

HB 3134-5
(LC 3683)
4/28/25 (EKJ/ps)

Requested by Representative NOSSE

**PROPOSED AMENDMENTS TO
HOUSE BILL 3134**

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

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

“SECTION 1. 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

1 by the Department of Consumer and Business Services by rule, and must
2 include:

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

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

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

12 “(D) A description of the process for filing a complaint with the depart-
13 ment.

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

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

17 “(A) Cost-sharing differentials;

18 “(B) Restrictions on coverage;

19 “(C) Prescription drug formularies;

20 “(D) Procedures by which a provider with prescribing authority may pre-
21 scribe clinically appropriate drugs not included on the formulary;

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

24 “(F) A summary of the criteria for determining whether a drug is exper-
25 imental or investigational.

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

30 “(f) Notice of the enrollee’s right to select a primary care provider and

1 specialty care providers.

2 “(g) How to obtain referrals for specialty care in accordance with ORS
3 743B.227.

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

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

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

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

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

11 “(m) Procedures, if any, by which enrollees may participate in the devel-
12 opment of the insurer’s corporate policies.

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

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

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

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

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

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

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

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

4 “(c) Written decisions.

5 “(d) An expedited response to a request for an internal appeal that ac-
6 commodates the clinical urgency of the situation.

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

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

14 “(B) No more than one level of internal appeal, a person who was in-
15 volved in the consideration of the initial denial may not be involved in the
16 internal appeal.

17 “(f)(A) An external review that meets the requirements of ORS 743B.252,
18 743B.254 and 743B.255, after the enrollee has exhausted internal appeals or
19 after the enrollee has been deemed to have exhausted internal appeals.

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

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

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

28 “(A) Submit for consideration by the insurer any written comments, doc-
29 uments, records and other materials relating to the adverse benefit determi-
30 nation; and

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

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

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

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

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

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

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

14 “(a) The insurer’s annual report on grievances and internal appeals sub-
15 mitted to the department under subsection (8) of this section.

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

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

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

27 “(7) Maintain for a period of at least six years written records that doc-
28 ument all grievances described in ORS 743B.001 (8)(a) and make the written
29 records available for examination by the department or by an enrollee or
30 authorized representative of an enrollee with respect to a grievance made

1 by the enrollee. The written records must include but are not limited to the
2 following:

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

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

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

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

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

9 “(f) The name of the covered person for whom the grievance was submit-
10 ted.

11 “(8) Provide to the department, in the format prescribed by the depart-
12 ment, an annual summary of the insurer’s aggregate data regarding:

13 “(a) Grievances;

14 “(b) Internal appeals;

15 “(c) Requests for external review; and

16 “(d) The following information, **which shall be published by the de-**
17 **partment, in a format that does not identify the insurer, to the**
18 **department’s website no later than March 1 of each calendar year,**
19 about requests for prior authorization received by the insurer:

20 “[A] *The number of requests received;*]

21 “[B] *The number of requests that were initially denied and the reasons for*
22 *the denials, including, but not limited to, lack of medical necessity or failure*
23 *to provide additional clinical information requested by the insurer;*]

24 “[C] *The number of requests that were initially approved; and]*

25 “[D] *The number of denials that were reversed by internal appeals or ex-*
26 *ternal reviews.]*

27 “(A) **The percentage and number of standard prior authorization**
28 **requests that were approved;**

29 “(B) **The percentage and number of standard prior authorization**
30 **requests that were denied;**

1 “(C) The percentage and number of standard prior authorization
2 requests that were approved after appeal;

3 “(D) The percentage and number of all prior authorization requests
4 for which the time frame for review was extended and the request was
5 approved;

6 “(E) The percentage and number of expedited prior authorization
7 requests that were approved;

8 “(F) The percentage and number of expedited prior authorization
9 requests that were denied;

10 “(G) The average and median times that elapsed between the sub-
11 mission of a request and a determination by the insurer for standard
12 prior authorization; and

13 “(H) The average and median times that elapsed between the sub-
14 mission of a request and a decision by the insurer for expedited prior
15 authorization.

16 “(9) Allow the exercise of any rights described in this section or ORS
17 743B.252 or 743B.255 by an authorized representative.

18 “(10) Procedures adopted under subsection (2) of this section for health
19 benefit plans other than grandfathered health plans must be consistent with
20 42 U.S.C. 300-gg-19 and rules adopted by the United States Department of
21 Health and Human Services implementing 42 U.S.C. 300-gg-19.

