A-Engrossed
House Bill 2466

Ordered by the House April 22
Including House Amendments dated April 22

Introduced and printed pursuant to House Rule 12.00. Presession filed (at the request of Governor John A. Kitzhaber, M.D., for Department of Consumer and Business Services)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure.

Modifies requirements for health [*benefit plans*] **insurance** consistent with federal law.
Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance; creating new provisions; amending ORS 731.146, 743.106, 743.552, 743.602, 743.730, 743.731, 743.734, 743.736, 743.737, 743.745, 743.748, 743.751, 743.754, 743.766, 743.769, 743.818, 743.826, 743.911, 743A.141, 750.003 and 750.055 and section 66, chapter 681, Oregon Laws 2013; repealing ORS 743.775; and declaring an emergency.

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

SECTION 1. Sections 2 and 3 of this 2015 Act are added to and made a part of the Insurance Code.

SECTION 2. (1) As used in this section:

(a) "Carrier" has the meaning given that term in ORS 743.730.

(b) "Health benefit plan" has the meaning given that term in ORS 743.730.

(c) "Grandfathered health plan" has the meaning given that term in ORS 743.730.

(d) "Transitional grandfathered large employer health benefit plan" means a grandfathered health plan that is issued or renewed by an employer with 51 to 100 employees.

(e) "Transitional large employer health benefit plan" means a health benefit plan, other than a grandfathered health plan, that is:

(A) Before January 1, 2016, issued to or renewed by an employer with 51 to 100 employees on the date the plan is issued or renewed;

(B) In effect on December 31, 2015; and

(C) According to guidance issued by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury, consistent with the requirements of:

(i) 42 U.S.C. 300gg;

(ii) 42 U.S.C. 300gg-1;

(iii) 42 U.S.C. 300gg-2;

(iv) 42 U.S.C. 300gg-5;

(v) 42 U.S.C. 300gg-6; and

(vi) 42 U.S.C. 300gg-8.

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

(2) A transitional large employer health benefit plan and a transitional grandfathered large employer health benefit plan are not subject to the requirements:

(a) In ORS 742.005 (6);

(b) In ORS 743.737 (1)(a), (8), (10) and (11); and

(c) Imposing limitations on participation and contribution rates contained in ORS 743.737.

(3) A transitional large employer health benefit plan is not subject to ORS 743.737 (3).

(4) A transitional large employer health benefit plan is considered discontinued under ORS 743.737 when the carrier stops renewing the plan.

(5) ORS 743.752 (2) does not apply when a carrier discontinues a group health benefit plan on account of the change in the definition of "small employer" from an employer with a maximum of 50 employees to an employer with a maximum of 100 employees.

(6) The Department of Consumer and Business Services may modify the requirements of this section or extend or delay the operative date of this section to the extent necessary to comply with guidance described in subsection (1)(e)(C) of this section.

SECTION 3. Notwithstanding ORS 743.736, 743.737 and 743.754, a carrier is not required to actively market:

(1) A health benefit plan sold only to a bona fide association, to groups that are not members of the bona fide association;

(2) A grandfathered health plan, to a group or individual who is not eligible for coverage under the plan;

(3) A group health benefit plan, to a group that is not eligible for coverage under the plan;

(4) A qualified health plan sold only through the health insurance exchange, to an individual or group outside of the exchange; or

(5) A policy of group health insurance that may be delivered or issued for delivery in this state without the approval of the Director of the Department of Consumer and Business Services under ORS 742.003 (1).

SECTION 4. ORS 731.146 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*] **a multistate qualified health plan to individuals or small employers through the program administered by the United States Office of Personnel Management pursuant to 42 U.S.C. 18054**.

