HB 3134-1
(LC 3683)
3/5/25 (EKJ/ps)

Requested by Representative NOSSE

PROPOSED AMENDMENTS TO
HOUSE BILL 3134

On page 1 of the printed bill, line 2, after "amending" delete the rest of the line and line 3 and insert: "ORS 243.144, 243.877, 414.072, 743B.001, 743B.250, 743B.420, 743B.423, 750.055 and 750.333."

Delete lines 5 through 27.

Delete pages 2 through 12 and insert:

"**PRIOR AUTHORIZATION**

"SECTION 1. ORS 743B.420 is amended to read:

"743B.420. Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:

"(1) Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than [*60 days*] **12 months** prior to the date the service is provided.

"(2) Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained [*no more than five business days*] prior to the date the service is provided.

"SECTION 2. ORS 743B.423 is amended to read:

"743B.423. (1) All insurers offering a health benefit plan **or dental-only plan** in this state that [*provide*] **require** utilization review or have utilization review provided on their behalf **by a third party** shall file an annual

summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

"(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

"(a) In addition to the requirements of ORS 743B.602, in establishing utilization review, the insurer must use clinical review criteria that are evidence-based and continuously updated based on new evidence and research, and take into account new developments in treatment.

"(b) The insurer must adjudicate claims for reimbursement in accordance with ORS 743B.450 based on the information submitted by the provider and may not require the provider to resubmit the information.

"(c) The criteria and the process used in the utilization review and the method of development of the criteria must be made available for review to contracting providers.

"(d) The insurer must have a website where:

"(A) The following information is clearly posted **in a form that is easily accessible to providers and beneficiaries, written in plain language, clearly understandable and searchable**:

"(i) All requirements for requesting coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, including **clinical criteria and** the specific documentation required for a request to be considered complete.

"(ii) A list of the specific treatments, drugs, devices or diagnostic or laboratory tests that are subject to utilization review.

"(B) A provider can make a secure electronic submission, meeting industry standards for privacy, of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, along with needed forms and documents, and receive an electronic acknowl-

edgement of receipt of the request.

"(e) If the insurer deems as incomplete a request made for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, the insurer must inform the provider of the specific information needed for the request to be considered complete.

"(f) The insurer must use a physician licensed under ORS 677.100 to 677.228 to make all final recommendations regarding coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review and to consult as needed.

"(g) The insurer must give a provider notice in writing of a denial of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review. The notice must be written in plain language, be understandable to providers and patients, [*and*] include the specific reason for the denial based on evidence-based, peer-reviewed literature **and state what other services would be covered, including a cost analysis of the alternative service**. If the denial is based on terms in a policy or certificate of insurance, the denial must cite the specific language in the policy or certificate.

"(h) The insurer must make available to any provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

"(i) Except as provided in paragraph (j) of this subsection **and section 9 of this 2025 Act**, an insurer must issue a determination on a provider's or [*an enrollee's*] **a beneficiary's** request for coverage of a nonemergency treatment, drug, device or diagnostic or laboratory test that is subject to utilization review within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued

length of stay.

"(j) If the insurer requires additional information from [*an enrollee*] **a beneficiary** or a provider to make a determination on a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, no later than two business days after receipt of the request, the insurer shall notify the [*enrollee*] **beneficiary** and the provider in writing of the additional information needed to make the determination. The insurer shall issue the determination by the later of:

"(A) Two business days after receipt of a response from the provider or [*enrollee*] **beneficiary** to the request for additional information; or

"(B) Fifteen days after the date of the request for additional information.

"(k) If a change in a drug formulary or other change in coverage impacts the coverage of any [*enrollee's*] **beneficiary's** treatment plan and the [*enrollee*] **beneficiary** has been stabilized on the treatment plan for at least 90 days, the insurer must continue to provide coverage of the treatment until utilization review and all internal appeals and external reviews are completed.

"(L) The insurer may not alter utilization review requirements, or initiate or implement new utilization review requirements, without giving a 60-day advance notice to all participating providers.

