SB 250-1
(LC 521)
3/26/19 (LHF/MNJ/ps)

Requested by SENATE COMMITTEE ON HEALTH CARE

PROPOSED AMENDMENTS TO
SENATE BILL 250

1 On page 1 of the printed bill, line 2, after "ORS" insert "731.146,
2 731.804,".
3 In line 4, delete "and 743.550" and insert ", 743.550, 743A.168, 743B.011,
4 743B.125, 743B.126, 743B.130 and 743B.800".
5 On page 11, after line 31, insert:
6 "**SECTION 25.** ORS 743B.125 is amended to read:
7 "743B.125. (1) With respect to coverage under an individual health benefit
8 plan **other than a grandfathered health plan**, a carrier may not impose
9 **a preexisting condition exclusion or** an individual coverage waiting pe-
10 riod.
11 "(2) With respect to individual coverage under a grandfathered health
12 plan, a carrier:
13 "(a) May impose an exclusion period for specified covered services appli-
14 cable to all individuals enrolling for the first time in the individual health
15 benefit plan.
16 "(b) May not impose a preexisting condition exclusion unless the exclu-
17 sion complies with the following requirements:
18 "(A) The exclusion applies only to a condition for which medical advice,
19 diagnosis, care or treatment was recommended or received during the six-
20 month period immediately preceding the individual's effective date of cover-
21 age.

"(B) The exclusion expires no later than six months after the individual's effective date of coverage.

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

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

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

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

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

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

"(b) The Department of Consumer and Business Services may allow a carrier to cap the number of individuals enrolled in an individual health benefit plan offered by the carrier if the department finds that issuing the health benefit plan to more individuals than are currently enrolled in the plan would have a material adverse effect upon the carrier's ability to fulfill the carrier's contractual obligations or result in the financial impairment of the carrier.

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

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

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

"(b) The policyholder or a representative of the policyholder engages in

fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

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

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

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

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

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

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

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

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

1 “(B) May not cancel coverage under the plan for 90 days after the date
2 of the notice required under subparagraph (A) of this paragraph; and
3 “(C) Shall offer in writing to each policyholder covered by the plan, all
4 other individual health benefit plans that the carrier offers in the specified
5 service area. The carrier shall offer the plans at least 90 days prior to dis-
6 continuation.
7 “(e) The carrier discontinues both offering and renewing an individual
8 health benefit plan, other than a grandfathered health plan, for all individ-
9 uals in this state or in a specified service area within this state, other than
10 a plan discontinued under paragraph (d) of this subsection.
11 “(f) The carrier discontinues both offering and renewing a grandfathered
12 health plan for all individuals in this state or in a specified service area
13 within this state, other than a plan discontinued under paragraph (d) of this
14 subsection.
15 “(g) With respect to plans that are being discontinued under paragraph
16 (e) or (f) of this subsection, the carrier shall:
17 “(A) Offer in writing to each policyholder covered by the plan, all health
18 benefit plans that the carrier offers to individuals in the specified service
19 area.
20 “(B) Offer the plans at least 90 days prior to discontinuation.
21 “(C) Act uniformly without regard to the claims experience of the affected
22 policyholders or the health status of any current or prospective enrollee.
23 “(h) The Director of the Department of Consumer and Business Services
24 orders the carrier to discontinue coverage in accordance with procedures
25 specified or approved by the director upon finding that the continuation of
26 the coverage would:
27 “(A) Not be in the best interests of the enrollee; or
28 “(B) Impair the carrier’s ability to meet the carrier’s contractual obli-
29 gations.
30 “(i) In the case of an individual health benefit plan that delivers covered

1 services through a specified network of health care providers, the enrollee
2 no longer lives, resides or works in the service area of the provider network
3 and the termination of coverage is not related to the health status of any
4 enrollee.

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

9 "[*(5)*] **(6)** A carrier may modify an individual health benefit plan at the
10 time of coverage renewal. The modification is not a discontinuation of the
11 plan under subsection [*(4)(c)*] **(5)(c)**, (e) and (f) of this section.

12 "[*(6)*] **(7)** Notwithstanding any other provision of this section, and subject
13 to the provisions of ORS 743B.310 (2) and (4), a carrier may rescind an in-
14 dividual health benefit plan if the policyholder or a representative of the
15 policyholder:

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

17 "(b) Makes an intentional misrepresentation of a material fact as pro-
18 hibited by the terms of the policy.

19 "[*(7)*] **(8)** A carrier that continues to offer coverage in the individual
20 market in this state is not required to offer coverage in all of the carrier's
21 individual health benefit plans. However, if a carrier elects to continue a
22 plan that is closed to new individual policyholders instead of offering alter-
23 native coverage in the carrier's other individual health benefit plans, the
24 coverage for all existing policyholders in the closed plan is renewable in
25 accordance with subsection [*(4)*] **(5)** of this section.

