

Requested by Representative MALSTROM

**PROPOSED AMENDMENTS TO  
HOUSE BILL 4156**

1 On page 1 of the printed bill, line 2, after the semicolon delete the rest  
2 of the line and line 3 and insert “creating new provisions; and amending ORS  
3 743B.005, 743B.013, 743B.105, 743B.125, 750.055 and 750.333.”.

4 After line 4, insert:

5 **“SECTION 1. Section 2 of this 2018 Act is added to and made a part  
6 of the Insurance Code.**

7 **“SECTION 2. (1)(a) There may be no deductible or other cost-  
8 sharing requirements, other than a flat dollar copayment, applied to  
9 prescription drugs covered as a pharmacy benefit or as a medical  
10 benefit in at least 25 percent of all individual, small employer and  
11 group health benefit plans that are offered by a carrier in each ge-  
12 ographic area served by the carrier. Any flat dollar copayment must  
13 be:**

14 **“(A) Reasonably graduated from one cost tier to the next higher  
15 cost tier; and**

16 **“(B) Proportional across all tiers.**

17 **“(b) As used in this subsection, ‘tier’ means a group of prescription  
18 drugs, within a drug formulary, to which defined cost-sharing re-  
19 quirements apply.**

20 **“(2) A health benefit plan is excluded from the count of individual,  
21 small employer and group health benefit plans offered by a carrier in**

1 a geographic region served by the carrier if the health benefit plan is:

2 “(a) Offered by a carrier as a plan that qualifies for a health savings  
3 account and that requires a deductible on prescription drugs to qualify  
4 for a health savings account; or

5 “(b) A catastrophic plan as defined in ORS 743.826.

6 **“SECTION 3.** ORS 743B.005 is amended to read:

7 “743B.005. For purposes of ORS 743.004, 743.007, 743.022, 743.535, 743B.003  
8 to 743B.127 and 743B.128 **and section 2 of this 2018 Act:**

9 “(1) ‘Actuarial certification’ means a written statement by a member of  
10 the American Academy of Actuaries or other individual acceptable to the  
11 Director of the Department of Consumer and Business Services that a carrier  
12 is in compliance with the provisions of ORS 743B.012 based upon the person’s  
13 examination, including a review of the appropriate records and of the  
14 actuarial assumptions and methods used by the carrier in establishing pre-  
15 mium rates for small employer health benefit plans.

16 “(2) ‘Affiliate’ of, or person ‘affiliated’ with, a specified person means any  
17 carrier who, directly or indirectly through one or more intermediaries, con-  
18 trols or is controlled by or is under common control with a specified person.  
19 For purposes of this definition, ‘control’ has the meaning given that term in  
20 ORS 732.548.

21 “(3) ‘Affiliation period’ means, under the terms of a group health benefit  
22 plan issued by a health care service contractor, a period:

23 “(a) That is applied uniformly and without regard to any health status  
24 related factors to an enrollee or late enrollee;

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

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

29 “(d) That begins on the enrollee’s or late enrollee’s first date of eligibility  
30 for coverage and runs concurrently with any eligibility waiting period under

1 the plan.

2 “(4) ‘Bona fide association’ means an association that:

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

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

6 “(c) Does not condition membership in the association on any factor re-  
7 lating to the health status of an individual or the individual’s dependent or  
8 employee;

9 “(d) Makes health insurance coverage that is offered through the associ-  
10 ation available to all members of the association regardless of the health  
11 status of the member or individuals who are eligible for coverage through  
12 the member;

13 “(e) Does not make health insurance coverage that is offered through the  
14 association available other than in connection with a member of the associ-  
15 ation;

16 “(f) Has a constitution and bylaws; and

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

19 “(5) ‘Carrier’ means any person who provides health benefit plans in this  
20 state, including:

21 “(a) A licensed insurance company;

22 “(b) A health care service contractor;

23 “(c) A health maintenance organization;

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

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

27 “(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but  
28 elects to be governed by ORS 743B.010 to 743B.013; or

29 “(e) Any other person or corporation responsible for the payment of ben-  
30 efits or provision of services.

1 “(6) ‘Dependent’ means the spouse or child of an eligible employee, subject  
2 to applicable terms of the health benefit plan covering the employee.

