CHAPTER 681

AN ACT HB 2240

Relating to coverage of health care services; creating new provisions; amending ORS 192.556, 410.080, 413.011, 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839, 433.443, 731.036, 731.146, 735.625, 741.300, 743.018, 743.019, 743.405, 743.417, 743.420, 743.522, 743.524, 743.526, 743.528, 743.550, 743.552, 743.560, 743.610, 743.730, 743.731, 743.733, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.757, 743.766, 743.767, 743.769, 743.777, 743.801, 743.804, 743.822, 743.894, 743A.090, 743A.168, 743A.192, 746.015 and 746.045 and section 1, chapter 867, Oregon Laws 2009; repealing ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761; and declaring an emergency.

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

IMPLEMENTATION OF FEDERAL REQUIREMENTS

SECTION 1. Sections 2, 3, 4, 5, 6 and 7 of this 2013 Act are added to and made a part of the Insurance Code.

SECTION 2. "Essential health benefits" are the items and services prescribed by the Department of Consumer and Business Services by rule in accordance with federal law, including:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

SECTION 3. (1) As used in this section, "health benefit plan" means a health benefit plan, as defined in ORS 743.730, that is offered in the individual or small group market.

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

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

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

(3) A procedure established under this section must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063.

SECTION 4. (1) As used in this section, "student health benefit plan" means a plan that is subject to rules adopted by the United States Department of Health and Human Services under 42 U.S.C. 18118(c).

(2) Notwithstanding any other provision of law, the Department of Consumer and Business Services shall by rule and in a manner consistent with federal law, adopt requirements for student health benefit plans.

SECTION 5. (1) The Department of Consumer and Business Services may require an insurer to provide a written notice to an insured to fully effectuate any law the department is responsible for enforcing, including, but not limited to, laws regarding:

(a) Enrollment periods.

(b) The termination of coverage.

(c) The availability of coverage outside of an open enrollment period.

(d) The rights of insureds.

(2) The department may prescribe by rule the form, manner and contents of any required notices. Any requirements must be designed to minimize the administrative burden on insurers, including by allowing notices to be combined into one notice, as appropriate.

SECTION 6. (1) Notwithstanding ORS 743.737 (8)(d) and 743.767 (3), at one time during the 2014 calendar year, insurers may increase their rates by an amount that reflects:

(a) The health insurance providers fee imposed under section 9010 of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by section 10905 of the Patient Protection and Affordable Care Act, and as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and

(b) A federal fee, tax or assessment imposed to pay for the costs of a federal reinsurance program.

(2) To the extent the existing rate was approved by the Department of Consumer and Business Services, the resulting rate, including the additional amount reflecting the health insurance providers fee and a federal fee, tax or

assessment, shall be considered an approved rate.

SECTION 7. "Group health insurance" means that form of health insurance covering groups of persons 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) 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. As used in this subsection, "employees" 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;

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

(f) The leased workers of a client employer; and

(g) Elected or appointed officials if a policy issued to insure employees of a public body provides that the term "employees" includes elected or appointed officials.

(2) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and 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.

(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 described 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. As used in this subsection, "employees" 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 policy may provide that the term "employees" includes 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.

NOTE: Section 8 was deleted by amendment. Subsequent sections were not renumbered.

SECTION 9. ORS 731.146, as amended by section 6, chapter 752, Oregon Laws 2007, is amended to read:

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

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

(b) Taking or receiving any application for insurance.

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

(d) Issuing or delivering policies of insurance.

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

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

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

(h) Offering individual or small group coverage under a multistate health benefit plan, as defined in ORS 743.730.

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

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

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

(b) Except as provided in ORS 743.015, doing or proposing to do any insurance business arising out

of a policy of group life insurance [*or group health insurance, or both,*] or a policy of blanket health insurance, if the master policy was validly issued to cover a group organized primarily for purposes other than the procurement of insurance and was delivered in and pursuant to the laws of another state in which:

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

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

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

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

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

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

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

SECTION 10. ORS 741.300 is amended to read:

741.300. As used in ORS 741.001 to 741.540:

(1) "Essential health benefits" [*means the health care services identified by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 18022 or approved by the secretary pursuant to a waiver granted under 42 U.S.C. 18052*] **has the meaning given that term in section 2 of this 2013 Act**.

(2) "Health care service contractor" has the meaning given that term in ORS 750.005.

(3) "Health insurance" has the meaning given that term in ORS 731.162, excluding disability income insurance.

(4) "Health insurance exchange" or "exchange" means an American Health Benefit Exchange as described in 42 U.S.C. 18031, 18032, 18033 and 18041 that is operated by the Oregon Health Insurance Exchange Corporation.

(5) "Health plan" means health insurance or health care coverage offered by an insurer.

(6) "Insurer" means an insurer as defined in ORS 731.106 that offers health insurance, a health care service contractor or a prepaid managed care health services organization.

(7) "Insurance producer" has the meaning given that term in ORS 731.104.

(8) "Prepaid managed care health services organization" has the meaning given that term in ORS 414.736.

(9) "State program" means a program providing medical assistance, as defined in ORS 414.025, and any health plan offered through the Public Employees' Benefit Board or the Oregon Educators Benefit Board.

SECTION 11. ORS 743.018 is amended to read:

743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. Premium rates are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007.

(2) Except as provided in ORS 743.737 [*and 743.760*] and subsection (3) of this section, a rate filing by a carrier for any of the following health benefit plans subject to ORS 743.730 to 743.773 shall be available for public inspection immediately upon submission of the filing to the director:

(a) Health benefit plans for small employers.

[*(b) Portability health benefit plans.*]

[*(c)*] **(b)** Individual health benefit plans.

(3) The director may by rule:

(a) Specify all information a carrier must submit as part of a rate filing under this section; and

(b) Identify the information submitted that will be exempt from disclosure under this section because the information constitutes a trade secret and would, if disclosed, harm competition.

(4) The director, after conducting an actuarial review of the rate filing, may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the director's discretion, the proposed rates are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses.

(5) In order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the director may consider:

(a) The insurer's financial position, including but not limited to profitability, surplus, reserves and investment savings.

(b) Historical and projected administrative costs and medical and hospital expenses.

(c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums.

(d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

(e) Changes to covered benefits or health benefit plan design.

(f) Changes in the insurer's health care cost containment and quality improvement efforts since

the insurer's last rate filing for the same category of health benefit plan.

(g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(h) Any public comments received under ORS 743.019 pertaining to the standards set forth in subsection (4) of this section and this subsection.

(6) With the written consent of the insurer, the director may modify a schedule or table of premium rates filed in accordance with subsection (1) of this section.

(7) The requirements of this section do not supersede other provisions of law that require insurers, health care service contractors or multiple employer welfare arrangements providing health insurance to file schedules or tables of premium rates or proposed premium rates with the director or to seek the director's approval of rates or changes to rates.

SECTION 12. ORS 743.405 is amended to read:

743.405. An individual health insurance policy must meet the following requirements:

(1) **The policy must include a statement of** the entire money and other considerations [*therefor shall be expressed therein*] **due**.

(2) **The policy must state** the time at which the insurance takes effect and terminates [*shall be expressed therein*].

(3) [*It shall*] **The policy may** purport to insure only one person, [*except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age and any other person dependent upon the policyholder*] **unless an adult member of a family applies for coverage of family members or other dependents**.

(4) The policy may not be issued individually to an individual in a group of persons [*as*] described in [*ORS 743.522*] **section 7 of this 2013 Act** for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan.

(5)**(a)** Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than [*10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than*] 12-point type.

(b) As used in this subsection, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions.

(6) **The policy must state** the exceptions and reductions of indemnity [*must be set forth in the policy*]. Except those required by ORS 743.411 to 743.477, exceptions and reductions shall be printed at the insurer's option either included with the applicable benefit provision or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the applicable benefit provision.

(7) Each form constituting the policy, including riders and indorsements, must be identified by a form number in the lower left-hand corner of the first page of the policy.

(8) The policy may not contain provisions purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short rate table filed with the Director of the Department of Consumer and Business Services.

SECTION 13. ORS 743.417 is amended to read:

743.417. (1) An individual health insurance policy shall [*contain a provision as follows: "GRACE PERIOD:*] **specify** a minimum grace period of **at least** 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 that contains a cancellation provision may add the following clause at the end of the provision [*set forth*] **described** 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*] **described** 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 13a. ORS 743.420 is amended to read:

743.420. (1) A health insurance policy**, other than a health benefit plan as defined in ORS 743.730,** shall contain a provision as follows: "REINSTATEMENT: If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the insurer or by any insurance producer 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 insurance producer 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 14. ORS 743.522 is amended to read:

743.522. [*(1) "Group health insurance" means that form of health insurance covering groups of persons 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:*]

[*(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. As used in this paragraph, "employees" 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;*]

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

[*(F) The leased workers of a client employer; and*]

[*(G) Elected or appointed officials if a policy issued to insure employees of a public body provides that the term "employees" includes elected or appointed officials.*]

[*(b) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and 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.*]

[*(c) 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 described in paragraph (b) of this subsection, 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. As used in this paragraph, "employees" 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 policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with such trusteeship.*]

[*(d) 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.*]

(1) As used in this section and ORS 743.533:

(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) "Employee" may include a retired employee.

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

(2) Group health insurance **may be** offered to a resident of this state under a group health insurance policy issued to a group other than one **of the groups** described in [*subsection (1) of this section may be delivered*] **section 7 of this 2013 Act** 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.

[*(3) As used in this section and ORS 743.533:*]

[*(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) "Employee" may include a retired employee.*]

[*(c) "Leased worker" means a worker provided by a worker leasing company licensed under ORS 656.850.*]

SECTION 14a. ORS 743.524 is amended to read:

743.524. (1) An insurer may not offer a policy of group health insurance to an association as the policyholder or offer coverage under such a policy, whether issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the association satisfies the requirements of an association under [*ORS 743.522 (1)(b)*] **section 7 (2) of this 2013 Act**.

(2) An insurer shall submit evidence to the director that the association satisfies the requirements under [*ORS 743.522 (1)(b)*] **section 7 (2) of this 2013 Act**. The director shall review the evidence and may request additional evidence as needed.

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

(4) The director may order an insurer to cease offering health insurance to an association if the director determines that the association does not meet the standards under [*ORS 743.522 (1)(b)*] **section 7 (2) of this 2013 Act**.

(5) The director may adopt rules to carry out this section.

SECTION 15. ORS 743.550 is amended to read:

743.550. (1) Student health insurance is subject to ORS 743.537, 743.540, 743.543, 743.546 and [*743.549*] **743.552**, except as provided in this section.

(2) Coverage under a student health insurance policy may be mandatory for all students at the institution, voluntary for all students at the institution, or mandatory for defined classes of students and voluntary for other classes of students. As used in this subsection, "classes" refers to undergraduates, graduate students, domestic students, international students or other like classifications. Any differences based on a student's nationality may be established only for the purpose of complying with federal law in effect when the policy is issued.

(3) When coverage under a student health insurance policy is mandatory, the policyholder may allow any student subject to the policy to decline coverage if the student provides evidence acceptable to the policyholder that the student has similar health coverage.

(4) A student health insurance policy may provide for any student to purchase optional supplemental coverage.

(5) Student health insurance coverage for athletic injuries may:

(a) Exclude coverage for injuries of students who have not obtained medical release for a similar injury; and

(b) Be provided in excess of or in addition to any other coverage under any other health insurance policy, including a student health insurance policy.

(6) A student health insurance policy may provide that coverage under the policy is secondary to any other health insurance for purposes of guidelines established under ORS 743.552.

(7) A student health insurance policy may provide, on request by the policyholder, that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(8) An insurer providing student health insurance as primary coverage may negotiate and enter into contracts for alternative rates of payment with providers and offer the benefit of such alternative rates to insureds who select such providers. An insurer may utilize such contracts by offering a choice of plans at the time an insured enrolls, one of which provides benefits only for services by members of a particular provider organization with whom the insurer has an agreement. If an insured chooses such a plan, benefits are payable only for services rendered by a member of that provider organization, unless such services were requested by a member of such organization or are rendered as the result of an emergency.

(9) Payments made under subsection (8) of this section shall discharge the insurer's obligation with respect to the amount of insurance paid.

(10) An insurer shall provide each student health insurance policyholder with a current roster of institutional and professional providers under contract to provide services at alternative rates under the group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state.