(i) Doing or proposing to do any insurance business in substance equivalent to any of paragraphs (a) to (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 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 5. ORS 743.106 is amended to read:

743.106. (1) No policy form shall be delivered or issued for delivery in this state unless:

(a) The policy text achieves a score of 40 or more on the Flesch reading ease test, or an equivalent score on any comparable test as provided in subsection (3) of this section;

(b) The policy, except for specification pages, schedules and tables is printed in not less than **12-point type, 13-point leading for health benefit plans, as defined in ORS 743.730, and** 10-point type, [*one point leaded*] **11-point leading for all other policies**;

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, including the text of any indorsements or riders; and

(d) The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the number of words if the policy has more than three pages.

(2) For the purposes of this section, a Flesch reading ease test score shall be calculated as follows:

(a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(c) The total number of syllables in the text shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted from 206.835 equals the Flesch reading ease test score for the policy form.

(e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be used:

(A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be counted as one word.

(B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence.

(C) A "syllable" means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) As used in this section, "text" includes all written matter except the following:

(A) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules or tables; and

(B) Policy language drafted to conform to the requirements of any state or federal law, regulation or agency interpretation; policy language required by any collectively bargained agreement; medical terminology; and words that are defined in the policy. However, the insurer shall identify the language or terminology excepted by this subparagraph and shall certify in writing that the language or terminology is entitled to be excepted by this subparagraph.

(3) Any other reading test may be approved by the Director of the Department of Consumer and Business Services as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the minimum required reading ease score on the test used, or stating that the score is lower than the minimum required but should be authorized in accordance with ORS 743.107. To confirm the accuracy of a certification, the director may require the submission of further information.

(5) At the option of the insurer, riders, indorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used.

SECTION 6. 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 coordination of benefits for individual and [*small*] group health insurance, including:

(1) The procedures by which persons insured under the policies are to be made aware of the existence of 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.

SECTION 7. ORS 743.602 is amended to read:

743.602. If a legally separated, divorced or surviving spouse elects continuation of coverage under ORS 743.601 (1) to (6):

(1) The monthly premium for the continuation shall not be greater than the amount that would be charged if the legally separated, divorced or surviving spouse were a current certificate holder of the group plan plus the amount that the group policyholder would contribute toward the premium if the legally separated, divorced or surviving spouse were a certificate holder of the group plan, plus an additional amount not to exceed two percent of the certificate holder and group plan holder contributions, for the costs of administration.

(2) The first premium shall be paid by the legally separated, divorced or surviving spouse within 45 days of the date of the election.

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(a) The failure to pay premiums when due, including any grace period allowed by the policy;

(b) The date that the group policy is terminated as to all group members except that if a different group policy is made available to group members, the legally separated, divorced or surviving spouse shall be eligible for continuation of coverage as if the original policy had not been terminated;

(c) The date on which the legally separated, divorced or surviving spouse becomes insured under any other group health plan;

(d) The date on which the legally separated[*,*] **or** divorced [*or surviving*] spouse remarries [*and becomes covered under another group health plan*]; or

(e) The date on which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage.

SECTION 8. ORS 743.730 is amended to read:

743.730. For purposes of ORS 743.730 to 743.773 **and 743.818 and section 3 of this 2015 Act**:

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

[*(9)*] **(8)** "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*] **is eligible for coverage under a group health benefit plan**.

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

[*(11)*] **(10)** "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)*] **(11)** "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

[*(13)*] **(12)** "Exclusion period" means a period during which specified treatments or services are

excluded from coverage.

[*(14)*] **(13)** "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)*] **(14)(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)*] **(15)** "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)*] **(16)** "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)*] **(17)(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*] **as defined in ORS 750.005**; 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)*] **(18)** "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)*] **(19)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(22)*] **(20)** "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)*] **(21)** "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

[*(24)*] **(22)** "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)*] **(23)** "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.

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

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

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

[*(29)(a) "Small employer" means an employer that employed an average of at least 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 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.*]

(27) "Small employer" has the meaning given that term in 42 U.S.C. 18024.

SECTION 9. ORS 743.730, as amended by section 59, chapter 681, Oregon Laws 2013, is amended to read:

743.730. For purposes of ORS 743.730 to 743.773 **and 743.818 and section 3 of this 2015 Act**:

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

[*(9)*] **(8)** "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*] **is eligible for coverage under a group health benefit plan**.