3 “(7) ‘Eligible employee’ means an employee who is eligible for coverage  
4 under a group health benefit plan.

5 “(8) ‘Employee’ means any individual employed by an employer.

6 “(9) ‘Enrollee’ means an employee, dependent of the employee or an indi-  
7 vidual otherwise eligible for a group or individual health benefit plan who  
8 has enrolled for coverage under the terms of the plan.

9 “(10) ‘Exchange’ means an American Health Benefit Exchange described  
10 in 42 U.S.C. 18031, 18032, 18033 and 18041.

11 “(11) ‘Exclusion period’ means a period during which specified treatments  
12 or services are excluded from coverage.

13 “(12) ‘Financial impairment’ means that a carrier is not insolvent and is:

14 “(a) Considered by the director to be potentially unable to fulfill its con-  
15 tractual obligations; or

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

18 “(13)(a) ‘Geographic average rate’ means the arithmetical average of the  
19 lowest premium and the corresponding highest premium to be charged by a  
20 carrier in a geographic area established by the director for the carrier’s:

21 “(A) Group health benefit plans offered to small employers; or

22 “(B) Individual health benefit plans.

23 “(b) ‘Geographic average rate’ does not include premium differences that  
24 are due to differences in benefit design, age, tobacco use or family composi-  
25 tion.

26 “(14) ‘Grandfathered health plan’ has the meaning prescribed by rule by  
27 the United States Secretaries of Labor, Health and Human Services and the  
28 Treasury pursuant to 42 U.S.C. 18011(e) that is in effect on January 1, 2017.

29 “(15) ‘Group eligibility waiting period’ means, with respect to a group  
30 health benefit plan, the period of employment or membership with the group

1 that a prospective enrollee must complete before plan coverage begins.

2 “(16)(a) ‘Health benefit plan’ means any:

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

5 “(B) Subscriber contract of a health care service contractor as defined in  
6 ORS 750.005; or

7 “(C) Plan provided by a multiple employer welfare arrangement or by  
8 another benefit arrangement defined in the federal Employee Retirement In-  
9 come Security Act of 1974, as amended, to the extent that the plan is subject  
10 to state regulation.

11 “(b) ‘Health benefit plan’ does not include:

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

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

16 “(C) Medicare supplement insurance policies;

17 “(D) Coverage of TRICARE services pursuant to contracts with the fed-  
18 eral government;

19 “(E) Benefits delivered through a flexible spending arrangement estab-  
20 lished pursuant to section 125 of the Internal Revenue Code of 1986, as  
21 amended, when the benefits are provided in addition to a group health ben-  
22 efit plan;

23 “(F) Separately offered long term care insurance, including, but not lim-  
24 ited to, coverage of nursing home care, home health care and community-  
25 based care;

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

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

30 “(I) Dental only coverage;

1 “(J) Vision only coverage;

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

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

4 “(M) Insurance arising out of a workers’ compensation or similar law;

5 “(N) Automobile medical payment insurance or insurance under which

6 benefits are payable with or without regard to fault and that is statutorily

7 required to be contained in any liability insurance policy or equivalent self-

8 insurance; or

9 “(O) Any employee welfare benefit plan that is exempt from state regu-

10 lation because of the federal Employee Retirement Income Security Act of

11 1974, as amended.

12 “(c) For purposes of this subsection, renewal of a short term health in-

13 surance policy includes the issuance of a new short term health insurance

14 policy by an insurer to a policyholder within 60 days after the expiration of

15 a policy previously issued by the insurer to the policyholder.

16 “(17) ‘Individual health benefit plan’ means a health benefit plan:

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

18 “(b) That provides individual coverage through a trust, association or

19 similar group, regardless of the situs of the policy or contract.

20 “(18) ‘Initial enrollment period’ means a period of at least 30 days fol-

21 lowing commencement of the first eligibility period for an individual.

