 743.435, 743.438, 743.441, 743.444, 743.447, 743.472, 743.498 and 743.550; and repealing ORS 743.450, 743.453, 743.456, 743.459, 743.462, 743.468, 743.471, 743.474, 743.477, 743.537 and 743B.324.

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

SECTION 1. Section 2 of this 2019 Act is added to and made a part of ORS 743.405 to 743.498.

SECTION 2. A health insurance policy containing any of the following provisions must explain the provision in terms prescribed or approved by the Department of Consumer and Business Services:

(1) Changes in indemnification of injuries or sickness or to the amount of premiums owed resulting from the insured's change to a more hazardous or less hazardous occupation.

(2) Adjustments to amounts payable under the health insurance policy if the age of the insured has been misstated.

(3) Limits on coverage provided by the health insurance policy if the insured has another policy or policies issued by the insurer or another insurer or has other valid coverage for the loss.

(4) The right of the insurer to deduct unpaid premiums from the payment on a claim.

(5) Conditions for the insurer to cancel the health insurance policy.

(6) That any provision of the health insurance policy that conflicts with the statutes of the state in which the insured resides may be amended to conform to the minimum requirements of the statutes.

(7) Limits on losses caused by the insured's commission of or attempt to commit a felony or to which a contributing factor was the insured's engagement in an illegal occupation.

SECTION 3. ORS 743.010 is amended to read:

743.010. [*(1)*] In addition to all other powers of the Director of the Department of Consumer and Business Services [*with respect thereto*], the director may [*issue*] **adopt** rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b):

[*(a)*] **(1)** Establishing minimum benefit standards;

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.

[*(b)*] **(2)** Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance;

[*(c)*] **(3)** Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies; [*and*]

(4) Prescribing the provisions described in ORS 743.405 to 743.498 and 743.406 or standards applicable to the provisions; and

[*(d)*] **(5)(a)** Establishing requirements for carriers offering health benefit plans that spend less than 12 percent of total medical expenditures on payments for primary care to submit with each rate filing a plan to increase spending on payments for primary care as a percentage of total medical expenditures by at least one percent each plan year.

[*(2)*] **(b)** As used in this [*section*] **subsection**:

[*(a)*] **(A)** "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

[*(b)*] **(B)** "Total medical expenditures" means payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

SECTION 4. ORS 743.010, as amended by section 15, chapter 489, Oregon Laws 2017, is amended to read:

743.010. [*(1)*] In addition to all other powers of the Director of the Department of Consumer and Business Services [*with respect thereto*], the director may [*issue*] **adopt** rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b):

[*(a)*] **(1)** Establishing minimum benefit standards;

[*(b)*] **(2)** Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance;

[*(c)*] **(3)** Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies; [*and*]

(4) Prescribing the provisions described in ORS 743.405 to 743.498 and 743.406 or standards applicable to the provisions; and

[*(d)*] **(5)(a)** Establishing requirements for carriers offering health benefit plans to spend at least 12 percent of total medical expenditures on payments for primary care.

[*(2)*] **(b)** As used in this [*section*] **subsection**:

[*(a)*] **(A)** "Primary care" means family medicine, general internal medicine, naturopathic medicine, obstetrics and gynecology, pediatrics or general psychiatry.

[*(b)*] **(B)** "Total medical expenditures" means payments to reimburse the cost of physical and mental health care provided to enrollees, excluding prescription drugs, vision care and dental care, whether paid on a fee-for-service basis or as part of a capitated rate or other type of payment mechanism.

SECTION 5. ORS 743.104 is amended to read:

743.104. (1) ORS 743.100 to 743.109 apply to all policies delivered or issued for delivery in this state, except:

(a) Any policy that is a security subject to federal jurisdiction.

(b) Any [*group policy covering a group of 1,000 or more lives at date of issue, other than a*] group credit life insurance policy or [*a*] group credit health insurance policy. [*However, this paragraph shall not exempt any certificate issued pursuant to a group policy.*]

(c) Any group annuity contract that serves as a funding vehicle for a pension, profit-sharing or deferred compensation plan.

[*(d) Any form used in connection with, as a conversion from, as an addition to, or, pursuant to a contractual provision, in exchange for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the date the form must be approved under section 9, chapter 708, Oregon Laws 1979.*]

[*(e) The renewal of a policy delivered or issued for delivery prior to the date the policy form must be approved under section 9, chapter 708, Oregon Laws 1979.*]

[*(f)*] **(d)** Any certificate issued pursuant to a group policy not delivered or issued for delivery in this state.

