House Bill 3077

Sponsored by COMMITTEE ON CONSUMER PROTECTION

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 **as introduced.**

Establishes Insurance Rate Review Board in Department of Consumer and Business Services. Requires board review and approval of all insurance rates, rating plans and rating systems filed or used by insurer, rating organization or advisory organization.

Declares emergency, effective July 1, 2007.

A BILL FOR AN ACT

Relating to insurance; creating new provisions; amending ORS 83.580, 183.457, 654.176, 731.260, 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312, 737.320, 737.322, 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490, 742.706, 743.015, 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781, Oregon Laws 2003; and declaring an emergency.

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

SECTION 1. Sections 2 to 6 of this 2007 Act are added to and made a part of ORS chapter 737.

SECTION 2. (1) The Insurance Rate Review Board is established in the Department of Consumer and Business Services. The purposes of the board are to represent the customers of insurers and the public generally in the regulation of insurance rates and to ensure that insurance rates are reasonable and justified.

(2) The board shall consist of five members appointed by the Governor.

(3) A member of the board may not be involved in the operation or management of an insurer or have a pecuniary interest or a direct financial interest in an insurer.

(4) The term of office of each member of the board is four years. Each member serves at the pleasure of the Governor. Before the expiration of the term of a member, the Governor shall appoint a successor whose term begins on July 1 next following. A member is eligible for reappointment for one additional term. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective for the unexpired term. The board shall nominate a slate of candidates whenever a vacancy occurs or is announced and shall forward the names of the recommended candidates to the Governor for consideration.

(5) The board shall select one of its members as chairperson and another as vice chairperson for the terms and with the duties and powers as the board considers necessary for the performance of the functions of those offices.

(6) The Governor may remove any member of the board at any time at the pleasure of the Governor. The board may remove a member as specified in the board bylaws.

(7) The board may appoint subcommittees and advisory groups as needed to assist the

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.

board.

(8) A majority of the members of the board then in office constitutes a quorum for the transaction of business.

(9) A member of the board is entitled to compensation and expenses as provided in ORS 292.495.

(10) The board shall appoint an administrator and employ other staff as necessary to carry out the functions of the board.

(11) The board shall adopt rules that the board considers necessary to carry out the functions of the board.

SECTION 3. (1) The Insurance Rate Review Board shall review and approve or disapprove all rates, rating plans and rating systems filed or used by an insurer or filed by a rating or advisory organization on behalf of an insurer. The insurer, rating organization or advisory organization has the burden of proving that the rates are reasonable and justified.

(2) A filing made under subsection (1) of this section is open to public inspection immediately upon submission to the board.

(3) Each filing shall be accompanied by the applicable fees established by the board by rule. The fees shall be based on the actual costs to the board of conducting the review process under this section.

(4) If, within 30 days of a filing, a majority of the members of the board requests a hearing or a person makes written application to the board for a hearing on the filing, the board shall hold a hearing on any rate, rating plan or rating system reviewed by the board under subsection (1) of this section prior to approving or disapproving the rate, rating plan or rating system.

(5) The board shall:

(a) Give written notice of the hearing to the insurer and to any person that has requested notice under subsection (6) of this section; and

(b) Provide copies of the information reviewed under subsection (1) of this section to any person that has requested information under subsection (6) of this section.

(6) A person may request in writing that the board mail to the person copies of the information reviewed under subsection (1) of this section or notices of hearings issued under subsection (5) of this section. The board shall acknowledge each request made under this subsection, establish mailing lists of persons that have requested information or notice under this subsection and maintain a record of all information and notices of hearings mailed pursuant to this subsection. The board may by rule establish fees to be charged to persons requesting information or notice under this subsection to defray the costs of mailings and maintenance of the lists.

(7) The board shall issue an order approving or disapproving the filing within:

(a) 45 days of a filing made under subsection (1) of this section; or

(b) 14 days of a hearing held under subsection (4) of this section.

(8) A filing approved by the board under this section shall be effective 14 days after the board issues an order approving the filing and shall remain effective during any review of the order.

(9) If the board disapproves a filing, the board shall send to the insurer, rating organization or advisory organization that made the filing written notice of the disapproval, specifying the reasons for the disapproval.

(10) An order issued under subsection (7) of this section may be reviewed as provided in ORS 183.480 to 183.540 for review of contested cases.

SECTION 4. (1) The Insurance Rate Review Board may enter into a written agreement with one or more organizations that represent broad customer interests in regulatory actions taken by the board. The agreement shall govern the manner in which the board may provide financial assistance to an organization found by the board to be qualified under subsection (2) of this section.

(2) Financial assistance under an agreement entered into under this section may be provided only to an organization that petitions the board to represent broad customer interests in proceedings before the board. The board by rule shall establish the qualifications that the board deems appropriate for determining which organizations are eligible for financial assistance under an agreement entered into under this section.

(3) In administering an agreement entered into under this section, the board may determine:

(a) The manner in which an organization may petition the board to represent customer interests before the board;

(b) The amount of financial assistance that may be provided to an organization;

(c) The manner in which the financial assistance will be distributed; and

(d) Other matters necessary to administer the agreement.

SECTION 5. (1) As used in this section and section 6 of this 2007 Act:

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

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

(2) An insurer that offers a group health benefit plan in this state may not deliver or issue for delivery a group health benefit plan unless the Insurance Rate Review Board has approved the rates under section 6 of this 2007 Act and the insurer has filed with the board the following:

(a) The proposed rates;

(b) If filing changes to a previously approved rate, an explanation of the changes;

(c) Financial information describing the basis for the proposed rates;

(d) The rate of return anticipated if the rates are approved;

(e) The average rate increase or decrease anticipated per enrollee;

(f) The medical loss ratio reserves and surpluses anticipated if the rates are approved;

(g) A summary of the insurer's nonmedical expenses for the most recent fiscal year; and

(h) Any other information required by the board by rule.

SECTION 6. (1) The Insurance Rate Review Board shall review a filing made by an insurer under section 5 of this 2007 Act and approve or disapprove the rates.

(2) The board shall approve the rates if the board determines that the health benefit plan provides for appropriate accessibility and affordability of needed health care services and that the rates are reasonable and justified.

(3) The board shall disapprove the rates if the board finds that:

(a) The benefits provided are unreasonable in relation to the rates charged; or

(b) The rates are unfair or excessive.

