Enrolled
House Bill 3126

Sponsored by Representatives WITT, KRUMMEL; Representatives KNOPP, NOLAN

CHAPTER .....

AN ACT

Relating to insurance; creating new provisions; amending ORS 652.710, 653.715, 653.745, 731.486, 742.003, 743.417, 743.420, 743.522, 743.560, 743.730, 743.737, 743.754 and 743.766; and declaring an emergency.

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

SECTION 1. ORS 731.486 is amended to read:

731.486. (1) The exemption in ORS 731.146 (2)(b) does not apply to an insurer that offers coverage under a group health insurance policy or a group life insurance policy in this state unless the Director of the Department of Consumer and Business Services determines that the exemption applies.

(2) The insurer shall submit evidence to the director that the exemption applies. When a master policy is delivered or issued for delivery outside this state to trustees of a fund for two or more employers, for one or more labor unions, for one or more employers and one or more labor unions or for an association, the insurer shall also submit evidence showing compliance with:

(a) ORS 743.526, for a policy of group health insurance; or

(b) ORS 743.354, for a policy of group life insurance.

(3) The director shall review the evidence submitted and may request additional evidence as needed.

(4) An insurer shall submit to the director any changes in the evidence submitted under subsection (2) of this section.

(5) The director may order an insurer to cease offering a policy or coverage under a policy if the director determines that the exemption under ORS 731.146 (2)(b) is no longer satisfied.

(6) Coverage under a master group life or health insurance policy delivered or issued for delivery outside this state that does not qualify for the exemption in ORS 731.146 (2)(b) may be offered in this state if the director determines that the state in which the policy was delivered or issued for delivery has requirements that are substantially similar to those established under section 3 of this 2001 Act or ORS 743.522 (5) and that the policy satisfies those requirements.

[*(6)*] **(7)** This section does not apply to any master policy issued to a multistate employer or labor union.

[*(7)*] **(8)** The director may adopt rules to carry out this section.

SECTION 2. Sections 3, 5 and 8 of this 2001 Act are added to and made a part of ORS chapter 743.

SECTION 3. **(1) Group life insurance coverage offered to a resident in this state under a group life insurance policy issued to a group other than one described in ORS 743.351 or 743.354 may be delivered if:**

(a) The Director of the Department of Consumer and Business Services finds that:

(A) The issuance of the policy is in the best interest of the public;

(B) The issuance of the policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged;

(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both; and

(c) An insurer has the discretion to exclude or limit coverage for a voluntary plan on any person for whom evidence of individual insurability is not satisfactory to the insurer.

(2) The requirements of ORS 743.303 do not apply to a policy authorized under subsection (1) of this section.

SECTION 4. ORS 743.522 is amended to read:

743.522. "Group health insurance" means that form of health insurance covering groups of persons [*as defined*] **described** in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

(1)**(a)** Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. [*The term "employees" as used in this subsection shall be deemed to include*] **As used in this paragraph, "employee" includes:**

(A) The officers, managers, and employees of the employer[,]**;**

(B) The individual proprietor or partners if the employer is an individual proprietor or partnership[,]**;**

(C) The officers, managers, and employees of subsidiary or affiliated corporations[,]**;**

(D) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise[. *The term "employees" as used in this subsection may include retired employees.*]**;**

(E) The trustees or their employees, or both, if their duties are principally connected with such trusteeship; and

(F) The leased workers of a client employer.

(b) A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. [*The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.*]

(2) Under a policy issued to an association, including a labor union, [*which*] **that** has an active existence for at least one year, [*which*] **that** has a constitution and bylaws and [*which*] **that** has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees. [*The term "employees" as used in this subsection may include retired employees.*]

(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subsection (2) of this section, insuring employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used in this subsection may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. [*The term "employees" as used in this subsection may include retired em-*

ployees.] The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.

[*(5) Under a policy issued to cover any other substantially similar group which, in the discretion of the Director of the Department of Consumer and Business Services, may be subject to the issuance of a group health insurance policy.*]

(5) Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsections (1) to (4) of this section may be delivered if:

(a) The Director of the Department of Consumer and Business Services finds that:

(A) The issuance of the policy is in the best interest of the public;

(B) The issuance of the policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged; and

(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both.

(6) As used in this section and section 5 of this 2001 Act:

(a) "Client employer" means an employer to whom workers are provided under contract and for a fee on a leased basis by a worker leasing company licensed under ORS 656.850.

(b) "Leased worker" means a worker provided by a worker leasing company licensed under ORS 656.850.