(2) A non-English language policy will be deemed to comply with ORS 743.106 if the insurer certifies that the policy is translated from an English language policy that complies with ORS 743.106.

SECTION 6. ORS 743.106 is amended to read:

743.106. **(1) As used in this section, "text" includes all written matter except the following:**

(a) The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions, specification pages, schedules or tables; and

(b) Policy language drafted to conform to the requirements of any state or federal law, regulation or agency interpretation, policy language required by any collectively bargained agreement, medical terminology and words that are defined in the policy. The insurer shall identify the language or terminology excepted by this paragraph and shall certify in writing that the language or terminology is entitled to be excepted by this paragraph.

[*(1)*] **(2)** [*No*] **A** policy form [*shall*] **may not** be delivered or issued for delivery in this state unless:

(a) The policy text [*achieves a score of 40 or more on the Flesch reading ease test, or an equivalent score on any comparable test as provided in subsection (3) of this section*] **is readable at the ninth grade reading level as determined using the Fry Graph Readability Formula**;

(b) The policy, except for specification pages, schedules and tables is printed in not less than 12-point type, 13-point leading for health benefit plans, as defined in ORS 743B.005, and 10-point type, 11-point leading for all other policies;

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, including the text of any indorsements or riders; and

(d) The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the number of words if the policy has more than three pages.

[*(2) For the purposes of this section, a Flesch reading ease test score shall be calculated as follows:*]

[*(a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, two 200-word samples per page may be analyzed*

instead of the entire form. The samples shall be separated by at least 20 printed lines.]

[*(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.*]

[*(c) The total number of syllables in the text shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.*]

[*(d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted from 206.835 equals the Flesch reading ease test score for the policy form.*]

[*(e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be used:*]

[*(A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be counted as one word.*]

[*(B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence.*]

[*(C) A "syllable" means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.*]

[*(f) As used in this section, "text" includes all written matter except the following:*]

[*(A) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules or tables; and*]

[*(B) Policy language drafted to conform to the requirements of any state or federal law, regulation or agency interpretation; policy language required by any collectively bargained agreement; medical terminology; and words that are defined in the policy. However, the insurer shall identify the language or terminology excepted by this subparagraph and shall certify in writing that the language or terminology is entitled to be excepted by this subparagraph.*]

(3) Any other reading test may be approved by the Director of the Department of Consumer and Business Services as an alternative to the [*Flesch reading ease test*] **Fry Graph Readability Formula** if it is comparable in result to the [*Flesch reading ease test*] **Fry Graph Readability Formula**.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the [*minimum required reading ease score*] **ninth grade reading level** on the test used, or stating that the [*score is lower than the minimum required*] **reading level is higher than the ninth grade reading level** but should be authorized in accordance with ORS 743.107. To confirm the accuracy of a certification, the director may require the submission of further information.

(5) At the option of the insurer, riders, indorsements, applications and other forms made a part of the policy may be [*scored*] **evaluated for readability** as separate forms or as part of the policy with which they may be used.

SECTION 7. ORS 743.107 is amended to read:

743.107. The Director of the Department of Consumer and Business Services may authorize a [*lower score than the Flesch reading ease test score*] **higher reading level than the Fry Graph Readability Formula reading level** required by ORS 743.106 when, in the director's sole discretion, the director finds that a [*lower required score*] **higher reading level**:

(1) Will provide a more accurate reflection of the readability of a policy form;

(2) Is warranted by the nature of a particular policy form or type or class of policy forms; or

(3) Is caused by certain policy language drafted to conform to the requirements of any state law, regulation or agency interpretation.

SECTION 8. ORS 743.408 is amended to read:

743.408. Except as provided in ORS 742.021, a health insurance policy [*shall*] **must** contain the provisions [*set forth*] **described** in ORS 743.411 to 743.444. The provisions shall be preceded individually by the [*caption appearing in the sections or, at the option of the insurer, by the appropriate*] individual or group captions or subcaptions as the Director of the Department of Consumer and Business Services may approve.