26 "[*(8)*] **(9)** An individual health benefit plan may not impose annual or
27 lifetime limits on the dollar amount of essential health benefits.

28 "[*(9)*] **(10)** A grandfathered health plan may not impose lifetime limits on
29 the dollar amount of essential health benefits.

30 "[*(10)*] **(11)** This section does not require a carrier to actively market, of-

1 fer, issue or accept applications for:

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

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

6 **"SECTION 26.** ORS 743B.126 is amended to read:

7 "743B.126. (1) Each carrier shall actively market all individual health
8 benefit plans sold by the carrier that are not grandfathered health plans.

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

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

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

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

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

services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.

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

"(a) A competitive health insurance market exists;

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

"(c) Consumers who purchase insurance are protected.

"SECTION 27. ORS 731.146 is amended to read:

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

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

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

"(c) Receiving or collecting any premium, commission, membership fee, assessment, due or other consideration for any insurance or any part thereof.

"(d) Issuing or delivering policies of insurance.

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

"(f) Advertising locally or circularizing therein without regard for the source of such circularization, whenever such advertising or circularization is for the purpose of solicitation of insurance business.

"(g) Doing any other kind of business specifically recognized as constituting the doing of an insurance business within the meaning of the Insurance Code.

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

"(i) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (h) of this subsection in a manner designed to evade the provisions of the Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

"SECTION 28. ORS 743B.130 is amended to read:

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

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

"(3) As used in this section, 'health benefit plan' has the meaning given that term in ORS 743B.005.

"SECTION 29. ORS 743B.011 is amended to read:

"743B.011. (1) **Except as provided in subsection (2) of this section,** every health benefit plan shall be subject to the provisions of ORS 743B.010 to 743B.013, if the plan provides health benefits covering one or more em-

ployees of a small employer and if any one of the following conditions is met:

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

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

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

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

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

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

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

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

"[*(3)(a)*] **(4)(a)** A carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their

1 dependents. The categories must be based on bona fide employment-based
2 classifications that are consistent with the employer's usual business prac-
3 tice.

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

7 "(c) If a small employer elects to offer coverage to dependents of eligible
8 employees, the carrier shall offer coverage to all dependents of eligible em-
9 ployees.

10 "[*(4)*] **(5)** An insurer may not deny, delay or terminate participation of an
11 individual in a group health benefit plan or exclude coverage otherwise
12 provided to an individual under a group health benefit plan based on a pre-
13 existing condition of the individual.

14 **"SECTION 30.** ORS 743A.168 is amended to read:

15 "743A.168. (1) As used in this section:

16 "(a) 'Behavioral health assessment' means an evaluation by a provider, in
17 person or using telemedicine, to determine a patient's need for behavioral
18 health treatment.

19 "(b) 'Behavioral health crisis' means a disruption in an individual's men-
20 tal or emotional stability or functioning resulting in an urgent need for im-
21 mediate outpatient treatment in an emergency department or admission to
22 a hospital to prevent a serious deterioration in the individual's mental or
23 physical health.

24 "(c) 'Chemical dependency' means the addictive relationship with any
25 drug or alcohol characterized by a physical or psychological relationship, or
26 both, that interferes on a recurring basis with the individual's social, psy-
27 chological or physical adjustment to common problems. For purposes of this
28 section, 'chemical dependency' does not include addiction to, or dependency
29 on, tobacco, tobacco products or foods.

30 "(d) 'Facility' means a corporate or governmental entity or other provider

of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

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

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

"(g) 'Provider' means:

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

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

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

"(D) A day or partial hospitalization program;

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

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

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

"(a) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to pro-

visions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

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

"(c) The coverage must include:

"(A) A behavioral health assessment;

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

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

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

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

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

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

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

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

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

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

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

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

"(C) Review shall be performed by or under the direction of a physician licensed under ORS 677.100 to 677.228, a psychologist licensed by the Oregon Board of Psychology, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

"(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these.

However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers **and issuers of individual health benefit plans that are not grandfathered health plans** shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers **and issuers of individual health benefit plans that are not grandfathered health plans** shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

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

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

"(4) The Legislative Assembly finds that health care cost containment is necessary and intends to encourage health insurance plans designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into the insurance, either

1 directly or by reference.

2 "(5) This section does not prevent a group health insurer **or issuer of**
3 **an individual health benefit plan that is not a grandfathered health**
4 **plan** from contracting with providers of health care services to furnish ser-
5 vices to policyholders or certificate holders according to ORS 743B.460 or
6 750.005, subject to the following conditions:

7 "(a) A group health insurer **or issuer of an individual health benefit**
8 **plan that is not a grandfathered health plan** is not required to contract
9 with all providers that are eligible for reimbursement under this section.