22 “(19) ‘Late enrollee’ means an individual who enrolls in a group health

23 benefit plan subsequent to the initial enrollment period during which the

24 individual was eligible for coverage but declined to enroll. However, an eli-

25 gible individual shall not be considered a late enrollee if:

26 “(a) The individual qualifies for a special enrollment period in accordance

27 with 42 U.S.C. 300gg or as prescribed by rule by the Department of Consumer

28 and Business Services;

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

30 “(c) A court issues an order that coverage be provided for a spouse or

1 minor child under an employee’s employer sponsored health benefit plan and  
2 request for enrollment is made within 30 days after issuance of the court  
3 order;

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

7 “(e) The individual’s coverage under Medicaid, Medicare, TRICARE, In-  
8 dian Health Service or a publicly sponsored or subsidized health plan, in-  
9 cluding, but not limited to, the medical assistance program under ORS  
10 chapter 414, has been involuntarily terminated within 63 days after applying  
11 for coverage in a group health benefit plan.

12 “(20) ‘Multiple employer welfare arrangement’ means a multiple employer  
13 welfare arrangement as defined in section 3 of the federal Employee Retire-  
14 ment Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject  
15 to ORS 750.301 to 750.341.

16 “(21) ‘Preexisting condition exclusion’ means:

17 “(a) Except for a grandfathered health plan, a limitation or exclusion of  
18 benefits or a denial of coverage based on a medical condition being present  
19 before the effective date of coverage or before the date coverage is denied,  
20 whether or not any medical advice, diagnosis, care or treatment was recom-  
21 mended or received for the condition before the date of coverage or denial  
22 of coverage.

23 “(b) With respect to a grandfathered health plan, a provision applicable  
24 to an enrollee or late enrollee that excludes coverage for services, charges  
25 or expenses incurred during a specified period immediately following enroll-  
26 ment for a condition for which medical advice, diagnosis, care or treatment  
27 was recommended or received during a specified period immediately preced-  
28 ing enrollment. For purposes of this paragraph pregnancy and genetic infor-  
29 mation do not constitute preexisting conditions.

30 “(22) ‘Premium’ includes insurance premiums or other fees charged for a

1 health benefit plan, including the costs of benefits paid or reimbursements  
2 made to or on behalf of enrollees covered by the plan.

3 “(23) ‘Rating period’ means the 12-month calendar period for which pre-  
4 mium rates established by a carrier are in effect, as determined by the car-  
5 rier.

6 “(24) ‘Representative’ does not include an insurance producer or an em-  
7 ployee or authorized representative of an insurance producer or carrier.

8 “(25) ‘Small employer’ means an employer who employed an average of  
9 at least one but not more than 50 full-time equivalent employees on business  
10 days during the preceding calendar year and who employs at least one full-  
11 time equivalent employee on the first day of the plan year, determined in  
12 accordance with a methodology prescribed by the Department of Consumer  
13 and Business Services by rule.”.

14 In line 5, delete “1” and insert “4”.

15 On page 5, delete lines 28 through 37 and insert “a prescription drug; or

16 “(c) Impose new utilization controls on a prescription drug, including but  
17 not limited to prior authorization or step therapy.

18 “(18)(a) Subsection (17) of this section does not prohibit a carrier, during  
19 a plan year, from:

20 “(A) Adding to a prescription drug formulary a prescription drug newly  
21 approved by the United States Food and Drug Administration;

22 “(B) Reducing a deductible, copayment, coinsurance or other cost sharing  
23 applicable to a prescription drug; or

24 “(C) Eliminating one or more utilization controls applicable to a pre-  
25 scription drug.

26 “(b) Subsection (17) of this section does not prohibit a pharmacist, when  
27 dispensing a prescription drug, from substituting a generic equivalent drug  
28 or an interchangeable biological product for the prescribed drug or product  
29 in accordance with ORS 689.515 or 689.522.

30 “(19) A carrier that offers a small employer health benefit plan that re-



1 imbuers the costs of prescription drugs sold by a retail pharmacy or ad-  
2 ministered by a health care provider shall make publicly available on the  
3 carrier’s website, without the necessity of entering a password, a user name  
4 or personally identifying information, all of the following:

5 “(a) The prescription drug formulary for each health benefit plan, elec-  
6 tronically searchable by drug name.

7 “(b) Notice of any change to the prescription drug formulary due to the  
8 deletion or addition of a drug, no later than 72 hours after the effective date  
9 of the change.

10 “(c) Notice of any change to the prescription drug formulary other than  
11 changes described in paragraph (b) of this subsection, such as changes to  
12 drug strength or form, no later than 14 calendar days after the effective date  
13 of the change.

14 “(d) The cost sharing typically paid by an enrollee for each drug on the  
15 prescription drug formulary, indicated by the following dollar ranges:

16 “(A) \$100 or less.

