

Minority Report
B-Engrossed
House Bill 2758

Ordered by the Senate June 3
Including House Amendments dated April 28 and Senate Minority
Report Amendments dated June 3

Sponsored by nonconcurring members of the Senate Committee on Health Care: Senators KNOPP, KRUSE

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.

Prohibits carrier or third party administrator from disclosing to persons, other than enrollee who receives health services, protected health information relating to services provided to enrollee. **Prohibits carrier or third party administrator from withholding protected health information regarding enrollee who is under 18 years of age from parent or guardian of enrollee unless enrollee states that disclosure will subject enrollee to unlawful conduct or unless required by federal law.** Requires carrier and third party administrator to adopt procedures for enrollee to request to have protected health information protected from disclosure to policyholder or certificate holder and redirected to enrollee.

Declares emergency, effective on passage.

A BILL FOR AN ACT

1
2 Relating to protected health information; creating new provisions; amending ORS 743.801, 743.804,
3 746.607, 750.055 and 750.333; and declaring an emergency.

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

5 **SECTION 1. Section 2 of this 2015 Act is added to and made a part of the Insurance Code.**

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

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

8 (b) "Communication" includes:

9 (A) An explanation of benefits notice;

10 (B) Information about an appointment;

11 (C) A notice of an adverse benefit determination;

12 (D) A carrier's or third party administrator's request for additional information regard-
13 ing a claim;

14 (E) A notice of a contested claim;

15 (F) The name and address of a provider, a description of services provided and other visit
16 information; and

17 (G) Any written, oral or electronic communication described in this paragraph from a
18 carrier or a third party administrator to a policyholder, certificate holder or enrollee that
19 contains protected health information.

20 (c) "Confidential communications request" means a request from an enrollee to a carrier
21 or third party administrator that communications be sent directly to the enrollee and that
22 the carrier or third party administrator refrain from sending communications concerning

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.

1 the enrollee to the policyholder or certificate holder.

2 (d) "Protected health information" has the meaning given that term in ORS 192.556.

3 (2) A carrier and a third party administrator doing business in this state:

4 (a) Shall permit any enrollee to submit a confidential communications request.

5 (b) Shall update an enrollee on the status of implementing a confidential communications
6 request upon the enrollee's inquiry.

7 (3) The procedure adopted by a carrier or third party administrator for enrollees to make
8 confidential communications requests:

9 (a) Must allow enrollees to use the form described in subsection (4) of this section and
10 may also allow enrollees to make the request by other means such as telephone or the
11 Internet.

12 (b) Shall ensure that the confidential communications request remains in effect until the
13 enrollee revokes the request in writing or submits a new confidential communications re-
14 quest.

15 (c) Shall ensure that the confidential communications request is acted upon and imple-
16 mented by the carrier or third party administrator not later than seven days after receipt
17 of a request by electronic means or 30 days after receipt of a request in hard copy.

18 (d) May not require an enrollee to waive any right to limit disclosure under this section
19 as a condition of eligibility for or coverage under a health benefit plan.

20 (e) Must be easy to understand and to complete.

21 (4) The Department of Consumer and Business Services shall work with stakeholders to
22 develop and make available to the public a standardized form that an enrollee may submit
23 to a carrier or third party administrator to make a confidential communications request.
24 The department may encourage health care providers to clearly display the form and make
25 it available to patients. At a minimum, the form must:

26 (a) Inform an enrollee about the enrollee's right to have protected health information
27 sent to the enrollee and not disclosed to the policyholder or certificate holder;

28 (b) Allow an enrollee to indicate where to redirect communications containing protected
29 health information, including a specified mail or electronic mail address or specified tele-
30 phone number;

31 (c) Allow an enrollee to designate a mail or electronic mail address or telephone number
32 for the carrier or third party administrator to contact the enrollee if additional information
33 or clarification is necessary to process the confidential communications request; and

34 (d) Include a disclaimer that it may take up to 30 days from the date of receipt for a
35 carrier or third party administrator to process the form.

36 (5) If an insurer makes an adverse benefit determination regarding a claim concerning
37 health care provided to an enrollee who has made a confidential communications request:

38 (a) The enrollee has the right to appeal the determination; and

39 (b) The policyholder or certificate holder may not appeal the adverse benefit determi-
40 nation unless the enrollee has signed an authorization to disclose claims information rele-
41 vant to the appeal.