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

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

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

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

30 “(A) Information sufficient to identify the claim involved, the date of

1 services, the health care provider and, if applicable, the claim amount;

2 “(B) A statement describing the availability, upon request, of the infor-
3 mation described in subsection (12) of this section;

4 “(C) The specific reason for the adverse benefit determination, a reference
5 to the specific plan provisions on which the determination is based, the de-
6 nial code and the meaning of the denial code and a description of the
7 standard that was used to make the determination, if any;

8 “(D) A description of available internal appeals and external reviews, in-
9 cluding expedited appeals and reviews, and instructions on how to initiate
10 an appeal or review; and

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

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

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

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

25 “(b) An authorization form, or other document that complies with state
26 and federal privacy laws and is approved by the department, with which an
27 enrollee that requests an external review under ORS 743B.255 may authorize
28 the insurer and the enrollee’s treating health care provider to disclose med-
29 ical records or other protected health information pertinent to the external
30 review.

1 “(14) As used in this section:

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

5 “(b) ‘Standard prior authorization’ means a prior authorization re-
6 quest that is not an expedited prior authorization request.

7 “SECTION 2. An insurer offering a health benefit plan that requires
8 prior authorization for surgical procedures may not require prior au-
9 thorization for an additional or related health care procedure that is
10 identified during the authorized surgical procedure if:

11 “(1) The provider, while providing an approved surgical procedure,
12 identifies a medical condition, disease or ailment that was not identi-
13 fied in the prior authorization request and, in accordance with gener-
14 ally accepted standards of medical practice, determines that
15 performing a related health care procedure, instead of or in addition
16 to the approved surgical procedure, is medically necessary and, in the
17 provider’s judgment, to interrupt or delay the provision of care in or-
18 der to obtain prior authorization for the additional or related health
19 care procedure would not be medically advisable;

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

22 “(3) The additional or related health care procedure is not exper-
23 imental or for investigation purposes.

24 “SECTION 3. (1) An insurer offering a health benefit plan in this
25 state that provides utilization review or has utilization review provided
26 on the insurer’s behalf shall utilize a prior authorization application
27 programming interface as described in 45 C.F.R. 156.223(b), as in effect
28 on February 28, 2024. The application programming interface shall en-
29 able a provider to:

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

1 “(b) Identify the information and documentation necessary to sub-
2 mit the request; and

3 “(c) Transfer prior authorization requests and determinations from
4 the provider’s electronic health records or practice management sys-
5 tem through a secure electronic transmission.

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

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

12 “743B.001. As used in this section and ORS 743.008, 743.029, 743.035,
13 743A.190, 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.225,
14 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
15 743B.258, 743B.310, 743B.400, 743B.403, 743B.405, 743B.420, 743B.422, 743B.423,
16 743B.424, 743B.450, 743B.451, 743B.452, 743B.453, 743B.454, 743B.505, 743B.550,
17 743B.555 and 743B.602 and section 2, chapter 35, Oregon Laws 2024, **and**
18 **sections 2 and 3 of this 2025 Act:**

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

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

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

26 “(c) Imposition of a preexisting condition exclusion as defined in ORS
27 743B.005, source-of-injury exclusion, network exclusion, annual benefit limit
28 or other limitation on otherwise covered items or services;

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

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

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

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

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

13 “(a) Medical necessity;

14 “(b) Appropriateness of an item or health service for which prior author-
15 ization is requested or for which an exception to step therapy has been re-
16 quested as described in ORS 743B.602; or

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

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

19 “(5) ‘Electronic funds transfer’ has the meaning given that term in ORS
20 293.525.

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

22 “(7) ‘Essential community provider’ has the meaning given that term in
23 rules adopted by the Department of Consumer and Business Services con-
24 sistent with the description of the term in 42 U.S.C. 18031 and the rules
25 adopted by the United States Department of Health and Human Services, the
26 United States Department of the Treasury or the United States Department
27 of Labor to carry out 42 U.S.C. 18031.

28 “(8) ‘Grievance’ means:

29 “(a) A communication from an enrollee or an authorized representative
30 of an enrollee expressing dissatisfaction with an adverse benefit determi-

1 nation, without specifically declining any right to appeal or review, that is:

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

3 “(B) In writing or orally, for an expedited response described in ORS
4 743B.250 (2)(d) or an expedited external review; or

5 “(b) A written complaint submitted by an enrollee or an authorized rep-
6 resentative of an enrollee regarding the:

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

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

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

13 “(9) ‘Health benefit plan’ has the meaning given that term in ORS
14 743B.005.

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

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

23 “(12) ‘Internal appeal’ means a review by an insurer of an adverse benefit
24 determination made 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 pro-
27 viders managed, owned, under contract with or employed by the insurer in
28 order to receive benefits under the plan, except for emergency or other
29 specified limited service; or

30 “(b) In addition to the requirements of paragraph (a) of this subsection,

1 offers a point-of-service provision that allows an enrollee to use providers
2 outside of the specified network or networks at the option of the enrollee
3 and receive a reduced level of benefits.