(c) "Employee" may include a retired employee.

SECTION 5. (1) A leasing company may offer group health insurance to its leased workers. If the leasing company does not offer group health insurance to its leased workers, the client employer may offer group health insurance to the leased workers.

(2) If a leasing company offers group health insurance to its leased workers, the leasing company shall offer group health insurance to all its leased workers in the same manner.

SECTION 6. ORS 743.730 is amended to read:

743.730. As used in ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer and portability health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting conditions provision;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) “Basic health benefit plan” means a health benefit plan for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Consumer and Business Services in accordance with ORS 743.736.

(5) “Bona fide association” means an association that meets the requirements of 42 U.S.C. 300gg-11 as amended and in effect on July 1, 1997.

(6) “Carrier” means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

(7) “Committee” means the Health Insurance Reform Advisory Committee created under ORS 743.745.

(8) “Creditable coverage” means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(9) “Department” means the Department of Consumer and Business Services.

(10) “Dependent” means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(11) “Director” means the Director of the Department of Consumer and Business Services.

(12) “Eligible employee” means an employee of a small employer who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. [*The term*] **“Eligible employee”** includes sole proprietors, partners of a partnership**, leased workers as defined in ORS 743.522** or independent contractors if they are included as employees under a health benefit plan of a small employer but does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

(13) “Enrollee” means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

(14) “Exclusion period” means a period during which specified treatments or services are excluded from coverage.

(15) “Financially impaired” means a member that is not insolvent and is:

(a) Considered by the Director of the Department of Consumer and Business Services to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(16)(a) “Geographic average rate” means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier′s:

(A) Small employer group health benefit plans;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) “Geographic average rate” does not include premium differences that are due to differences in benefit design or family composition.

(17) “Group eligibility waiting period” means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(18)(a) “Health benefit plan” means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) “Health benefit plan” does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers′ compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(19) “Health statement” means any information that is intended to inform the carrier or agent of the health status of an enrollee or prospective enrollee in a health benefit plan. “Health statement” includes the standard health statement developed by the Health Insurance Reform Advisory Committee.

(20) “Implementation of chapter 836, Oregon Laws 1989” means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

(21) “Individual coverage waiting period” means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

(22) “Initial enrollment period” means a period of at least 30 days following commencement of the first eligibility period for an individual.

(23) “Insurance Pool Governing Board” means the Insurance Pool Governing Board established by ORS 653.725.

(24) “Late enrollee” means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997;

(b) The individual applies for coverage during an open enrollment period;

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee′s health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual′s coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

(25) “Multiple employer welfare arrangement” means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(26) “Oregon Medical Insurance Pool” means the pool created under ORS 735.610.

(27) “Preexisting conditions provision” means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diag-

nosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition related to such information; and

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743.707.

(28) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(29) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(30) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 25 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bona fide partnership, independent contractor or employer-employee relationship exists. "Small employer" includes companies that are eligible to file a consolidated tax return pursuant to ORS 317.715.

(31) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one or more small employers. A fully insured multiple employer welfare arrangement otherwise exempt under ORS 750.303 (4) may elect to be a small employer carrier governed by the provisions of ORS 743.733 to 743.737.

SECTION 7. ORS 742.003 is amended to read:

742.003. (1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the Director of the Department of Consumer and Business Services. This section does not apply to:

(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject;

(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder; [*or*]

(c) Forms of group life or health insurance policies, or both, [*which*] **that** have been agreed upon as a result of negotiations between the policyholder and the insurer[.]**; or**

(d) Forms complying with specific requirements regarding delivery or issuance for delivery in this state established by the director by rule.

(2) The director shall within 30 days after the filing of any such form approve or disapprove the form. The director shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

(3) The 30-day period referred to in subsection (2) of this section may be extended by the director for an additional period not to exceed 30 days if the director gives written notice within the first 30-day period to the insurer proposing to deliver the form that the director needs such additional time for the consideration of such form.

(4) The director may at any time request an insurer to furnish the director a copy of any form exempted under subsection (1) of this section.

SECTION 8. Before a health insurer selling an individual policy or group health benefit plan, as defined in ORS 743.730, may cancel a policy for nonpayment of premium, the insurer must mail a separate notice to the policyholder at least 10 days prior to the end of the grace period informing the policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the

applicable grace period required by ORS 743.417 and 743.560. The notice shall be in writing and mailed by first class mail to the last-known address of the policyholder.