42 (6) As used in this section, "enrollee" does not include an individual who is in the custody
43 of the Department of Corrections.

44 (7) The department shall interpret this section in a manner that is consistent with fed-
45 eral law.

1 **(8) Notwithstanding subsection (2) of this section, a carrier or third party administrator**
2 **may not comply with a confidential communications request to withhold communications to**
3 **the parent or guardian of an enrollee who is under 18 years of age unless:**

4 **(a) The request is accompanied by the enrollee’s statement of reasonable belief that dis-**
5 **closure of specific information will subject the enrollee to unlawful conduct; or**

6 **(b) Federal law requires the insurer to comply with the confidential communications re-**
7 **quest.**

8 **SECTION 3. (1) No later than December 1, 2016, the Department of Consumer and Busi-**
9 **ness Services shall report, in the manner prescribed by ORS 192.245, on:**

10 **(a) The effectiveness of the process described in section 2 of this 2015 Act in allowing**
11 **health insurance enrollees to redirect insurance communications containing protected health**
12 **information, the extent to which enrollees are using the process and whether the process is**
13 **working properly; and**

14 **(b) The education and outreach activities conducted by carriers or third party adminis-**
15 **trators to inform Oregonians about their right to have protected health information redi-**
16 **rected.**

17 **(2) The department shall require carriers or third party administrators to report data**
18 **necessary for the department to produce the report described in subsection (1) of this sec-**
19 **tion.**

20 **SECTION 4. ORS 743.801 is amended to read:**

21 743.801. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 743.811,
22 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854,
23 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912, 743.913,
24 743.917 and 743.918 **and section 2 of this 2015 Act:**

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

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

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

30 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury
31 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
32 services;

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

35 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
36 course of treatment for purposes of continuity of care under ORS 743.854.

37 (2) “Authorized representative” means an individual who by law or by the consent of a person
38 may act on behalf of the person.

39 (3) “Enrollee” has the meaning given that term in ORS 743.730.

40 (4) “Grievance” means:

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

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

45 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expe-

1 dited external review; or

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

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

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

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

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

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

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

16 (8) "Internal appeal" means a review by an insurer of an adverse benefit determination made
17 by the insurer.

18 (9) "Managed health insurance" means any health benefit plan that:

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

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

25 (10) "Medical services contract" means a contract between an insurer and an independent
26 practice association, between an insurer and a provider, between an independent practice associ-
27 ation and a provider or organization of providers, between medical or mental health clinics, and
28 between a medical or mental health clinic and a provider to provide medical or mental health ser-
29 vices. "Medical services contract" does not include a contract of employment or a contract creating
30 legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other
31 similar professional organizations permitted by statute.

32 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

33 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
34 ployed by an insurer;

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

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

39 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has
40 as its sole financial incentive a hold harmless provision under which providers in the preferred
41 network agree to accept as payment in full the maximum allowable amounts that are specified in
42 the medical services contracts.

43 (12) "Prior authorization" means a determination by an insurer prior to provision of services
44 that the insurer will provide reimbursement for the services. "Prior authorization" does not include
45 referral approval for evaluation and management services between providers.

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

4 (14) "Utilization review" means a set of formal techniques used by an insurer or delegated by
5 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
6 cacy or efficiency of health care services, procedures or settings.

7 **SECTION 5.** ORS 743.801, as amended by section 3, chapter 596, Oregon Laws 2013, is amended
8 to read:

9 743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808,
10 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839,
11 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.911, 743.912,
12 743.913, 743.917 and 743.918 **and section 2 of this 2015 Act:**

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

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

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

18 (c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury
19 exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or
20 services;

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

23 (e) Determination that a course or plan of treatment that an enrollee is undergoing is an active
24 course of treatment for purposes of continuity of care under ORS 743.854.

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

27 (3) "Enrollee" has the meaning given that term in ORS 743.730.

28 (4) "Grievance" means:

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

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

33 (B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expe-
34 dited external review; or

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

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

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

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

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

43 (6) "Independent practice association" means a corporation wholly owned by providers, or whose
44 membership consists entirely of providers, formed for the sole purpose of contracting with insurers
45 for the provision of health care services to enrollees, or with employers for the provision of health

1 care services to employees, or with a group, as described in ORS 731.098, to provide health care
2 services to group members.

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

4 (8) "Internal appeal" means a review by an insurer of an adverse benefit determination made
5 by the insurer.