"(m) In addition to the requirements of ORS 743B.420, an approved request for coverage of a treatment, other than a prescription drug, shall be binding on the insurer for a period ending on the later of the following:

"(A) The reasonable duration of the treatment based on clinical standards; or

"(B) [*Sixty days*] **Twelve months** after the date that the treatment begins following approval of prior authorization.

"(n) Except as provided in paragraph (o) of this subsection, an approved request for coverage of a prescription drug shall be binding on the insurer for one year from the date that the treatment begins following approval of

the request [*if the drug:*]

"[*(A) Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;*]

"[*(B) Continues to be prescribed throughout the 12-month period; and*]

"[*(C)(i) Is prescribed for a condition that is within the scope of use for the drug as approved by the United States Food and Drug Administration; or*]

"[*(ii) Has been proven to be a safe and effective form of treatment for the enrollee's medical condition based on clinical practice guidelines developed from peer-reviewed medical literature*].

"(o) Paragraph (n) of this subsection does not apply if:

"(A) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

"(B) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

"**(p) Notwithstanding paragraphs (m), (n) and (o) of this subsection, an approved request for coverage of a prescription drug or treatment of a degenerative disease or condition shall be binding on the insurer until either the disease or condition is cured or the death of the patient occurs.**

"[*(p)*] **(q)** Paragraphs (k), (m)**, (n)** and [*(n)*] **(p)** of this subsection do not require an insurer to reimburse the cost of care for a patient who is no longer enrolled in the health benefit plan **or dental-only plan** offered by the insurer.

"SECTION 3. An insurer offering a health benefit plan that requires prior authorization for surgical procedures:

"(1) May not require prior authorization for an additional or related health care procedure that is identified during the authorized surgical procedure if:

"(a) The provider, while providing an approved surgical procedure, determines, in accordance with generally accepted standards of medical practice, that providing a related health care procedure, instead of or in addition to the approved surgical procedure, is medically necessary and, in the provider's judgment, to interrupt or delay the provision of care in order to obtain prior authorization for the additional or related health care procedure would not be medically advisable;

"(b) The additional or related health care procedure is a covered benefit under the enrollee's health benefit plan; and

"(c) The additional or related health care procedure is not experimental or for investigation purposes.

(2) The insurer shall complete a review of the additional or related health care procedure within 30 days from the day the procedure was performed. The review shall be completed by a medical professional with the same medical speciality as the provider who performed the procedure.

"SECTION 4. (1) All insurers offering a health benefit plan or dental-only plan in this state that provide utilization review or have utilization review provided on their behalf shall utilize a prior authorization application programming interface that meets the requirements described in 45 C.F.R. 170.215(a). The application programming interface shall enable a provider to:

"(a) Determine whether prior authorization is required;

"(b) Identify the information and documentation necessary to submit the request; and

"(c) Transfer prior authorization requests and determinations from the provider's electronic health records or practice management system through a secure electronic transmission.

"(2) An insurer shall respond through the application programming interface described in subsection (1) of this section to a request that

was submitted by a provider through the application programming interface.

"SECTION 5. ORS 743B.250 is amended to read:

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

"(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

"(a) The insurer's written policy on the rights of enrollees, including the right:

"(A) To participate in decision making regarding the enrollee's health care.

"(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

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

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

"(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the Department of Consumer and Business Services by rule, and must include:

"(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

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

"(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

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

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

"(d) A summary of the insurer's policies on prescription drugs, including:

"(A) Cost-sharing differentials;

"(B) Restrictions on coverage;

"(C) Prescription drug formularies;

"(D) Procedures by which a provider with prescribing authority may prescribe clinically appropriate drugs not included on the formulary;

"(E) Procedures for the coverage of clinically appropriate prescription drugs not included on the formulary; and

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

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

"(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

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

"(h) Restrictions on services obtained outside of the insurer's network or service area.

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

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

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

"(L) Procedures, if any, for changing providers.

"(m) Procedures, if any, by which enrollees may participate in the devel-

opment of the insurer's corporate policies.

"(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment.

"(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

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

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

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

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

"(a) Timely notice of adverse benefit determinations.

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

"(c) Written decisions.