SECTION 9. ORS 743.417 is amended to read:

743.417. (1) [*A*] **An individual** health insurance policy shall contain a provision as follows: "GRACE PERIOD: A **minimum** grace period of [___ *(insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days*] **10 days after the premium due date** will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

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

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

SECTION 10. ORS 743.420 is amended to read:

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

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

SECTION 11. ORS 743.560 is amended to read:

743.560. **(1) A group health insurance policy shall contain a provision allowing a minimum grace period of 10 days after the premium due date for payment of premium.**

(2) An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, that seeks to terminate a policy for nonpayment of premium shall notify the policyholder as described in section 8 of this 2001 Act.

[*(1)*] **(3)** An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall notify the group policyholder[*, the Bureau of Labor and Industries and the Department of Consumer and Business Services*] when the policy is terminated and the coverage is not replaced by the group policyholder. The notice required under this subsection:

(a) Must be given on a form prescribed by the Department **of Consumer and Business Services**;

(b) Must explain the rights of the certificate holders regarding continuation of coverage provided by federal and state law and portability coverage in accordance with ORS 743.760; and

(c) Must be given by mail and must be mailed not later than 10 working days after the date on which the group policy terminates according to the terms of the policy.

[*(2)*] **(4)** A group health insurance policy to which subsection [*(1)*] **(3)** of this section applies shall contain a provision requiring the insurer to notify the group policyholder[*, the Bureau of Labor and Industries and the Department of Consumer and Business Services*] when the policy is terminated and the coverage is not replaced by the group policyholder. Each certificate issued under the policy shall also contain a statement of the provision required under this subsection.

[*(3)*] **(5)** If an insurer fails to give notice as required by this section, the insurer shall continue the group health insurance policy of the group policyholder in full force from the date notice should have been provided until the date that the notice is received by the policyholder[*, the Bureau of Labor and Industries and the Department of Consumer and Business Services, whichever date is the latest,*] and shall waive the premiums owing for the period for which the coverage is continued under this subsection. The time period within which the certificate holder may exercise any right to continuation or portability shall commence on the date that the policyholder[*, the Bureau of Labor and Industries and the Department of Consumer and Business Services receive the notice, whichever date is the latest*] **receives the notice**.

[*(4)*] **(6)** The insurer shall supply the employer holding the terminated policy with the necessary information for the employer to be able to notify properly the employee of the employee's right to continuation of coverage under state and federal law and portability coverage in accordance with ORS 743.760.

SECTION 12. ORS 743.737 is amended to read:

743.737. Health benefit plans covering small employers shall be subject to the following provisions:

(1) A preexisting conditions provision in a small employer health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a small employer health benefit plan shall terminate its effect as follows:

(a) For an enrollee, not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Ten months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new small employer health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a small employer health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services, as established by the Health Insurance Reform Advisory Committee, applicable to all individuals enrolling for the first time in the small employer health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder except:

(a) For nonpayment of the required premiums by the policyholder, small employer or contract holder.

(b) For fraud or misrepresentation of the policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

(c) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) For noncompliance with the small employer carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

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

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

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

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the small employer market in this state or in the specified service area.

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

(A) Must give notice to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all health benefit plans that the carrier offers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

(C) Offer the plans at least [*180*] **90** days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(i) When, in the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(j) When, in the case of a health benefit plan that is offered in the small employer market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A small employer carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(6) Notwithstanding any provision of subsection (5) of this section to the contrary, any small employer carrier health benefit plan subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(7) A small employer carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan.

(8) Premium rates for small employer health benefit plans subject to ORS 743.733 to 743.737 shall be subject to the following provisions:

(a) Each small employer carrier issuing health benefit plans to small employers must file its geographic average rate for a rating period with the director on or before March 15 of each year.

(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers shall not vary from the geographic average rate by more than the following:

(i) 50 percent on October 1, 1996; and

(ii) 33 percent on October 1, 1999.

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on differences in the ages of participating employees, except that the premium rate may be adjusted to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition. In addition:

(i) A small employer carrier shall apply uniformly the carrier's schedule of age adjustments for small employer groups as approved by the director; and

(ii) Except as otherwise provided in this section, the premium rate established for a health benefit plan by a small employer carrier shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) The variation in premium rates between different small employer health benefit plans offered by a small employer carrier must be based solely on objective differences in plan design or coverage and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase

in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age, except an additional adjustment may be made to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition.

(e) Premium rates for health benefit plans shall comply with the requirements of this section.