(11) As used in this section, "student health insurance"**:**

(a) Means that form of health insurance under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or recognized student government at a public university listed in ORS 352.002, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, that is available exclusively to students at the college, school or other institution.

(b) Does not include a student health benefit plan as defined in section 4 of this 2013 Act.

SECTION 15a. ORS 743.552 is amended to read:

743.552. The Director of the Department of Consumer and Business Services shall by rule establish

guidelines for the [*application of ORS 743.549,*] **coordination of benefits for individual and small group health insurance,** including:

(1) The procedures by which persons insured under [*such*] **the** policies are to be made aware of the existence of [*such*] a **coordination of benefits** provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments**.** [*under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision.*]

SECTION 16. ORS 743.610, as amended by section 3, chapter 24, Oregon Laws 2012, is amended to read:

743.610. (1) As used in this section:

(a) "Covered person" means an individual who was a certificate holder under a group health insurance policy:

(A) On the day before a qualifying event; and

(B) During the three-month period ending on the date of the qualifying event.

(b) "Qualified beneficiary" means:

(A) A spouse or dependent child of a covered person who, on the day before a qualifying event, was insured under the covered person's group health insurance policy; or

(B) A child born to or adopted by a covered person during the period of the continuation of coverage under this section who would have been insured under the covered person's policy if the child had been born or adopted on the day before the qualifying event.

(c) "Qualifying event" means the loss of membership in a group health insurance policy caused by:

(A) Voluntary or involuntary termination of the employment of a covered person;

(B) A reduction in hours worked by a covered person;

(C) A covered person becoming eligible for Medicare;

(D) A qualified beneficiary losing dependent child status under a covered person's group health insurance policy;

(E) Termination of membership in the group covered by the group health insurance policy; or

(F) The death of a covered person.

(2)**(a)** A [*group health insurance policy*] **grandfathered health plan, as defined in ORS 743.730,** providing coverage **under a group health insurance policy** for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(b) A group health insurance policy that provides coverage for one or more of the essential health benefits, other than a grandfathered health plan, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(3) Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for:

(a) Medicare; or

(b) **The same** coverage [*for hospital or medical expenses*] under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

(4) The continued coverage [*need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy other than hospital and medical expense benefits*] **must be offered in the same manner as it is provided to other certificate holders under the group health insurance policy**.

(5) A covered person or qualified beneficiary [*who wishes to continue coverage must provide the insurer with a written request for continuation no later than 10 days after the later of the date of a qualifying event or*] **must submit a written request for continuation of coverage to the insurer within the time prescribed by the insurer, except that an insurer may not require a request to be submitted less than 10 days after the later of:**

(a) The date of a qualifying event; or

(b) The date the insurer provides the notice required by subsection (10) of this section.

(6) A covered person or qualified beneficiary who requests continuation of coverage shall pay the premium on a monthly basis and in advance to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate for the insurance being continued under the group policy as of the date the premium payment is due.

(7) Continuation of coverage as provided under this section ends on the earliest of the following dates:

(a) Nine months after the date of the qualifying event that was the basis for the continuation of coverage.

(b) The end of the period for which the last timely premium payment for the coverage is received by the insurer.

(c) The premium payment due date coinciding with or next following the date that continuation of coverage ceases to be available in accordance with subsection (3) of this section.

(d) The date that the policy is terminated. However, if the policyholder replaces the terminated policy with similar coverage under another group health insurance policy:

(A) The covered person and qualified beneficiaries may obtain coverage under the replacement policy for the balance of the period that the covered person or qualified beneficiary would have remained covered under the terminated policy in accordance with this section; and

(B) The terminated policy must continue to provide benefits to the covered person and qualified beneficiaries to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

(9) A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer may not be subjected to a waiting period for coverage under the employer's group health insurance policy if the covered person was eligible for coverage at the time of the layoff, regardless of whether the covered person continued coverage during the layoff.

(10) If an insurer terminates the group health insurance coverage of a covered person or qualified beneficiary without providing replacement coverage that meets the criteria in subsection (7)(d) of this section, the insurer shall provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event under subsection (5) of this section. The notice shall include information prescribed by the Director of the Department of Consumer and Business Services.

(11) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986.

SECTION 17. ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, and section 20, chapter 38, Oregon Laws 2012, is amended to read:

743.730. For purposes of 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 condition exclusion*];

(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 that provides bronze plan coverage and that is approved by the Department of Consumer and Business Services under ORS 743.736.*]

[*(5)*] **(4)** "Bona fide association" means an association that [*meets the requirements of 42 U.S.C. 300gg-91 as amended and in effect on March 23, 2010.*]**:**

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

[*(6) "Bronze plan" means a health benefit plan that meets the criteria for a bronze plan prescribed by the director by rule pursuant to ORS 743.822 (2).*]

[*(7)*] **(5)** "Carrier[,]" [*except as provided in ORS 743.760,*] means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

[*(8)*] **(6)** "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.

[*(9)*] **(7)** "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

[*(10)*] **(8)** "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

[*(11)*] **(9)** "Eligible employee" means an employee 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. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

[*(12)*] **(10)** "Employee" means any individual employed by an employer.

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

[*(14)*] **(12)** "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

[*(15)*] **(13)** "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

[*(16)*] **(14)** "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director 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.

[*(17)(a)*] **(15)(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) Group health benefit plans offered to small employers; **or**

(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**, age, tobacco use** or family composition.

[*(18)*] **(16)** "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

[*(19)*] **(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.

[*(20)(a)*] **(18)(a)** "Health benefit plan" means any:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) 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, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) 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;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) 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; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

[*(21) "Health statement" means any information that is intended to inform the carrier or insurance producer of the health status of an enrollee or prospective enrollee in a health benefit plan. "Health statement" includes the standard health statement approved by the director under ORS 743.745.*]

[*(22)*] **(19)** "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.

(20) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

[*(23)*] **(21)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(24)*] **(22)** "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 February 17, 2009*] **or as prescribed by rule by the Department of Consumer and Business Services**;

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

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored 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 that 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

[*(25)*] **(23)** "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

[*(26)*] **(24)** "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.

[*(27)*] **(25)** "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

[*(28) "Preexisting condition exclusion" 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, diagnosis, 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) Except for coverage under an individual grandfathered health plan, a preexisting condition exclusion may not exclude coverage for services, charges or expenses incurred by an individual who is under 19 years of age.*]

(26) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a 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, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

[*(29)*] **(27)** "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.

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

[*(31)*] **(29)** "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

[*(32) "Silver plan" means an individual or small group health benefit plan that meets the criteria for a silver plan prescribed by the director by rule pursuant to ORS 743.822 (2).*]

[*(33)(a)*] **(30)(a)** "Small employer" means an employer that employed an average of at least [*two*] **one** but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least [*two eligible employees on the date on which coverage takes effect under a health benefit plan offered by the employer*] **one eligible employee on the first day of the plan year**.

(b) Any person that is treated as a single employer under [*subsection (b), (c), (m) or (o) of*] section 414 **(b), (c), (m) or (o)** of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

SECTION 18. ORS 743.731 is amended to read:

743.731. The purposes of ORS 743.730 to 743.773 **and section 3 of this 2013 Act** are:

(1) To promote the availability of health insurance coverage to groups regardless of their enrollees' health status or claims experience;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers of small employer[, *portability*] and individual health benefit plans;

(4) To [*establish limitations on*] **prohibit** the use of preexisting condition exclusions **except in grandfathered health plans**;

[*(5) To make basic health benefit plans available to all small employers;*]

[*(6)*] **(5)** To encourage the availability of [*portability and*] individual health benefit plans for individuals who are not enrolled in group health benefit plans;

[*(7)*] **(6)** To improve renewability and continuity of coverage for employers and covered individuals;

[*(8)*] **(7)** To improve the efficiency and fairness of the health insurance marketplace; and

[*(9)*] **(8)** To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152), and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services.

SECTION 19. ORS 743.733 is amended to read:

743.733. (1) If an affiliated group of employers is treated as a single employer under [*subsection (b), (c), (m) or (o) of*] section 414 **(b), (c), (m) or (o)** of the Internal Revenue Code of 1986, a carrier may issue a single group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

[*(2) If a carrier determines that an employer has more than 50 employees, the carrier may provide a quote for a group health benefit plan that is not subject to ORS 743.733 to 743.737. If the employer's workforce consists of at least two but not more than 50 eligible employees, the carrier shall inform the employer that if coverage is limited to the eligible employees, the carrier must treat the employer as a small employer and shall provide a separate quote on that basis.*]

[*(3)*] **(2)** Subsequent to the issuance of a health benefit plan to a small employer, **other than a plan issued through the Oregon Health Insurance Exchange,** a carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer.

(3)(a) [*The provisions of*] ORS 743.733 to 743.737 shall continue to apply to a health benefit plan issued **outside of the exchange** to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

(b) ORS 743.733 to 743.737 shall continue to apply to an employer that receives coverage through the exchange until the employer no longer receives coverage through the exchange and is no longer a small employer.

SECTION 20. ORS 743.734, as amended by section 13, chapter 500, Oregon Laws 2011, is amended to read:

743.734. (1) Every health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

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

[*(2) Except as provided in ORS 743.733 to 743.737, 743.764 and 743A.012, no state law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.*]

[*(3)*] **(2)** Except as otherwise provided by ORS 743.733 to 743.737 or other law, no health benefit plan offered to a small employer shall:

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

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

[*(4) Except to determine the application of a preexisting condition exclusion for a late enrollee who is 19 years of age or older, a carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing*

services or arranging for the provision of services under a health benefit plan.]

[*(5) Except as provided in this section and ORS 743.737, a carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee of a small employer that are based on the actual or expected health status of any eligible employee.*]

[*(6)(a)*] **(3)(a)** A carrier may provide different health benefit plans to different categories of employees of a small employer [*that has at least 26 but no more than 50 eligible employees*] when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(b) Except as provided in ORS 743.736 [*(9)*] **(8)**, a carrier that offers coverage to a small employer [*with no more than 25 eligible employees*] shall offer coverage to all eligible employees of the small employer[*, without regard to the actual or expected health status of any eligible employee*].

(c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier shall offer coverage to all dependents of eligible employees[*, without regard to the actual or expected health status of any eligible dependent*].

[*(7)*] **(4)** Notwithstanding any other provision of law, an insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual [*if the individual is under 19 years of age*].

SECTION 21. ORS 743.736 is amended to read:

743.736. (1) As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers [*an approved basic health benefit plan and all of the other plans of the carrier that have been*] **all of the carrier's health benefit plans,** approved by the Department of Consumer and Business Services for use in the small employer market**, for which the small employer is eligible**.

[*(2) A carrier shall submit to the department, for approval in accordance with ORS 742.003, the policy form or forms containing its basic health benefit plan.*]

[*(3)*] **(2)** A carrier that offers a health benefit plan in the small employer market only [*through*] **to** one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

[*(4)*] **(3)** A carrier shall issue to a small employer any health benefit plan[*, including a basic health benefit plan,*] that is offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

[*(5)*] **(4)** A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries [*shall*] **may** not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement [*shall*] **may** not include any requirements that relate to the actual or expected health status of the prospective enrollee.

[*(6)*] **(5)** A carrier shall, pursuant to subsection [*(4)*] **(3)** of this section, accept applications from and offer coverage to a small employer group covered under an existing health benefit plan regardless of whether a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a carrier accepts an application for a small employer group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

[*(7)*] **(6)** A carrier is not required to accept applications from and offer coverage pursuant to subsection [*(4)*] **(3)** of this section if the department finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

[*(8)*] **(7)** A carrier shall market fairly all health benefit plans[*, including basic health benefit plans,*] that are offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

[*(9)(a)*] **(8)(a)** Subsection [*(4)*] **(3)** of this section does not require a carrier to offer coverage to or accept applications from:

(A) A small employer if the small employer is not physically located in the carrier's approved service area;

(B) An employee of a small employer if the employee does not work or reside within the carrier's approved service areas; or

(C) Small employers located within an area where the carrier reasonably anticipates, and demonstrates to the department, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those small employer groups because of its obligations to existing small employer group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection [*shall*] **may** not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

[*(10)*] **(9)** For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

[*(11)*] **(10)** A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743.737 [*(6)(e)*] **(3)(e)**, elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans to small employers in this state for a period of five years from one of the following dates:

(a) The date of notice to the department pursuant to ORS 743.737 [*(6)(e)*] **(3)(e)**; or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the department provides notice to the carrier that the department has determined that the carrier has effectively discontinued offering health benefit plans to small employers in this state.