(4) When determining the reasonableness of a rate and whether to approve or disapprove

the rate, the board shall consider but is not limited to whether the insurer is:

(a) Eliminating or adding benefits covered under the health benefit plan;

(b) Increasing or decreasing benefits covered under the health benefit plan and whether the increase or decrease in benefits is due to a change in the formulas, methodologies or schedules that serve as the basis for making benefit determinations;

(c) Increasing or decreasing coinsurance, deductibles, copayments or other amounts to be paid by enrollees; or

(d) Establishing new conditions or requirements, such as preauthorization requirements to obtain benefits under the health benefit plan, or eliminating conditions or requirements.

SECTION 7. ORS 83.580 is amended to read:

83.580. (1) The amount, if any, included for automobile insurance, shall not exceed the premiums chargeable in accordance with rate filings made by the insurer with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** for such insurance.

(2) The amount, if any, included for life, health and accident or other insurance, other than automobile insurance, shall not exceed the premiums charged by the insurer.

(3) Except as provided in ORS 743.377, the motor vehicle dealer or financing agency, if an amount for automobile or other insurance on the motor vehicle is included in a retail installment contract, shall within 30 days after execution of the retail installment contract send or cause to be sent to the buyer a policy or policies or certificate of insurance, written by an insurance company authorized to do business in this state, clearly setting forth the amount of the premium, the kind or kinds of insurance and the scope of the coverage and all the terms, exceptions, limitations, restrictions and conditions of the contract or contracts of insurance. The buyer of a motor vehicle under a retail installment contract shall have the privilege of purchasing such insurance from an insurance producer of the selection of the buyer and of selecting an insurance company acceptable to the motor vehicle dealer; provided, however, that the inclusion of the insurance premium in the retail installment contract when the buyer selects the insurance producer or company, shall be optional with the motor vehicle dealer and in such case the motor vehicle dealer or financing agency shall have no obligation to send, or cause to be sent, to the buyer the policy or certificate of insurance.

(4) If an insurance policy or certificate that was obtained for an amount included in the retail installment contract is canceled, the unearned insurance premium refund received by the holder of the contract shall be credited to the last maturing installments of the retail installment contract except to the extent applied toward payment for similar insurance protecting the interests of the buyer or of the buyer and the holder of the contract.

SECTION 8. ORS 183.457 is amended to read:

183.457. (1) Notwithstanding ORS 8.690, 9.160 and 9.320, and unless otherwise authorized by another law, a person participating in a contested case hearing conducted by an agency described in this subsection may be represented by an attorney or by an authorized representative subject to the provisions of subsection (2) of this section. The Attorney General shall prepare model rules for proceedings with lay representation that do not have the effect of precluding lay representation. No rule adopted by a state agency shall have the effect of precluding lay representation. The agencies before which an authorized representative may appear are:

(a) The State Landscape Contractors Board in the administration of the Landscape Contractors Law.

(b) The State Department of Energy and the Energy Facility Siting Council.

(c) The Environmental Quality Commission and the Department of Environmental Quality.

(d) The Department of Consumer and Business Services **and the Insurance Rate Review Board** for proceedings in which an insured appears pursuant to ORS 737.505.

(e) The Department of Consumer and Business Services and any other agency for the purpose of proceedings to enforce the state building code, as defined by ORS 455.010.

(f) The State Fire Marshal in the Department of State Police.

(g) The Department of State Lands for proceedings regarding the issuance or denial of fill or removal permits under ORS 196.800 to 196.825.

(h) The Public Utility Commission.

(i) The Water Resources Commission and the Water Resources Department.

(j) The Land Conservation and Development Commission and the Department of Land Conservation and Development.

(k) The State Department of Agriculture, for purposes of hearings under ORS 215.705.

(L) The Bureau of Labor and Industries.

(2) A person participating in a contested case hearing as provided in subsection (1) of this section may appear by an authorized representative if:

(a) The agency conducting the contested case hearing has determined that appearance of such a person by an authorized representative will not hinder the orderly and timely development of the record in the type of contested case hearing being conducted;

(b) The agency conducting the contested case hearing allows, by rule, authorized representatives to appear on behalf of such participants in the type of contested case hearing being conducted; and

(c) The officer presiding at the contested case hearing may exercise discretion to limit an authorized representative's presentation of evidence, examination and cross-examination of witnesses, or presentation of factual arguments to ensure the orderly and timely development of the hearing record, and shall not allow an authorized representative to present legal arguments except to the extent authorized under subsection (3) of this section.

(3) The officer presiding at a contested case hearing in which an authorized representative appears under the provisions of this section may allow the authorized representative to present evidence, examine and cross-examine witnesses, and make arguments relating to the:

(a) Application of statutes and rules to the facts in the contested case;

(b) Actions taken by the agency in the past in similar situations;

(c) Literal meaning of the statutes or rules at issue in the contested case;

(d) Admissibility of evidence; and

(e) Proper procedures to be used in the contested case hearing.

(4) Upon judicial review, no limitation imposed by an agency presiding officer on the participation of an authorized representative shall be the basis for reversal or remand of agency action unless the limitation resulted in substantial prejudice to a person entitled to judicial review of the agency action.

(5) For the purposes of this section, "authorized representative" means a member of a participating partnership, an authorized officer or regular employee of a participating corporation, association or organized group, or an authorized officer or employee of a participating governmental authority other than a state agency.

SECTION 9. ORS 654.176 is amended to read:

654.176. (1) In order to promote health and safety in places of employment in this state:

(a) Every public or private employer of more than 10 employees shall establish and administer

a safety committee in accordance with rules adopted pursuant to ORS 654.182.

(b) Every public or private employer of 10 or fewer employees shall establish and administer a safety committee in accordance with rules adopted pursuant to ORS 654.182 if the Director of the Department of Consumer and Business Services finds that:

(A) The employer has a lost workday cases incidence rate in the top 10 percent of all rates for employers in the same industry; or

(B) The employer is not an agricultural employer and the workers' compensation premium classification assigned to the greatest portion of the payroll for the employer has a premium rate in the top 25 percent of premium rates for all classes as approved by the [*director*] **Insurance Rate Review Board** pursuant to ORS 737.320 (3).

(2) In making determinations under subsection (1) of this section, the director shall utilize the most recent departmental statistics regarding occupational injuries and illnesses and workers' compensation loss cost rates approved according to ORS 737.320 (3) for use in this state.

SECTION 10. ORS 731.260 is amended to read:

731.260. No person shall file or cause to be filed with the Director of the Department of Consumer and Business Services **or the Insurance Rate Review Board** any article, certificate, report, statement, application or any other information required or permitted to be so filed under the Insurance Code and known to such person to be false or misleading in any material respect.