17 “(B) More than \$100 but not more than \$250.

18 “(C) More than \$250 but not more than \$500.

19 “(D) More than \$500 but not more than \$1,000.

20 “(E) More than \$1,000.

21 “(e) Any prior authorization, step therapy or other utilization control  
22 applicable to each drug on the prescription drug formulary.”.

23 In line 38, delete “2” and insert “5”.

24 On page 8, delete lines 16 through 25 and insert “a prescription drug; or

25 “(c) Impose new utilization controls on a prescription drug, including but  
26 not limited to prior authorization or step therapy.

27 “(11)(a) Subsection (10) of this section does not prohibit a carrier, during  
28 a plan year, from:

29 “(A) Adding to a prescription drug formulary a prescription drug newly  
30 approved by the United States Food and Drug Administration;

1 “(B) Reducing a deductible, copayment, coinsurance or other cost sharing  
2 applicable to a prescription drug; or

3 “(C) Eliminating one or more utilization controls applicable to a pre-  
4 scription drug.

5 “(b) Subsection (10) of this section does not prohibit a pharmacist, when  
6 dispensing a prescription drug, from substituting a generic equivalent drug  
7 or an interchangeable biological product for the prescribed drug or product  
8 in accordance with ORS 689.515 or 689.522.

9 “(12) A carrier that offers a group health benefit plan that reimburses the  
10 costs of prescription drugs sold by a retail pharmacy or administered by a  
11 health care provider shall make publicly available on the carrier’s website,  
12 without the necessity of entering a password, a user name or personally  
13 identifying information, all of the following:

14 “(a) The prescription drug formulary for each health benefit plan, elec-  
15 tronically searchable by drug name.

16 “(b) Notice of any change to the prescription drug formulary due to the  
17 deletion or addition of a drug, no later than 72 hours after the effective date  
18 of the change.

19 “(c) Notice of any change to the prescription drug formulary other than  
20 changes described in paragraph (b) of this subsection, such as changes to  
21 drug strength or form, no later than 14 calendar days after the effective date  
22 of the change.

23 “(d) The cost sharing typically paid by an enrollee for each drug on the  
24 prescription drug formulary, indicated by the following dollar ranges:

25 “(A) \$100 or less.

26 “(B) More than \$100 but not more than \$250.

27 “(C) More than \$250 but not more than \$500.

28 “(D) More than \$500 but not more than \$1,000.

29 “(E) More than \$1,000.

30 “(e) Any prior authorization, step therapy or other utilization control

1 applicable to each drug on the prescription drug formulary.”.

2 In line 26, delete “3” and insert “6”.

3 On page 10, delete lines 39 through 45 and delete page 11 and insert “a  
4 prescription drug; or

5 “(c) Impose new utilization controls on a prescription drug, including but  
6 not limited to prior authorization or step therapy.

7 “(12)(a) Subsection (11) of this section does not prohibit a carrier, during  
8 a plan year, from:

9 “(A) Adding to a prescription drug formulary a prescription drug newly  
10 approved by the United States Food and Drug Administration;

11 “(B) Reducing a deductible, copayment, coinsurance or other cost sharing  
12 applicable to a prescription drug; or

13 “(C) Eliminating one or more utilization controls applicable to a pre-  
14 scription drug.

15 “(b) Subsection (11) of this section does not prohibit a pharmacist, when  
16 dispensing a prescription drug, from substituting a generic equivalent drug  
17 or an interchangeable biological product for the prescribed drug or product  
18 in accordance with ORS 689.515 or 689.522.

19 “(13) A carrier that offers an individual health benefit plan that reim-  
20 burses the costs of prescription drugs sold by a retail pharmacy or adminis-  
21 tered by a health care provider shall make publicly available on the carrier’s  
22 website, without the necessity of entering a password, a user name or per-  
23 sonally identifying information, all of the following:

24 “(a) The prescription drug formulary for each health benefit plan, elec-  
25 tronically searchable by drug name.

26 “(b) Notice of any change to the prescription drug formulary due to the  
27 deletion or addition of a drug, no later than 72 hours after the effective date  
28 of the change.