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

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

"(A) Two levels of internal appeal, a person who was involved in the

consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

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

"(f)(A) An external review that meets the requirements of ORS 743B.252, 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

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

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

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

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

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

"(3) Establish procedures for notifying affected enrollees of:

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

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

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

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

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

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

"(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

"(c) Information about the insurer's procedures for credentialing network providers.

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

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

"(a) Notices and claims associated with each grievance.

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

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

"(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

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

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

"(8) Provide to the department, in the format prescribed by the depart-

ment, **and post to the insurer's publicly accessible website,** an annual summary of the insurer's aggregate data regarding:

"(a) Grievances;

"(b) Internal appeals;

"(c) Requests for external review; and

"(d) The following information about requests for prior authorization received by the insurer:

"(A) The number of requests received **in the following service categories:**

"(i) Medical procedures;

"(ii) Diagnostic testing and images;

"(iii) Prescription drugs; and

"(iv) Other prior authorization requests;

"(B) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or failure to provide additional clinical information requested by the insurer;

"(C) The number of requests that were initially approved; [*and*]

"(D) The number of denials that were reversed by internal appeals or external reviews[.]**; and**

"(E) The number of days it took to approve or deny a request.

"(9) Allow the exercise of any rights described in this section or ORS 743B.252 or 743B.255 by an authorized representative.

"(10) Procedures adopted under subsection (2) of this section for health benefit plans other than grandfathered health plans must be consistent with 42 U.S.C. 300-gg-19 and rules adopted by the United States Department of Health and Human Services implementing 42 U.S.C. 300-gg-19.

"(11) An adverse benefit determination under subsection (2)(a) of this section that is provided to an enrollee in a health benefit plan other than a grandfathered health plan must:

"(a) Be provided in a culturally and linguistically appropriate manner;

"(b) Be consistent with federal requirements regarding the manner and content for notices of benefit determinations and federal requirements for the full and fair review of adverse benefit determinations; and

"(c) Include the information required by subsection (4) of this section and:

"(A) Information sufficient to identify the claim involved, the date of services, the health care provider and, if applicable, the claim amount;

"(B) A statement describing the availability, upon request, of the information described in subsection (12) of this section;

"(C) The specific reason for the adverse benefit determination, a reference to the specific plan provisions on which the determination is based, the denial code and the meaning of the denial code and a description of the standard that was used to make the determination, if any;

"(D) A description of available internal appeals and external reviews, including expedited appeals and reviews, and instructions on how to initiate an appeal or review; and

"(E) Contact information for the office of consumer assistance within the Department of Consumer and Business Services.

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

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

"(a) An explanation and discussion of the decision to uphold the initial adverse benefit determination; and

"(b) An authorization form, or other document that complies with state

and federal privacy laws and is approved by the department, with which an enrollee that requests an external review under ORS 743B.255 may authorize the insurer and the enrollee's treating health care provider to disclose medical records or other protected health information pertinent to the external review.

"**(14) Annually review the health care services, including procedures, prescription drugs and diagnostic services, that are subject to utilization review and remove the utilization review requirement for any health care service that interferes with access to quality health care, does not reduce health care disparities or is primarily for the economic benefit of the insurer. Each insurer shall submit an annual report to the department affirming that this review has occurred and indicating which utilization review requirements have been removed.**

"SECTION 6. ORS 414.072 is amended to read:

"414.072. (1) As used in this section, 'coordinated care organization' has the meaning given that term in ORS 414.025.

"(2) The Oregon Health Authority shall compile and annually post to the authority's website a report of the following information, in the aggregate, that was reported to the authority by coordinated care organizations regarding requests for prior authorization received by coordinated care organizations or risk-bearing entities acting for or in concert with coordinated care organizations:

"(a) The number of requests received;

"(b) The number of requests that were initially denied and the reasons for the denials, including, but not limited to, lack of medical necessity or incomplete requests; [*and*]

"(c) The number of denials that were reversed on an appeal[.]**; and**

"**(d) The number of days it took to approve or deny a request.**

"**PRIOR AUTHORIZATION REDUCTION PROGRAM**

"SECTION 7. An insurer offering a health benefit plan or dental-only plan in this state shall institute a Prior Authorization Reduction Program as described in section 8 of this 2025 Act no later than July 1, 2026. The intent of this program is to eliminate or substantially modify prior authorization requirements and reduce administrative burdens for providers.