SECTION 11. ORS 731.754 is amended to read:

731.754. (1) The Director of the Department of Consumer and Business Services may use the following only for the purpose of monitoring the solvency of insurers and health care service contractors and the need for possible corrective action with respect to insurers and health care service contractors:

(a) Reports and financial plans of action that are made confidential under ORS 731.752; and

(b) Instructions adopted and amended by the National Association of Insurance Commissioners for use by insurers and health care service contractors in preparing reports and financial plans of action referred to in paragraph (a) of this subsection.

(2) The director **and the Insurance Rate Review Board** may not use reports, financial plans of action and instructions referred to in subsection (1) of this section for ratemaking, for reviewing rate filings or in a rate proceeding related thereto, or to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance that an insurer, a health care service contractor or an affiliate is authorized to transact. Such reports and financial plans of action also shall not be introduced as evidence in a rate proceeding.

(3) This section does not restrict the authority of the director to use information included in reports, financial plans or instructions referred to in subsection (1) of this section that is available from other sources.

SECTION 12. ORS 731.804 is amended to read:

731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business in this state shall pay assessments that the Director of the Department of Consumer and Business Services determines necessary to support the legislatively authorized budget of the Department of Consumer and Business Services with respect to functions of the department under the Insurance Code**, including the functions of the Insurance Rate Review Board**. The director shall determine the assessments according to one or more percentage rates established by the director by rule. The director shall specify in the rule when assessments shall be made and payments shall be due. The premium-weighted average of the percentage rates shall not exceed nine-hundredths of one percent

of the gross amount of premiums received by an insurer or its insurance producers from and under its policies covering direct domestic risks, after deducting the amount of return premiums paid and the amount of dividend payments made to policyholders with respect to such policies. In the case of reciprocal insurers, the amount of savings paid or credited to the accounts of subscribers shall be deducted from the gross amount of premiums. In establishing the percentage rate or rates, the director shall use the most recent premium data approved by the director. In establishing the amounts to be collected under this subsection, the director shall take into consideration the expenses of the department for administering the Insurance Code and the fees collected under subsection (2) of this section. When the director establishes two or more percentage rates:

(a) Each rate shall be based on such expenses of the department ascribed by the director to the line of insurance for which the rate is established.

(b) Each rate shall be applied to the gross amount of premium received by an insurer or its insurance producers for the applicable line of insurance as provided in this subsection.

(2) The director may collect fees for specific services provided by the department under the Insurance Code according to a schedule of fees established by the director by rule. The director may collect such fees in advance. In establishing the schedule for fees, the director shall take into consideration the cost of each service for which a fee is imposed.

(3) Establishment and amendment of the schedule of fees under subsection (2) of this section are subject to prior approval of the Oregon Department of Administrative Services and a report to the Emergency Board prior to adopting the fees and shall be within the budget authorized by the Legislative Assembly as that budget may be modified by the Emergency Board.

(4) The director may not collect an assessment under subsection (1) of this section from any of the following persons:

(a) A fraternal benefit society complying with ORS chapter 748.

(b) Any person or class of persons designated by the director by rule.

(5) The director may not collect an assessment under subsection (1) of this section with respect to premiums received from any of the following policies:

(a) Workers′ compensation insurance policies.

(b) Annuity policies, whether fixed or variable in nature.

(c) Wet marine and transportation insurance policies.

(d) Any category of policies designated by the director by rule.

SECTION 13. ORS 735.230 is amended to read:

735.230. The board of directors of the joint underwriting association shall engage the services of an independent actuarial firm to develop and recommend actuarially sound rates, rating plans, rating rules and classifications. The [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** shall approve rates filed by the joint underwriting association in accordance with ORS 737.310. All rates approved for the joint underwriting association shall be actuarially sound and calculated to be self-supporting.

SECTION 14. ORS 737.045 is amended to read:

737.045. (1) If the Director of the Department of Consumer and Business Services has reason to believe that a rate, rating plan or rating system filed or used by an insurer or filed by a rating or advisory organization on behalf of an insurer **and approved by the Insurance Rate Review Board** does not comply with the requirements and standards of this chapter, the director may issue an order directing the insurer or the rating or advisory organization to discontinue or desist from the noncompliance. An order issued under this subsection is subject to the provisions of ORS 731.252.

(2) If the director holds a hearing on an order issued pursuant to subsection (1) of this section, the insurer or rating or advisory organization filing or using the rate, rating plan or rating system shall pay to the director the just and legitimate costs of the hearing, including actual necessary expenses.

(3) If the [*director*] **board** finds after a hearing under ORS 737.340 that any rate, rating plan or rating system violates the provisions of this chapter, the director may issue an order specifying the violation and stating when, within a reasonable period of time, the further use of such rate, rating plan or rating system by an insurer or rating or advisory organization shall be prohibited.

(4) If the director **or board** finds after a hearing under ORS 737.215 or 737.340 that an insurer or rating or advisory organization is in violation of any provision of this chapter other than the provisions dealing with rates, rating plans or rating systems, the director may issue an order specifying the violation and requiring compliance within a reasonable time.

(5) If the director finds after a hearing under ORS 737.215 that the violation of any of the provisions of this chapter applicable to it by any insurer or rating organization that has been the subject of a hearing was willful, the director may suspend or revoke the certificate of authority of such insurer or the license of such rating organization.

(6) If the director finds after a hearing that any rating organization has willfully engaged in any fraudulent or dishonest act or practices, the director may suspend or revoke the license of such organization.

SECTION 15. ORS 737.205 is amended to read:

737.205. (1) Every insurer shall file with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** copies of the rates, rating plans and rating systems used by it. Except as provided in ORS 737.207, 737.209 and 737.320 (2), each filing shall become effective [*immediately on the date specified therein but not earlier than the date such filing is received by the director*] **14 days after the board issues an order approving the filing**. This subsection does not apply to inland marine risks which by general custom of the business are not written according to manual rates or rating plans.

(2) An insurer may satisfy its obligation to make such filings by becoming a member of or a subscriber to a licensed rating organization which makes such filings, and by authorizing the [*director*] **board** to accept such filings on its behalf. [*Such*] **The** insurer may [*so*] adopt the filings of a rating organization on part of the classes of risks insured by it and may make its own filings as to other classes which shall be uniform throughout the insurer's territorial classification. This subsection does not apply to workers' compensation insurance filings except to the extent that the rating organization filings of rating plans or systems under ORS 737.320 are complete and usable by an insurer without the addition of allowances for expenses, taxes or profit.