[*(12)*] **(11)** This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152).

SECTION 22. ORS 743.737 is amended to read:

743.737. [*(1) A preexisting condition exclusion 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 condition exclusion in a small employer health benefit plan shall expire as follows:*]

[*(a) For an enrollee, on the earlier of the following dates:*]

[*(A) Six months after the enrollee's effective date of coverage; or*]

[*(B) Ten months after the start of any required group eligibility waiting period.*]

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

[*(3) In applying a preexisting condition exclusion 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 after 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:*]

(1) A health benefit plan issued to a small employer:

(a) Must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

(b) May:

[*(a)*] **(A) Require** an affiliation period that does not exceed two months for an enrollee or [*three months*] **90 days** for a late enrollee; [*or*]

[*(b)*] **(B) Impose** an exclusion period for specified covered services, as established under ORS 743.745, applicable to all individuals enrolling for the first time in the small employer health benefit plan[.]**; or**

[*(4)*] **(C)** [*A health benefit plan issued to a small employer may*] Not apply a preexisting condition exclusion to [*a person under 19 years of age*] **any enrollee**.

[*(5)*] **(2)** Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period [*of up to 12 months or, if 19 years of age or older, may be subjected to a preexisting condition exclusion for up to 12 months. If both a waiting period and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 12 months*] **that does not exceed 90 days**.

[*(6)*] **(3)** 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 unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) 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) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) 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 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) 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 department 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 to small employers 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) The carrier discontinues offering or renewing, or offering and renewing, a health benefit plan, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

(j) The Director of the Department of Consumer and Business Services 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.

(k) 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.

(L) In the case of a health benefit plan that is offered in the small employer market only [*through*] **to** 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.

[*(7)*] **(4)** A 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 subsection [*(6)(e)*] **(3)(e)**, (g) and (h) of this section.

[*(8)*] **(5)** Notwithstanding any provision of subsection [*(6)*] **(3)** of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(9)*] **(6)** Notwithstanding any provision of subsection [*(6)*] **(3)** of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed

by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(10)*] **(7)(a)** A 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 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

[*(11)*] **(8)** Premium rates for small employer health benefit plans shall be subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

[*(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers may not vary from the geographic average rate by more than 50 percent on or after January 1, 2008, except as provided in subparagraph (D) of this paragraph*].

[*(B)*] **(b)(A)** The variations in premium rates [*described in subparagraph (A) of this paragraph*] **charged during a rating period for health benefit plans issued to small employers** shall be based solely on the factors specified in subparagraph [*(C)*] **(B)** of this paragraph. A carrier may elect which of the factors specified in subparagraph [*(C)*] **(B)** of this paragraph apply to premium rates for health benefit plans for small employers. [*The factors that are based on contributions or participation may vary with the size of the employer.*] All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

[*(C)*] **(B)** The variations in premium rates described in subparagraph (A) of this paragraph may be based **only** on one or more of the following factors **as prescribed by the department by rule**:

(i) The ages of enrolled employees and their dependents**, except that the rate for adults may not vary by more than three to one**;

[*(ii) The level at which the small employer contributes to the premiums payable for enrolled employees and their dependents;*]

[*(iii) The level at which eligible employees participate in the health benefit plan;*]

[*(iv)*] **(ii)** The level at which enrolled employees and their dependents **18 years of age and older** engage in tobacco use[*;*]**, except that the rate may not vary by more than 1.5 to one; and**

[*(v) The level at which enrolled employees and their dependents engage in health promotion, disease prevention or wellness programs;*]

[*(vi) The period of time during which a small employer retains uninterrupted coverage in force with the same carrier; and*]

[*(vii)*] **(iii)** Adjustments to reflect [*the provision of benefits not required to be covered by the basic health benefit plan and*] differences in family composition.

[*(D)(i) The premium rates determined in accordance with this paragraph may be further adjusted by a carrier to reflect the expected claims experience of the covered small employer, but the extent of this adjustment may not exceed five percent of the annual premium rate otherwise payable by the small employer. The adjustment under this subparagraph may not be cumulative from year to year.*]

[*(ii) The premium rates adjusted under this subparagraph, except rates for small employers with 25 or fewer employees, are not subject to the provisions of subparagraph (A) of this paragraph.*]

[*(E)*] **(C)** A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage**, age, tobacco use and family composition** and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A 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 small employer health benefit plans shall comply with the requirements of this section.

[*(12)*] **(9)** In connection with the offering for sale of any health benefit plan to a small employer, each 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 premiums**, and the extent to which the carrier will consider age, **tobacco use,** family composition and geographic factors in establishing and adjusting rates[*;*] **and premiums; and**

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

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

[*(d) Provisions affecting any preexisting condition exclusion.*]

[*(13)(a)*] **(10)(a)** Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its small employer health benefit plans, 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) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the carrier are actuarially sound. Each certification shall be in a uniform form and manner and shall contain such information as specified by the department. A copy of each certification shall be retained by the carrier at its principal place of business. **A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.**

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and 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 to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

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

[*(15)*] **(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.

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

[*(17)*] **(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 February 17, 2009*] **by federal law and rules adopted by the department**.

[*(18)*] **(15)** A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of [*the*] essential health benefits [*prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law*].

[*(19)*] **(16)** This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan [*as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152)*].

SECTION 23. ORS 743.745 is amended to read:

743.745. [*(1) The Director of the Department of Consumer and Business Services shall determine the form and level of coverages under the basic health benefit plans pursuant to ORS 743.736 to be made available by carriers and the portability health benefit plans to be made available pursuant to ORS 743.760 or 743.761. The director may take into consideration the levels of health benefit plans provided in Oregon and the appropriate medical and economic factors and shall establish benefit levels, cost sharing, exclusions and limitations. The health benefit plans described in this section may include cost containment features including, but not limited to:*]

[*(a) Preferred provider provisions;*]

[*(b) Utilization review of health care services including review of medical necessity of hospital and physician services;*]

[*(c) Case management benefit alternatives;*]

[*(d) Other managed care provisions;*]

[*(e) Selective contracting with hospitals, physicians and other health care providers; and*]

[*(f) Reasonable benefit differentials applicable to participating and nonparticipating providers.*]

[*(2)*] **(1)** In order to ensure the broadest availability of small employer[*, portability*] and individual health benefit plans, the [*director*] **Department of Consumer and Business Services** may approve market conduct and other requirements for carriers and insurance producers, including:

(a) Registration by each carrier with the department [*of Consumer and Business Services*] of the carrier's intention to offer group health benefit plans

under ORS 743.733 to 743.737 or individual health benefit plans, or both.

(b) To the extent deemed necessary by the [*director*] **department** to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer[*, portability*] and individual health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued to small employers and individuals.

(c) Methods concerning periodic demonstration by carriers offering health benefit plans to individuals or small employers and insurance producers that the carriers and insurance producers are marketing or issuing health benefit plans in fulfillment of the purposes of ORS 743.730 to 743.773.

[*(3)*] **(2)** The [*director shall develop a standard health statement to be used for all late enrollees and by all carriers offering individual policies of health insurance.*] **department may require carriers and insurance producers offering health benefit plans to individuals or small employers to use the open and special enrollment periods prescribed by the department by rule.**

[*(4)*] **(3)** [*The director shall develop a list of the specified services*] For small employer [*and portability*] plans**, the department may specify services** for which carriers may impose an exclusion period, the duration of the allowable exclusion period for each specified service and the manner in which credit will be given for exclusion periods imposed pursuant to prior health insurance coverage.

SECTION 24. ORS 743.748, as amended by section 18, chapter 500, Oregon Laws 2011, is amended to read:

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers [*with more than 50 employees*] **that are not small employers**.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

SECTION 25. ORS 743.751 is amended to read:

743.751. [*(1) Except to determine the application of a preexisting condition exclusion for a late enrollee who is 19 years of age or older or as prescribed by the Department of Consumer and Business Services by rule, a carrier offering group health benefit plans shall not use health statements when offering such plans to a group of two or more prospective certificate holders and shall not use any other method to determine the actual or expected health status of eligible prospective enrollees. Nothing in this section shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan or from obtaining aggregate group information related to historical medical claims expenses and health behavior surveys for rating purposes.*]

[*(2) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.*]

(1) Except for an individual grandfathered health plan, a carrier may require an applicant for individual or small group health benefit plan coverage to provide health-related information only for the purpose of health care management and may not use the information to deny coverage.

(2) Except for an individual grandfathered health plan, if a carrier requires an applicant to provide health-related information, the carrier must also notify the applicant, in the form and manner prescribed by the Department of Consumer and Business Services, that the information may not be used to deny coverage.

SECTION 26. ORS 743.752 is amended to read:

743.752. (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of

two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS 743.754 [*(6)(e)*] **(5)(e)**, elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the group market in this state for a period of five years from one of the following dates:

(a) The date of notice to the Director of the Department of Consumer and Business Services pursuant to ORS 743.754 [*(6)(e)*] **(5)(e)**; or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering group health benefit plans in this state.

(3) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans.

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status of the employees or their dependents.

(5) A multiple employer welfare arrangement, professional or trade association, or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry or their subsidiaries as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

SECTION 27. ORS 743.754 is amended to read:

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

[*(1) A preexisting condition exclusion 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 condition exclusion may not apply to a person under 19 years of age and shall expire as follows:*]

[*(a) For an enrollee, on the earlier of the following dates:*]

[*(A) Six months after the enrollee's effective date of coverage; or*]

[*(B) Twelve months after the start of any required group eligibility waiting period.*]

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

[*(3) In applying a preexisting condition exclusion to an enrollee or late enrollee who is 19 years of age or older, except as provided in this subsection, all 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 after the enrollment date in the new 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 plan, application of:*]

(1) Except in the case of a late enrollee and except as otherwise provided in this section, a carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(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 plan.

[*(4)*] **(3)** Late enrollees may be subjected to a group eligibility waiting period [*of up to 12 months or, if 19 years of age or older, may be subjected to a preexisting condition exclusion for up to 12 months. If both a waiting period and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed 12 months*] **that does not exceed 90 days**.

[*(5)*] **(4)** Each **group health benefit** plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided [*in 42 U.S.C. 300gg as amended and in effect on February 17, 2009*] **by federal law and rules adopted by the Department of Consumer and Business Services**.

[*(6)*] **(5)** Each **group health benefit** plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

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

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) 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) The policyholder fails to comply with the contribution requirements under the plan.

(e) 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 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) 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 department 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) The carrier discontinues offering or renewing, or offering and renewing, a **group** health benefit plan, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health plan for all groups in this state or in a specified service are within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

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

(B) Offer the plans at least 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.

(j) The Director of the Department of Consumer and Business Services 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.

(k) 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.

(L) In the case of a **health benefit** plan that is offered in the group market only [*through*] **to** 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.

[*(7)*] **(6)** 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 subsection [*(6)(e)*] **(5)(e)**, (g) and (h) of this section.

[*(8)*] **(7)** Notwithstanding any provision of subsection [*(6)*] **(5)** of this section to the contrary, a carrier may not rescind the coverage of an enrollee under [*the*] **a group health benefit** plan unless:

(a) The enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(9)*] **(8)** Notwithstanding any provision of subsection [*(6)*] **(5)** of this section to the contrary, a

carrier may not rescind a **group health benefit** plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

[*(10)*] **(9)** 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)*] **(5)** of this section.

[*(11)*] **(10)** A group health benefit plan may not impose annual or lifetime limits on the dollar amount of [*the*] essential health benefits [*prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law*].

[*(12)*] **(11)** This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a group not eligible for coverage under such a plan [*as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152)*].

SECTION 28. ORS 743.766, as amended by section 4, chapter 24, Oregon Laws 2012, is amended to read:

743.766. [*(1) All carriers that offer an individual health benefit plan and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established under ORS 743.745 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 other than:*]

[*(A) A preexisting condition exclusion that complies with the following requirements:*]

[*(i) The exclusion applies 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;*]

[*(ii) The exclusion expires no later than six months after the individual's effective date of coverage; and*]

[*(iii) Except for grandfathered health plans, the exclusion does not apply to individuals who are under 19 years of age;*]

[*(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) Except for grandfathered health plans, pregnancy of individuals who are under 19 years of age may not constitute a preexisting condition for purposes of this section.*]

(1) With respect to coverage under an individual health benefit plan, a carrier:

(a) May not impose an individual coverage waiting period that exceeds 90 days.