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

[*(11)*] **(10)** "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)*] **(11)** "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

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

[*(14)*] **(13)** "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)*] **(14)(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)*] **(15)** "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)*] **(16)** "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)*] **(17)(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*] **as defined in ORS 750.005**; 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)*] **(18)** "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)*] **(19)** "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

[*(22)*] **(20)** "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)*] **(21)** "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

[*(24)*] **(22)** "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)*] **(23)** "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.

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

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

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

[*(29)(a) "Small employer" means an employer that employed an average of at least one but not more than 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.*]

(27) "Small employer" has the meaning given that term in 42 U.S.C. 18024 unless otherwise prescribed by the department by rule in accordance with guidance issued by the United States Department of Health and Human Services, the United States Department of Labor or the United States Department of the Treasury.

SECTION 10. Section 66, chapter 681, Oregon Laws 2013, is amended to read:

Sec. 66. (1)(a) The amendments to ORS 743.730 by section 17**,** [*of this 2013 Act*] **chapter 681, Oregon Laws 2013,** become operative January 2, 2014.

(b) The amendments to ORS 743.730 by section 59**,** [*of this 2013 Act*] **chapter 681, Oregon Laws 2013,** become operative January [*2*] **1**, 2016.

(2) The amendments to ORS 731.146, 743.734 and 743.822 by sections 9, 20 and 31**,** [*of this 2013 Act*] **chapter 681, Oregon Laws 2013,** become operative January 2, 2014.

SECTION 11. ORS 743.731 is amended to read:

743.731. The purposes of ORS 743.730 to 743.773 and 743.923 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 and individual health benefit plans;

(4) To prohibit the use of preexisting condition exclusions except in **individual** grandfathered health plans;

(5) To encourage the availability of individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(6) To improve renewability and continuity of coverage for employers and covered individuals;

(7) To improve the efficiency and fairness of the health insurance marketplace; and

(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 12. ORS 743.734 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 Re-

venue Code of 1986, as amended.

(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.

(3)(a) A carrier may provide different health benefit plans to different categories of employees of a small employer 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 [*(8)*] **(7)**, a carrier that offers coverage to a small employer shall offer coverage to all eligible employees of the small employer.

(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.

(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.

SECTION 13. 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 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 that offers a health benefit plan in the small employer market only 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.*]

[*(3)*] **(2)** A carrier shall issue to a small employer any 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.

[*(4)*] **(3)** 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 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 may not include any requirements that relate to the actual or expected health status of the prospective enrollee.

[*(5)*] **(4)** A carrier shall, pursuant to subsection [*(3)*] **(2)** 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.

[*(6)*] **(5)** A carrier is not required to accept applications from and offer coverage pursuant to subsection [*(3)*] **(2)** 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.

[*(7)*] **(6)** A carrier shall **actively** market [*fairly*] all 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.

[*(8)(a)*] **(7)(a)** Subsection [*(3)*] **(2)** 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 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.

[*(9)*] **(8)** 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.

[*(10)*] **(9)** A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743.737 (3)(e)[,] **or** 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 (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.

[*(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 14. ORS 743.737 is amended to read:

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

(a) Must cover essential health benefits consistent with 42 U.S.C. [*300gg-11*] **300gg-6**.

(b) May[*:*]

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

[*(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*]

[*(C)*] **(c) May** not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(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)**(A)** 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)*] **(B)** With respect to plans that are being discontinued under [*paragraph (g) or (h) of this subsection,*] **subparagraph (A) of this paragraph, other than plans described in section 3 of this 2015 Act,** the carrier must:

[*(A)*] **(i)** 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)*] **(ii)** Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

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

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

[*(j)*] **(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 enrollees; or

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

[*(k)*] **(i)** 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)*] **(j)** In the case of a health benefit plan that is offered in the small employer market only 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.