[*(3) A filing shall be open to public inspection immediately upon submission to the director.*]

SECTION 16. ORS 737.207 is amended to read:

737.207. (1) As used in this section, a market may be a line, subline or classification of commercial liability insurance.

(2) Filings of commercial liability insurance rates for markets specified by the Director of the Department of Consumer and Business Services shall be submitted by an insurer or rating organization to the [*director*] **Insurance Rate Review Board** for review prior to the effective date [*if the average annual rate level increase or decrease for each market exceeds 15 percent*]. Factors to be considered by the [*director*] **board** in [*specifying a market to be subject to this section*] **approving or disapproving filings** may include:

(a) The nature and extent of competition;

(b) The size and significance of the coverage provided;

(c) Reinsurance availability;

(d) The volume of cancellations and nonrenewals; and

(e) Changing conditions in the economic, judicial and social environment.

(3) Except as otherwise provided in ORS 737.209, the effective date of a commercial liability insurance filing required by subsection (2) of this section to be submitted to the [*director*] **board** for review shall be the date specified therein but not earlier than the 30th day after the filing is received by the [*director*] **board**. After review of the filing, the [*director*] **board** may authorize an earlier effective date, if appropriate. The 30-day waiting period may be extended to 60 days if the [*director*] **board** gives written notice within [*such*] **the** waiting period to the insurer or rating organization [*which*] **that** made the filing that the extended period is needed for consideration of the filing. A filing subject to subsection (2) of this section that has not been approved or disapproved within the waiting period, or any extension thereof, shall be deemed approved.

(4) Supporting actuarial data shall accompany every filing of commercial liability insurance rates. The data shall be in sufficient detail to justify the rate level change and shall demonstrate compliance with ORS 737.310 governing the making of rates.

SECTION 17. ORS 737.209 is amended to read:

737.209. (1) The [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** may hold a hearing on a filing made pursuant to ORS 737.207 if the director determines that [*such*] **holding** a hearing would aid the [*director*] **board** in determining whether to approve or disapprove the filing. A hearing under this section may be held at a place designated by the [*director*] **board** and upon not less than 10 days' written notice to the insurer or rating organization that made the filing and to any other person [*the director decides should be notified*] **that requests notification**. A filing that is the subject of a hearing under this section becomes effective, if approved, as provided in subsection (4) of this section.

(2) A hearing held pursuant to subsection (1) of this section must be conducted by an administrative law judge assigned from the Office of Administrative Hearings established under ORS 183.605. The administrative law judge shall report findings, conclusions and recommendations to the [*director*] **board** within 30 days of the close of the hearing. The insurer or rating organization proposing the rate filing shall have the burden of proving that the rate proposal is justified and shall pay to the [*director*] **board** the fair and reasonable costs of the hearing, including actual necessary expenses.

(3) Within 10 days of receiving a report from the administrative law judge, the [*director*] **board** shall issue an order approving or disapproving the filing.

(4) An order issued under subsection (3) of this section may be reviewed as provided in ORS 183.480 to 183.540 for review of contested cases. A filing approved by the [*director*] **board** under this section shall be effective [*10*] **14** days after the order issued under subsection (3) of this section and shall remain effective during any review of the order.

SECTION 18. ORS 737.310 is amended to read:

737.310. The following standards shall apply to the making and use of rates:

(1) Rates shall not be excessive, inadequate or unfairly discriminatory.

(2) As to all classes of insurance, other than workers' compensation and title insurance:

(a) No rate shall be held to be excessive unless:

(A) Such rate is unreasonably high for the insurance provided; and

(B) A reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

(b) No rate shall be held inadequate unless such rate is unreasonably low for the insurance provided and:

(A) Use or continued use of such rate endangers the solvency of the insurer; or

(B) The use of such rate by the insurer has, or if continued will have, the effect of destroying competition or creating a monopoly.

(3) Rates for each classification of coverage shall be based on the claims experience of insurers within Oregon on that classification of coverage unless that experience provides an insufficient base for actuarially sound rates.

(4) Due consideration shall be given to past and prospective loss experience within this state, to the hazards of conflagration and catastrophe, to a reasonable margin for profit and to contingencies, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses specially applicable to this state, and to all other relevant factors, including judgment factors deemed relevant, within this state.

(5) In addition to subsection (4) of this section, rates for home protection insurance may include provision for unreimbursed costs of risk inspection and for loss costs under policies which are terminated without premium because the related home sale is not made.

(6) In the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available.

(7) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the requirements of the operating methods of any such insurer or group of insurers with respect to any class of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expenses are applicable.

(8) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates for casualty, surety or inland marine risks may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses.

(9) Due consideration shall be given, in the making and use of rates for all insurance, to investment income earned by the insurer, to insurer profits and to accumulated reserves for vocational rehabilitation services and for claim costs related to orders or awards made pursuant to ORS 656.278.

(10) The Director of the Department of Consumer and Business Services, by rule, shall prescribe the conditions under which a division of payroll between different manual classifications is permitted for purposes of computing workers' compensation premiums.

(11)(a) The [*director shall*] **Insurance Rate Review Board may** not approve any workers' compensation rating system that does not include a plan for rewarding employers, however small, that have good loss experience or programs likely to improve accident prevention. However, this paragraph is not intended to require that all employers be experience rated.

(b) The [*director shall*] **board may** not approve any workers' compensation rating system that does not allow the insurer to include potential third party recovery as one of the variables in the claims reserving process.

(12) At the time an insurer issues a workers' compensation insurance policy to an insured for the first time, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are to be assigned and shall provide an adequate description of work activities in each classification. In the event an insurer recommences coverage following its termination, the notice required under this subsection must be given only if the gap in coverage exceeds six months.

(13) If an insurer determines the workers' compensation insurance policy of an insured needs reclassification, the insurer:

(a) May bill an additional premium for the revised classification after the insurer has provided the insured at least 60 days' written notice of the reclassification.

(b) Shall bill retroactively to policy inception or date of change in insured's operations for any reclassification that results in a net reduction of premium.

(c) May, notwithstanding paragraph (a) of this subsection, retroactively bill an insured for reclassification during the policy year without prior notice of reclassification if the insurer shows by a preponderance of the evidence that:

(A) The insured knew that the employees were misclassified, or the insured was adequately informed by the insurer of the proper classification for the insured's employees;

(B) The insured provided improper or inaccurate information concerning its operations; or

(C) The insured's operations changed after the date information on the employees was obtained from the insured.