(b) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(c) With respect to individual coverage under a grandfathered health plan, a carrier may not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

(A) The exclusion applies 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.

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

[*(3)*] **(2)** If the carrier elects to restrict coverage [*through the application of a preexisting condition exclusion or an individual coverage waiting period provision*] **as described in subsection (1) of this section**, the carrier shall reduce the duration of the [*provision*] **period during which the restriction is imposed** 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 after 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.*]

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

[*(5)*] **(4)** [*If a carrier accepts an individual for coverage under*] **A carrier shall renew** an individual health benefit plan, **including a health benefit plan issued through a bona fide association,** [*the carrier shall renew the policy*] unless:

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

(b) The policyholder or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(c) The carrier discontinues 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 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) 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 department 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) The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan, other than a grandfathered health 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.

(f) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier must:

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

(B) Offer the plans at least 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) The Director of the Department of Consumer and Business Services 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.

(i) 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.

(j) 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.

[*(6)*] **(5)** 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 subsection [*(5)(c)*] **(4)(c)**, (e) and (f) of this section.

[*(7)*] **(6)** Notwithstanding any other provision of this section, and subject to the provisions of ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

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

(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

[*(8) 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.*]

[*(9)*] **(7)** 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)*] **(4)** of this section.

[*(10)*] **(8)** An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of [*the*] essential health benefits [*prescribed by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. 300gg-11, except as permitted by federal law*].

[*(11)*] **(9)** This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan [*as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152)*].

SECTION 29. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans shall be subject to the following provisions:

(1) Each carrier must file the carrier's initial geographic average rate and any changes to the geographic average rate for its individual health benefit plans with the Director of the Department of Consumer and Business Services.

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, **age, tobacco use and** family composition [*and age*]. For age adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

(3) A carrier may not increase the rates of an individual health benefit plan more than once in a 12-month period except as approved by the director. Annual rate increases shall be effective on the anniversary date of the individual health benefit plan's issuance. The percentage increase in the premium rate charged for an individual health benefit plan for a new rating period may not exceed the sum of the following:

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan 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 and*] differences in benefit design**, age, tobacco use** and family composition.

[*(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge shall be approved by the Director of the Department of Consumer and Business Services and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting condition exclusion.*]

(4) A carrier offering an individual health benefit plan in this state shall include:

(a) In one risk pool, all of the insureds residing in this state who are covered in the carrier's individual health benefit plans that are not grandfathered health plans or student health plans; and

(b) In a separate risk pool, all of the insureds residing in this state who are covered in the carrier's individual grandfathered health plans.

SECTION 30. ORS 743.777 is amended to read:

743.777. (1) As used in subsections (2) to (6) of this section:

(a) "Explanation of benefits" means claim processing advice or notification of action on claims.

(b) "Payment, remittance and reconciliation information" means all information required for premium billing or invoicing, facilitating timely electronic payment of premiums due, delinquency notification, final billing notification or termination of coverage.

(c) "Plan renewal information" means all correspondence and materials related to an offer to renew insurance provided by an insurer to a health insurance purchaser.

(d) "Quote information" means all correspondence and materials related to an offer to insure or a rate quotation provided by an insurer to a health insurance purchaser.

(e) "Sale and enrollment information" means all information documenting the sale of a policy or certificate of health insurance, the renewal of a policy or certificate of health insurance, the enrollment of members in a group health insurance plan or the enrollment of an individual in an individual health insurance plan, including but not limited to:

(A) The application for insurance;

(B) Initial and ongoing documentation required by the insurer to be provided by an insured to establish eligibility and enrollment, adjudicate and process claims and prove prior creditable coverage or duplicate coverage;

(C) Premium information;

(D) Documentation of the payment of a premium; and

(E) Membership identification cards.

(2) In the administration of small employer group health insurance or individual health insurance, an insurer may communicate one or more of the following by electronic means:

(a) Quote information.

(b) Sale and enrollment information.

(c) Payment, remittance and reconciliation information.

(d) Explanation of benefits.

(e) Plan renewal information.

(f) Notifications required by law.

(g) Other communications, documentation, revisions or materials otherwise provided on paper.

(3) Electronic administration of small employer group or individual health insurance plans shall be transacted using secure systems specifically designed by the insurer for the purpose of electronic health insurance administration.

(4) An insurer who elects to offer discounted rates for a health insurance plan utilizing electronic administration shall include the schedule of discounts for utilization of electronic administration as part of a small employer group health insurance or individual health insurance rate filing. The rate discounts may be graduated and must be proportionate to the amount of administrative cost savings the insurer anticipates as a result of the use of electronic transactions described in subsections (2) and (3) of this section.

(5) Discounted rates allowed under subsections (4) to (6) of this section shall be applied uniformly to all similarly situated small employer group or individual health insurance purchasers of an insurer.

(6) Discounts in premium rates under subsections (4) to (6) of this section are not premium rate variations for purposes of ORS 743.737 [*(11)*] **(8)** or 743.767.

(7) Subsections (1) to (6) of this section do not require an insurer to offer discounted rates for a health insurance plan utilizing electronic administration or require a small employer group or an individual health insurance purchaser to use electronic administration.

SECTION 31. ORS 743.822, as amended by section 8, chapter 24, Oregon Laws 2012, and section 21, chapter 38, Oregon Laws 2012, is amended to read:

743.822. (1) In each individual or small group market**,** in which a carrier offers a health benefit plan through [*the exchange*] or outside of the **Oregon Health Insurance** Exchange, [*a*] **the** carrier must offer to residents of this state [*bronze and silver plans*] **a bronze and a silver plan** approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section.

(2) The [*Director of the Department of Consumer and Business Services*] **department** shall prescribe by rule the[*:*]

[*(a) Requirements for a bronze plan to ensure that a bronze plan offered in this state is actuarially equivalent to 60 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).*]

[*(b) Requirements for a silver plan to ensure that a silver plan offered in this state is actuarially equivalent to 70 percent of the full actuarial value of benefits included in the essential health benefits package prescribed by the United States Secretary of Health and Human Services under 42 U.S.C. 18022(a).*]

[*(c)*] form, level of coverage and benefit design for the bronze and silver plans [*to be used by carriers in the individual and small group market in this state.*] **that must be offered under subsection (1) of this section.**

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

SECTION 32. ORS 743.894 is amended to read:

743.894. (1) As used in this section, "rescind" means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance policy for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

(2) An insurer may not rescind coverage of an individual under a health benefit plan or group or individual health insurance policy unless:

(a) The individual or a person seeking coverage on behalf of the individual:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or policy; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the Department of Consumer and Business Services, to the individual.

(3) An insurer may not rescind coverage of a group under a health benefit plan unless:

(a) The plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee or policy holder who would be affected by the rescission of coverage.

(4) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(5) This section does not apply to long term care insurance that is subject to ORS 743.650 to 743.665.

SECTION 33. ORS 743A.090 is amended to read:

743A.090. (1) All individual and group health benefit plans, as defined in ORS 743.730, that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.

(2) The coverage of natural and adopted children required by subsection (1) of this section shall consist of coverage of preventive health services and treatment of injury or sickness, including the neces-

sary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of an additional premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished to the insurer within 31 days after the date of birth or date of placement in order to effectuate the coverage required by this section and to have the coverage extended beyond the 31-day period.

(4) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

[*(5) This section does not prohibit an insurer from denying or limiting coverage based on a preexisting condition of a child who is 19 years of age or older.*]

[*(6)*] **(5)** As used in this section:

(a) "Child" means an individual who is under 26 years of age.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

[*(7)*] **(6)** The provisions of ORS 743A.001 do not apply to this section.

SECTION 34. ORS 743A.192 is amended to read:

743A.192. (1) A health benefit plan, as defined in ORS 743.730[*.*]**:**

(a) Shall provide coverage for the routine costs of the care of patients enrolled in and participating in [*qualifying*] **approved** clinical trials[*.*]**;**

(b) May not exclude, limit or impose additional conditions on the coverage of the routine costs for items and services furnished in connection with participation in an approved clinical trial; and

(c) May not include provisions that discriminate against an individual on the basis of the individual's participation in an approved clinical trial.

(2) As used in [*subsection (1) of*] this section, "routine costs":

(a) Means **all** medically necessary conventional care, items or services [*covered by*] **consistent with the coverage provided by** the health benefit plan if typically provided [*absent*] **to a patient who is not enrolled in** a clinical trial.

(b) Does not include:

(A) The drug, device or service being tested in the **approved** clinical trial unless the drug, device or service would be covered for that indication by the health benefit plan if provided outside of [*a*] **an approved** clinical trial;

(B) Items or services required solely for the provision of the drug device or service being tested in the clinical trial;

(C) Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;

[*(D) Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;*]

[*(E)*] **(D)** Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

[*(F)*] **(E)** Items or services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial; or

[*(G)*] **(F)** Items or services that are not covered by the health **benefit** plan if provided outside of the clinical trial.

(3) As used in [*subsection (1) of*] this section, [*"qualifying*] **"approved** clinical trial" means a clinical trial that is:

(a) Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

(b) Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

(c) Conducted as an investigational new drug application, an investigational device exemption or a biologics license application subject to approval by the United States Food and Drug Administration; or

(d) Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

(4) The coverage required by this section may be subject to provisions of the health benefit plan that apply to other benefits within the same category, including but not limited to copayments, deductibles and coinsurance.

(5) An insurer that provides coverage required by this section is not, based upon that coverage, liable for any adverse effects of the **approved** clinical trial.

(6) This section is exempt from ORS 743A.001.

SECTION 35. ORS 746.015 is amended to read:

746.015. (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits

payable under insurance policies, or in any other terms or conditions of insurance policies.

(2) Discrimination by an insurer in the application of its underwriting standards or rates based solely on an individual's physical disability is prohibited, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. For purposes of this subsection, "physical disability" shall include, but not be limited to, blindness, deafness, hearing or speaking impairment or loss, or partial loss, of function of one or more of the upper or lower extremities.

(3) Discrimination by an insurer in the application of its underwriting standards or rates based solely upon an insured's or applicant's attaining or exceeding 65 years of age is prohibited, unless such discrimination is clearly based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(4)(a) An insurer may not, on the basis of the status of an insured or prospective insured as a victim of domestic violence or sexual violence, do any of the following:

(A) Deny, cancel or refuse to issue or renew an insurance policy;

(B) Demand or require a greater premium or payment;

(C) Designate domestic violence or sexual violence, physical or mental injuries sustained as a result of domestic violence or sexual violence or treatment received for such injuries as a [*preexisting*] condition for which coverage will be denied or reduced;

(D) Exclude or limit coverage for losses or deny a claim; or

(E) Fix any lower rate for or discriminate in the fees or commissions of an insurance producer for writing or renewing a policy.

(b) The fact that an insured or prospective insured is or has been a victim of domestic violence or sexual violence shall not be considered a permitted underwriting or rating criterion.

(c) Nothing in this subsection prohibits an insurer from taking an action described in paragraph (a) of this subsection if the action is otherwise permissible by law and is taken in the same manner and to the same extent with respect to all insureds and prospective insureds without regard to whether the insured or prospective insured is a victim of domestic violence or sexual violence.

(d) An insurer that complies in good faith with the requirements of this subsection shall not be subject to civil liability due to such compliance.

(e) For purposes of this subsection, "domestic violence" means the occurrence of one or more of the following acts between family or household members:

(A) Attempting to cause or intentionally or knowingly causing physical injury;

(B) Intentionally or knowingly placing another in fear of imminent serious physical injury; or

(C) Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427.

(f) For purposes of this subsection, "sexual violence" means the commission of a sexual offense described in ORS 163.305 to 163.467, 163.427 or 163.525.

(5) If the Director of the Department of Consumer and Business Services has reason to believe that an insurer in the application of its underwriting standards or rates is not complying with the requirements of this section, the director shall, unless the director has reason to believe the noncompliance is willful, give notice in writing to the insurer stating in what manner such noncompliance is alleged to exist and specifying a reasonable time, not less than 10 days after the date of mailing, in which the noncompliance may be corrected.