"SECTION 8. A Prior Authorization Reduction Program shall:

"(1) Be developed by all insurers offering a health benefit plan or dental-only plan in this state that require prior authorization in consultation with in-network providers;

"(2) Define which providers are qualified providers who are eligible to participate in the program;

"(3) Eliminate or substantially modify prior authorization requirements in a manner than reduces the administrative burden for qualified providers and beneficiaries;

"(4) Identify health care services and related benefits that should have prior authorization requirements reduced or eliminated based on:

"(a) The performance of providers with respect to adherence to nationally recognized, evidence-based medical guidelines, appropriateness and efficiency; and

"(b) Provider specialty or experience. Eligibility for the program may not be limited by provider specialty.

"PHYSICAL THERAPIST GROUPS

"SECTION 9. (1) As used in this section:

"(a) 'Chronic pain' means pain that persists or recurs for more than three months.

"(b) 'New episode of care' means treatment for a new or recurring condition that the enrollee has not been treated for by the provider

within the previous 90 days.

"(2) In addition to the requirements of ORS 743B.423 and ORS 743B.602, an insurer offering a health benefit plan that reimburses the cost of physical therapy and requires utilization review may not:

"(a) Require prior authorization for rehabilitative and habilitative services for the first 12 visits for each new episode of care. After the first 12 visits for a new episode of care, an insurer may not require prior authorization more frequently than the longer time period of once every six visits or once every 30 days.

"(b) Require prior authorization for rehabilitative and habilitative services provided to enrollees with chronic pain for the 90 days immediately following the diagnosis of chronic pain. After the 90 days an insurer may not require prior authorization for the longer time period of once every six visits or once every 30 days.

"(c) Deny a request for prior authorization if:

"(A) The carrier did not respond to the prior authorization request in the timeline required in subsection (3) or (4) of this section; or

"(B) The carrier informed the provider or the enrollee that prior authorization is not required either orally or in writing, including via an online platform or as contained in the enrollee's health plan documents.

"(d) Deny a request for coverage of a medically necessary covered benefit when the request is made after the service has been performed on the basis that the request was not made prior to service if the provider or enrollee can demonstrate that the service is medically necessary and is a service that would have been covered with prior authorization.

"(3) Notwithstanding ORS 743B.423, and except as provided in subsection (4) of this section, an insurer must issue a determination on a provider's or enrollee's request for coverage that is subject to utili-

zation review within 24 hours after receipt of the request.

"(4) If the insurer requires additional information from an enrollee or a provider to make a determination on a request for coverage that is subject to utilization review, no later than 24 hours after receipt of the request, the insurer shall notify the enrollee and the provider of the additional information needed to make the determination. The insurer shall issue the determination within 24 hours of receiving the additional information.

"**FUTURE AMENDMENTS**

"**SECTION 10.** ORS 743B.423, as amended by section 2 of this 2025 Act, is amended to read:

"743B.423. (1) All insurers offering a health benefit plan or dental-only plan in this state that require utilization review or have utilization review provided on their behalf by a third party shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

"(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

"(a) In addition to the requirements of ORS 743B.602, in establishing utilization review, the insurer must use clinical review criteria that are evidence-based and continuously updated based on new evidence and research, and take into account new developments in treatment.

"(b) The insurer must adjudicate claims for reimbursement in accordance with ORS 743B.450 based on the information submitted by the provider and may not require the provider to resubmit the information.

"(c) The criteria and the process used in the utilization review and the

method of development of the criteria must be made available for review to contracting providers.

"(d) The insurer must have a website where:

"(A) The following information is clearly posted in a form that is easily accessible to providers and beneficiaries, written in plain language, clearly understandable and searchable:

"(i) All requirements for requesting coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, including clinical criteria and the specific documentation required for a request to be considered complete.

"(ii) A list of the specific treatments, drugs, devices or diagnostic or laboratory tests that are subject to utilization review.