29 “(c) Notice of any change to the prescription drug formulary other than  
30 changes described in paragraph (b) of this subsection, such as changes to

1 drug strength or form, no later than 14 calendar days after the effective date  
2 of the change.

3 “(d) The cost sharing typically paid by an enrollee for each drug on the  
4 prescription drug formulary, indicated by the following dollar ranges:

5 “(A) \$100 or less.

6 “(B) More than \$100 but not more than \$250.

7 “(C) More than \$250 but not more than \$500.

8 “(D) More than \$500 but not more than \$1,000.

9 “(E) More than \$1,000.

10 “(e) Any prior authorization, step therapy or other utilization control  
11 applicable to each drug on the prescription drug formulary.

12 **“SECTION 7.** ORS 750.055 is amended to read:

13 “750.055. (1) The following provisions apply to health care service con-  
14 tractors to the extent not inconsistent with the express provisions of ORS  
15 750.005 to 750.095:

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

17 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,  
18 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-  
19 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,  
20 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,  
21 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

22 “(c) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and  
23 732.517 to 732.596, not including ORS 732.582.

24 “(d) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to  
25 733.680 and 733.695 to 733.780.

26 “(e) ORS 734.014 to 734.440.

27 “(f) ORS 735.600 to 735.650.

28 “(g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to  
29 742.162 and 742.518 to 742.542.

30 “(h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020,

1 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to  
2 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,  
3 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680  
4 to 743.689, 743.788 and 743.790.

5 “(i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,  
6 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,  
7 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,  
8 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,  
9 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,  
10 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188,  
11 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260 and section 2, chapter  
12 771, Oregon Laws 2013.

13 “(j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to  
14 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,  
15 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285,  
16 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341,  
17 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,  
18 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,  
19 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 **and section 2 of this**  
20 **2018 Act.**

21 “(k) The following provisions of ORS chapter 744:

22 “(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to  
23 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regu-  
24 lation of insurance producers;

25 “(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635,  
26 744.650, 744.655 and 744.665, relating to the regulation of insurance consult-  
27 ants; and

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

30 “(L) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605,

1 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660,  
2 746.668, 746.670, 746.675, 746.680 and 746.690.

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

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

9 “(b) ORS 743A.024, unless the patient is referred by a physician, physician  
10 assistant or nurse practitioner associated with a group practice health  
11 maintenance organization.

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

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

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

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

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

27 **“SECTION 8.** ORS 750.055, as amended by section 21, chapter 771, Oregon  
28 Laws 2013, section 7, chapter 25, Oregon Laws 2014, section 82, chapter 45,  
29 Oregon Laws 2014, section 9, chapter 59, Oregon Laws 2015, section 7, chap-  
30 ter 100, Oregon Laws 2015, section 7, chapter 224, Oregon Laws 2015, section

1 11, chapter 362, Oregon Laws 2015, section 10, chapter 470, Oregon Laws  
2 2015, section 30, chapter 515, Oregon laws 2015, section 10, chapter 206,  
3 Oregon Laws 2017, section 6, chapter 417, Oregon Laws 2017, and section 22,  
4 chapter 479, Oregon Laws 2017, is amended to read:

5 “750.055. (1) The following provisions apply to health care service con-  
6 tractors to the extent not inconsistent with the express provisions of ORS  
7 750.005 to 750.095:

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

9 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385,  
10 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.485, as pro-  
11 vided in subsection (2) of this section, ORS 731.488, 731.504, 731.508, 731.509,  
12 731.510, 731.511, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.730, 731.731,  
13 731.735, 731.737, 731.750, 731.752, 731.804, 731.808 and 731.844 to 731.992.

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

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

18 “(e) ORS 734.014 to 734.440.

19 “(f) ORS 735.600 to 735.650.

20 “(g) ORS 742.001 to 742.009, 742.013, 742.016, 742.061, 742.065, 742.150 to  
21 742.162 and 742.518 to 742.542.

22 “(h) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.019, 743.020,  
23 743.022, 743.023, 743.028, 743.029, 743.038, 743.040, 743.044, 743.050, 743.100 to  
24 743.109, 743.402, 743.405, 743.406, 743.417, 743.472, 743.492, 743.495, 743.498,  
25 743.522, 743.523, 743.524, 743.526, 743.535, 743.550, 743.650 to 743.656, 743.680  
26 to 743.689, 743.788 and 743.790.