(6)(a) If the director has reason to believe that noncompliance by an insurer with the requirements of this section is willful, or if, within the period prescribed by the director in the notice required by subsection (5) of this section, the insurer does not make the changes necessary to correct the noncompliance specified by the director or establish to the satisfaction of the director that such specified noncompliance does not exist, the director may hold a hearing in connection therewith. Not less than 10 days before the date of such hearing the director shall mail to the insurer written notice of the hearing, specifying the matters to be considered.

(b) If, after the hearing, the director finds that the insurer's application of its underwriting standards or rates violates the requirements of this section, the director may issue an order specifying in what respects such violation exists and stating when, within a reasonable period of time, further such application shall be prohibited. If the director finds that the violation was willful, the director may suspend or revoke the certificate of authority of the insurer.

(7) Affiliated workers' compensation insurers having reinsurance agreements which result in one carrier ceding 80 percent or more of its workers' compensation premium to the other, while utilizing different workers' compensation rate levels without objective evidence to support such differences, shall be presumed to be engaging in unfair discrimination.

SECTION 35a. ORS 746.045 is amended to read:

746.045. **(1)** No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the insurance producer's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy.

(2) A premium discount or rebate is not prohibited by this section if the discount or rebate is:

(a) Offered in connection with a program of health promotion or disease prevention, as described in 42 U.S.C. 300gg-4;

(b) Paid for participation in a program to promote healthy behaviors under ORS 743.824; or

(c) Offered in connection with a wellness program defined by the Department of Consumer and Business Services by rule.

PORTABILITY HEALTH PLANS

SECTION 36. ORS 743.019 is amended to read:

743.019. (1) When an insurer files a schedule or table of premium rates for individual[, *portability*] or small employer health insurance under ORS 743.018, the Director of the Department of Consumer and Business Services shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The director shall post all comments to the website of the Department of Consumer and Business Services without delay.

(2) The director shall give written notice to an insurer approving or disapproving a rate filing or, with the written consent of the insurer, modifying a rate filing submitted under ORS 743.018 no later than 10 business days after the close of the public comment period. The notice shall comply with the requirements of ORS 183.415.

SECTION 37. ORS 743.804, as amended by section 6, chapter 24, Oregon Laws 2012, is amended to read:

743.804. All insurers offering a health benefit plan in this state shall:

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

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

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

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

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

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

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

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

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

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

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

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

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

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

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

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

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

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks.

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

(g) How to obtain referrals for specialty care in accordance with ORS 743.856.

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

(i) The availability of continuity of care as required by ORS 743.854.

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

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

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

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

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

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

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information.

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

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743.807, 743.814 and 743.817.

(2) Establish procedures for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations in a form and manner approved by the department or prescribed by the department by rule.

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

(c) Written decisions meeting criteria established by the Director of the Department of Consumer and Business Services by rule.

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

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual [*and portability*] health benefit plans. If an insurer provides:

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

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

(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and is conducted in a manner approved by the department or prescribed by the department by rule, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

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

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

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

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

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

(3) Establish procedures for notifying affected enrollees of:

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

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

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

(4) Provide the information described in subsection (2) of this section and ORS 743.859 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

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

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

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

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

(6) Provide, upon the request of an enrollee, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease, to the extent the insurer maintains such criteria. Nothing in this subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743.801 (4)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

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

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

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

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

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

(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

(9) Allow the exercise of any rights described in this section by an authorized representative.

SECTION 37a. (1) A carrier may not provide coverage under a portability health benefit plan in this state after December 31, 2013.

(2) A carrier discontinuing a portability health benefit plan in accordance with this section must comply with the requirements of ORS 743.737, 743.766 (4)(c) and 743.769.

SECTION 38. The Director of the Department of Consumer and Business Services may take any action before the operative date specified in section 64 of this 2013 Act that is necessary to implement the relevant provisions on and after the operative date specified in section 64 of this 2013 Act.

MODIFICATIONS TO HEALTH CARE FOR ALL OREGON CHILDREN PROGRAM

SECTION 39. ORS 414.231 is amended to read:

414.231. (1) As used in this section, "child" means a person under 19 years of age.

(2) The Health Care for All Oregon Children program is established to make affordable, accessible health care available to all of Oregon's children. The program is composed of:

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option administered by the Office of Private Health Partnerships under ORS 414.826.

(3) A child is eligible for [*the program*] **medical assistance under either subsection (2)(a) or (b) of this section** if the child is lawfully present in this state and the income of the child's family is at or below 300 percent of the federal poverty guidelines. There is no asset limit to qualify for the program. **The Department of Human Services or the Oregon Health Authority may prescribe by rule additional eligibility criteria for medical assistance described in subsection (2)(a) and (b) of this section consistent with federal requirements for receiving federal financial participation in the costs of the program and consistent with this section.**

(4)(a) A child receiving medical assistance [*under the program*] **through the Health Care for All Oregon Children program** is continuously eligible for a minimum period of 12 months **or until the child reaches 19 years of age, whichever comes first**.

(b) The department [*of Human Services*] **or the authority** shall reenroll a child for successive 12-month periods of enrollment as long as the child is eligible for medical assistance on the date of reenrollment **and the child has not yet reached 19 years of age**.

(c) [*The department may not require*] **A child may not be required to submit** a new application as a condition of reenrollment under paragraph (b) of this subsection [*and*]**, and the department or the authority** must determine the child's eligibility for medical assistance using information and sources available to the department **or the authority** or documentation **that is** readily available **to the child or the child's caretaker**.

(5) Except for medical assistance funded by Title XIX of the Social Security Act, the department or the [*Oregon Health*] authority may prescribe by rule a period of uninsurance prior to enrollment in the program.

ABOLISHMENT OF OFFICE OF PRIVATE HEALTH PARTNERSHIPS AND FAMILY HEALTH INSURANCE ASSISTANCE PROGRAM

SECTION 40. (1) The Office of Private Health Partnerships is abolished. On the operative date of this section, the tenure of office of the Administrator of the Office of Private Health Partnerships and the deputy director of the Office of Private Health Partnerships ceases.

(2) The unexpended balances of amounts in the Family Health Insurance Assistance Program Account and other amounts authorized to be expended by the office for the biennium beginning July 1, 2013, from revenues dedicated, continuously appropriated, appropriated or otherwise made available to the office for the purpose of administering the Family Health Insurance Assistance Program are transferred to the Oregon Health Authority Fund established in ORS 413.101 and are available for expenditure by the Oregon Health Authority for the biennium beginning July 1, 2013, for the purpose of administering and enforcing the duties, functions and powers of the office with respect to the Family Health Insurance Assistance Program.

(3) Nothing in this section, the amendments to ORS 192.556, 410.080, 413.011, 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839 and 433.443 and section 1, chapter 867, Oregon Laws 2009, by sections 42 to 53 of this 2013 Act or the repeal of ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710 and 735.712 by section 65 of this 2013 Act:

(a) Relieves a person of a liability, duty or obligation accruing under or with respect to the duties, functions and powers of the office. The authority may undertake the collection or enforcement of any such liability, duty or obligation.

(b) Affects any action, proceeding or prosecution involving or with respect to the duties, functions and powers of the office that were begun before and pending on the operative date of this section, except that the authority is substituted for the office in the action, proceeding or prosecution.

(4) The rights and obligations of the office legally incurred under contracts, leases and business transactions executed, entered into or begun before the operative date of this section

are transferred to the authority. For the purpose of succession to these rights and obligations, the authority is a continuation of the office.

(5) Notwithstanding the abolishment of the office by subsection (1) of this section, the rules of the office in effect on the operative date of this section continue in effect until superseded or repealed by rules of the authority. References in rules of the office to the office or an officer or employee of the office are considered to be references to the authority or an officer or employee of the authority.

(6) Whenever, in any statutory law or resolution of the Legislative Assembly or in any rule, document, record or proceeding authorized by the Legislative Assembly, reference is made to the office or an officer or employee of the office, the reference is considered to be a reference to the authority or an officer or employee of the authority.

SECTION 41. The Director of the Oregon Health Authority and the Administrator of the Office of Private Health Partnerships may take any action before the operative date specified in section 64 of this 2013 Act that is necessary to enable the director and the administrator to carry out section 40 of this 2013 Act.

SECTION 42. ORS 192.556 is amended to read:

192.556. As used in ORS 192.553 to 192.581:

(1) "Authorization" means a document written in plain language that contains at least the following:

(a) A description of the information to be used or disclosed that identifies the information in a specific and meaningful way;

(b) The name or other specific identification of the person or persons authorized to make the requested use or disclosure;

(c) The name or other specific identification of the person or persons to whom the covered entity may make the requested use or disclosure;

(d) A description of each purpose of the requested use or disclosure, including but not limited to a statement that the use or disclosure is at the request of the individual;

(e) An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure;

(f) The signature of the individual or personal representative of the individual and the date;

(g) A description of the authority of the personal representative, if applicable; and

(h) Statements adequate to place the individual on notice of the following:

(A) The individual's right to revoke the authorization in writing;

(B) The exceptions to the right to revoke the authorization;

(C) The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization; and

(D) The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected.

(2) "Covered entity" means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.553 to 192.581; or

(d) A health care clearinghouse.

(3) "Health care" means care, services or supplies related to the health of an individual.

(4) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating deidentified information; and

(j) Fundraising.

(5) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.005;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743A.184; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(6) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, an employer, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(7) "Health insurer" means:

(a) An insurer as defined in ORS 731.106 who offers:

(A) A health benefit plan as defined in ORS 743.730;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(8) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(a) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(9) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(10) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or a representative under ORS 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 192.573.

(11)(a) "Protected health information" means individually identifiable health information that is maintained or transmitted in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

(12) "State health plan" means:

(a) Medical assistance as defined in ORS 414.025;

(b) The Health Care for All Oregon Children program; **or**

[*(c) The Family Health Insurance Assistance Program established in ORS 414.841 to 414.864; or*]

[*(d)*] **(c)** Any medical assistance or premium assistance program operated by the Oregon Health Authority.

(13) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers.

SECTION 43. ORS 410.080 is amended to read:

410.080. (1) The Department of Human Services is the designated single state agency for all federal programs under ORS 409.010 and 410.040 to 410.300 except that the Oregon Health Authority is the single state agency responsible for supervising the administration of all programs funded by Title XIX or Title XXI of the Social Security Act as provided in ORS 413.032 [*(1)(j)*] **(1)(i)**.

(2) Except as provided in ORS 410.070 (2)(d) and 410.100, the administration of services to clients under ORS 410.040 to 410.300 shall be through area agencies, and shall comply with all applicable federal regulations.

SECTION 44. ORS 413.011, as amended by section 15, chapter 38, Oregon Laws 2012, is amended to read:

413.011. (1) The duties of the Oregon Health Policy Board are to:

(a) Be the policy-making and oversight body for the Oregon Health Authority established in ORS 413.032 and all of the authority's departmental divisions.

(b) Develop and submit a plan to the Legislative Assembly by December 31, 2010, to provide and fund access to affordable, quality health care for all Oregonians by 2015.

(c) Develop a program to provide health insurance premium assistance to all low and moderate income individuals who are legal residents of Oregon.

(d) Establish and continuously refine uniform, statewide health care quality standards for use by all purchasers of health care, third-party payers and health care providers as quality performance benchmarks.

(e) Establish evidence-based clinical standards and practice guidelines that may be used by providers.

(f) Approve and monitor community-centered health initiatives described in ORS 413.032 [*(1)(i)*] **(1)(h)** that are consistent with public health goals, strategies, programs and performance standards adopted by the Oregon Health Policy Board to improve the health of all Oregonians, and shall regularly report to the Legislative Assembly on the accomplishments and needed changes to the initiatives.

(g) Establish cost containment mechanisms to reduce health care costs.

(h) Ensure that Oregon's health care workforce is sufficient in numbers and training to meet the demand that will be created by the expansion in health coverage, health care system transformations, an increasingly diverse population and an aging workforce.

(i) Work with the Oregon congressional delegation to advance the adoption of changes in federal law or policy to promote Oregon's comprehensive health reform plan.

(j) Establish a health benefit package in accordance with ORS 741.340 to be used as the baseline for all health benefit plans offered through the Oregon Health Insurance Exchange.

(k) [*By December 31, 2010,*] Investigate and report **annually** to the Legislative Assembly[*, and annually thereafter,*] on the feasibility and advisability of future changes to the health insurance market in Oregon, including but not limited to the following:

(A) A requirement for every resident to have health insurance coverage.