SECTION 9. ORS 743.411 is amended to read:

743.411. [*A health insurance policy shall contain a provision as follows: "ENTIRE CONTRACT; CHANGES: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No insurance producer has authority to change this policy or to waive any of its provisions."*]

A health insurance policy must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that:

(1) The policy, including the indorsements and attached papers, if any, constitutes the entire contract of insurance;

(2) A change to the policy is not valid until approved by an executive officer of the insurer and indorsed on or attached to the policy; and

(3) An insurance producer does not have the authority to change the policy or to waive any of its provisions.

SECTION 10. ORS 743.414 is amended to read:

743.414. [*(1) A health insurance policy shall contain a provision as follows: "TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period."*]

(1) A health insurance policy must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured of a two-year time limit on defenses arising from misstatements made by the insured in the application for the policy and any other periods after which the policy becomes incontestable.

(2) The policy [*provision set forth*] **terms described** in subsection (1) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period[*, or to limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance*].

[*(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the provision set forth in subsection (1) of this section the following provision, from which the clause in parentheses may be omitted at the insurer's option: "INCONTESTABLE: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."*]

[*(4) The policy shall contain a provision as follows, which shall be a separate paragraph under the same caption as, and immediately following, the provision set forth in subsection (1) or (3) of this section: "No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical*

condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy."]

SECTION 11. ORS 743.417 is amended to read:

743.417. [*(1)*] An individual health insurance policy [*shall*] **must** specify**, in terms prescribed or approved by the Department of Consumer and Business Services,** a minimum grace period of at least 10 days after the premium due date for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

[*(2) A policy that contains a cancellation provision may add the following clause at the end of the provision described in subsection (1) of this section: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."*]

[*(3) A policy in which the insurer reserves the right to refuse renewal shall have the following clause at the beginning of the provision described in subsection (1) of this section: "Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. The insurer shall state in the notice the reason for its refusal to renew this policy."*]

SECTION 12. ORS 743.420 is amended to read:

743.420. [*(1)*] A health insurance policy, other than a health benefit plan as defined in ORS 743B.005, **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured of any conditions for the renewal of the policy if the insured fails to pay the premium within the grace period.** [*shall contain a provision as follows: "REINSTATEMENT: If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the insurer or by any insurance producer duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such insurance producer requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."*]

[*(2) The last sentence of the provision set forth in subsection (1) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue.*]

SECTION 13. ORS 743.423 is amended to read:

743.423. [*(1)*] A health insurance policy **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured of the procedures and time limits for presenting a notice of claim and for notifying the insurer that a disability indemnified under a loss-of-time benefit in the policy continues.** [*shall contain a provision as*

follows: "NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."]

[*(2) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the provision set forth in subsection (1) of this section: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of such disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given."*]

SECTION 14. ORS 743.426 is amended to read:

743.426. A health insurance policy [*shall contain a provision as follows: "CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made."*] **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that if the insured submits a notice of claim to the insurer:**

(1) The insurer must furnish the claimant with forms used by the insurer for filing a proof of loss.

(2) If the insurer fails to provide the forms used by the insurer for filing a proof of loss or provides the forms more than 15 days after the notice of claim is submitted, the claimant is deemed to have complied with any policy requirements as to proof of loss if the claimant provides written proof of the occurrence giving rise to the claim and the character and the extent of the loss for which the claim is made.

SECTION 15. ORS 743.429 is amended to read:

743.429. A health insurance policy [*shall contain a provision as follows: "PROOFS OF LOSS:*] **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that:**

(1) Written proof of loss must be furnished to the insurer at its office**,** in **the** case of **a** claim for loss for which [*this*] **the** policy provides any periodic payment contingent upon continuing loss**,** within 90 days after the termination of the period for which the insurer is liable [*and*]**;**

(2) In **the** case of **a** claim for any other loss**, written proof of loss must be furnished to the insurer at its office** within 90 days after the date of such loss[.]**; and**

(3) Failure to furnish such proof within the time required [*shall*] **does** not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity,

later than one year from the time proof is otherwise required.[*"*]

SECTION 16. ORS 743.432 is amended to read:

743.432. A health insurance policy [*shall contain a provision as follows: "TIME OF PAYMENT OF CLAIMS:*] **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that:**

(1) Indemnities payable under [*this*] **the** policy for any loss other than loss for which [*this*] **the** policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss[.]**; and**