6 (9) "Managed health insurance" means any health benefit plan that:

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

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

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

20 (11)(a) "Preferred provider organization insurance" means any health benefit plan that:

21 (A) Specifies a preferred network of providers managed, owned or under contract with or em-
22 ployed by an insurer;

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

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

27 (b) "Preferred provider organization insurance" does not mean a health benefit plan that has
28 as its sole financial incentive a hold harmless provision under which providers in the preferred
29 network agree to accept as payment in full the maximum allowable amounts that are specified in
30 the medical services contracts.

31 (12) "Prior authorization" means a determination by an insurer prior to provision of services
32 that the insurer will provide reimbursement for the services. "Prior authorization" does not include
33 referral approval for evaluation and management services between providers.

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

37 (14) "Utilization review" means a set of formal techniques used by an insurer or delegated by
38 the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, effi-
39 cacy or efficiency of health care services, procedures or settings.

40 **SECTION 6.** ORS 743.804 is amended to read:

41 743.804. All insurers offering a health benefit plan in this state shall:

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

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

- 1 (A) To participate in decision making regarding the enrollee's health care.
- 2 (B) To be treated with respect and with recognition of the enrollee's dignity and need for pri-
3 vacy.
- 4 (C) To have grievances handled in accordance with this section.
- 5 (D) To be provided with the information described in this section.
- 6 (b) An explanation of the procedures described in subsection (2) of this section for making cov-
7 erage determinations and resolving grievances. The explanation must be culturally and linguistically
8 appropriate, as prescribed by the department by rule, and must include:
 - 9 (A) The procedures for requesting an expedited response to an internal appeal under subsection
10 (2)(d) of this section or for requesting an expedited external review of an adverse benefit determi-
11 nation;
 - 12 (B) A statement that if an insurer does not comply with the decision of an independent review
13 organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;
 - 14 (C) The procedure to obtain assistance available from the insurer, if any, and from the Depart-
15 ment of Consumer and Business Services in filing grievances; and
 - 16 (D) A description of the process for filing a complaint with the department.
- 17 (c) A summary of benefits and an explanation of coverage in a form and manner prescribed by
18 the department by rule.
 - 19 (d) A summary of the insurer's policies on prescription drugs, including:
 - 20 (A) Cost-sharing differentials;
 - 21 (B) Restrictions on coverage;
 - 22 (C) Prescription drug formularies;
 - 23 (D) Procedures by which a provider with prescribing authority may prescribe drugs not included
24 on the formulary;
 - 25 (E) Procedures for the coverage of prescription drugs not included on the formulary; and
 - 26 (F) A summary of the criteria for determining whether a drug is experimental or investigational.
 - 27 (e) A list of network providers and how the enrollee can obtain current information about the
28 availability of providers and how to access and schedule services with providers, including clinic
29 and hospital networks.
 - 30 (f) Notice of the enrollee's right to select a primary care provider and specialty care providers.
 - 31 (g) How to obtain referrals for specialty care in accordance with ORS 743.856.
 - 32 (h) Restrictions on services obtained outside of the insurer's network or service area.
 - 33 (i) The availability of continuity of care as required by ORS 743.854.
 - 34 (j) Procedures for accessing after-hours care and emergency services as required by ORS
35 743A.012.
 - 36 (k) Cost-sharing requirements and other charges to enrollees.
 - 37 (L) Procedures, if any, for changing providers.
 - 38 (m) Procedures, if any, by which enrollees may participate in the development of the insurer's
39 corporate policies.
 - 40 (n) A summary of how the insurer makes decisions regarding coverage and payment for treat-
41 ment or services, including a general description of any prior authorization and utilization control
42 requirements that affect coverage or payment.
 - 43 (o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other provid-
44 ers.
 - 45 (p) A summary of the insurer's procedures for protecting the confidentiality of medical records

1 and other enrollee information **and the requirement under section 2 of this 2015 Act that a**
2 **carrier or third party administrator send communications containing protected health in-**
3 **formation only to the enrollee who is the subject of the protected health information.**

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

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

7 (2) Establish procedures for making coverage determinations and resolving grievances that pro-
8 vide for all of the following:

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

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

13 (c) Written decisions meeting criteria established by the Director of the Department of Con-
14 sumer and Business Services by rule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 **SECTION 7.** ORS 746.607 is amended to read:

28 **746.607. Except as provided in section 2 of this 2015 Act,** a health insurer:

29 (1) May use or disclose personal information of an individual in a manner that is consistent with
30 an authorization provided by the individual or a personal representative of the individual.