"**(iii) Data on the number of exemptions from prior authorization requirements or alternatives to prior authorization requirements that are available under the Prior Authorization Reduction Program described in section 8 of this 2025 Act, including:**

"(I) The number of providers offered an exemption or alternative requirement, including the providers' specialties;

"(II) The number and categorized types of exemptions or alternative requirements offered to providers; and

"(III) The prescription drug, diagnostic test, procedure or health care service for which an exemption or alternative requirement was offered.

"(B) A provider can make a secure electronic submission, meeting industry standards for privacy, of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review, along with needed forms and documents, and receive an electronic acknowledgement of receipt of the request.

"(e) If the insurer deems as incomplete a request made for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to

utilization review, the insurer must inform the provider of the specific information needed for the request to be considered complete.

"(f) The insurer must use a physician licensed under ORS 677.100 to 677.228 to make all final recommendations regarding coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review and to consult as needed.

"(g) The insurer must give a provider notice in writing of a denial of a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization review. The notice must be written in plain language, be understandable to providers and patients, include the specific reason for the denial based on evidence-based, peer-reviewed literature and state what other services would be covered, including a cost analysis of the alternative service. If the denial is based on terms in a policy or certificate of insurance, the denial must cite the specific language in the policy or certificate.

"(h) The insurer must make available to any provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

"(i) Except as provided in paragraph (j) of this subsection and section 9 of this 2025 Act, an insurer must issue a determination on a provider's or a beneficiary's request for coverage of a nonemergency treatment, drug, device or diagnostic or laboratory test that is subject to utilization review within a reasonable period of time appropriate to the medical circumstances but no later than two business days after receipt of the request, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

"(j) If the insurer requires additional information from a beneficiary or a provider to make a determination on a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to utilization

review, no later than two business days after receipt of the request, the insurer shall notify the beneficiary and the provider in writing of the additional information needed to make the determination. The insurer shall issue the determination by the later of:

"(A) Two business days after receipt of a response from the provider or beneficiary to the request for additional information; or

"(B) Fifteen days after the date of the request for additional information.

"(k) If a change in a drug formulary or other change in coverage impacts the coverage of any beneficiary's treatment plan and the beneficiary has been stabilized on the treatment plan for at least 90 days, the insurer must continue to provide coverage of the treatment until utilization review and all internal appeals and external reviews are completed.

"(L) The insurer may not alter utilization review requirements, or initiate or implement new utilization review requirements, without giving a 60-day advance notice to all participating providers.

"(m) In addition to the requirements of ORS 743B.420, an approved request for coverage of a treatment, other than a prescription drug, shall be binding on the insurer for a period ending on the later of the following:

"(A) The reasonable duration of the treatment based on clinical standards; or

"(B) Twelve months after the date that the treatment begins following approval of prior authorization.

"(n) Except as provided in paragraph (o) of this subsection, an approved request for coverage of a prescription drug shall be binding on the insurer for one year from the date that the treatment begins following approval of the request.

"(o) Paragraph (n) of this subsection does not apply if:

"(A) A therapeutic equivalent of the prescription drug or a generic alternative to the prescription drug is or becomes available as a substitute for the drug for which prior authorization is requested or was approved; or

"(B) A biologic product is or becomes available that is determined by the United States Food and Drug Administration to be interchangeable with the drug for which prior authorization is requested or approved.

"(p) Notwithstanding paragraphs (m), (n) and (o) of this subsection, an approved request for coverage of a prescription drug or treatment of a degenerative disease or condition shall be binding on the insurer until either the disease or condition is cured or the death of the patient occurs.

"(q) Paragraphs (k), (m), (n) and (p) of this subsection do not require an insurer to reimburse the cost of care for a patient who is no longer enrolled in the health benefit plan or dental-only plan offered by the insurer.