(14) In consultation with system participants, the director shall analyze the rating classification system to investigate changes that simplify the system and reduce costs for employers and insurers while preserving rate equity and minimizing the potential for abuse. The director shall give particular emphasis to the method of allocating payroll to rating classifications and to alternatives to methods that require verifiable payroll records. Upon completion of this analysis, the director shall implement appropriate changes to the system.

(15) The director shall adopt rules to carry out the provisions of this section and may by rule specify procedures relating to rating and ratemaking by workers' compensation insurers.

(16) A rate increase based solely upon an insured's attaining or exceeding 65 years of age shall be presumed to be unfairly discriminatory unless the increase is clearly based on sound actuarial principles or is related to actual or reasonably anticipated experience.

SECTION 19. ORS 737.312 is amended to read:

737.312. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to such insurance but who are unable to procure such insurance through ordinary methods. Such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements and rate modifications to be subject to the approval of the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board**.

SECTION 20. ORS 737.320 is amended to read:

737.320. (1) The [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** shall review title insurance filings[,] and each workers' compensation insurance filing[*, as soon as reasonably possible after they have been made in order*] to determine whether they meet the requirements of this chapter.

(2) The effective date of each title and workers' compensation insurance filing shall be [*the date specified therein but not earlier than the 30th day after the date the filing is received by the director*

or from the date of receipt of the information furnished in support of a filing or specific portions of such filing if such supporting information is required by the director] **14 days after the board issues an order approving the filing**. The waiting period may be extended by the [*director*] **board** for not more than 30 days if the [*director*] **board** gives written notice within [*such*] **the** waiting period to the insurer or rating organization [*which*] **that** made the filing that the [*director*] **board** needs such additional time for the consideration of such filing or specific portions of such filing. Upon written application by such insurer or rating organization, the [*director*] **board** may authorize a filing or specific portions of such filing, which the [*director*] **board** has reviewed, to become effective before the expiration of the waiting period. A filing or portions of a filing shall be deemed to meet the requirements of this chapter unless disapproved by the [*director*] **board** within the waiting period or any extension thereof.

(3) Filings of workers' compensation rates, rating plans and rating systems by a workers' compensation rating organization shall be limited to provisions for claim payment approved or established by the [*director*] **board**, and shall not include allowances for or recognition of expenses, taxes or profit. A workers' compensation rating organization shall make such filings with the [*director*] **board**, which filings shall be subject to this section. The organization shall also file the workers' compensation policy forms to be used by its members. The filing shall include a report of investment income.

(4) Filings of workers' compensation rates by an insurer shall specify allowances for expenses, taxes and profits.

(5) The [*director*] **board** shall investigate and evaluate all workers' compensation filings to determine whether the filings meet the requirements of this chapter. The [*director*] **board** shall employ [*such*] experts and other personnel as may be reasonably necessary to make such investigation and evaluation, the cost of which shall be paid out of the fund created under ORS 705.145.

(6) Notwithstanding the provisions of ORS 737.205 (1), the [*director*] **board** may require any person to comply with the requirements of subsection (2) of this section if the [*director*] **board** has good cause to believe that a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

(7) The [*director*] **board** may require insurers to use, as that portion of a rate filing that constitutes the amount for claim payment, rates prescribed by the [*director*] **board** based upon rating information determined pursuant to ORS 731.216 (3).

SECTION 21. ORS 737.322 is amended to read:

737.322. Notwithstanding any other provision of this chapter:

(1) The [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** shall not approve any workers' compensation rate filing for an assigned risk pool that provides for any surcharge. As used in this subsection, a "surcharge" does not include a modification pursuant to an experience rating plan approved by the [*director*] **board**.

(2) The [*director*] **board** shall adopt rules providing for approval of workers' compensation rating plans that include provisions allowing for reasonable retroactive application of experience rating modification factors. Nothing in this subsection affects retrospective rating plans.

(3) If the [*director*] **board** disapproves a workers' compensation rate or rating plan and the insurer or rating organization requests a hearing before the [*director*] **board**, the burden of proof is upon the insurer or rating organization to prove that the filing meets the requirements of this chapter.

(4) If the [*director*] **board** holds a hearing on an order disapproving a workers' compensation

rate, rating plan or rating system, the insurer or rating or advisory organization filing or using the rate, rating plan or rating system shall pay to the [*director*] **board** the just and legitimate costs of the hearing, including actual necessary expenses.

SECTION 22. ORS 737.325 is amended to read:

737.325. (1) Under [*such*] rules [*and regulations as the Director of the Department of Consumer and Business Services adopts, the director,*] **adopted by the Insurance Rate Review Board, the board,** by written order, may suspend or modify the requirement of filing as to any class of insurance, or subdivision or combination thereof, or as to classes of risks, for which the rates cannot practicably be filed before they are used. Such orders[*,*] **and** rules [*and regulations*] shall be made known to insurers and rating organizations affected [*thereby*] **by the orders and rules**. The [*director*] **board** may make such examination as the [*director*] **board** deems advisable to ascertain whether any rates affected by [*such*] **the** order meet the standards set forth in ORS 737.310.

(2) Upon the written application of the insured, stating the reasons therefor, filed with the [*director*] **board** and approved by the [*director*] **board**, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

SECTION 23. ORS 737.336 is amended to read:

737.336. (1) If within the waiting period or the extension thereof, if any, as provided in ORS 737.320 (2), the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** finds that a filing does not meet the requirements of this chapter, the [*director*] **board** shall send to the insurer or rating organization [*which*] **that** made [*such*] **the** filing written notice of disapproval of [*such*] **the** filing, specifying therein in what respects the [*director*] **board** finds [*such*] **the** filing fails to meet the requirements and stating that [*such*] **the** filing shall not become effective.

(2) If the Director **of the Department of Consumer and Business Services** has reason to believe that an insurer or rating or advisory organization is not complying with the requirements and standards of this chapter other than the requirements and standards dealing with rates, rating plans or rating systems, unless the director has reason to believe such noncompliance is willful, the director shall give notice in writing to such insurer or rating or advisory organization stating in what manner such noncompliance is alleged to exist and specifying a reasonable time, not less than 10 days after the date of mailing, in which such noncompliance may be corrected.

SECTION 24. ORS 737.340 is amended to read:

737.340. [*(1)*] Any person aggrieved with respect to any filing that is in effect, other than the insurer or rating organization that made the filing, may make written application to the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** for a hearing on the filing. The application shall specify the grounds to be relied upon by the applicant.