(B) A payroll tax as a means to encourage employers to continue providing health insurance to their employees.

(C) The implementation of a system of interoperable electronic health records utilized by all health care providers in this state.

(L) Meet cost-containment goals by structuring reimbursement rates to reward comprehensive management of diseases, quality outcomes and the efficient use of resources by promoting cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations.

(m) Oversee the expenditure of moneys from the Health Care Workforce Strategic Fund to support grants to primary care providers and rural health practitioners, to increase the number of primary care educators and to support efforts to create and develop career ladder opportunities.

(n) Work with the Public Health Benefit Purchasers Committee, administrators of the medical assistance program and the Department of Corrections to identify uniform contracting standards for health benefit plans that achieve maximum quality and cost outcomes and align the contracting standards for all state programs to the greatest extent practicable.

(2) The Oregon Health Policy Board is authorized to:

(a) Subject to the approval of the Governor, organize and reorganize the authority as the board considers necessary to properly conduct the work of the authority.

(b) Submit directly to the Legislative Counsel, no later than October 1 of each even-numbered year, requests for measures necessary to provide statutory authorization to carry out any of the board's duties or to implement any of the board's recommendations. The measures may be filed prior to the beginning of the legislative session in accordance with the rules of the House of Representatives and the Senate.

(3) If the board or the authority is unable to perform, in whole or in part, any of the duties described in ORS 413.006 to 413.042, 413.101 and

741.340 without federal approval, the authority is authorized to request, in accordance with ORS 413.072, waivers or other approval necessary to perform those duties. The authority shall implement any portions of those duties not requiring legislative authority or federal approval, to the extent practicable.

(4) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on the board by ORS 413.006 to 413.042, 413.101 and 741.340 and by other statutes.

(5) The board shall consult with the Department of Consumer and Business Services in completing the tasks set forth in subsection (1)(j) and (k)(A) of this section.

SECTION 45. ORS 413.032 is amended to read:

413.032. (1) The Oregon Health Authority is established. The authority shall:

(a) Carry out policies adopted by the Oregon Health Policy Board;

(b) Administer the Oregon Integrated and Coordinated Health Care Delivery System established in ORS 414.620;

(c) Administer the Oregon Prescription Drug Program;

[*(d) Administer the Family Health Insurance Assistance Program;*]

[*(e)*] **(d)** Develop the policies for and the provision of publicly funded medical care and medical assistance in this state;

[*(f)*] **(e)** Develop the policies for and the provision of mental health treatment and treatment of addictions;

[*(g)*] **(f)** Assess, promote and protect the health of the public as specified by state and federal law;

[*(h)*] **(g)** Provide regular reports to the board with respect to the performance of health services contractors serving recipients of medical assistance, including reports of trends in health services and enrollee satisfaction;

[*(i)*] **(h)** Guide and support, with the authorization of the board, community-centered health initiatives designed to address critical risk factors, especially those that contribute to chronic disease;

[*(j)*] **(i)** Be the state Medicaid agency for the administration of funds from Titles XIX and XXI of the Social Security Act and administer medical assistance under ORS chapter 414;

[*(k)*] **(j)** In consultation with the Director of the Department of Consumer and Business Services, periodically review and recommend standards and methodologies to the Legislative Assembly for:

(A) Review of administrative expenses of health insurers;

(B) Approval of rates; and

(C) Enforcement of rating rules adopted by the Department of Consumer and Business Services;

[*(L)*] **(k)** Structure reimbursement rates for providers that serve recipients of medical assistance to reward comprehensive management of diseases, quality outcomes and the efficient use of resources and to promote cost-effective procedures, services and programs including, without limitation, preventive health, dental and primary care services, web-based office visits, telephone consultations and telemedicine consultations;

[*(m)*] **(L)** Guide and support community three-share agreements in which an employer, state or local government and an individual all contribute a portion of a premium for a community-centered health initiative or for insurance coverage;

[*(n)*] **(m)** Develop, in consultation with the Department of Consumer and Business Services, one or more products designed to provide more affordable options for the small group market; and

[*(o)*] **(n)** Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).

(2) The Oregon Health Authority is authorized to:

(a) Create an all-claims, all-payer database to collect health care data and monitor and evaluate health care reform in Oregon and to provide comparative cost and quality information to consumers, providers and purchasers of health care about Oregon's health care systems and health plan networks in order to provide comparative information to consumers.

(b) Develop uniform contracting standards for the purchase of health care, including the following:

(A) Uniform quality standards and performance measures;

(B) Evidence-based guidelines for major chronic disease management and health care services with unexplained variations in frequency or cost;

(C) Evidence-based effectiveness guidelines for select new technologies and medical equipment; and

(D) A statewide drug formulary that may be used by publicly funded health benefit plans.

(3) The enumeration of duties, functions and powers in this section is not intended to be exclusive nor to limit the duties, functions and powers imposed on or vested in the Oregon Health Authority by ORS 413.006 to 413.042, 413.101 and 741.340 or by other statutes.

SECTION 46. ORS 413.201 is amended to read:

413.201. (1) The Oregon Health Authority is responsible for statewide outreach and marketing of the Health Care for All Oregon Children program established in ORS 414.231 and administered by the authority [*and the Office of Private Health Partnerships*] with the goal of enrolling in those programs all eligible children residing in this state.

(2) To maximize the enrollment and retention of eligible children in the Health Care for All Oregon Children program, the authority shall develop and administer a grant program to provide funding to organizations and community based groups to deliver culturally specific and targeted outreach and direct application assistance to:

(a) Members of racial, ethnic and language minority communities;

(b) Children living in geographic isolation; and

(c) Children and family members with additional barriers to accessing health care, such as cognitive, mental health or sensory disorders, physical disabilities or chemical dependency, and children experiencing homelessness.

SECTION 47. ORS 414.041 is amended to read:

414.041. (1) The Oregon Health Authority, under the direction of the Oregon Health Policy Board and in collaboration with the Department of Human Services, shall implement a streamlined and simple application process for the medical assistance and premium assistance programs administered by the Oregon Health Authority [*and the Office of Private Health Partnerships*]. The process shall include, but not be limited to:

(a) An online application that may be submitted via the Internet;

(b) Application forms that are readable at a sixth grade level and that request the minimum amount of information necessary to begin processing the application; and

(c) Application assistance from qualified staff to aid individuals who have language, cognitive, physical or geographic barriers to applying for medical assistance or premium assistance.

(2) In developing the simplified application forms, the department shall consult with persons not employed by the department who have experience in serving vulnerable and hard-to-reach populations.

(3) The Oregon Health Authority shall facilitate outreach and enrollment efforts to connect eligible individuals with all available publicly funded health programs[*, including but not limited to the Family Health Insurance Assistance Program*].

SECTION 48. ORS 414.231, as amended by section 39 of this 2013 Act, is amended to read:

414.231. (1) As used in this section, "child" means a person under 19 years of age.

(2) The Health Care for All Oregon Children program is established to make affordable, accessible health care available to all of Oregon's children. The program is composed of:

(a) Medical assistance funded in whole or in part by Title XIX of the Social Security Act, by the State Children's Health Insurance Program under Title XXI of the Social Security Act and by moneys appropriated or allocated for that purpose by the Legislative Assembly; and

(b) A private health option [*administered by the Office of Private Health Partnerships under*] **described in** ORS 414.826.

(3) A child is eligible for medical assistance under either subsection (2)(a) or (b) of this section if the child is lawfully present in this state and the income of the child's family is at or below 300 percent of the federal poverty guidelines. There is no asset limit to qualify for the program. The Department of Human Services or the Oregon Health Authority may prescribe by rule additional eligibility criteria for medical assistance described in subsection (2)(a) and (b) of this section consistent with federal requirements for receiving federal financial participation in the costs of the program and consistent with this section.

(4)(a) A child receiving medical assistance through the Health Care for All Oregon Children program is continuously eligible for a minimum period of 12 months or until the child reaches 19 years of age, whichever comes first.

(b) The department or the authority shall reenroll a child for successive 12-month periods of enrollment as long as the child is eligible for medical assistance on the date of reenrollment and the child has not yet reached 19 years of age.

(c) A child may not be required to submit a new application as a condition of reenrollment under paragraph (b) of this subsection, and the department or the authority must determine the child's eligibility for medical assistance using information and sources available to the department or the authority or documentation that is readily available to the child or the child's caretaker.

[*(5) Except for medical assistance funded by Title XIX of the Social Security Act, the department or the authority may prescribe by rule a period of uninsurance prior to enrollment in the program.*]

SECTION 49. ORS 414.826 is amended to read:

414.826. (1) As used in this section:

(a) "Child" means a person under 19 years of age who is lawfully present in this state.

(b) "Dental plan" [*has the meaning given that term in ORS 414.841*] **means a policy or certificate of group or individual health insurance, as defined in ORS 731.162, providing payment or reimbursement only for the expenses of dental care**.

(c) "Health benefit plan" has the meaning given that term in ORS [*414.841*] **743.730**.

(2) The [*Office of Private Health Partnerships*] **Oregon Health Authority** shall administer a private health option to expand access to private health insurance for Oregon's children.

(3) The [*office*] **authority** shall adopt by rule criteria for health benefit plans to qualify for premium assistance under the private health option. The criteria may include, but are not limited to, the following:

[*(a) The health benefit plan meets or exceeds the requirements for a basic benchmark health benefit plan under ORS 414.856.*]

[*(b)*] **(a)** The health benefit plan offers a benefit package comparable to the health services provided to children receiving medical assistance, including mental health, vision and dental services, and without any exclusion of or delay of coverage for preexisting conditions.

[*(c)*] **(b)** The health benefit plan imposes copayments or other cost sharing that is based upon a family's ability to pay.

[*(d)*] **(c)** Expenditures for the health benefit plan qualify for federal financial participation.

(4) To qualify for premium assistance under the private health option:

(a) A dental plan must provide coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function and treat emergency conditions.

(b) Expenditures for the dental plan must qualify for federal financial participation.

(5) The amount of premium assistance provided under this section shall be:

(a) Equal to the full cost of the premiums for a health benefit plan and a dental plan for children whose family income is at or below 200 percent of the federal poverty guidelines and who have access to employer sponsored health insurance; and

(b) Based on a sliding scale under criteria established by the [*office*] **authority** by rule for children whose family income is above 200 percent but at or below 300 percent of the federal poverty guidelines, regardless of whether the child has access to coverage under an employer sponsored health benefit plan or dental plan.

[*(6) A child whose family income is more than 300 percent of the federal poverty guidelines shall be offered the opportunity to purchase a health benefit plan or dental plan through the private health option but may not receive premium assistance.*]

(6) Premium assistance may be available under this section to a child described in subsection (5)(b) of this section for a health benefit plan purchased through the Oregon Health Insurance Exchange.

SECTION 50. ORS 414.828 is amended to read:

414.828. Notwithstanding eligibility criteria and premium assistance amounts determined pursuant to ORS 414.826, the [*Office of Private Health Partnerships*] **Oregon Health Authority** shall provide premium assistance under the private health option to eligible children to the extent the Legislative Assembly appropriates funds for that purpose or establishes expenditure limitations to provide such premium assistance.

SECTION 51. ORS 414.839 is amended to read:

414.839. Subject to funds available, the Oregon Health Authority may provide medical assistance in the form of premium assistance for the purchase of health insurance coverage provided by public programs or private insurance, including but not limited to:

[*(1) The Family Health Insurance Assistance Program;*]

[*(2)*] **(1)** Medical assistance described in ORS 414.115; and

[*(3)*] **(2)** The Health Care for All Oregon Children program established in ORS 414.231.

SECTION 52. ORS 433.443 is amended to read:

433.443. (1) As used in this section:

(a) "Covered entity" means:

(A) The Children's Health Insurance Program;

[*(B) The Family Health Insurance Assistance Program established under ORS 414.842;*]

[*(C)*] **(B)** A health insurer that is an insurer as defined in ORS 731.106 and that issues health insurance as defined in ORS 731.162;

[*(D)*] **(C)** The state medical assistance program; and

[*(E)*] **(D)** A health care provider.