31 (2) May use or disclose protected health information of an individual without obtaining an au-
32 thorization from the individual or a personal representative of the individual:

33 (a) For its own treatment, payment or health care operations; or

34 (b) As otherwise permitted or required by state or federal law or by order of the court.

35 (3) May disclose, subject to any requirements established by rule under ORS 746.608 and con-
36 sistent with federal law, protected health information of an individual without obtaining an author-
37 ization from the individual or a personal representative of the individual:

38 (a) To another covered entity for health care operations activities of the entity that receives the
39 information if:

40 (A) Each entity has or had a relationship with the individual who is the subject of the protected
41 health information; and

42 (B) The protected health information pertains to the relationship and the disclosure is for the
43 purpose of:

44 (i) Health care operations listed in ORS 746.600 (13)(a) or (b); or

45 (ii) Health care fraud and abuse detection or compliance;

1 (b) To another covered entity or any other health care provider for treatment activities of a
2 health care provider; or

3 (c) To another covered entity or any other health care provider for the payment activities of the
4 entity that receives the information.

5 (4) May use or disclose personal financial information of an individual:

6 (a) To perform a business, professional or insurance function, subject to any requirements es-
7 tablished by rule under ORS 746.608 for an authorization by an individual or a personal represen-
8 tative of an individual; or

9 (b) Without obtaining an authorization by the individual or the personal representative of the
10 individual as otherwise permitted or required by state or federal law or by order of the court.

11 (5) May charge a reasonable, cost-based fee, provided that the fee includes only the cost of:

12 (a) Copying personal information requested by an individual or a personal representative of the
13 individual, including the cost of supplies for and labor of copying;

14 (b) Postage, when an individual or a personal representative of the individual has requested that
15 copies of personal information or an explanation or summary of protected health information be
16 mailed; or

17 (c) Preparing an explanation or summary of personal information if requested by an individual
18 or a personal representative of the individual.

19 (6) Shall provide adequate notice of the uses and disclosures of personal information that may
20 be made by the health insurer and of the individual's rights and the health insurer's legal duties
21 with respect to personal information.

22 (7) Shall permit an individual or a personal representative of an individual to request:

23 (a) Access to inspect or obtain a copy of the individual's personal financial information or pro-
24 tected health information that is maintained in a designated record set about the individual; or

25 (b) That the health insurer correct, amend or delete personal information.

26 **SECTION 8.** ORS 750.055, as amended by section 5, chapter 25, Oregon Laws 2014, and section
27 80, chapter 45, Oregon Laws 2014, is amended to read:

28 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
29 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

30 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
31 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
32 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
33 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

34 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not
35 including ORS 732.582.

36 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
37 to 733.780.

38 (d) ORS chapter 734.

39 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
40 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
41 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550 to
42 743.552, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to
43 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864,
44 743.894, 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036,
45 743A.048, 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082,

1 743A.084, 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144,
2 743A.148, 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188,
3 743A.190, 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, [and] section 2,
4 chapter 25, Oregon Laws 2014, **and section 2 of this 2015 Act.**

5 (f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

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

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

12 (i) ORS 735.600 to 735.650.

13 (j) ORS 743.680 to 743.689.

14 (k) ORS 744.700 to 744.740.

15 (L) ORS 743.730 to 743.773.

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

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

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

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

26 **SECTION 9.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section
27 6, chapter 25, Oregon Laws 2014, and section 81, chapter 45, Oregon Laws 2014, is amended to read:

28 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
29 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

30 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
31 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
32 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
33 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

34 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not
35 including ORS 732.582.

36 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
37 to 733.780.

38 (d) ORS chapter 734.

39 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
40 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
41 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,
42 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,
43 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,
44 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,
45 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,

1 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,
2 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,
3 743A.192 and 743A.250 and section 2, chapter 771, Oregon Laws 2013, [and] section 2, chapter 25,
4 Oregon Laws 2014, **and section 2 of this 2015 Act.**

5 (f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

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

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

12 (i) ORS 743.680 to 743.689.

13 (j) ORS 744.700 to 744.740.

14 (k) ORS 743.730 to 743.773.