(9) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates, and the extent to which the carrier will consider age, family composition and geographic factors in establishing and adjusting rates;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting conditions provision.

(10)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15 an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the small employer carrier are actuarially sound. Each such certification shall be in a uniform form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except in cases of violations of ORS 743.733 to 743.737, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(11) A small employer carrier shall not provide any financial or other incentive to any agent that would encourage such agent to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(12) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

(13) A small employer carrier must include a provision that offers coverage to all eligible employees and to all dependents to the extent the employer chooses to offer coverage to dependents.

(14) All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

(15) All small employer health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277.

SECTION 13. ORS 743.754 is amended to read:

743.754. The following requirements apply to all group health benefit plans covering two or more certificate holders:

(1) A preexisting conditions provision in a group health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of

coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a group health benefit plan shall terminate its effect as follows:

(a) For an enrollee not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Twelve months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all group benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new group health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a group health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the group health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) All group health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

(6) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation of the policyholder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

(c) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) For noncompliance with the carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

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

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

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

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the group market in this state or in the specified service area.

(f) When the carrier discontinues offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health

care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least [*180*] **90** days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(i) When, in the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(j) When, in the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(7) Notwithstanding any provision of subsection (6) of this section to the contrary, a group health benefit plan may be rescinded by a carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(8) A carrier that continues to offer coverage in the group market in this state is not required to offer coverage in all of the carrier's group health benefit plans. If a carrier, however, elects to continue a plan that is closed to new policyholders instead of offering alternative coverage in its other group health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (6) of this section.

(9) All group health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277.

(10) This section applies only to group health benefit plans that are not small employer health benefit plans.

SECTION 14. ORS 743.766 is amended to read:

743.766. (1) All carriers who offer individual health benefit plans and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established by the Health Insurance Reform Advisory Committee and may not use any other method to determine the

health status of an individual. Nothing in this subsection shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the carrier shall not impose exclusions or limitations on coverage greater than:

(A) A preexisting conditions provision that complies with the following requirements:

(i) The provision shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage; and

(ii) The provision shall terminate its effect no later than six months following the individual's effective date of coverage;

(B) An individual coverage waiting period of 90 days; or

(C) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) Pregnancy may constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting conditions provision or an individual coverage waiting period provision, the carrier shall reduce the duration of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.

(5) If a carrier accepts an individual for coverage under an individual health benefit plan, the carrier shall renew the policy except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation by the policyholder.

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

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

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

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

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the individual market in this state or in the specified service area.

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

(A) Must give notice of the decision to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) When the carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more individual health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least [*180*] **90** days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(f) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet its contractual obligations.

(g) When, in the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

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

(i) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide service to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(j) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (c) and (e) of this subsection.

(6) Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan for fraud, material misrepresentation or concealment by an enrollee.

(7) A carrier that withdraws from the market for individual health benefit plans must continue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

(8) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.

(9) All individual health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277.

SECTION 15. ORS 652.710 is amended to read:

652.710. (1) All moneys collected by an employer from employees or retained from their wages for the purpose of providing for or furnishing to such employees medical and surgical attention, hospital care, X-rays, ambulance, nursing or any related service or care contingent upon sickness or injury pursuant to a contract are trust funds and shall be placed and kept in separate accounts by the employer and shall promptly be paid over to the contractor. Such funds shall in no event become a part of the assets of the employer.

(2) If the employer fails to place and keep such funds in separate accounts and pay them over to the contractor or if the funds become commingled with the funds of the employer and the employer becomes bankrupt, insolvent or goes through voluntary or involuntary liquidation, or if a

receiver is appointed to operate or liquidate the affairs of the employer, the funds not paid to the contractor shall be entitled to the same preference as given to claims of the State Accident Insurance Fund Corporation, as provided in ORS 656.562.

(3) On and after July 1, 1992, when an employer that is a group health insurance policyholder subject to the provisions of ORS 743.560 receives notice that the group health insurance policy is terminated by the insurer and the employer does not replace coverage with any other group health insurance policy, the employer shall notify all employees who were covered under the terminated group policy. The employer's notification to the employees shall:

(a) Explain the employee's rights regarding continuation or conversion of coverage under state and federal law; and

(b) Be delivered to each employee in person or to the employee's home address as recorded in the employer's records not later than 10 working days after the receipt of notice from the insurer pursuant to ORS 743.560 [*(1) to*] (3) **to (5)**.

(4) In addition to any other penalty provided by law, the Commissioner of the Bureau of Labor and Industries may assess a civil penalty not to exceed $1,000 for each violation of subsection (1) or (3) of this section.

