

HOUSE AMENDMENTS TO HOUSE BILL 3134

By COMMITTEE ON RULES

May 5

1 On page 1 of the printed bill, line 2, after “provisions;” delete the rest of the line and line 3 and
2 insert “and amending ORS 743B.001, 743B.250, 750.055 and 750.333.”.

3 Delete lines 5 through 27 and delete pages 2 through 12 and insert:

4 “**SECTION 1.** ORS 743B.250 is amended to read:

5 “743B.250. All insurers offering a health benefit plan in this state shall:

6 “(1) Provide to all enrollees directly or in the case of a group policy to the employer or other
7 policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon re-
8 quest, the following information:

9 “(a) The insurer’s written policy on the rights of enrollees, including the right:

10 “(A) To participate in decision making regarding the enrollee’s health care.

11 “(B) To be treated with respect and with recognition of the enrollee’s dignity and need for pri-
12 vacy.

13 “(C) To have grievances handled in accordance with this section.

14 “(D) To be provided with the information described in this section.

15 “(b) An explanation of the procedures described in subsection (2) of this section for making
16 coverage determinations and resolving grievances. The explanation must be culturally and linguis-
17 tically appropriate, as prescribed by the Department of Consumer and Business Services by rule, and
18 must include:

19 “(A) The procedures for requesting an expedited response to an internal appeal under subsection
20 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-
21 nation;

22 “(B) A statement that if an insurer does not comply with the decision of an independent review
23 organization under ORS 743B.256, the enrollee may sue the insurer under ORS 743B.258;

24 “(C) The procedure to obtain assistance available from the insurer, if any, and from the De-
25 partment of Consumer and Business Services in filing grievances; and

26 “(D) A description of the process for filing a complaint with the department.

27 “(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by
28 the department by rule.

29 “(d) A summary of the insurer’s policies on prescription drugs, including:

30 “(A) Cost-sharing differentials;

31 “(B) Restrictions on coverage;

32 “(C) Prescription drug formularies;

33 “(D) Procedures by which a provider with prescribing authority may prescribe clinically appro-
34 priate drugs not included on the formulary;

35 “(E) Procedures for the coverage of clinically appropriate prescription drugs not included on the

1 formulary; and

2 “(F) A summary of the criteria for determining whether a drug is experimental or
3 investigational.

4 “(e) A list of network providers and how the enrollee can obtain current information about the
5 availability of providers and how to access and schedule services with providers, including clinic
6 and hospital networks. The list must be available online and upon request in printed format.

7 “(f) Notice of the enrollee’s right to select a primary care provider and specialty care providers.

8 “(g) How to obtain referrals for specialty care in accordance with ORS 743B.227.

9 “(h) Restrictions on services obtained outside of the insurer’s network or service area.

10 “(i) The availability of continuity of care as required by ORS 743B.225.

11 “(j) Procedures for accessing after-hours care and emergency services as required by ORS
12 743A.012.

13 “(k) Cost-sharing requirements and other charges to enrollees.

14 “(L) Procedures, if any, for changing providers.

15 “(m) Procedures, if any, by which enrollees may participate in the development of the insurer’s
16 corporate policies.

17 “(n) A summary of how the insurer makes decisions regarding coverage and payment for treat-
18 ment or services, including a general description of any prior authorization and utilization review
19 requirements that affect coverage or payment.

20 “(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other pro-
21 viders.

22 “(p) A summary of the insurer’s procedures for protecting the confidentiality of medical records
23 and other enrollee information and the requirement under ORS 743B.555 that a carrier or third
24 party administrator send communications containing protected health information only to the
25 enrollee who is the subject of the protected health information.

26 “(q) An explanation of assistance provided to non-English-speaking enrollees.

27 “(r) Notice of the information available from the department that is filed by insurers as required
28 under ORS 743B.200, 743B.202 and 743B.423.

29 “(2) Establish procedures, in accordance with requirements adopted by the department, for
30 making coverage determinations and resolving grievances that provide for all of the following:

31 “(a) Timely notice of adverse benefit determinations.

32 “(b) A method for recording all grievances, including the nature of the grievance and significant
33 action taken.

34 “(c) Written decisions.