(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 [*(3)(e), (g) and (h)*] **(3)(e) and (g)** of this section.

(5) Notwithstanding any provision of subsection (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.

(6) Notwithstanding any provision of subsection (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 pre-

scribed 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.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. 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.

(8) Premium rates for small employer health benefit plans**, except grandfathered health 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 variations in premium rates charged during a rating period for health benefit plans issued to small employers shall be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(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 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

(iii) Adjustments to reflect differences in family composition.

(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 and differences in family composition.

[*(e) Premium rates for small employer health benefit plans shall comply with the requirements of this section.*]

(9) Premium rates for grandfathered health plans shall be subject to requirements prescribed by the department by rule.

[*(9)*] **(10)** 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*] **considers** 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.

[*(10)(a)*] **(11)(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.

[*(11)*] **(12)** 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.

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

[*(13)*] **(14)** 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.

[*(14)*] **(15)** All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the department.

[*(15)*] **(16)** A small employer health benefit plan may not impose annual or lifetime limits on the

dollar amount of essential health benefits.

[*(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.*]

SECTION 15. ORS 743.745 is amended to read:

743.745. (1) In order to ensure the broadest availability of small employer and individual health benefit plans, the 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 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 department to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer 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.

(2) The 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.

[*(3) For small employer 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 16. ORS 743.748 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 **shall prescribe by rule the data that each carrier offering a health benefit plan is required to submit to the department** on or before April 1 of each year [*a report that contains:*] **and the form and manner for reporting the data.**

[*(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 Reinsurance Program;*]

[*(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 that are not small employers.*]

(2) A carrier may be required to report data under this section if the data:

(a) Is consistent with data reported in the carrier's annual report; and

(b) Is necessary for the department to assess the changing dynamics of the commercial health insurance market.

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

SECTION 17. ORS 743.748, as amended by section 38, chapter 698, Oregon Laws 2013, 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 **shall prescribe by rule the data that each carrier offering a health benefit plan is required to submit to the department** on or before April 1 of each year [*a report that contains:*] **and the form and manner for reporting the data.**

[*(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;*]

[*(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 that are not small employers.*]

(2) A carrier may be required to report data under this section if the data:

(a) Is consistent with data reported in the carrier's annual report; and

(b) Is necessary for the department to assess the changing dynamics of the commercial health insurance market.

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

SECTION 18. ORS 743.751 is amended to read:

743.751. [*(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.*]

(1) Except as provided in subsection (2) of this section, a carrier may not:

(a) Require an applicant to provide health-related information as a precondition for the issuance of an individual health benefit plan policy; or

(b) Deny coverage under an individual health benefit plan policy based on health-related information provided by the applicant.

(2) A carrier may require an applicant for an individual grandfathered health plan to complete the standard health statement prescribed by the Department of Consumer and Business Services prior to enrollment for the purpose of:

(a) Determining eligibility for coverage; or

(b) Imposing a preexisting condition provision.

(3) A carrier may require an enrollee in a health benefit plan to complete the standard health statement prescribed by the department for the purpose of:

(a) Managing the enrollee's health care; or

(b) Administering:

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

(B) A program to promote healthy behaviors under ORS 743.824; or

(C) A wellness program defined by the department by rule.

SECTION 19. 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) [*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.*]

[*(3) Late enrollees may be subjected to*]

(b) A group eligibility waiting period **for late enrollees** that does not exceed 90 days.

[*(4)*] **(3)** Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(4)(a) A carrier shall issue to a group any of the carrier's group health benefit plans offered by the carrier if the group is eligible for the plan, applies for the plan, agrees to make the required premium payments and agrees to satisfy the other requirements of the plan.

(b) The department may waive the requirements of this subsection if the department finds that issuing a plan to a group or groups would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(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 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)**(A)** 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)*] **(B)** With respect to plans that are being discontinued under [*paragraph (g) or (h) of this subsection*] **subparagraph (A) of this paragraph**, the carrier must:

[*(A)*] **(i)** 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)*] **(ii)** Offer the plans at least 90 days prior to discontinuation.