(5) Civil penalties under this section shall be imposed as provided in ORS 183.090.

(6) All sums collected as penalties pursuant to this section shall be first applied toward reimbursement of the costs incurred in determining the violations, conducting hearings under this section and assessing and collecting such penalties. The remainder, if any, of the sums collected as penalties pursuant to this section shall be paid over by the commissioner to the Division of State Lands for the benefit of the Common School Fund of this state. The division shall issue a receipt for the money to the commissioner.

(7) The Commissioner of the Bureau of Labor and Industries may adopt rules reasonably necessary for the administration of this section.

SECTION 16. The Director of the Department of Consumer and Business Services shall adopt rules necessary for the implementation and administration of section 8 of this 2001 Act and the amendments to ORS 743.417, 743.420, 743.560, 743.737, 743.754 and 743.766 by sections 9 to 14 of this 2001 Act.

SECTION 17. Section 8 of this 2001 Act and the amendments to ORS 743.417, 743.420, 743.560, 743.737, 743.754 and 743.766 by sections 9 to 14 of this 2001 Act apply to individual or group health insurance policies issued or renewed on or after the operative date of section 8 of this 2001 Act and the amendments to ORS 743.417, 743.420, 743.560, 743.737, 743.754 and 743.766 by sections 9 to 14 of this 2001 Act.

SECTION 18. Section 8 of this 2001 Act and the amendments to ORS 652.710, 743.417, 743.420, 743.560, 743.737, 743.754 and 743.766 by sections 9 to 15 of this 2001 Act become operative January 1, 2002.

SECTION 19. ORS 653.715 is amended to read:

653.715. It is the intent of the Legislative Assembly by enactment of ORS 653.705 to 653.850 to increase access to health insurance and health care by providing:

(1) Information about health benefit plans and the premiums charged for those plans to self-employed individuals and small employers in Oregon;

(2) Direct assistance to health insurance agents and health insurance consumers regarding health benefit plans; [*and*]

(3) A central source for information about resources for health care and health insurance[.]**; and**

(4) Health benefit plans for small employers that have not provided a group health benefit plan for eligible employees for a period of at least one year.

SECTION 20. ORS 653.745 is amended to read:

653.745. (1) In carrying out its duties under ORS 653.705 to 653.850, the Insurance Pool Governing Board shall:

(a) Enter into contracts for administration of ORS 653.705 to 653.850 including collection of premiums and paying carriers.

(b) Retain consultants and employ staff.

(c) Enter into contracts with carriers or health care providers for health benefit plans, including contracts where final payment may be reduced if usage is below a level fixed in the contract.

(d) Set premium rates for eligible employees and small employers.

(e) Perform other duties to provide low-cost health benefit plans of types likely to be purchased by small employers.

(f) Establish contributions to be paid by small employers toward the premiums incurred on behalf of covered eligible employees.

(2) Notwithstanding any other health benefit plan contracted for and offered by the board, the board shall contract for a health benefit plan or plans best designed to meet the needs and provide for the welfare of eligible employees and small employers.

(3) The board may approve more than one carrier for each type of plan contracted for and offered, but the number of carriers shall be held to a number consistent with adequate service to eligible employees and family members.

(4) Where appropriate for a contracted and offered health benefit plan, the board shall provide options under which an eligible employee may arrange coverage for family members of the employee.

(5) In developing any health benefit plan, the board may provide an option of additional coverage for eligible employees and family members at an additional cost or premium.

(6) Transfer of enrollment from one health benefit plan to another shall be open to all eligible employees and family members under rules adopted by the board.

(7) If the board requests less health care service or benefit than is otherwise required by state law, a carrier is not required to offer such service or benefit.

(8) Health benefit plans for small employers contracted for and offered by the board must provide a sufficient level of benefits to be eligible for a subsidy under ORS 653.810.

[*(2)*] **(9)** The board may employ whatever means are reasonably necessary to carry out the purposes of ORS 653.705 to 653.850. Such authority includes but is not limited to authority to seek clarification, amendment, modification, suspension or termination of any agreement or contract which in the board's judgment requires such action.

SECTION 21. This 2001 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2001 Act takes effect on its passage.

Passed by House May 9, 2001

Repassed by House July 5, 2001

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Chief Clerk of House

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Speaker of House

Passed by Senate July 5, 2001

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President of Senate

Received by Governor:

.....M.,....., 2001

Approved:

.....M.,....., 2001

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2001

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Secretary of State