35 “(d) An expedited response to a request for an internal appeal that accommodates the clinical
36 urgency of the situation.

37 “(e) At least one but not more than two levels of internal appeal for group health benefit plans
38 and one level of internal appeal for individual health benefit plans and for any denial of an exception
39 to a prescription drug formulary. If an insurer provides:

40 “(A) Two levels of internal appeal, a person who was involved in the consideration of the initial
41 denial or the first level of internal appeal may not be involved in the second level of internal appeal;
42 and

43 “(B) No more than one level of internal appeal, a person who was involved in the consideration
44 of the initial denial may not be involved in the internal appeal.

45 “(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255,

1 after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have
2 exhausted internal appeals.

3 “(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to
4 strictly comply with this section and federal requirements for internal appeals.

5 “(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing
6 course of treatment under the health benefit plan pending the conclusion of the internal appeal
7 process.

8 “(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee
9 to:

10 “(A) Submit for consideration by the insurer any written comments, documents, records and
11 other materials relating to the adverse benefit determination; and

12 “(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies
13 of all documents, records and other information relevant to the adverse benefit determination.

14 “(3) Establish procedures for notifying affected enrollees of:

15 “(a) A change in or termination of any benefit; and

16 “(b)(A) The termination of a primary care delivery office or site; and

17 “(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

18 “(4) Provide the information described in subsection (2) of this section and ORS 743B.254 at each
19 level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an
20 enrollee who files a grievance.

21 “(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

22 “(a) The insurer’s annual report on grievances and internal appeals submitted to the department
23 under subsection (8) of this section.

24 “(b) A description of the insurer’s efforts, if any, to monitor and improve the quality of health
25 services.

26 “(c) Information about the insurer’s procedures for credentialing network providers.

27 “(6) In addition to the requirements in ORS 743B.423 and 743B.602, provide, upon the request
28 of an enrollee, a written summary of information that the insurer may consider in its utilization
29 review of a particular condition or disease, to the extent the insurer maintains such criteria. This
30 subsection does not require an insurer to advise an enrollee how the insurer would cover or treat
31 that particular enrollee’s disease or condition. Utilization review criteria that are proprietary shall
32 be subject to oral disclosure only.

33 “(7) Maintain for a period of at least six years written records that document all grievances
34 described in ORS 743B.001 (8)(a) and make the written records available for examination by the
35 department or by an enrollee or authorized representative of an enrollee with respect to a grievance
36 made by the enrollee. The written records must include but are not limited to the following:

37 “(a) Notices and claims associated with each grievance.

38 “(b) A general description of the reason for the grievance.

39 “(c) The date the grievance was received by the insurer.

40 “(d) The date of the internal appeal or the date of any internal appeal meeting held concerning
41 the appeal.

42 “(e) The result of the internal appeal at each level of appeal.

43 “(f) The name of the covered person for whom the grievance was submitted.

44 “(8) Provide to the department, in the format prescribed by the department, an annual summary
45 of the insurer’s aggregate data regarding:

1 “(a) Grievances;
2 “(b) Internal appeals;
3 “(c) Requests for external review; and
4 “(d) The following information, **which shall be published by the department, in a format**
5 **that does not identify the insurer, to the department’s website no later than March 1 of each**
6 **calendar year**, about requests for prior authorization received by the insurer:
7 “[(A) *The number of requests received;*]
8 “[(B) *The number of requests that were initially denied and the reasons for the denials, including,*
9 *but not limited to, lack of medical necessity or failure to provide additional clinical information re-*
10 *quested by the insurer;*]
11 “[(C) *The number of requests that were initially approved; and*]
12 “[(D) *The number of denials that were reversed by internal appeals or external reviews.*]
13 “(A) **The percentage and number of standard prior authorization requests that were ap-**
14 **proved;**
15 “(B) **The percentage and number of standard prior authorization requests that were de-**
16 **nied;**
17 “(C) **The percentage and number of standard prior authorization requests that were ap-**
18 **proved after appeal;**
19 “(D) **The percentage and number of all prior authorization requests for which the time**
20 **frame for review was extended and the request was approved;**
21 “(E) **The percentage and number of expedited prior authorization requests that were ap-**
22 **proved;**
23 “(F) **The percentage and number of expedited prior authorization requests that were de-**
24 **nied;**
25 “(G) **The average and median times that elapsed between the submission of a request and**
26 **a determination by the insurer for standard prior authorization; and**
27 “(H) **The average and median times that elapsed between the submission of a request and**
28 **a decision by the insurer for expedited prior authorization.**
29 “(9) Allow the exercise of any rights described in this section or ORS 743B.252 or 743B.255 by
30 an authorized representative.
31 “(10) Procedures adopted under subsection (2) of this section for health benefit plans other than
32 grandfathered health plans must be consistent with 42 U.S.C. 300-gg-19 and rules adopted by the
33 United States Department of Health and Human Services implementing 42 U.S.C. 300-gg-19.
34 “(11) An adverse benefit determination under subsection (2)(a) of this section that is provided
35 to an enrollee in a health benefit plan other than a grandfathered health plan must:
36 “(a) Be provided in a culturally and linguistically appropriate manner;
37 “(b) Be consistent with federal requirements regarding the manner and content for notices of
38 benefit determinations and federal requirements for the full and fair review of adverse benefit de-
39 terminations; and
40 “(c) Include the information required by subsection (4) of this section and:
41 “(A) Information sufficient to identify the claim involved, the date of services, the health care
42 provider and, if applicable, the claim amount;
43 “(B) A statement describing the availability, upon request, of the information described in sub-
44 section (12) of this section;
45 “(C) The specific reason for the adverse benefit determination, a reference to the specific plan

1 provisions on which the determination is based, the denial code and the meaning of the denial code
2 and a description of the standard that was used to make the determination, if any;

3 “(D) A description of available internal appeals and external reviews, including expedited ap-
4 peals and reviews, and instructions on how to initiate an appeal or review; and

5 “(E) Contact information for the office of consumer assistance within the Department of Con-
6 sumer and Business Services.

7 “(12) Upon the request of an enrollee, an insurer that makes an adverse benefit determination
8 with respect to the enrollee under a health benefit plan other than a grandfathered health plan must
9 provide the enrollee with the diagnosis code, the meaning of the diagnosis code, the treatment code
10 and the meaning of the treatment code that are associated with the adverse benefit determination.

11 “(13) An adverse benefit determination issued to an enrollee following the final level of internal
12 appeals by an insurer under a health benefit plan other than a grandfathered health plan must, in
13 addition to the requirements under subsection (11) of this section, include:

14 “(a) An explanation and discussion of the decision to uphold the initial adverse benefit deter-
15 mination; and

16 “(b) An authorization form, or other document that complies with state and federal privacy laws
17 and is approved by the department, with which an enrollee that requests an external review under
18 ORS 743B.255 may authorize the insurer and the enrollee’s treating health care provider to disclose
19 medical records or other protected health information pertinent to the external review.

20 “(14) As used in this section:

21 “(a) ‘Expedited prior authorization’ means a prior authorization that must be expedited
22 in order to avoid jeopardizing the enrollee’s life, health or ability to maintain or regain
23 maximum function.

24 “(b) ‘Standard prior authorization’ means a prior authorization request that is not an
25 expedited prior authorization request.

26 “**SECTION 2.** An insurer offering a health benefit plan that requires prior authorization
27 for surgical procedures may not require prior authorization for an additional or related
28 health care procedure that is identified during the authorized surgical procedure if:

29 “(1) The provider, while providing an approved surgical procedure, identifies a medical
30 condition, disease or ailment that was not identified in the prior authorization request and,
31 in accordance with generally accepted standards of medical practice, determines that per-
32 forming a related health care procedure, instead of or in addition to the approved surgical
33 procedure, is medically necessary and, in the provider’s judgment, to interrupt or delay the
34 provision of care in order to obtain prior authorization for the additional or related health
35 care procedure would not be medically advisable;

36 “(2) The additional or related health care procedure is a covered benefit under the
37 enrollee’s health benefit plan; and

38 “(3) The additional or related health care procedure is not experimental or for investi-
39 gation purposes.