(b) "Health care provider" includes but is not limited to:

(A) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(B) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

(C) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(D) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(E) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(F) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(G) An emergency medical services provider licensed under ORS chapter 682;

(H) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(I) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(J) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(K) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(M) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(N) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(O) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(P) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(Q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(R) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(S) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(T) A health care facility as defined in ORS 442.015;

(U) A home health agency as defined in ORS 443.005;

(V) A hospice program as defined in ORS 443.850;

(W) A clinical laboratory as defined in ORS 438.010;

(X) A pharmacy as defined in ORS 689.005;

(Y) A diabetes self-management program as defined in ORS 743A.184; and

(Z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(c) "Individual" means a natural person.

(d) "Individually identifiable health information" means any oral or written health information in any form or medium that is:

(A) Created or received by a covered entity, an employer or a health care provider that is not a covered entity; and

(B) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(i) The past, present or future physical or mental health or condition of an individual;

(ii) The provision of health care to an individual; or

(iii) The past, present or future payment for the provision of health care to an individual.

(e) "Legal representative" means attorney at law, person holding a general power of attorney, guardian, conservator or any person appointed by a court to manage the personal or financial affairs of a person, or agency legally responsible for the welfare or support of a person.

(2)(a) During a public health emergency declared under ORS 433.441, the Public Health Director may, as necessary to appropriately respond to the public health emergency:

(A) Adopt reporting requirements for and provide notice of those requirements to health care providers, institutions and facilities for the purpose of obtaining information directly related to the public health emergency;

(B) After consultation with appropriate medical experts, create and require the use of diagnostic and treatment protocols to respond to the public health emergency and provide notice of those protocols to health care providers, institutions and facilities;

(C) Order, or authorize local public health administrators to order, public health measures appropriate to the public health threat presented;

(D) Upon approval of the Governor, take other actions necessary to address the public health emergency and provide notice of those actions to health care providers, institutions and facilities, including public health actions authorized by ORS 431.264;

(E) Take any enforcement action authorized by ORS 431.262, including the imposition of civil penalties of up to $500 per day against individuals, institutions or facilities that knowingly fail to comply with requirements resulting from actions taken in accordance with the powers granted to the Public Health Director under subparagraphs (A), (B) and (D) of this paragraph; and

(F) The authority granted to the Public Health Director under this section:

(i) Supersedes any authority granted to a local public health authority if the local public health authority acts in a manner inconsistent with guidelines established or rules adopted by the director under this section; and

(ii) Does not supersede the general authority granted to a local public health authority or a local public health administrator except as authorized by law or necessary to respond to a public health emergency.

(b) The authority of the Public Health Director to take administrative action, and the effectiveness of any action taken, under paragraph (a)(A), (B), (D), (E) and (F) of this subsection terminates upon the expiration of the [*proclaimed*] **declared** state of public health emergency, unless the actions are continued under other applicable law.

(3) Civil penalties under subsection (2) of this section shall be imposed in the manner provided in ORS 183.745. The Public Health Director must establish that the individual, institution or facility subject to the civil penalty had actual notice of the action taken that is the basis for the penalty. The maximum aggregate total for penalties that may be imposed against an individual, institution or facility under subsection (2) of this section is $500 for each day of violation, regardless of the number of violations of subsection (2) of this section that occurred on each day of violation.

(4)(a) During a [*proclaimed*] **declared** state of public health emergency, the Public Health Director and local public health administrators shall be given immediate access to individually identifiable health information necessary to:

(A) Determine the causes of an illness related to the public health emergency;

(B) Identify persons at risk;

(C) Identify patterns of transmission;

(D) Provide treatment; and

(E) Take steps to control the disease.

(b) Individually identifiable health information accessed as provided by paragraph (a) of this subsection may not be used for conducting nonemergency epidemiologic research or to identify persons at risk for post-traumatic mental health problems, or for any other purpose except the purposes listed in paragraph (a) of this subsection.

(c) Individually identifiable health information obtained by the Public Health Director or local public health administrators under this subsection may not be disclosed without written authorization of the identified individual except:

(A) Directly to the individual who is the subject of the information or to the legal representative of that individual;

(B) To state, local or federal agencies authorized to receive such information by state or federal law;

(C) To identify or to determine the cause or manner of death of a deceased individual; or

(D) Directly to a health care provider for the evaluation or treatment of a condition that is the subject of a proclamation of a state of public health emergency issued under ORS 433.441.

(d) Upon expiration of the state of public health emergency, the Public Health Director or local public health administrators may not use or disclose any individually identifiable health information that has been obtained under this section. If a state of emergency that is related to the state of public health emergency has been declared under ORS 401.165, the Public Health Director and local public health administrators may continue to use any individually identifiable information obtained as provided under this section until termination of the state of emergency.

(5) All civil penalties recovered under this section shall be paid into the State Treasury and credited to the General Fund and are available for general governmental expenses.

(6) The Public Health Director may request assistance in enforcing orders issued pursuant to this section from state or local law enforcement authorities. If so requested by the Public Health Director, state and local law enforcement authorities, to the extent resources are available, shall assist in enforcing orders issued pursuant to this section.

(7) If the Oregon Health Authority adopts temporary rules to implement the provisions of this section, the rules adopted are not subject to the provisions of ORS 183.335 (6)(a). The authority may amend temporary rules adopted pursuant to this subsection as often as necessary to respond to the public health emergency.

SECTION 53. Section 1, chapter 867, Oregon Laws 2009, as amended by section 46, chapter 828, Oregon Laws 2009, section 2, chapter 73, Oregon Laws 2010, and section 31, chapter 602, Oregon Laws 2011, is amended to read:

Sec. 1. (1) The Health System Fund is established in the State Treasury, separate and distinct from the General Fund. Interest earned by the Health System Fund shall be credited to the fund.

(2) Amounts in the Health System Fund are continuously appropriated to the Oregon Health Authority for the purpose of funding the Health Care for All Oregon Children program established in ORS 414.231, health services described in ORS 414.025 (8)(a) to (j) and other health services. Moneys in the fund may also be used by the authority to:

(a) Provide grants to community health centers and safety net clinics under ORS 413.225.

(b) Pay refunds due under section 41, chapter 736, Oregon Laws 2003, and under section 11, chapter 867, Oregon Laws 2009.

(c) Pay administrative costs incurred by the authority to administer the assessment in section 9, chapter 867, Oregon Laws 2009.

(d) Provide health services described in ORS 414.025 (8) to individuals described in ORS 414.025 (3)(f)(B).

[*(3) The authority shall develop a system for reimbursement by the authority to the Office of Private Health Partnerships out of the Health System Fund for costs associated with administering the private health option pursuant to ORS 414.826.*]

CONFORMING AMENDMENTS

SECTION 54. ORS 731.036 is amended to read:

731.036. Except as provided in ORS 743.061 or as specifically provided by law, the Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

(1) A bail bondsman, other than a corporate surety and its agents.

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date.

(3) A religious organization providing insurance benefits only to its employees, if the organization is in existence and exempt from taxation under section 501(c)(3) of the federal Internal Revenue Code on September 13, 1975.

(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for tort liability in accordance with ORS 30.282.

(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance program for property damage in accordance with ORS 30.282.

(6) Cities, counties, school districts, community college districts, community college service districts or districts, as defined in ORS 198.010 and 198.180, that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employees or retired employees, or their dependents, or students engaged in school activities, or combination of employees and dependents, with or without employee or student contributions, if all of the following conditions are met:

(a) The individual or jointly self-insured program meets the following minimum requirements:

(A) In the case of a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals;

(B) In the case of an individual public body program other than a school district, community college district or community college service district, the number of covered employees and dependents and retired employees and dependents aggregates at least 500 individuals; and

(C) In the case of a joint program of two or more public bodies, the number of covered employees and dependents and retired employees and dependents aggregates at least 1,000 individuals;

(b) The individual or jointly self-insured health insurance program includes all coverages and benefits required of group health insurance policies under ORS chapters 743 and 743A;

(c) The individual or jointly self-insured program must have program documents that define program benefits and administration;

(d) Enrollees must be provided copies of summary plan descriptions including:

(A) Written general information about services provided, access to services, charges and scheduling applicable to each enrollee's coverage;

(B) The program's grievance and appeal process; and

(C) Other group health plan enrollee rights, disclosure or written procedure requirements established under ORS chapters 743 and 743A;

(e) The financial administration of an individual or jointly self-insured program must include the following requirements:

(A) Program contributions and reserves must be held in separate accounts and used for the exclusive benefit of the program;

(B) The program must maintain adequate reserves. Reserves may be invested in accordance with the provisions of ORS chapter 293. Reserve adequacy must be calculated annually with proper actuarial calculations including the following:

(i) Known claims, paid and outstanding;

(ii) A history of incurred but not reported claims;

(iii) Claims handling expenses;

(iv) Unearned contributions; and

(v) A claims trend factor; and

(C) The program must maintain adequate reinsurance against the risk of economic loss in accordance with the provisions of ORS 742.065 unless the program has received written approval for an alternative arrangement for protection against economic loss from the Director of the Department of Consumer and Business Services;

(f) The individual or jointly self-insured program must have sufficient personnel to service the employee benefit program or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services;

(g) The individual or jointly self-insured program shall be subject to assessment in accordance with ORS 735.614 [*and former enrollees shall be eligible for portability coverage in accordance with ORS 735.616*];

(h) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Consumer and Business Services copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

(i) Each public body in a joint insurance program is liable only to its own employees and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool.

(7) All ambulance services.

(8) A person providing any of the services described in this subsection. The exemption under this subsection does not apply to an authorized insurer providing such services under an insurance policy. This subsection applies to the following services:

(a) Towing service.

(b) Emergency road service, which means adjustment, repair or replacement of the equipment, tires or mechanical parts of a motor vehicle in order to permit the motor vehicle to be operated under its own power.

(c) Transportation and arrangements for the transportation of human remains, including all necessary and appropriate preparations for and actual transportation provided to return a decedent's remains from the decedent's place of death to a location designated by a person with valid legal authority under ORS 97.130.

(9)(a) A person described in this subsection who, in an agreement to lease or to finance the purchase of a motor vehicle, agrees to waive for no additional charge the amount specified in paragraph (b) of this subsection upon total loss of the motor vehicle because of physical damage, theft or other occurrence, as specified in the agreement. The exemption established in this subsection applies to the following persons:

(A) The seller of the motor vehicle, if the sale is made pursuant to a motor vehicle retail installment contract.

(B) The lessor of the motor vehicle.

(C) The lender who finances the purchase of the motor vehicle.

(D) The assignee of a person described in this paragraph.

(b) The amount waived pursuant to the agreement shall be the difference, or portion thereof, between the amount received by the seller, lessor, lender or assignee, as applicable, that represents the actual cash value of the motor vehicle at the date of loss, and the amount owed under the agreement.

(10) A self-insurance program for tort liability or property damage that is established by two or more affordable housing entities and that complies with the same requirements that public bodies must meet under ORS 30.282 (6). As used in this subsection:

(a) "Affordable housing" means housing projects in which some of the dwelling units may be purchased or rented, with or without government assistance, on a basis that is affordable to individuals of low income.

(b) "Affordable housing entity" means any of the following:

(A) A housing authority created under the laws of this state or another jurisdiction and any agency or instrumentality of a housing authority, including but not limited to a legal entity created to conduct a self-insurance program for housing authorities that complies with ORS 30.282 (6).

(B) A nonprofit corporation that is engaged in providing affordable housing.

(C) A partnership or limited liability company that is engaged in providing affordable housing and that is affiliated with a housing authority described in subparagraph (A) of this paragraph or a nonprofit corporation described in subparagraph (B) of this paragraph if the housing authority or nonprofit corporation:

(i) Has, or has the right to acquire, a financial or ownership interest in the partnership or limited liability company;

(ii) Has the power to direct the management or policies of the partnership or limited liability company;

(iii) Has entered into a contract to lease, manage or operate the affordable housing owned by the partnership or limited liability company; or

(iv) Has any other material relationship with the partnership or limited liability company.

(11) A community-based health care initiative approved by the Administrator of the Office for Oregon Health Policy and Research under ORS 735.723 operating a community-based health care improvement program approved by the administrator.

(12) Except as provided in ORS 735.500 and 735.510, a person certified by the Department of Consumer and Business Services to operate a retainer medical practice.

SECTION 55. ORS 735.625 is amended to read:

735.625. (1) Except as provided in subsection (3)(c) of this section, the Oregon Medical Insurance Pool Board shall offer major medical expense coverage to every eligible person.