[*(2) If the director finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds are established, and that such grounds otherwise justify holding such a hearing, the director shall do one of the following:*]

[*(a) Issue an order under ORS 737.045 (1). The director shall not act under this paragraph if the filing concerns a rate, rating plan or rating system subject to ORS 737.320 (1).*]

[*(b) Hold a hearing, within 30 days after receipt of such application, at a place designated by the director and upon not less than 10 days' written notice to the applicant and to the insurer or rating organization that made the filing.*]

SECTION 25. ORS 737.505 is amended to read:

737.505. (1) Every rating organization and every insurer [*which*] **that** makes its own rates,

within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, shall furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to such rate.

(2) Every rating organization and every insurer [*which*] **that** makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by the authorized representative, on written request by the person or authorized representative to review the manner in which such rating system has been applied in connection with the insurance afforded the person. If the rating organization or insurer fails to grant or reject such request within 30 days after it is made, the applicant may proceed in the same manner as if the application had been rejected.

(3) Any party affected by the action of such rating organization or such insurer on such request, within 30 days after written notice of such action, may appeal to the [*Director of the Department of Consumer and Business Services, who*] **Insurance Rate Review Board, which**, after a hearing held at a place designated by the [*director*] **board** upon not less than 10 days' written notice to the appellant and to such rating organization or insurer, shall affirm or reverse such action.

(4) Appeals to the Director **of the Department of Consumer and Business Services** pursuant to ORS 737.318 with regard to a final premium audit billing must be made within 60 days after receipt of the billing.

(5) The director may, upon a showing of good cause, stay any workers' compensation insurer's collection effort on a final premium audit billing during the pendency of an appeal authorized by subsection (4) of this section.

SECTION 26. ORS 737.526 is amended to read:

737.526. (1) Reasonable rules and plans may be promulgated by the Director of the Department of Consumer and Business Services for the interchange of data necessary for the application of rating plans.

(2) In order to further uniform administration of rate regulatory laws, the director**, the Insurance Rate Review Board** and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult and cooperate with them with respect to rate making and the application of rating systems.

SECTION 27. ORS 737.535 is amended to read:

737.535. No person shall willfully withhold information from or knowingly give false or misleading information to the Director of the Department of Consumer and Business Services, to any statistical agency designated by the director, **to the Insurance Rate Review Board,** to any rating organization, or to any insurer, which will affect the rates or premiums chargeable under this chapter.

SECTION 28. ORS 737.600 is amended to read:

737.600. (1) As used in this section, "fictitious grouping" means a grouping by way of membership, license, franchise, contract, agreement or any method other than common ownership, or use and control.

(2) No insurer shall:

(a) Make available, through any rating plan or form, property, inland marine, casualty or surety insurance, or any combination thereof, at a preferred rate or premium to any person based upon a fictitious grouping of that person.

(b) Write or deliver a form, plan or policy of insurance covering a grouping or combination of

persons or risks, any of which are within this state, at a preferred rate or form other than that offered to the public generally and persons not in the group, unless the form, plan or policy and the rates or premiums to be charged therefor have been approved by the Director of the Department of Consumer and Business Services **or by the Insurance Rate Review Board**. The director [*shall*] **or board may** not approve any form, plan or policy, or the rates therefor, that would constitute a violation of paragraph (a) of this subsection.

(3) Nothing in this section applies:

(a) To policies of life or health insurance;

(b) To insurance for public bodies as defined in ORS 30.260;

(c) To insurance for employers subject to ORS chapter 656 who are primarily engaged in farming. Any contract negotiated by an exempt farming group, including the rate, shall be restricted to members of the group;

(d) To property and casualty insurance policies for personal, family or household purposes, and not for commercial or business purposes, under the following conditions:

(A) If the policies are offered to members of an association, including a labor union, which has had an active existence for at least one year, has a constitution and bylaws and is maintained in good faith for purposes other than that of obtaining insurance;

(B) If the policies are based on premiums that are adequate to support coverage of the group without subsidy by other rate payers; and

(C) If the insurer does not unfairly discriminate against holders of other insurance policies;

(e) To liability and property insurance required under ORS 825.160 for persons who apply for or who have received authority issued by the Department of Transportation under ORS chapter 825 to transport logs, poles, pilings, peeler cores, lumber, shingles, veneer, plywood, particle board, wallboard, siding, cordwood in long or short lengths, sawdust, hog fuel, wood chips, wood pellets, bark dust or cut trees that are or will be sold for use as Christmas trees;

(f) To liability or casualty insurance issued in this state on commercial risks, if:

(A) The policy requires active participation in a plan of risk management which has established measures and procedures to minimize both the frequency and severity of losses;

(B) The policy passes on the benefits of reduced losses to plan participants; and

(C) Rates are actuarially measurable and credible and sufficiently related to actual and expected loss and expense experience of the group so as to assure that nonmembers of the group are not unfairly discriminated against; or

(g) To insurance for child care facilities that are certified in accordance with ORS chapter 657A.

(4) Under ORS 731.244, the director shall make rules necessary for implementation of this section.

SECTION 29. ORS 742.003 is amended to read:

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

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

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

and benefits thereunder;

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

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

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

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

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

SECTION 30. ORS 742.490 is amended to read:

742.490. (1) Any rate, rating plan or rating system filed with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** for a motor vehicle insurance policy offering liability, personal injury protection or collision coverage, shall provide an appropriate reduction in premium charges for such coverage if:

(a) The principal operator of the covered vehicle is an insured 55 years of age or older.

(b) The principal operator of the covered vehicle has successfully completed, within the appropriate time as specified in this subsection, a motor vehicle accident prevention course approved by the Department of Transportation. To meet the requirements of this subsection, a course must be completed no more than three years prior to the beginning of the policy period for which the discounted rate applies if the person is less than 70 years of age at the time of taking the course or no more than two years prior to the beginning of the policy period for which the discounted rate applies if the person is 70 years of age or more at the time of taking the course.

(c) There are no persons under 25 years of age who regularly operate the vehicle.

(d) The vehicle is not classified for underwriting purposes as used for a business.

(2) If the person qualifying for a premium reduction under subsection (1) of this section is the principal operator of two or more vehicles, the premium discount shall apply to only one vehicle. No more than one premium discount may be applied to one vehicle.

SECTION 31. ORS 742.706 is amended to read:

742.706. (1) If an insurer offers or purports to renew a commercial liability policy, but on terms less favorable to the insured or at higher rates, the new terms or rates may take effect on the renewal date, if the insurer provides the insured, and the insurance producer if any, 45 days′ written notice. If the insurer does not provide such notice, the insured may cancel the renewal policy within 45 days after receipt of the notice or delivery of the renewal policy. Earned premium for the period of time the renewal policy was in force shall be calculated pro rata at the lower of the current or previous year′s rate. If the insured accepts the renewal, any premium increase or changes in terms shall be effective immediately following the prior policy′s expiration date.