40 “**SECTION 3.** (1) An insurer offering a health benefit plan in this state that provides
41 utilization review or has utilization review provided on the insurer’s behalf shall utilize a
42 prior authorization application programming interface as described in 45 C.F.R. 156.223(b),
43 as in effect on February 28, 2024. The application programming interface shall enable a pro-
44 vider to:

45 “(a) Determine whether prior authorization is required;

1 “(b) Identify the information and documentation necessary to submit the request; and
2 “(c) Transfer prior authorization requests and determinations from the provider’s elec-
3 tronic health records or practice management system through a secure electronic trans-
4 mission.

5 “(2) An insurer shall respond through the application programming interface described
6 in subsection (1) of this section to a request that was submitted by a provider through the
7 application programming interface.

8 “**SECTION 4.** ORS 743B.001, as amended by section 3, chapter 35, Oregon Laws 2024, is
9 amended to read:

10 “743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195,
11 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
12 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420,
13 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550,
14 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024, **and sections 2 and 3 of this**
15 **2025 Act:**

16 “(1) ‘Adverse benefit determination’ means an insurer’s denial, reduction or termination of a
17 health care item or service, or an insurer’s failure or refusal to provide or to make a payment in
18 whole or in part for a health care item or service, that is based on the insurer’s:

19 “(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

20 “(b) Rescission or cancellation of a policy or certificate;

21 “(c) Imposition of a preexisting condition exclusion as defined in ORS 743B.005, source-of-injury
22 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
23 services;

24 “(d) Determination that a health care item or service is experimental, investigational or not
25 medically necessary, effective or appropriate;

26 “(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
27 course of treatment for purposes of continuity of care under ORS 743B.225; or

28 “(f) Denial, in whole or in part, of a request for prior authorization, a request for an exception
29 to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory
30 test that is subject to other utilization review requirements.

31 “(2) ‘Authorized representative’ means an individual who by law or by the consent of a person
32 may act on behalf of the person.

33 “(3) ‘Clinical review criteria’ means screening procedures, decision rules, medical protocols and
34 clinical guidance used by an insurer or other entity in conducting utilization review and evaluating:

35 “(a) Medical necessity;

36 “(b) Appropriateness of an item or health service for which prior authorization is requested or
37 for which an exception to step therapy has been requested as described in ORS 743B.602; or

38 “(c) Any other coverage that is subject to utilization review.

39 “(4) ‘Credit card’ has the meaning given that term in 15 U.S.C. 1602.

40 “(5) ‘Electronic funds transfer’ has the meaning given that term in ORS 293.525.

41 “(6) ‘Enrollee’ has the meaning given that term in ORS 743B.005.

42 “(7) ‘Essential community provider’ has the meaning given that term in rules adopted by the
43 Department of Consumer and Business Services consistent with the description of the term in 42
44 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services,
45 the United States Department of the Treasury or the United States Department of Labor to carry

1 out 42 U.S.C. 18031.

2 “(8) ‘Grievance’ means:

3 “(a) A communication from an enrollee or an authorized representative of an enrollee expressing
4 dissatisfaction with an adverse benefit determination, without specifically declining any right to
5 appeal or review, that is:

6 “(A) In writing, for an internal appeal or an external review; or

7 “(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an ex-
8 pedited external review; or

9 “(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee
10 regarding the:

11 “(A) Availability, delivery or quality of a health care service;

12 “(B) Claims payment, handling or reimbursement for health care services and, unless the
13 enrollee has not submitted a request for an internal appeal, the complaint is not disputing an ad-
14 verse benefit determination; or

15 “(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

16 “(9) ‘Health benefit plan’ has the meaning given that term in ORS 743B.005.

17 “(10) ‘Independent practice association’ means a corporation wholly owned by providers, or
18 whose membership consists entirely of providers, formed for the sole purpose of contracting with
19 insurers for the provision of health care services to enrollees, or with employers for the provision
20 of health care services to employees, or with a group, as described in ORS 731.098, to provide health
21 care services to group members.

22 “(11) ‘Insurer’ includes a health care service contractor as defined in ORS 750.005.

23 “(12) ‘Internal appeal’ means a review by an insurer of an adverse benefit determination made
24 by the insurer.