27 “(i) ORS 743A.010, 743A.012, 743A.014, 743A.020, 743A.034, 743A.036,  
28 743A.040, 743A.044, 743A.048, 743A.051, 743A.052, 743A.058, 743A.060,  
29 743A.062, 743A.063, 743A.064, 743A.065, 743A.066, 743A.068, 743A.070,  
30 743A.080, 743A.082, 743A.084, 743A.088, 743A.090, 743A.100, 743A.104,

1 743A.105, 743A.108, 743A.110, 743A.124, 743A.140, 743A.141, 743A.148,  
2 743A.150, 743A.160, 743A.168, 743A.170, 743A.175, 743A.185, 743A.188,  
3 743A.190, 743A.192, 743A.250, 743A.252 and 743A.260.

4 “(j) ORS 743B.001, 743B.003 to 743B.127, 743B.128, 743B.130, 743B.195 to  
5 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250, 743B.252, 743B.253,  
6 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.280 to 743B.285,  
7 743B.287, 743B.300, 743B.310, 743B.320, 743B.323, 743B.330, 743B.340, 743B.341,  
8 743B.342, 743B.343 to 743B.347, 743B.400, 743B.403, 743B.407, 743B.420,  
9 743B.423, 743B.450, 743B.451, 743B.452, 743B.453, 743B.470, 743B.475, 743B.505,  
10 743B.550, 743B.555, 743B.601, 743B.602 and 743B.800 **and section 2 of this**  
11 **2018 Act.**

12 “(k) The following provisions of ORS chapter 744:

13 “(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to  
14 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regu-  
15 lation of insurance producers;

16 “(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635,  
17 744.650, 744.655 and 744.665, relating to the regulation of insurance consult-  
18 ants; and

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

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

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

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

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



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

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

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

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

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

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

18 **“SECTION 9.** ORS 750.333 is amended to read:

19 “750.333. (1) The following provisions apply to trusts carrying out a mul-  
20 tiple employer welfare arrangement:

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

22 “(b) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316,  
23 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414,  
24 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620,  
25 731.640 to 731.652, 731.804, 731.808 and 731.844 to 731.992.

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

28 “(d) ORS 734.014 to 734.440.

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

30 “(f) ORS 743.004, 743.005, 743.007, 743.008, 743.010, 743.018, 743.020, 743.023,

1 743.028, 743.029, 743.053, 743.405, 743.406, 743.524, 743.526 and 743.535.

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

9 “(h) ORS 743B.001, 743B.003 to 743B.127 (except 743B.125 to 743B.127),  
10 743B.195 to 743B.204, 743B.220, 743B.222, 743B.225, 743B.227, 743B.250,  
11 743B.252, 743B.253, 743B.254, 743B.255, 743B.256, 743B.257, 743B.258, 743B.310,  
12 743B.320, 743B.321, 743B.330, 743B.340, 743B.341, 743B.342, 743B.343, 743B.344,  
13 743B.345, 743B.347, 743B.400, 743B.403, 743B.407, 743B.420, 743B.423, 743B.451,  
14 743B.453, 743B.470, 743B.505, 743B.550, 743B.555 and 743B.601 **and section 2**  
15 **of this 2018 Act.**

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

17 “(A) ORS 744.001 to 744.009, 744.011, 744.013, 744.014, 744.018, 744.022 to  
18 744.033, 744.037, 744.052 to 744.089, 744.091 and 744.093, relating to the regu-  
19 lation of insurance producers;

20 “(B) ORS 744.605, 744.609, 744.619, 744.621, 744.626, 744.631, 744.635,  
21 744.650, 744.655 and 744.665, relating to the regulation of insurance consult-  
22 ants; and

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

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

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

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

29 “(b) References to certificates of authority shall be considered references  
30 to certificates of multiple employer welfare arrangement.

1       “(c) Contributions shall be considered premiums.

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

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

6       “**SECTION 10. Section 2 of this 2018 Act and the amendments to**  
7 **ORS 743B.005, 743B.013, 743B.105, 743B.125, 750.055 and 750.333 by**  
8 **sections 3 to 9 of this 2018 Act apply to health benefit plans for which**  
9 **the Department of Consumer and Business Services has not approved**  
10 **rates on the effective date of this 2018 Act.”.**

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