(2) Nonrenewal of a commercial liability policy shall not be effective until at least 45 days after the insured receives a written notice of nonrenewal. If, after an insurer provides a notice of nonrenewal as described in this subsection, the insurer extends the policy 90 days or less, an addi-

tional notice of nonrenewal is not required with respect to the extension.

(3) Subsection (1) of this section does not apply:

(a) If the change is a rate, form or plan filed with the Director of the Department of Consumer and Business Services **or the Insurance Rate Review Board** and applicable to the entire line of insurance or class of business to which the policy belongs; or

(b) To a premium increase based on the altered nature or extent of the risk insured against.

(4) If a commercial liability policy is issued for a term longer than one year, and for additional consideration a premium is guaranteed, the insurer may not refuse to renew the policy or increase the premium for the term of that policy.

SECTION 32. ORS 743.015 is amended to read:

743.015. (1) All credit life and credit health insurance policies subject to ORS 743.371 to 743.380, and all certificates of insurance, notices of proposed insurance, applications for insurance, indorsements and riders used in connection with such kinds of policies, delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board**. Such forms are subject to approval, disapproval or withdrawal of approval by the [*director*] **Director of the Department of Consumer and Business Services or the board** as provided in ORS 742.003, 742.005 and 742.007.

(2) An insurer may revise the schedules of premium rates from time to time and shall file the revised schedules with the [*director*] **board**. An insurer may not issue any credit life or credit health insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the [*director*] **board**.

(3) If a group policy of credit life or credit health insurance has been or is delivered in another state, the insurer shall file only the group certificate, the individual application and the notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and (4). The [*director*] **board** shall approve the group certificate, the individual application and the notice of proposed insurance if the forms conform with the requirements specified in ORS 743.377 (2) and (4) and the schedules of premium rates applicable to the insurance evidenced by the certificate or notice are not in excess of the insurer's schedules of premium rates filed with the [*director*] **board**.

SECTION 33. ORS 743.018 is amended to read:

743.018. [*Except for group life and health insurance, and except as provided in ORS 743.015,*] Every insurer shall file with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables.

SECTION 34. ORS 743.405 is amended to read:

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

(1) The entire money and other considerations therefor shall be expressed therein.

(2) The time at which the insurance takes effect and terminates shall be expressed therein.

(3) It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder.

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

(5) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. As used in this subsection, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy. Except those required by ORS 743.411 to 743.480, exceptions and reductions shall be printed at the insurer's option either included with the applicable benefit provision or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the applicable benefit provision.

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

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

SECTION 35. ORS 743.527 is amended to read:

743.527. (1) Every group health insurance policy delivered or issued for delivery in this state shall contain in substance the following provisions, applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when the premium for the policy or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees insured under the policy due to a strike or lockout, the policy, upon timely payment of the premium, will continue in effect with respect to those employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

(b) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be:

(A) The rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy; or

(B) If the policy does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under the policy at the date of cessation of work by the total number of persons insured under the policy on such date.

(c) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the

amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.

(2) Every group health insurance policy delivered or issued for delivery in this state may contain in substance the following provisions applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy is contingent upon the collection of individual contributions by the union representing the employees when the policyholder is not a trustee and by the policyholder or the policyholder's agent when the policyholder is a trustee.

(b) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy on each employee is contingent upon timely payment of contributions by the employees and timely payment of the premium by the entity responsible for collecting the individual contributions.

(c) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, each individual premium rate under the policy may be increased by not more than 20 percent, or by any higher percentage approved by the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board**, during the period of cessation of work in order to provide sufficient compensation to the insurer for increased administrative costs and increased mortality and morbidity. If the policy contains the provision allowed under this paragraph, an employee's contribution paid under subsection (1)(a) of this section shall be increased by the same percentage.

(d) A provision that, when the policy is a policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section, if the premium is unpaid at the date of cessation of work and the premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of the premium prior to the date the next premium becomes due under the terms of the policy.

(e) Any provision with respect to the continuation of the policy as provided in subsection (1)(a) of this section that the Director **of the Department of Consumer and Business Services** may approve.

(3) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of a policy to increase or decrease the premium rates before, during or after a cessation of work by employees insured under the policy when the insurer had the right to increase the premium rates even if the cessation of work did not occur. If such a premium rate change is made, it shall be effective on such date as the insurer shall determine in accordance with the terms of the policy.

(4) Nothing in this section shall be deemed to require continuation of any coverage in a group health insurance policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section for longer than:

(a) The time that 75 percent of insured employees continue such coverage;

(b) For an individual employee, the time at which the employee takes full-time employment with another employer; or

(c) Six months after cessation of work by the insured employees.

SECTION 36. ORS 743.737 is amended to read:

743.737. Health benefit plans covering small employers shall be subject to the following pro-

visions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Must give notice of the decision to the Director of the Department of Consumer and Busi-

ness Services and to all policyholders covered by the plans;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

retains the rights of an enrollee under ORS 743.804.

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

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

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

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

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

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

(i) 33 percent on or after October 1, 1999; and

(ii) 43 percent on or after July 1, 2004.

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

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

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

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

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer [*more than once in a 12-month period*] **without the approval of the board**. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the

prior rating period to the first day of the new period; and

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

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

(f) A small employer carrier may apply a participation credit of five percent to the rates determined under paragraph (b) of this subsection for a small employer if all eligible employees enroll in the health benefit plan. If a carrier applies a participation credit under this paragraph, the carrier must apply the credit to each small employer that qualifies.

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

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

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

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

(d) Provisions affecting any preexisting conditions provision.

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

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

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

(11) A small employer carrier shall not provide any financial or other incentive to any 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) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

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

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

SECTION 37. ORS 743.737, as amended by section 6, chapter 599, Oregon Laws 2003, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier

or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

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

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

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

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

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

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

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

(ii) 33 percent on October 1, 1999.

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

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

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

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

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer [*more than once in a 12-month period*] **without the approval of the board**. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

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

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

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

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

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

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

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

(d) Provisions affecting any preexisting conditions provision.

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

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

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

(11) A small employer carrier shall not provide any financial or other incentive to any 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) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

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

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

SECTION 38. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

(a) "Carrier" means an insurer authorized to issue a policy of health insurance in this state. "Carrier" does not include a multiple employer welfare arrangement.