(2) Subject to due written proof of loss, all accrued indemnities for loss for which [*this*] **the** policy provides periodic payment will be paid [_____ *(insert period for payment*] **within a specified period of time,** which must not be less frequently than monthly[*)*]**,** and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.[*"*]

SECTION 17. ORS 743.435 is amended to read:

743.435. [*(1) A health insurance policy shall contain a provision as follows: "PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."*]

[*(2) The following provisions, or either of them, may be included with the provision set forth in subsection (1) of this section at the option of the insurer:*]

[*(a) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."*]

A health insurance policy must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured:

(1) Regarding the payment of indemnities for loss of life to the beneficiary designated or to the estate of the insured if no beneficiary is designated; and

[*(b)*] **(2) That,** ["] subject to any written direction of the insured in the application or otherwise**,** all or a portion of any indemnities provided by [*this*] **the** policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services**.** [*; but it is not required that the service be rendered by a particular hospital or person."*]

SECTION 18. ORS 743.438 is amended to read:

743.438. A health insurance policy [*shall contain a provision as follows: "PHYSICAL EXAMINATIONS AND AUTOPSY:*] **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that** the insurer at its own expense [*shall have*] **has** the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim [*hereunder*] **under the policy** and to

make an autopsy in case of death [*where it is not forbidden*] **unless prohibited** by law.[*"*]

SECTION 19. ORS 743.441 is amended to read:

743.441. A health insurance policy [*shall contain a provision as follows: "LEGAL ACTIONS: No action*] **must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured that:**

(1) The insured may not bring an action at law or in equity [*shall be brought*] to recover on [*this*] **the** policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of [*this*] **the** policy[*. No such action shall be brought*]**; and**

(2) The insured may not bring an action in law or equity after the expiration of three years after the time written proof of loss is required to be furnished.[*"*]

SECTION 20. ORS 743.444 is amended to read:

743.444. [*(1) A health insurance policy shall contain a provision as follows: "CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy."*]

[*(2) The first clause of the provision set forth in subsection (1) of this section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.*]

A health insurance policy must contain terms prescribed or approved by the Department of Consumer and Business Services informing the insured of the insured's rights under the policy to change the designated beneficiary and that the insurer may not require the consent of a beneficiary to surrender or assign the policy or to change beneficiaries under the policy.

SECTION 21. ORS 743.447 is amended to read:

743.447. Except as provided in ORS 742.021, provisions in a health insurance policy respecting the matters set forth in ORS [*743.450 to 743.477 shall*] **743.465 must** be in the words that appear in [*such sections. Any such provision contained in the policy shall*] **ORS 743.465 and must** be preceded individually by the appropriate caption appearing in [*such sections*] **ORS 743.465** or, at the option of the insurer, by [*such*] **an** appropriate individual or group [*captions or subcaptions as*] **caption approved by** the Director of the Department of Consumer and Business Services [*may approve*].

SECTION 22. ORS 743.472 is amended to read:

743.472. An insurer selling individual health insurance policies may cancel or refuse to renew an individual health insurance policy only if the insurer makes a determination to cancel or not to renew all policies of the same type and form as the individual policy, or if the ground for cancellation or nonrenewal is any of the following and is stated as a provision of the policy:

(1) A fraudulent or material misstatement made by the applicant in an application for the health policy. A material misstatement is subject to any time limit, as specified by law and included in the policy, for voiding the policy on the basis of a misstatement. For purposes of this subsection, a misstatement may include an incorrect statement or a misrepresentation, omission or concealment of fact;

(2) Excess or other insurance in the same insurer[*, as described in ORS 743.456*];

(3) Nonpayment of premium; or

(4) Any other reason specified by the Director of the Department of Consumer and Business Services by rule.

SECTION 23. ORS 743.498 is amended to read:

743.498. (1) A health insurance policy which is noncancelable or guaranteed renewable as those

terms are used in ORS 743.495, except that the insured's right is for a limited period of more than one year rather than for life, shall contain the applicable one of the following statements, or such other statement which, in the opinion of the Director of the Department of Consumer and Business Services, is equally clear or more definite as to the subject matter **and complies with ORS 743.106**:

(a) "THIS POLICY IS NONCANCELABLE _____" (designating the applicable period such as, for example, "to age _____ (specify)," or "for the period of _____ (specify) years from date of issuance") if the policy is noncancelable for such period.