25 “(13) ‘Managed health insurance’ means any health benefit plan that:

26 “(a) Requires an enrollee to use a specified network or networks of providers managed, owned,
27 under contract with or employed by the insurer in order to receive benefits under the plan, except
28 for emergency or other specified limited service; or

29 “(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service
30 provision that allows an enrollee to use providers outside of the specified network or networks at
31 the option of the enrollee and receive a reduced level of benefits.

32 “(14) ‘Medical services contract’ means a contract between an insurer and an independent
33 practice association, between an insurer and a provider, between an independent practice associ-
34 ation and a provider or organization of providers, between medical or mental health clinics, and
35 between a medical or mental health clinic and a provider to provide medical or mental health ser-
36 vices. ‘Medical services contract’ does not include a contract of employment or a contract creating
37 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
38 similar professional organizations permitted by statute.

39 “(15)(a) ‘Preferred provider organization insurance’ means any health benefit plan that:

40 “(A) Specifies a preferred network of providers managed, owned or under contract with or em-
41 ployed by an insurer;

42 “(B) Does not require an enrollee to use the preferred network of providers in order to receive
43 benefits under the plan; and

44 “(C) Creates financial incentives for an enrollee to use the preferred network of providers by
45 providing an increased level of benefits.

1 “(b) ‘Preferred provider organization insurance’ does not mean a health benefit plan that has
2 as its sole financial incentive a hold harmless provision under which providers in the preferred
3 network agree to accept as payment in full the maximum allowable amounts that are specified in
4 the medical services contracts.

5 “(16) ‘Prior authorization’ means a form of utilization review that requires a provider or an
6 enrollee to request a determination by an insurer, prior to the provision of health care that is sub-
7 ject to utilization review, that the insurer will provide reimbursement for the health care requested.
8 ‘Prior authorization’ does not include referral approval for evaluation and management services be-
9 tween providers.

10 “(17)(a) ‘Provider’ means a person licensed, certified or otherwise authorized or permitted by
11 laws of this state to administer medical or mental health services in the ordinary course of business
12 or practice of a profession.

13 “(b) With respect to the statutes governing the billing for or payment of claims, ‘provider’ also
14 includes an employee or other designee of the provider who has the responsibility for billing claims
15 for reimbursement or receiving payments on claims.

16 “(18) ‘Step therapy’ means a utilization review protocol, policy or program in which an insurer
17 requires certain preferred drugs for treatment of a specific medical condition be proven ineffective
18 or contraindicated before a prescribed drug may be reimbursed.

19 “(19) ‘Utilization review’ means a set of formal techniques used by an insurer or delegated by
20 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
21 cacy or efficiency of health care items, services, procedures or settings.

22 “**SECTION 5.** ORS 750.055, as amended by section 3, chapter 24, Oregon Laws 2024, section 4,
23 chapter 35, Oregon Laws 2024, section 21, chapter 70, Oregon Laws 2024, and section 162, chapter
24 73, Oregon Laws 2024, is amended to read:

25 “750.055. (1) The following provisions apply to health care service contractors to the extent not
26 inconsistent with the express provisions of ORS 750.005 to 750.095:

27 “(a) ORS 705.137, 705.138 and 705.139.

28 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
29 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
30 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
31 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

32 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
33 including ORS 732.582, and ORS 732.650 to 732.689.

34 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
35 to 733.780.

36 “(e) ORS 734.014 to 734.440.

37 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
38 742.542.

39 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
40 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
41 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
42 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

43 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
44 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
45 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,

1 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
2 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
3 and 743A.315 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 70, Oregon Laws
4 2024.

5 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
6 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
7 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
8 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
9 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
10 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
11 [and] section 2, chapter 35, Oregon Laws 2024, **and section 2 of this 2025 Act.**

12 “(j) The following provisions of ORS chapter 744:

13 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
14 ducers;

15 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

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

17 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,
18 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and
19 746.690.

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

23 “(a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
24 ates an in-house drug outlet.

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

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

28 “(4) Any for-profit health care service contractor organized under the laws of any other state
29 that is not governed by the insurance laws of the other state is subject to all requirements of ORS
30 chapter 732.

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

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

36 “(6) The Director of the Department of Consumer and Business Services may, after notice and
37 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
38 and 750.045 that are necessary for the proper administration of these provisions.