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

[*(j)*] **(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 enrollees; or

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

[*(k)*] **(i)** 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)*] **(j)** In the case of a health benefit plan that is offered in the group market only 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.

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

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under 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.

(8) Notwithstanding any provision of subsection (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.

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

[*(10)*] **(9)** A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

[*(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.*]

SECTION 20. ORS 743.766 is amended to read:

743.766. (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)*] **(b)** 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.

(2) If the carrier elects to restrict coverage as described in subsection (1) of this section, the carrier shall reduce the duration of the 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.

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

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, 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)**(A)** 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)*] **(B)** With respect to plans that are being discontinued under [*paragraph (e) or (f) of this subsection*] **subparagraph (A) of this paragraph**, the carrier must:

[*(A)*] **(i)** 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)*] **(ii)** Offer the plans at least 90 days prior to discontinuation.

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

[*(h)*] **(f)** 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)*] **(g)** 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)*] **(h)** 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.

(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 (4)(c), (e) and (f)*] **(4)(c) and (e)** of this section.

(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.

(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 (4) of this section.

(8) An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(9) A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.

[*(9)*] **(10)** This section does not require a carrier to actively market[,] **or** offer[*, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan.*]**:**

(a) A bona fide association health benefit plan to individuals who are not members of the bona fide association; or

(b) A grandfathered health plan to a small employer that is not eligible for coverage under the plan.

SECTION 21. ORS 743.766, as amended by section 20 of this 2015 Act, is amended to read:

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

(a) May not impose an individual coverage waiting period.

(b) 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.

[*(2) If the carrier elects to restrict coverage as described in subsection (1) of this section, the carrier shall reduce the duration of the 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.]

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

[*(4)*] **(3)** A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, 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 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 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)(A) The carrier discontinues offering or 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.

(B) With respect to plans that are being discontinued under subparagraph (A) of this paragraph, the carrier must:

(i) 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.

(ii) Offer the plans at least 90 days prior to discontinuation.

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

(f) 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.

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

(h) 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.

[*(5)*] **(4)** 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 (4)(c) and (e) of this section.

[*(6)*] **(5)** 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.

[*(7)*] **(6)** 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 (4) of this section.

[*(8)*] **(7)** An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

[*(9)*] **(8)** A grandfathered health plan may not impose lifetime limits on the dollar amount of essential health benefits.

[*(10)*] **(9)** This section does not require a carrier to actively market or offer:

(a) A bona fide association health benefit plan to individuals who are not members of the bona fide association; or

(b) A grandfathered health plan to a small employer that is not eligible for coverage under the plan.

SECTION 22. 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 [*(4)(c)*] **(3)(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 [*(4)(c)*] **(3)(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 23. ORS 743.818 is amended to read:

743.818. (1) A carrier offering a health benefit plan [*as defined in ORS 743.730*]**, an insurer offering insurance against the risk of economic loss assumed under a less than fully insured employee health plan described in ORS 742.065** and a third party administrator licensed under ORS 744.702 shall annually submit to the Department of Consumer and Business Services, in a form and manner prescribed by the department, data concerning the number of covered lives of the carrier**, insurer** or third party administrator, reported by line of business and by zip code.

(2) The department shall aggregate the data collected under subsection (1) of this section and may publish reports on the number of covered lives in Oregon, by line of business and by region.

SECTION 24. ORS 743.826 is amended to read:

743.826. A carrier may offer a catastrophic plan only [*through the exchange and only*] to an individual who:

(1) Is under 30 years of age at the beginning of the plan year; or

(2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year.

SECTION 25. ORS 743.911 is amended to read:

743.911. (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743.913 or has the effect of relieving either party of [*their*] **its** obligations under this section and ORS 743.913.

(3) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(4) This section does not create an assignment of payment to a provider.

(5) Each insurer shall report to the Director of the Department of Consumer and Business Services [*annually*] on its compliance under this section according to requirements established by the

director.