4 “(14) ‘Medical services contract’ means a contract between an insurer and
5 an independent practice association, between an insurer and a provider, be-
6 tween an independent practice association and a provider or organization of
7 providers, between medical or mental health clinics, and between a medical
8 or mental health clinic and a provider to provide medical or mental health
9 services. ‘Medical services contract’ does not include a contract of employ-
10 ment or a contract creating legal entities and ownership thereof that are
11 authorized under ORS chapter 58, 60 or 70, or other similar professional or-
12 ganizations permitted by statute.

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

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

17 “(B) Does not require an enrollee to use the preferred network of pro-
18 viders in order to receive benefits under the plan; and

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

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

26 “(16) ‘Prior authorization’ means a form of utilization review that re-
27 quires a provider or an enrollee to request a determination by an insurer,
28 prior to the provision of health care that is subject to utilization review, that
29 the insurer will provide reimbursement for the health care requested. ‘Prior
30 authorization’ does not include referral approval for evaluation and man-

1 agement services between providers.

2 “(17)(a) ‘Provider’ means a person licensed, certified or otherwise author-
3 ized or permitted by laws of this state to administer medical or mental health
4 services in the ordinary course of business or practice of a profession.

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

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

13 “(19) ‘Utilization review’ means a set of formal techniques used by an
14 insurer or delegated by the insurer designed to monitor the use of or evalu-
15 ate the medical necessity, appropriateness, efficacy or efficiency of health
16 care items, services, procedures or settings.

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

21 “750.055. (1) The following provisions apply to health care service con-
22 tractors to the extent not inconsistent with the express provisions of ORS
23 750.005 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,
26 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
27 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
28 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
29 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

30 “(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 section 2 of this 2025 Act.**

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

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

3 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
4 sultants; and

5 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
6 ministrators.

7 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
8 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
9 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

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

30 “(6) The Director of the Department of Consumer and Business Services

1 may, after notice and hearing, adopt reasonable rules not inconsistent with
2 this section and ORS 750.003, 750.005, 750.025 and 750.045 that are necessary
3 for the proper administration of these provisions.

4 **“SECTION 6.** ORS 750.055, as amended by section 21, chapter 771, Oregon
5 Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45,
6 Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chap-
7 ter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section
8 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws
9 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206,
10 Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22,
11 chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018,
12 section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon
13 Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97,
14 Oregon Laws 2021, section 12, chapter 37, Oregon Laws 2022, section 5,
15 chapter 111, Oregon Laws 2023, section 2, chapter 152, Oregon Laws 2023,
16 section 4, chapter 24, Oregon Laws 2024, section 5, chapter 35, Oregon Laws
17 2024, section 22, chapter 70, Oregon Laws 2024, and section 163, chapter 73,
18 Oregon Laws 2024, is amended to read:

19 “750.055. (1) The following provisions apply to health care service con-
20 tractors to the extent not inconsistent with the express provisions of ORS
21 750.005 to 750.095:

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

23 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,
24 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
25 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
26 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
27 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

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

30 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to

1 733.680 and 733.695 to 733.780.

2 “(e) ORS 734.014 to 734.440.

3 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to
4 742.162 and 742.518 to 742.542.

5 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022,
6 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to
7 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,
8 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680
9 to 743.689, 743.788 and 743.790.

10 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,
11 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
12 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
13 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
14 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,
15 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.175, 743A.185,
16 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260, 743A.310 and
17 743A.315 and section 2, chapter 70, Oregon Laws 2024.

18 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195,
19 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225,
20 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
21 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320,
22 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347,
23 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452,
24 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602
25 and 743B.800 and section 2, chapter 24, Oregon Laws 2024, [and] section 2,
26 chapter 35, Oregon Laws 2024, **and section 2 of this 2025 Act.**

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

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

30 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-

1 sultants; and

2 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
3 ministrators.

4 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
5 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
6 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

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

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

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

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

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

5 “750.055. (1) The following provisions apply to health care service con-
6 tractors to the extent not inconsistent with the express provisions of ORS
7 750.005 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,
10 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-
11 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,
12 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,
13 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

14 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and
15 732.517 to 732.596, not including ORS 732.582, and ORS 732.650 to 732.689.

16 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to
17 733.680 and 733.695 to 733.780.

18 “(e) ORS 734.014 to 734.440.

19 “(f) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to
20 742.162 and 742.518 to 742.542.

21 “(g) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.022,
22 743.023, 743.025, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to
23 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,
24 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680
25 to 743.689, 743.788 and 743.790.

26 “(h) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,
27 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
28 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
29 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
30 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,

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

5 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195,
6 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225,
7 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
8 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320,
9 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347,
10 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452,
11 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602
12 and 743B.800 and section 2, chapter 24, Oregon Laws 2024, section 2, chapter
13 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

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

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

17 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
18 sultants; and

19 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
20 ministrators.