39 “**SECTION 6.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section
40 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59,
41 Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws
42 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section
43 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter
44 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon
45 Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019,

1 section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12,
2 chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152,
3 Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
4 2024, section 22, chapter 70, Oregon Laws 2024, and section 163, chapter 73, Oregon Laws 2024, is
5 amended to read:

6 “750.055. (1) The following provisions apply to health care service contractors to the extent not
7 inconsistent with the express provisions of ORS 750.005 to 750.095:

8 “(a) ORS 705.137, 705.138 and 705.139.

9 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
10 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
11 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
12 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

13 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
14 including ORS 732.582, and ORS 732.650 to 732.689.

15 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
16 to 733.780.

17 “(e) ORS 734.014 to 734.440.

18 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
19 742.542.

20 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
21 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
22 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
23 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

24 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
25 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
26 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
27 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
28 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
29 and 743A.315 and section 2, chapter 70, Oregon Laws 2024.

30 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200,
31 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
32 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310,
33 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403,
34 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,
35 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024,
36 [and] section 2, chapter 35, Oregon Laws 2024, **and section 2 of this 2025 Act.**

37 “(j) The following provisions of ORS chapter 744:

38 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
39 ducers;

40 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

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

42 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608,
43 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and
44 746.690.

45 “(2) The following provisions of the Insurance Code apply to health care service contractors

1 except in the case of group practice health maintenance organizations that are federally qualified
2 pursuant to Title XIII of the Public Health Service Act:

3 “(a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-
4 ates an in-house drug outlet.

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

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

8 “(4) Any for-profit health care service contractor organized under the laws of any other state
9 that is not governed by the insurance laws of the other state is subject to all requirements of ORS
10 chapter 732.

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

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

16 “(6) The Director of the Department of Consumer and Business Services may, after notice and
17 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
18 and 750.045 that are necessary for the proper administration of these provisions.

19 “**SECTION 7.** ORS 750.055, as amended by section 3, chapter 24, Oregon Laws 2024, section 4,
20 chapter 35, Oregon Laws 2024, section 21, chapter 70, Oregon Laws 2024, and section 162, chapter
21 73, Oregon Laws 2024, and section 5 of this 2025 Act, is amended to read:

22 “750.055. (1) The following provisions apply to health care service contractors to the extent not
23 inconsistent with the express provisions of ORS 750.005 to 750.095:

24 “(a) ORS 705.137, 705.138 and 705.139.

25 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398
26 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS
27 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652,
28 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

29 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not
30 including ORS 732.582, and ORS 732.650 to 732.689.

31 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
32 to 733.780.

33 “(e) ORS 734.014 to 734.440.

34 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to 742.162 and 742.518 to
35 742.542.

36 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025,
37 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406,
38 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650
39 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

40 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044,
41 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
42 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
43 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
44 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310
45 and 743A.315 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 70, Oregon Laws

2024.

“(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024, section 2, chapter 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

“(j) The following provisions of ORS chapter 744:

“(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

“(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

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

“(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

“(4) Any for-profit health care service contractor organized under the laws of any other state that is not governed by the insurance laws of the other state is subject to all requirements of ORS chapter 732.

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

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

“(6) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary for the proper administration of these provisions.

“**SECTION 8.** ORS 750.055, as amended by section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45, Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chapter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206, Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22, chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018, section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97, Oregon Laws 2021, section 12, chapter 37, Oregon Laws 2022, section 5, chapter 111, Oregon Laws 2023, section 2, chapter 152, Oregon Laws 2023, section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws

2024, section 22, chapter 70, Oregon Laws 2024, and section 163, chapter 73, Oregon Laws 2024, and section 6 of this 2025 Act, is amended to read:

“750.055. (1) The following provisions apply to health care service contractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

“(a) ORS 705.137, 705.138 and 705.139.

“(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as provided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

“(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.596, not including ORS 732.582, and ORS 732.650 to 732.689.

“(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

“(e) ORS 734.014 to 734.440.

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

“(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022, 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680 to 743.689, 743.788 and 743.790.

“(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036, 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.175, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310 and 743A.315 and section 2, chapter 70, Oregon Laws 2024.