(6) The director shall adopt by rule a definition of "clean claim" and shall consider the definition of "clean claim" used by the federal Department of Health and Human Services for the payment of Medicare claims.

SECTION 26. ORS 743A.141 is amended to read:

743A.141. (1) As used in this section, "hearing aid" means any nondisposable, wearable instrument or device designed to aid or compensate for impaired human hearing and any necessary ear mold, part, attachments or accessory for the instrument or device, except batteries and cords.

(2) A health benefit plan, as defined in ORS 743.730, shall provide payment, coverage or reimbursement for one hearing aid per hearing impaired ear if:

(a) Prescribed, fitted and dispensed by a licensed audiologist with the approval of a licensed physician; and

(b) **Medically** necessary for the treatment of hearing loss in [*an enrollee in the plan who is:*] **a dependent child enrolled in the plan.**

[*(A) 18 years of age or younger; or*]

[*(B) 19 to 25 years of age and enrolled in a secondary school or an accredited educational institution.*]

(3)(a) The maximum benefit amount required by this section is $4,000 every 48 months, but a health benefit plan may offer a benefit that is more favorable to the enrollee. **An insurer shall adjust** the benefit amount [*shall be adjusted*] on January 1 of each year to reflect the increase since January 1, 2010, in the U.S. City Average Consumer Price Index for All Urban Consumers for medical care as published by the Bureau of Labor Statistics of the United States Department of Labor.

(b) [*A health benefit plan*] **An insurer** may not impose any financial or contractual penalty upon an audiologist if an enrollee elects to purchase a hearing aid priced higher than the benefit amount by paying the difference between the benefit amount and the price of the hearing aid.

(4) [*A health benefit plan may subject*] The payment, coverage or reimbursement required under this section **may be subject** to provisions of the **health benefit** plan that apply to other durable medical equipment benefits covered by the plan, including but not limited to provisions relating to deductibles, coinsurance and prior authorization.

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

SECTION 27. ORS 750.003 is amended to read:

750.003. The purpose of this section and ORS 750.005, 750.025 and 750.045 is to encourage and guarantee the development of health care service contractors by licensing and regulating their operation to [*insure*] **ensure** that they provide high quality health care services through state licensed organizations meeting reasonable standards as to administration, services and financial soundness.

SECTION 28. ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section 80, chapter 45, Oregon Laws 2014, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] **and** 731.870 [*and 743.061*].

(b) ORS 731.485, except in the case of a group practice health maintenance organization

that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

[*(b)*] **(c)** ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

[*(c)*] **(d)** ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

[*(d)*] **(e)** ORS chapter 734.

(f) ORS 735.600 to 735.650.

[*(e)*] **(g)** ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061,** 743.100 to 743.109, 743.402, **743.417,** 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550 to 743.552, 743.560, **743.565,** 743.600 to 743.610, 743.650 to 743.656, [*743.764,*] **743.680 to 743.689, 743.730 to 743.773, 743.777, 743.788, 743.790,** 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 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, **743.923,** 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 25, Oregon Laws 2014.

[*(f)*] **(h)** The provisions of ORS chapter 744 relating to the regulation of insurance producers **and third party administrators**.

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

[*(h)*] **(j)** ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

[*(i) ORS 735.600 to 735.650.*]

[*(j) ORS 743.680 to 743.689.*]

[*(k) ORS 744.700 to 744.740.*]

[*(L) ORS 743.730 to 743.773.*]

[*(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.*]

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

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

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

SECTION 29. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 6, chapter 25, Oregon Laws 2014, and section 81, chapter 45, Oregon Laws 2014, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] **and** 731.870 [*and 743.061*].

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

[*(b)*] **(c)** ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

[*(c)*] **(d)** ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

[*(d)*] **(e)** ORS chapter 734.

(f) ORS 735.600 to 735.650.