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

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

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

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

25 **SECTION 10.** ORS 750.055, as amended by section 33, chapter 698, Oregon Laws 2013, section
26 21, chapter 771, Oregon Laws 2013, section 7, chapter 25, Oregon Laws 2014, and section 82, chapter
27 45, Oregon Laws 2014, is amended to read:

28 750.055. (1) The following provisions of the Insurance Code apply to health care service con-
29 tractors to the extent not inconsistent with the express provisions of ORS 750.005 to 750.095:

30 (a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386,
31 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510,
32 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735,
33 731.737, 731.750, 731.752, 731.804, 731.844 to 731.992, 731.870 and 743.061.

34 (b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not
35 including ORS 732.582.

36 (c) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695
37 to 733.780.

38 (d) ORS chapter 734.

39 (e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to
40 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.472, 743.492,
41 743.495, 743.498, 743.499, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.550, 743.552,
42 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.764, 743.804, 743.807, 743.808, 743.814 to 743.839,
43 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.894,
44 743.911, 743.912, 743.913, 743.917, 743A.010, 743A.012, 743A.020, 743A.034, 743A.036, 743A.048,
45 743A.058, 743A.062, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070, 743A.080, 743A.082, 743A.084,

1 743A.088, 743A.090, 743A.100, 743A.104, 743A.105, 743A.110, 743A.140, 743A.141, 743A.144, 743A.148,
2 743A.150, 743A.160, 743A.164, 743A.168, 743A.170, 743A.175, 743A.184, 743A.185, 743A.188, 743A.190,
3 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014, **and section 2 of this 2015**
4 **Act.**

5 (f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

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

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

12 (i) ORS 743.680 to 743.689.

13 (j) ORS 744.700 to 744.740.

14 (k) ORS 743.730 to 743.773.

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

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

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

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

25 **SECTION 11.** ORS 750.333, as amended by section 8, chapter 25, Oregon Laws 2014, is amended
26 to read:

27 750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a mul-
28 tiple employer welfare arrangement:

29 (a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328,
30 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484,
31 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992 and 743.061.

32 (b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

33 (c) ORS chapter 734.

34 (d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

35 (e) ORS 743.028, 743.053, 743.499, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560,
36 743.562, 743.600, 743.601, 743.602, 743.610, 743.730 to 743.773 (except 743.766 to 743.773), 743.801,
37 743.804, 743.807, 743.808, 743.814 to 743.839, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858,
38 743.859, 743.861, 743.862, 743.863, 743.864, 743.894, 743.912, 743.917, 743A.012, 743A.020, 743A.034,
39 743A.052, 743A.064, 743A.065, 743A.080, 743A.082, 743A.100, 743A.104, 743A.110, 743A.144, 743A.150,
40 743A.170, 743A.175, 743A.184, 743A.192 and 743A.250 and section 2, chapter 25, Oregon Laws 2014,
41 **and section 2 of this 2015 Act.**

42 (f) ORS 743A.010, 743A.014, 743A.024, 743A.028, 743A.032, 743A.036, 743A.040, 743A.048,
43 743A.058, 743A.066, 743A.068, 743A.070, 743A.084, 743A.088, 743A.090, 743A.105, 743A.140, 743A.141,
44 743A.148, 743A.168, 743A.180, 743A.185, 743A.188 and 743A.190. Multiple employer welfare arrange-
45 ments to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this para-

1 graph only as provided in ORS 743.730 to 743.773.

2 (g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insur-
3 ance consultants, and ORS 744.700 to 744.740.

4 (h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

5 (i) ORS 731.592 and 731.594.

6 (j) ORS 731.870.

7 (2) For the purposes of this section:

8 (a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

9 (b) References to certificates of authority shall be considered references to certificates of mul-
10 tiple employer welfare arrangement.

11 (c) Contributions shall be considered premiums.

12 (3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the
13 transaction of health insurance.

14 **SECTION 12. The Department of Consumer and Business Services shall work with**
15 **stakeholders and consumer groups to develop the standardized form described in section 2**
16 **of this 2015 Act and shall make the form available to the public not later than 90 days after**
17 **the effective date of this 2015 Act.**

18 **SECTION 13. Section 2 of this 2015 Act applies to health benefit plans issued or renewed**
19 **on or after January 1, 2016.**

20 **SECTION 14. This 2015 Act being necessary for the immediate preservation of the public**
21 **peace, health and safety, an emergency is declared to exist, and this 2015 Act takes effect**
22 **on its passage.**

23