“(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 and section 2, chapter 24, Oregon Laws 2024, section 2, chapter 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

“(j) The following provisions of ORS chapter 744:

“(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance producers;

“(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

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

“(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

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

“(a) ORS 731.485, if the group practice health maintenance organization wholly owns and oper-

1 ates an in-house drug outlet.

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

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

5 “(4) Any for-profit health care service contractor organized under the laws of any other state
6 that is not governed by the insurance laws of the other state is subject to all requirements of ORS
7 chapter 732.

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

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

13 “(6) The Director of the Department of Consumer and Business Services may, after notice and
14 hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025
15 and 750.045 that are necessary for the proper administration of these provisions.

16 “**SECTION 9.** ORS 750.333, as amended by section 5, chapter 24, Oregon Laws 2024, and section
17 23, chapter 70, Oregon Laws 2024, is amended to read:

18 “750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
19 arrangement:

20 “(a) ORS 705.137, 705.138 and 705.139.

21 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
22 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
23 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
24 731.992.

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

26 “(d) ORS 734.014 to 734.440.

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

28 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
29 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and 743B.221.

30 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
31 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
32 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
33 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
34 743A.170, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260
35 and 743A.310 and section 2, chapter 70, Oregon Laws 2024.

36 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
37 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
38 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
39 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
40 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 and section 2,
41 chapter 24, Oregon Laws 2024, **and section 2 of this 2025 Act.**

42 “(i) The following provisions of ORS chapter 744:

43 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
44 ducers;

45 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and

1 “(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.
2 “(j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.
3 “(2) For the purposes of this section:
4 “(a) A trust carrying out a multiple employer welfare arrangement is an insurer.
5 “(b) References to certificates of authority are references to certificates of multiple employer
6 welfare arrangement.
7 “(c) Contributions are premiums.
8 “(3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
9 insurance.
10 “(4) The Department of Consumer and Business Services may adopt rules that are necessary to
11 implement the provisions of ORS 750.301 to 750.341.
12 “**SECTION 10.** ORS 750.333, as amended by section 5, chapter 24, Oregon Laws 2024, and sec-
13 tion 23, chapter 70, Oregon Laws 2024, and section 9 of this 2025 Act, is amended to read:
14 “750.333. (1) The following provisions apply to trusts carrying out a multiple employer welfare
15 arrangement:
16 “(a) ORS 705.137, 705.138 and 705.139.
17 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
18 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
19 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804, 731.808 and 731.844 to
20 731.992.
21 “(c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.
22 “(d) ORS 734.014 to 734.440.
23 “(e) ORS 742.001 to 742.009, 742.013, 742.016, 742.061 and 742.065.
24 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023, 743.028, 743.029,
25 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and 743B.221.
26 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040,
27 743A.048, 743A.051, 743A.052, 743A.058, 743A.060, 743A.062, 743A.063, 743A.064, 743A.065, 743A.066,
28 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105,
29 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148, 743A.150, 743A.160, 743A.168, 743A.169,
30 743A.170, 743A.175, 743A.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260
31 and 743A.310 and section 2, chapter 70, Oregon Laws 2024.
32 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197,
33 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,
34 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340,
35 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
36 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 and section 2,
37 chapter 24, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.
38 “(i) The following provisions of ORS chapter 744:
39 “(A) ORS 744.052 to 744.089, 744.091 and 744.093, relating to the regulation of insurance pro-
40 ducers;
41 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance consultants; and
42 “(C) ORS 744.700 to 744.740, relating to the regulation of third party administrators.
43 “(j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.
44 “(2) For the purposes of this section:
45 “(a) A trust carrying out a multiple employer welfare arrangement is an insurer.

1 “(b) References to certificates of authority are references to certificates of multiple employer
2 welfare arrangement.

3 “(c) Contributions are premiums.

4 “(3) The provision of health benefits under ORS 750.301 to 750.341 is the transaction of health
5 insurance.

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

8 “**SECTION 11. Sections 2 and 3 of this 2025 Act are added to and made a part of the In-**
9 **surance Code.**

10 “**SECTION 12. Section 3 of this 2025 Act and the amendments to ORS 750.055 and 750.333**
11 **by sections 7, 8 and 10 of this 2025 Act become operative on January 1, 2027.”.**