10 "(b) An insurer or health care service contractor shall, subject to sub-
11 section (2) of this section, pay benefits toward the covered charges of non-
12 contracting providers of services for the treatment of chemical dependency
13 or mental or nervous conditions. The insured shall, subject to subsection (2)
14 of this section, have the right to use the services of a noncontracting pro-
15 vider of services for the treatment of chemical dependency or mental or
16 nervous conditions, whether or not the services for chemical dependency or
17 mental or nervous conditions are provided by contracting or noncontracting
18 providers.

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

20 "(A) Educational or correctional services or sheltered living provided by
21 a school or halfway house;

22 "(B) A long-term residential mental health program that lasts longer than
23 45 days;

24 "(C) Psychoanalysis or psychotherapy received as part of an educational
25 or training program, regardless of diagnosis or symptoms that may be pres-
26 ent;

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

28 "(E) Support groups.

29 "(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may
30 receive covered outpatient services under the terms of the insured's policy

while the insured is living temporarily in a sheltered living situation.

"(7) The Oregon Health Authority shall establish a process for the certification of an organization described in subsection (1)(g)(F) of this section that:

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

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

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

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

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

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

"SECTION 31. ORS 743B.800 is amended to read:

"743B.800. (1) As used in this section, 'health benefit plan' means a health benefit plan, as defined in ORS 743B.005, that is offered in the individual or small group market.

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

"(a) The procedure may include:

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

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

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

"SECTION 32. ORS 731.804 is amended to read:

"731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business in this state shall pay assessments that the Director of the Department of Consumer and Business Services determines are necessary to support the legislatively authorized budget of the Department of Consumer and Business Services with respect to functions of the department under the Insurance Code. The director shall determine the assessments according to one or more percentage rates established by the director by rule. The director shall specify in the rule when assessments shall be made and payments shall be due. The premium-weighted average of the percentage rates may not exceed nine-hundredths of one percent of the gross amount of premiums received by an insurer or the insurer's insurance producers from

and under the insurer's policies covering direct domestic risks, after deducting the amount of return premiums paid and the amount of dividend payments made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount of premiums. In establishing the percentage rate or rates, the director shall use the most recent premium data approved by the director. In establishing the amounts to be collected under this subsection, the director shall take into consideration the expenses of the department for administering the Insurance Code and the fees collected under subsection (2) of this section. When the director establishes two or more percentage rates:

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

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

"(2) The director may collect fees for specific services provided by the department under the Insurance Code according to a schedule of fees established by the director by rule. The director may collect such fees in advance. In establishing the schedule for fees, the director shall take into consideration the cost of each service for which a fee is imposed.

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

"(b) Any fees collected under paragraph (a) of this subsection must be the actuarial equivalent of costs attributed to the provision and administration of the required coverage by an insurer that is not ex-

1 **empt.**

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

5 **“(d) Notwithstanding ORS 646A.628, fees paid in accordance with**
6 **paragraph (a) of this subsection shall be deposited in the General Fund**
7 **to become available for general governmental expenses.**

8 “[*(3)*] **(4)** Establishment and amendment of the schedule of fees under
9 subsection (2) of this section are subject to prior approval of the Oregon
10 Department of Administrative Services and a report to the Emergency Board
11 prior to adopting the fees and shall be within the budget authorized by the
12 Legislative Assembly as that budget may be modified by the Emergency
13 Board.

14 “[*(4)*] **(5)** The director may not collect an assessment under subsection (1)
15 of this section from any of the following persons:

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

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

18 “[*(5)*] **(6)** The director may not collect an assessment under subsection (1)
19 of this section with respect to premiums received from any of the following
20 policies:

21 “(a) Workers’ compensation insurance policies.

22 “(b) Wet marine and transportation insurance policies.

23 “(c) Any category of policies designated by the director by rule.”.

24 **“SECTION 33. Section 34 of this 2019 Act is added to and made a**
25 **part of the Insurance Code.**

26 **“SECTION 34. Except as otherwise provided for in the Insurance**
27 **Code, an individual may not, on the basis of actual or perceived race,**
28 **color, national origin, sex, sexual orientation, gender identity, age or**
29 **disability, be excluded from participation in, be denied the benefits of**
30 **or otherwise be subjected to discrimination under any health benefit**

1 **plan issued or delivered in this state.**”.

2 In line 32, delete “25” and insert “35”.

3 Delete lines 34 through 38 and insert:

4 “**SECTION 36. Sections 2 and 34 of this 2019 Act and the amend-**
5 **ments to ORS 731.146, 731.804, 743.010, 743.104, 743.106, 743.107, 743.408,**
6 **743.411, 743.414, 743.417, 743.420, 743.423, 743.426, 743.429, 743.432, 743.435,**
7 **743.438, 743.441, 743.444, 743.447, 743.472, 743.498, 743.550, 743A.168,**
8 **743B.011, 743B.125, 743B.126, 743B.130 and 743B.800 by sections 3 to 32**
9 **of this 2019 Act apply to health insurance policies issued or renewed**
10 **on or after the effective date of this 2019 Act.**”.

11 ____________