21 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
22 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
23 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

30 “(b) ORS 743A.024, unless the patient is referred by a physician, physician

1 associate or nurse practitioner associated with a group practice health
2 maintenance organization.

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

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

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

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

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

18 **“SECTION 8.** ORS 750.055, as amended by section 21, chapter 771, Oregon
19 Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45,
20 Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chap-
21 ter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section
22 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws
23 2015, section 30, chapter 515, Oregon Laws 2015, section 10, chapter 206,
24 Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, section 22,
25 chapter 479, Oregon Laws 2017, section 10, chapter 7, Oregon Laws 2018,
26 section 69, chapter 13, Oregon Laws 2019, section 38, chapter 151, Oregon
27 Laws 2019, section 5, chapter 441, Oregon Laws 2019, section 85, chapter 97,
28 Oregon Laws 2021, section 12, chapter 37, Oregon Laws 2022, section 5,
29 chapter 111, Oregon Laws 2023, section 2, chapter 152, Oregon Laws 2023,
30 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

1 743A.315 and section 2, chapter 70, Oregon Laws 2024.

2 “(i) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195,
3 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.221, 743B.222, 743B.225,
4 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
5 743B.258, 743B.280 to 743B.285, 743B.287, 743B.300, 743B.310, 743B.320,
6 743B.323, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343 to 743B.347,
7 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.450, 743B.451, 743B.452,
8 743B.453, 743B.470, 743B.475, 743B.505, 743B.550, 743B.555, 743B.601, 743B.602
9 and 743B.800 and section 2, chapter 24, Oregon Laws 2024, section 2, chapter
10 35, Oregon Laws 2024, and [section 2] **sections 2 and 3** of this 2025 Act.

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

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

14 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
15 sultants; and

16 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
17 ministrators.

18 “(k) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,
19 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,
20 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

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

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

1 insurers.

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

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

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

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

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

17 “750.333. (1) The following provisions apply to trusts carrying out a mul-
18 tiple employer welfare arrangement:

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

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

24 “(c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680
25 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,
29 743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and
30 743B.221.

1 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034,
2 743A.036, 743A.040, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
3 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
4 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
5 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,
6 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.175, 743A.180,
7 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260 and
8 743A.310 and section 2, chapter 70, Oregon Laws 2024.

9 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127),
10 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225,
11 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
12 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342,
13 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
14 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and
15 743B.601 and section 2, chapter 24, Oregon Laws 2024, **and section 2 of this**
16 **2025 Act.**

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

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

20 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
21 sultants; and

22 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
23 ministrators.

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

25 “(2) For the purposes of this section:

26 “(a) A trust carrying out a multiple employer welfare arrangement is an
27 insurer.

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

30 “(c) Contributions are premiums.

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

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

5 **“SECTION 10.** ORS 750.333, as amended by section 5, chapter 24, Oregon
6 Laws 2024, and section 23, chapter 70, Oregon Laws 2024, and section 9 of
7 this 2025 Act, is amended to read:

8 “750.333. (1) The following provisions apply to trusts carrying out a mul-
9 tiple employer welfare arrangement:

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

11 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316,
12 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414,
13 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620,
14 731.640 to 731.652, 731.804, 731.808 and 731.844 to 731.992.

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

17 “(d) ORS 734.014 to 734.440.

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

19 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023,
20 743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526, 743.535 and
21 743B.221.

22 “(g) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.024, 743A.034,
23 743A.036, 743A.040, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,
24 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,
25 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,
26 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,
27 743A.150, 743A.160, 743A.168, 743A.169, 743A.170, 743A.175, 743A.180,
28 743A.185, 743A.188, 743A.190, 743A.192, 743A.250, 743A.252, 743A.260 and
29 743A.310 and section 2, chapter 70, Oregon Laws 2024.

30 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127),

1 743B.195, 743B.197, 743B.200, 743B.202, 743B.204, 743B.220, 743B.222, 743B.225,
2 743B.227, 743B.250, 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257,
3 743B.258, 743B.310, 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342,
4 743B.343, 743B.344, 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,
5 743B.423, 743B.451, 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and
6 743B.601 and section 2, chapter 24, Oregon Laws 2024, and [section 2]
7 **sections 2 and 3** of this 2025 Act.

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

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

11 “(B) ORS 744.602 to 744.665, relating to the regulation of insurance con-
12 sultants; and

13 “(C) ORS 744.700 to 744.740, relating to the regulation of third party ad-
14 ministrators.

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

16 “(2) For the purposes of this section:

17 “(a) A trust carrying out a multiple employer welfare arrangement is an
18 insurer.

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

21 “(c) Contributions are premiums.

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

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

26 **“SECTION 11. Sections 2 and 3 of this 2025 Act are added to and**
27 **made a part of the Insurance Code.**

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