"**CONFORMING AMENDMENTS**

"SECTION 11. ORS 243.144, as amended by section 9, chapter 17, Oregon Laws 2024, is amended to read:

"243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743A.140;

"(3) ORS 743A.141;

"(4) ORS 743B.256;

"(5) ORS 743B.287 (4);

"(6) ORS 743B.420;

"(7) ORS 743B.423;

"(8) ORS 743B.601;

"(9) ORS 743B.810;

"(10) ORS 743A.325; [*and*]

"(11) ORS 743A.051 (2)(c)[.]**;**

"(12) ORS 743B.250;

"(13) ORS 743B.602;

"(14) Section 3 of this 2025 Act;

"(15) Section 4 of this 2025 Act;

"(16) Section 7 of this 2025 Act;

"(17) Section 8 of this 2025 Act; and

"(18) Section 9 of this 2025 Act.

"SECTION 12. ORS 243.144, as amended by sections 9 and 10, chapter 17, Oregon Laws 2024, is amended to read:

"243.144. Benefit plans offered by the Public Employees' Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743A.140;

"(3) ORS 743A.141;

"(4) ORS 743B.256;

"(5) ORS 743B.287 (4);

"(6) ORS 743B.420;

"(7) ORS 743B.423;

"(8) ORS 743B.601;

"(9) ORS 743B.810; [*and*]

"(10) ORS 743A.325[.]**;**

"(11) ORS 743B.250;

"(12) ORS 743B.602;

"(13) Section 3 of this 2025 Act;

"(14) Section 4 of this 2025 Act;

"(15) Section 7 of this 2025 Act;

"(16) Section 8 of this 2025 Act; and

"(17) Section 9 of this 2025 Act.

"SECTION 13. ORS 243.877, as amended by section 11, chapter 17, Oregon Laws 2024, is amended to read:

"243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743A.140;

"(3) ORS 743A.141;

"(4) ORS 743B.256;

"(5) ORS 743B.287 (4);

"(6) ORS 743B.420;

"(7) ORS 743B.423;

"(8) ORS 743B.601;

"(9) ORS 743B.810;

"(10) ORS 743A.325; [*and*]

"(11) ORS 743A.051 (2)(c)**;**

"(12) ORS 743B.250;

"(13) ORS 743B.602;

"(14) Section 3 of this 2025 Act;

"(15) Section 4 of this 2025 Act;

"(16) Section 7 of this 2025 Act;

"(17) Section 8 of this 2025 Act; and

"(18) Section 9 of this 2025 Act.

"SECTION 14. ORS 243.877, as amended by sections 11 and 12, chapter 17, Oregon Laws 2024, is amended to read:

"243.877. Benefit plans offered by the Oregon Educators Benefit Board that reimburse the cost of medical and other health services and supplies must comply with the requirements for health benefit plan coverage described in:

"(1) ORS 743A.058;

"(2) ORS 743A.140;

"(3) ORS 743A.141;

"(4) ORS 743B.256;

"(5) ORS 743B.287 (4);

"(6) ORS 743B.420;

"(7) ORS 743B.423;

"(8) ORS 743B.601;

"(9) ORS 743B.810; [*and*]

"(10) ORS 743A.325**;**

"(11) ORS 743B.250;

"(12) ORS 743B.602;

"(13) Section 3 of this 2025 Act;

"(14) Section 4 of this 2025 Act;

"(15) Section 7 of this 2025 Act;

"(16) Section 8 of this 2025 Act; and

"(17) Section 9 of this 2025 Act.

"**SECTION 15.** ORS 743B.001, as amended by section 3, chapter 35, Oregon Laws 2024, is amended to read:

"743B.001. As used in this section and ORS 743.008, 743.029, 743.035, 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423, 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550, 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024**, and sections 3, 4, 7, 8 and 9 of this 2025 Act**:

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

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

"(b) Rescission or cancellation of a policy or certificate;

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

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

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

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

"(2) 'Authorized representative' means an individual who by law or by the consent of a person may act on behalf of the person.

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

"(a) Medical necessity;

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

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

"(4) 'Credit card' has the meaning given that term in 15 U.S.C. 1602.

"(5) 'Electronic funds transfer' has the meaning given that term in ORS 293.525.

"(6) 'Enrollee' has the meaning given that term in ORS 743B.005.