(b) "THIS POLICY IS GUARANTEED RENEWABLE _____" (designating the applicable period such as, for example, "to age _____ (specify)," or "for the period of _____ (specify) years from date of issuance") if the policy is guaranteed renewable for such period.

(2) Except for policies meeting the conditions specified in ORS 743.495 or subsection (1) of this section, and except as provided in subsection (3) of this section, a health insurance policy shall contain the applicable one of the following statements, or such other statement which, in the opinion of the director, is equally clear or more definite as to the subject matter:

(a) "THIS POLICY MAY BE CANCELED BY THE INSURER ONLY FOR A REASON PERMITTED BY LAW" if the policy contains a provision for cancellation by the insurer.

(b) "THE INSURER MAY REFUSE TO RENEW THIS POLICY ONLY FOR A REASON PERMITTED BY LAW" if the policy is not guaranteed renewable.

(3) The limitations and requirements as to the use of terms contained in ORS 743.495 and this section shall not prohibit the use of other terms for policies having other guarantees of renewability, provided such terms, in the opinion of the director are accurate, clear and not likely to be confused with the terms contained in ORS 743.495 and this section, and are incorporated in a concise statement relating to the guarantees of renewability.

(4) The statement required by this section shall be printed in a type not smaller than the type used for captions. It shall appear prominently on the first page of the policy and shall be a part of the brief description if the policy has a brief description on its first page.

SECTION 24. ORS 743.550 is amended to read:

743.550. (1) Student health insurance is subject to ORS [*743.537,*] 743.540, 743.543, 743.546 and 743B.475, except as provided in this section.

(2) Coverage under a student health insurance policy may be mandatory for all students at the institution, voluntary for all students at the institution, or mandatory for defined classes of students and voluntary for other classes of students. As used in this subsection, "classes" refers to undergraduates, graduate students, domestic students, international students or other like classifications. Any differences based on a student's nationality may be established only for the purpose of complying with federal law in effect when the policy is issued.

(3) When coverage under a student health insurance policy is mandatory, the policyholder may allow any student subject to the policy to decline coverage if the student provides evidence acceptable to the policyholder that the student has similar health coverage.

(4) A student health insurance policy may provide for any student to purchase optional supplemental coverage.

(5) Student health insurance coverage for athletic injuries may:

(a) Exclude coverage for injuries of students who have not obtained medical release for a similar injury; and

(b) Be provided in excess of or in addition to any other coverage under any other health insur-

ance policy, including a student health insurance policy.

(6) A student health insurance policy may provide that coverage under the policy is secondary to any other health insurance for purposes of guidelines established under ORS 743B.475.

(7) A student health insurance policy may provide, on request by the policyholder, that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(8) An insurer providing student health insurance as primary coverage may negotiate and enter into contracts for alternative rates of payment with providers and offer the benefit of such alternative rates to insureds who select such providers. An insurer may utilize such contracts by offering a choice of plans at the time an insured enrolls, one of which provides benefits only for services by members of a particular provider organization with whom the insurer has an agreement. If an insured chooses such a plan, benefits are payable only for services rendered by a member of that provider organization, unless such services were requested by a member of such organization or are rendered as the result of an emergency.

(9) Payments made under subsection (8) of this section shall discharge the insurer's obligation with respect to the amount of insurance paid.

(10) An insurer shall provide each student health insurance policyholder with a current roster of institutional and professional providers under contract to provide services at alternative rates under the group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state.

(11) As used in this section, "student health insurance":

(a) Means that form of health insurance under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or recognized student government at a public university listed in ORS 352.002, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, that is available exclusively to students at the college, school or other institution.

(b) Does not include a student health benefit plan as defined in ORS 743.551.

SECTION 25. ORS 743.450, 743.453, 743.456, 743.459, 743.462, 743.468, 743.471, 743.474, 743.477, 743.537 and 743B.324 are repealed.

SECTION 26. Section 2 of this 2019 Act and the amendments to ORS 743.010, 743.104, 743.106, 743.107, 743.408, 743.411, 743.414, 743.417, 743.420, 743.423, 743.426, 743.429, 743.432, 743.435, 743.438, 743.441, 743.444, 743.447, 743.472, 743.498 and 743.550 by sections 3 to 24 of this 2019 Act apply to health insurance policies issued or renewed on or after the effective date of this 2019 Act.