[*(e)*] **(g)** ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061,** 743.100 to 743.109, 743.402, **743.417,** 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552, 743.560, **743.565,** 743.600 to 743.610, 743.650 to 743.656, [*743.764,*] **743.680 to 743.689, 743.730 to 743.773, 743.777, 743.788, 743.790,** 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 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, **743.923,** 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, and section 2, chapter 25, Oregon Laws 2014.

[*(f)*] **(h)** The provisions of ORS chapter 744 relating to the regulation of insurance producers **and third party administrators**.

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

[*(h)*] **(j)** ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

[*(i) ORS 743.680 to 743.689.*]

[*(j) ORS 744.700 to 744.740.*]

[*(k) ORS 743.730 to 743.773.*]

[*(L) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.*]

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

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

chapter 732.

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

SECTION 30. ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, and section 82, chapter 45, Oregon Laws 2014, is amended to read:

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

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992[,] **and** 731.870 [*and 743.061*].

(b) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

[*(b)*] **(c)** ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

[*(c)*] **(d)** ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

[*(d)*] **(e)** ORS chapter 734.

(f) ORS 735.600 to 735.650.

[*(e)*] **(g)** ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, **743.061,** 743.100 to 743.109, 743.402, **743.417,** 743.472, 743.492, 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552, 743.560, **743.565,** 743.600 to 743.610, 743.650 to 743.656, [*743.764,*] **743.680 to 743.689, 743.730 to 743.773, 743.777, 743.788, 743.790,** 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 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, **743.923,** 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014.

[*(f)*] **(h)** The provisions of ORS chapter 744 relating to the regulation of insurance producers **and third party administrators**.

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

[*(h)*] **(j)** ORS 743A.024, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician, physician assistant or nurse practitioner associated with a group practice health maintenance organization.

[*(i) ORS 743.680 to 743.689.*]

[*(j) ORS 744.700 to 744.740.*]

[*(k) ORS 743.730 to 743.773.*]

[*(L) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.*]

(2) For the purposes of this section, health care service contractors shall be deemed insurers.

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

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

SECTION 31. ORS 743.775 is repealed.

SECTION 32. Section 2 of this 2015 Act is repealed on January 2, 2020.

SECTION 33. (1) The amendments to ORS 743.734, 743.736, 743.737, 743.751, 743.754, 750.003 and 750.055 by sections 12 to 14, 18, 19 and 27 to 30 of this 2015 Act apply to:

(a) A health benefit plan issued or renewed on or after the effective date of this 2015 Act; and

(b) A health benefit plan that, according to its terms, would renew on or after the effective date of this 2015 Act but is renewed prior to the effective date of this 2015 Act.

(2) If a health benefit plan was issued prior to the effective date of this 2015 Act, the amendments to ORS 743.734, 743.736, 743.737, 743.751, 743.754, 750.003 and 750.055 by sections 12 to 14, 18, 19 and 27 to 30 of this 2015 Act apply beginning on the date the health benefit plan is renewed.

(3) The amendments to ORS 743.106, 743.602, 743.730, 743.748, 743.766, 743.769, 743.818, 743.826, 743.911 and 743A.141 and section 66, chapter 681, Oregon Laws 2013, by sections 5, 7 to 10, 16, 17 and 21 to 26 of this 2015 Act apply to:

(a) A health benefit plan issued or renewed on or after January 1, 2016; and

(b) A health benefit plan that, according to its terms, would renew on or after January 1, 2016, but is renewed prior to January 1, 2016.

(4) If a health benefit plan was issued after the effective date of this 2015 Act and prior to January 1, 2016, the amendments to ORS 743.106, 743.602, 743.730, 743.748, 743.766, 743.769, 743.818, 743.826, 743.911 and 743A.141 and section 66, chapter 681, Oregon Laws 2013, by sections 5, 7 to 10, 16, 17 and 21 to 26 of this 2015 Act apply beginning on the date the health benefit plan is renewed.

SECTION 34. The amendments to ORS 743.766 and 743.769 by sections 21 and 22 of this 2015 Act become operative on January 1, 2016.

SECTION 35. This 2015 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect on its passage.