(b)(A) "Eligible individual" means an individual who:

(i) Has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application; or

(ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application.

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include an individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

(c) "Portability health benefit plans" and "portability plans" mean health benefit plans for eligible individuals that are required to be offered by all carriers offering group health benefit plans and that have been approved by the Director of the Department of Consumer and Business Services in accordance with this section.

(2)(a) In order to improve the availability and affordability of health benefit plans for individuals leaving coverage under group health benefit plans, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the director two portability health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the type of coverage provided by health maintenance organizations. For each type of portability plan, the committee shall design and submit to the director:

(A) A prevailing benefit plan, which shall reflect the benefit coverages that are prevalent in the group health insurance market; and

(B) A low cost benefit plan, which shall emphasize affordability for eligible individuals.

(b) Except as provided in ORS 743.730 to 743.773, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to portability health benefit plans.

(3) The director shall approve the portability health benefit plans if the director determines that the plans provide for appropriate accessibility and affordability of needed health care services and comply with all other provisions of this section.

(4) After the director's approval of the portability plans submitted by the committee under this section, each carrier offering group health benefit plans shall submit to the director the policy form or forms containing at least one low cost benefit and one prevailing benefit portability plan offered by the carrier that meets the required standards. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(5) Within 180 days after approval by the director of the portability plans submitted by the committee, as a condition of transacting group health insurance in this state, each carrier offering group health benefit plans shall make available to eligible individuals the prevailing benefit and low cost benefit portability plans that have been submitted by the carrier and approved by the director under subsection (4) of this section.

(6) A carrier offering group health benefit plans shall issue to an eligible individual who is leaving or has left group coverage provided by that carrier any portability plan offered by the carrier if the eligible individual applies for the plan within 63 days of termination of prior coverage and

agrees to make the required premium payments and to satisfy the other provisions of the portability plan.

(7) Premium rates for portability plans shall be subject to the following provisions:

(a) Each carrier must file the geographic average rate for each of its portability health benefit plans for a rating period with the [*director*] **Insurance Rate Review Board** on or before March 15 of each year.

(b) The premium rates charged during the rating period for each portability health benefit plan shall not vary from the geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. Adjustments for age shall comply with the following:

(A) For each plan, the variation between the lowest premium rate and the highest premium rate shall not exceed 100 percent of the lowest premium rate.

(B) Premium variations shall be determined by applying uniformly the carrier's schedule of age adjustments for portability plans as approved by the [*director*] **board**.

(c) Premium variations between the portability plans and the rest of the carrier's group plans must be based solely on objective differences in plan design or coverage and must not include differences based on the actual or expected health status of individuals who select portability health benefit plans. For purposes of determining the premium variations under this paragraph, a carrier may:

(A) Pool all portability plans with all group health benefit plans; or

(B) Pool all portability plans for eligible individuals leaving small employer group health benefit plan coverage with all plans offered to small employers and pool all portability plans for eligible individuals leaving other group health benefit plan coverage with all health benefit plans offered to such other groups.

(d) A carrier may not increase the rates of a portability plan issued to an enrollee [*more than once in any 12-month period*] **without the approval of the board**. Annual rate increases shall be effective on the anniversary date of the plan issued to the enrollee. The percentage increase in the premium rate charged to an enrollee for a new rating period may not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age.

(8) No portability plans under this section may contain preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(9) Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee, except:

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

(b) For fraud or misrepresentation by the policyholder;

(c) When the carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or

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

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

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

(10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its portability 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) Each such carrier shall file with the director annually on or before March 15 an actuarial certification that the carrier is in compliance with this section and that its rating methods are actuarially sound. Each such certification shall be in a form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the carrier at its principal place of business.

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

(11) A carrier offering group health benefit plans shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer to market and sell portability plans of the carrier on the basis of an eligible individual's anticipated claims experience.

(12) An individual who is eligible to obtain a portability plan in accordance with this section may obtain such a plan regardless of whether the eligible individual qualifies for a period of continuation coverage under federal law or under ORS 743.600 or 743.610. However, an individual who has elected such continuation coverage is not eligible to obtain a portability plan until the continuation coverage has been discontinued by the individual or has been exhausted.

SECTION 39. ORS 743.767 is amended to read:

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

(1) Each carrier must file the geographic average rate for its individual health benefit plans for a rating period with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board** on or before March 15 of each year.

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

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

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan measured from the first day of the prior rating period to the first day of the new period; and

(b) Any adjustment attributable to changes in age and differences in benefit design and family composition.

(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge

shall be approved by the Director of the Department of Consumer and Business Services and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting conditions provision.

SECTION 40. Section 6, chapter 781, Oregon Laws 2003, is amended to read:

Sec. 6. (1) If an insurer obtains coverage with the State Accident Insurance Fund Corporation for medical professional liability insurance issued by the insurer to a doctor to whom section 1**, chapter 781, Oregon Laws 2003,** [*of this 2003 Act*] applies, the insurer shall reduce the premium charged to the doctor in a manner that fully recognizes savings made available by coverage offered under section 1**, chapter 781, Oregon Laws 2003,** [*of this 2003 Act*].

(2) An insurer to which subsection (1) of this section applies shall demonstrate the difference in its rates for medical professional liability insurance for purposes of subsection (1) of this section in its filing of rates with the [*Director of the Department of Consumer and Business Services*] **Insurance Rate Review Board**.

SECTION 41. Notwithstanding the term of office specified by section 2 of this 2007 Act, of the members first appointed to the Insurance Rate Review Board under section 2 of this 2007 Act:

(1) One shall serve for a term ending July 1, 2009;

(2) Two shall serve for terms ending July 1, 2010; and

(3) Two shall serve for terms ending July 1, 2088.

SECTION 42. Sections 3 to 6 of this 2007 Act and the amendments to ORS 83.580, 183.457, 654.176, 731.260, 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312, 737.320, 737.322, 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490, 742.706, 743.015, 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781, Oregon Laws 2003, by sections 7 to 40 of this 2007 Act become operative on January 1, 2008.

SECTION 43. Sections 3 to 6 of this 2007 Act and the amendments to ORS 83.580, 183.457, 654.176, 731.260, 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312, 737.320, 737.322, 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490, 742.706, 743.015, 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781, Oregon Laws 2003, by sections 7 to 40 of this 2007 Act apply to all policies of insurance issued or renewed on or after January 1, 2008.

SECTION 44. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect July 1, 2007.