"(7) 'Essential community provider' has the meaning given that term in

rules adopted by the Department of Consumer and Business Services consistent with the description of the term in 42 U.S.C. 18031 and the rules adopted by the United States Department of Health and Human Services, the United States Department of the Treasury or the United States Department of Labor to carry out 42 U.S.C. 18031.

"(8) 'Grievance' means:

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

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

"(B) In writing or orally, for an expedited response described in ORS 743B.250 (2)(d) or an expedited external review; or

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

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

"(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

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

"(9) 'Health benefit plan' has the meaning given that term in ORS 743B.005.

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

"(11) 'Insurer' includes a health care service contractor as defined in ORS 750.005.

"(12) 'Internal appeal' means a review by an insurer of an adverse benefit determination made by the insurer.

"(13) 'Managed health insurance' means any health benefit plan that:

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

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

"(14) 'Medical services contract' means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. 'Medical services contract' does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

"(15)(a) 'Preferred provider organization insurance' means any health benefit plan that:

"(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

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

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

"(b) 'Preferred provider organization insurance' does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision

under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

"(16) 'Prior authorization' means a form of utilization review that requires a provider or an enrollee to request a determination by an insurer, prior to the provision of health care that is subject to utilization review, that the insurer will provide reimbursement for the health care requested. 'Prior authorization' does not include referral approval for evaluation and management services between providers.

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

"(b) With respect to the statutes governing the billing for or payment of claims, 'provider' also includes an employee or other designee of the provider who has the responsibility for billing claims for reimbursement or receiving payments on claims.

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

"(19) 'Utilization review' means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care items, services, procedures or settings.

"SECTION 16. ORS 750.055, as amended by section 3, chapter 24, Oregon Laws 2024, section 4, chapter 35, Oregon Laws 2024, section 21, chapter 70, Oregon Laws 2024, and section 162, chapter 73, Oregon Laws 2024, 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 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, and section 2, chapter 35, Oregon Laws 2024**, and sections 3, 4, 7, 8 and 9 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 17. 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, 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, and section 2, chapter 35, Oregon Laws 2024 **and sections 3, 4, 7, 8 and 9 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 18. ORS 750.333, as amended by section 5, chapter 24, Oregon Laws 2024, and section 23, chapter 70, Oregon Laws 2024, is amended to read:

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

"(a) ORS 705.137, 705.138 and 705.139.

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

"(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.

"(d) ORS 734.014 to 734.440.

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

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

"(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034, 743A.036, 743A.040, 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.180, 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260 and 743A.310 and section 2, chapter 70, Oregon Laws 2024.

"(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127), 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 and section 2, chapter 24, Oregon Laws 2024 **and sections 3, 4, 7, 8 and 9 of this 2025 Act**.

"(i) 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.

"(j) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

"(2) For the purposes of this section:

"(a) A trust carrying out a multiple employer welfare arrangement is an insurer.

"(b) References to certificates of authority are references to certificates of multiple employer welfare arrangement.

"(c) Contributions are premiums.

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

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

"INSURANCE CODE

SECTION 19. Sections 3, 4, 7, 8 and 9 of this 2025 Act are added to and made a part of the Insurance Code.

"CAPTIONS

"SECTION 20. The unit captions used in this 2025 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2025 Act.

"DATES

SECTION 21. (1) The amendments to ORS 743B.420, 743B.423 and 743B.250 by sections 1, 2 and 5 of this 2025 Act apply to health benefit plans and dental-only plans issued, renewed or extended on or after January 1, 2026.

"(2) The amendments to ORS 750.055 and 750.333 by sections 16, 17 and 18 of this 2025 Act apply to health care service contracts and multiple employer welfare arrangements issued, renewed or extended on or after January 1, 2026.

"(3) The amendments to ORS 243.144 by sections 11 and 12 of this 2025 Act apply to benefit plans issued, renewed or extended on or after January 1, 2026.

"(4) The amendments to ORS 243.877 by sections 13 and 14 of this 2025 Act apply to benefit plans issued, renewed or extended on or after January 1, 2026.

"SECTION 22. The amendments to ORS 743B.423 by section 10 of this 2025 Act become operative July 1, 2026.".

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