(2) The coverage to be issued by the board, its schedule of benefits, exclusions and other limitations, shall be established through rules adopted by the board, taking into consideration the advice and recommendations of the pool members. In the absence of such rules, the pool shall adopt by rule the minimum benefits prescribed by section 6 (Alternative 1) of the Model Health Insurance Pooling Mechanism Act of the National Association of Insurance Commissioners (1984).

(3)(a) In establishing portability coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to the portability health benefit plans established under ORS 743.760.

(b) In establishing medical insurance coverage under the pool, the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations that the board determines are equivalent to those found in the commercial group or employer-based medical insurance market.

(c) The board may provide a separate Medicare supplement policy for individuals under the age of 65 who are receiving Medicare disability benefits. The board shall adopt rules to establish benefits, deductibles, coinsurance, exclusions and limitations, premiums and eligibility requirements for the Medicare supplement policy.

(d) In establishing medical insurance coverage for persons eligible for coverage under ORS 735.615 (1)(d), the board shall consider the levels of medical insurance provided in this state and medical economic factors identified by the board. The board may adopt rules to establish benefit levels, deductibles, coinsurance factors, exclusions and limitations to create benefit plans that qualify the person for the credit for health insurance costs under section 35 of the federal Internal Revenue Code, as amended and in effect on December 31, 2004.

(4)(a) Premiums charged for coverages issued by the board may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(b) Separate schedules of premium rates based on age and geographical location may apply for individual risks.

(c) The board shall determine the applicable medical and portability risk rates either by calculating the average rate charged by insurers offering coverages in the state comparable to the pool coverage or by using reasonable actuarial techniques. The risk rates shall reflect anticipated experience and expenses for such coverage. Rates for pool coverage may not be more than 125 percent of rates established as applicable for medically eligible individuals or for persons eligible for pool coverage under ORS 735.615 (1)(d), or 100 percent of rates established as applicable for portability eligible individuals.

(d) The board shall annually determine adjusted benefits and premiums. The adjustments shall be in keeping with the purposes of ORS 735.600 to 735.650, subject to a limitation of keeping pool losses under one percent of the total of all medical insurance premiums, subscriber contract charges and 110 percent of all benefits paid by member self-insurance arrangements. The board may determine the total number of persons that may be enrolled for coverage at any time and may permit and prohibit enrollment in order to maintain the number authorized. Nothing in this paragraph authorizes the board to prohibit enrollment for any reason other than to control the number of persons in the pool.

(5)(a) The board may apply:

(A) A waiting period of not more than 90 days during which the person has no available coverage; or

(B) Except as provided in paragraph (c) of this subsection, a preexisting conditions provision of not more than six months from the effective date of coverage under the pool.

(b) In determining whether a preexisting conditions provision applies to an eligible enrollee, except as provided in this subsection, the board shall credit the time the eligible enrollee was covered under a previous health benefit plan if the previous health benefit plan was continuous to a date not more than 63 days prior to the effective date of the new coverage under the Oregon Medical Insurance Pool, exclusive of any applicable waiting period. The Oregon Medical Insurance Pool Board need not credit the time for previous coverage to which the insured or dependent is otherwise entitled under this subsection with respect to benefits and services covered in the pool coverage that were not covered in the previous coverage.

(c) The board may adopt rules applying a preexisting conditions provision to a person who is eligible for coverage under ORS 735.615 (1)(d).

(d) For purposes of this subsection, a "preexisting conditions provision" means a provision that excludes coverage for services, charges or expenses incurred during a specified period not to exceed six months following the insured's effective date of coverage, for a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the insured's effective date of coverage.

(6)(a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or self-insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except the Medicaid portion of the medical assistance program offering a level of health services described in ORS 414.707.

(b) The board shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(7) [*Except as provided in ORS 735.616,*] No mandated benefit statutes apply to pool coverage under ORS 735.600 to 735.650.

(8) Pool coverage may be furnished through a health care service contractor or such alternative delivery system as will contain costs while maintaining quality of care.

SECTION 56. ORS 743.526 is amended to read:

743.526. (1) An insurer may not offer a policy of group health insurance described in [*ORS 743.522 (1)(c)*] **section 7 (3) of this 2013 Act** that insures persons in this state or offer coverage under such a policy, whether the policy is to be issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the requirements of this section and [*ORS 743.522 (1)(c)*] **section 7 (3) of this 2013 Act** are satisfied.

(2) The director shall determine with respect to a policy whether the trustees are the policyholder. If the director determines that the trustees are the policyholder and if the policy is issued or proposed to be issued in this state, the policy is subject to the Insurance Code. If the director determines that the trustees are not the policyholder, the evidence of coverage that is issued or proposed to be issued in this state to a participating employer, labor union or association shall be deemed to be a group health insurance policy subject to the provisions of the Insurance Code. The director may determine that the trustees are not the policyholder if:

(a) The evidence of coverage issued or proposed to be issued to a participating employer, labor union or association is in fact the primary statement of coverage for the employer, labor union or association; and

(b) The trust arrangement is under the actual control of the insurer.

(3) An insurer shall submit evidence to the director showing that the requirements of subsection (2) of this section and [*ORS 743.522 (1)(c)*] **section 7 (3) of this 2013 Act** are satisfied. The director shall review the evidence and may request additional evidence as needed.

(4) An insurer shall submit to the director any changes in the evidence submitted under subsection (3) of this section.

(5) The director may adopt rules to carry out this section.

SECTION 57. ORS 743.528 is amended to read:

743.528. A group health insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.

(2) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable, and the applicable rights and conditions set forth in ORS 743.527, 743.529[,] **and** 743.600 to 743.610 [*and 743.760*]. If de-

pendents are included in the coverage, only one statement need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

SECTION 58. 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 ORS 743.565.

(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 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.

(4) A group health insurance policy to which subsection (3) of this section applies shall contain a provision requiring the insurer to notify the group policyholder 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.

(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 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 receives the notice.

(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 59. ORS 743.730, as amended by section 49, chapter 500, Oregon Laws 2011, section 20, chapter 38, Oregon Laws 2012, and section 17 of this 2013 Act, is amended to read:

743.730. For purposes of 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 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 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;

(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) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon Health Insurance Exchange.

(7) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

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

(9) "Eligible employee" means an employee 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. "Eligible employee" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

(10) "Employee" means any individual employed by an employer.

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

(12) "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

(13) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(14) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director 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.

(15)(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) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(16) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(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:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) 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, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) 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;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) 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; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after

the expiration of a policy previously issued by the insurer to the policyholder.

(19) "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.

(20) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

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

(22) "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 or as prescribed by rule by the Department of Consumer and Business Services;

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

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored 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 that 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(24) "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.

(25) "Oregon Medical Insurance Pool" means the pool created under ORS 735.610.

(26) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a 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, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(27) "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.

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

(29) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(30)(a) "Small employer" means an employer that employed an average of at least one but not more than [*50*] **100** employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

SECTION 60. ORS 743.757 is amended to read:

743.757. (1) As used in this section, "guaranteed association" means an association that:

(a) The Director of the Department of Consumer and Business Services has determined under ORS 743.524 meets the requirements described in [*ORS 743.522 (1)(b)*] **section 7 (2) of this 2013 Act**; and

(b) Is a statewide nonprofit organization representing the interests of individuals licensed under ORS chapter 696.

(2) A carrier may offer a health benefit plan to a guaranteed association if the plan provides health benefits covering 500 or more members or dependents of members of the association.

(3) When a carrier offers coverage to a guaranteed association under subsection (2) of this section, the carrier shall offer coverage to all members of the association and all dependents of the members of the association without regard to the actual or expected health status of any member or any dependent of a member of the association.

(4) A carrier offering a health benefit plan under subsection (2) of this section shall establish premium rates as follows:

(a) For the initial 12-month period of coverage, the carrier shall submit to the director a certified statement that the premium rates charged to the guaranteed association are actuarially sound. The statement must be signed by an actuary certifying the accuracy of the rating methodology as established by the American Academy of Actuaries.

(b) For any subsequent 12-month period of coverage, according to a rating methodology as established by the American Academy of Actuaries.

(5) A member of a guaranteed association may apply for coverage offered by a carrier under subsection (2) of this section only:

(a) If the member has been an active member of the association for no less than 30 days;

(b) During an annual open enrollment period offered by the association; and

(c) After meeting any additional eligibility requirements agreed upon by the association and the carrier.

(6) Notwithstanding subsection (5) of this section, if a member or a dependent of a member of a guaranteed association terminates coverage under the health benefit plan, the member or dependent shall be excluded from coverage for 12 months from the date of termination of coverage. The member may enroll for coverage of the member or the dependent during an annual open enrollment period following the expiration of the exclusion period.

SECTION 61. ORS 743.769 is amended to read:

743.769. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier **that are not grandfathered health plans**.

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

(3) Subsection (2) of this section does not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

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

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

(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743.766 [*(5)(c)*] **(4)(c)** or to discontinue offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the director pursuant to ORS 743.766 [*(5)(c)*] **(4)(c)** or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care providers who are under contract with the carrier.

SECTION 61a. ORS 743.801, as amended by section 5, chapter 24, Oregon Laws 2012, is amended to read:

743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

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

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

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

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

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

(e) Determination that a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

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

(3) "Enrollee" has the meaning given that term in ORS 743.730.

(4) "Grievance" means:

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

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

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

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

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

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

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

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "Independent practice association" means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in [*ORS 743.522*] **section 7 of this 2013 Act**, to provide health care services to group members.

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

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

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

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

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

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

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

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

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

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

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

(12) "Prior authorization" means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. "Prior authorization" does not include referral approval for evaluation and management services between providers.

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

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

SECTION 62. ORS 743A.168 is amended to read:

743A.168. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

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

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

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

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

(e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(A) A health care facility;

(B) A residential program or facility;

(C) A day or partial hospitalization program;

(D) An outpatient service; or

(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

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

(4)(a) Nothing in this section requires coverage for:

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

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

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

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

(E) A screening interview or treatment program under ORS 813.021.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

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

(a) The provider is approved by the [*Department of Human Services*] **Oregon Health Authority**;

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

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

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

(6) Payments may not be made under this section for support groups.

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

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

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

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, posttreatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

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

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all eligible providers.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress.

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

CAPTIONS

SECTION 63. The unit captions used in this 2013 Act are provided only for the convenience of the reader and do not become part of the statutory law of this state or express any legislative intent in the enactment of this 2013 Act.

REPEALS AND OPERATIVE AND EFFECTIVE DATES

SECTION 64. Sections 2 to 6 and 40 of this 2013 Act and the amendments to ORS 192.556, 410.080, 413.011, 413.032, 413.201, 414.041, 414.231, 414.826, 414.828, 414.839, 433.443, 731.036, 735.625, 741.300, 743.018, 743.019, 743.405, 743.417, 743.420, 743.522, 743.524, 743.526, 743.528, 743.550, 743.552, 743.560, 743.610, 743.731, 743.733, 743.736, 743.737, 743.745, 743.748, 743.751, 743.752, 743.754, 743.757, 743.766, 743.767, 743.769, 743.777, 743.801, 743.804, 743.894, 743A.090, 743A.192, 746.015 and 746.045 and section 1, chapter 867, Oregon Laws 2009, by sections 10 to 16, 18, 19, 21 to 30, 32 to 37, 42 to 58, 60, 61 and 61a of this 2013 Act become operative January 1, 2014.

SECTION 65. ORS 414.831, 414.841, 414.842, 414.844, 414.846, 414.848, 414.851, 414.852, 414.854, 414.856, 414.858, 414.861, 414.862, 414.864, 414.866, 414.868, 414.870, 414.872, 735.616, 735.700, 735.701, 735.702, 735.703, 735.705, 735.707, 735.709, 735.710, 735.712, 743.549, 743.760 and 743.761 are repealed January 1, 2014.

SECTION 66. (1)(a) The amendments to ORS 743.730 by section 17 of this 2013 Act become operative January 2, 2014.

(b) The amendments to ORS 743.730 by section 59 of this 2013 Act become operative January 2, 2016.

(2) The amendments to ORS 731.146, 743.734 and 743.822 by sections 9, 20 and 31 of this 2013 Act become operative January 2, 2014.

SECTION 67. This 2013 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2013 Act takes effect on its passage.

Approved by the Governor July 29, 2013
Filed in the office of Secretary of State July 30, 2013
Effective date July 29, 2013