

House Bill 3107

Sponsored by Representative KOTEK

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

1
2 Relating to insurance; creating new provisions; amending ORS 83.580, 183.457, 654.176, 731.260,
3 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312, 737.320, 737.322,
4 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490, 742.706, 743.015,
5 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781, Oregon Laws
6 2003; and declaring an emergency.

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

8 **SECTION 1. Sections 2 to 6 of this 2007 Act are added to and made a part of ORS chapter**
9 **737.**

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

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

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

17 **(4) The term of office of each member of the board is four years. Each member serves**
18 **at the pleasure of the Governor. Before the expiration of the term of a member, the Gover-**
19 **nor shall appoint a successor whose term begins on July 1 next following. A member is eli-**
20 **gible for reappointment for one additional term. If there is a vacancy for any cause, the**
21 **Governor shall make an appointment to become immediately effective for the unexpired**
22 **term. The board shall nominate a slate of candidates whenever a vacancy occurs or is an-**
23 **ounced and shall forward the names of the recommended candidates to the Governor for**
24 **consideration.**

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

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

30 **(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.

1 board.

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

4 (9) A member of the board is entitled to compensation and expenses as provided in ORS
5 292.495.

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

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

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

14 (2) A filing made under subsection (1) of this section is open to public inspection imme-
15 diately upon submission to the board.

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

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

24 (5) The board shall:

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

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

29 (6) A person may request in writing that the board mail to the person copies of the in-
30 formation reviewed under subsection (1) of this section or notices of hearings issued under
31 subsection (5) of this section. The board shall acknowledge each request made under this
32 subsection, establish mailing lists of persons that have requested information or notice under
33 this subsection and maintain a record of all information and notices of hearings mailed pur-
34 suant to this subsection. The board may by rule establish fees to be charged to persons re-
35 questing information or notice under this subsection to defray the costs of mailings and
36 maintenance of the lists.

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

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

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

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

43 (9) If the board disapproves a filing, the board shall send to the insurer, rating organ-
44 ization or advisory organization that made the filing written notice of the disapproval, spec-
45 ifying the reasons for the disapproval.

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

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

8 (2) Financial assistance under an agreement entered into under this section may be
 9 provided only to an organization that petitions the board to represent broad customer in-
 10 terests in proceedings before the board. The board by rule shall establish the qualifications
 11 that the board deems appropriate for determining which organizations are eligible for finan-
 12 cial assistance under an agreement entered into under this section.

13 (3) In administering an agreement entered into under this section, the board may deter-
 14 mine:

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

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

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

19 (d) Other matters necessary to administer the agreement.

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

21 (a) "Enrollee" means an employee, a dependent of the employee or an individual other-
 22 wise eligible for a group health benefit plan who has enrolled for coverage under the terms
 23 of the plan.

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

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

29 (a) The proposed rates;

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

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

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

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

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

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

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

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

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

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

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

44 (b) The rates are unfair or excessive.

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

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

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

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

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

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

10 **SECTION 7.** ORS 83.580 is amended to read:

11 83.580. (1) The amount, if any, included for automobile insurance, shall not exceed the premiums
 12 chargeable in accordance with rate filings made by the insurer with the [*Director of the Department*
 13 *of Consumer and Business Services*] **Insurance Rate Review Board** for such insurance.

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

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

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

35 **SECTION 8.** ORS 183.457 is amended to read:

36 183.457. (1) Notwithstanding ORS 8.690, 9.160 and 9.320, and unless otherwise authorized by an-
 37 other law, a person participating in a contested case hearing conducted by an agency described in
 38 this subsection may be represented by an attorney or by an authorized representative subject to the
 39 provisions of subsection (2) of this section. The Attorney General shall prepare model rules for
 40 proceedings with lay representation that do not have the effect of precluding lay representation.
 41 No rule adopted by a state agency shall have the effect of precluding lay representation. The
 42 agencies before which an authorized representative may appear are:

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

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

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

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

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

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

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

9 (h) The Public Utility Commission.

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

11 (j) The Land Conservation and Development Commission and the Department of Land Conser-
12 vation and Development.

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

14 (L) The Bureau of Labor and Industries.

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

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

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

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

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

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

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

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

33 (d) Admissibility of evidence; and

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

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

39 (5) For the purposes of this section, "authorized representative" means a member of a partic-
40 ipating partnership, an authorized officer or regular employee of a participating corporation, asso-
41 ciation or organized group, or an authorized officer or employee of a participating governmental
42 authority other than a state agency.

43 **SECTION 9.** ORS 654.176 is amended to read:

44 654.176. (1) In order to promote health and safety in places of employment in this state:

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

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

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

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

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

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

14 **SECTION 10.** ORS 731.260 is amended to read:

15 731.260. No person shall file or cause to be filed with the Director of the Department of Con-
 16 sumer and Business Services **or the Insurance Rate Review Board** any article, certificate, report,
 17 statement, application or any other information required or permitted to be so filed under the In-
 18 surance Code and known to such person to be false or misleading in any material respect.

19 **SECTION 11.** ORS 731.754 is amended to read:

20 731.754. (1) The Director of the Department of Consumer and Business Services may use the
 21 following only for the purpose of monitoring the solvency of insurers and health care service con-
 22 tractors and the need for possible corrective action with respect to insurers and health care service
 23 contractors:

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

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

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

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

37 **SECTION 12.** ORS 731.804 is amended to read:

38 731.804. (1) Except as otherwise provided in this section, each authorized insurer doing business
 39 in this state shall pay assessments that the Director of the Department of Consumer and Business
 40 Services determines necessary to support the legislatively authorized budget of the Department of
 41 Consumer and Business Services with respect to functions of the department under the Insurance
 42 Code, **including the functions of the Insurance Rate Review Board**. The director shall determine
 43 the assessments according to one or more percentage rates established by the director by rule. The
 44 director shall specify in the rule when assessments shall be made and payments shall be due. The
 45 premium-weighted average of the percentage rates shall not exceed nine-hundredths of one percent

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

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

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

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

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

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

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

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

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

28 (a) Workers' compensation insurance policies.

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

30 (c) Wet marine and transportation insurance policies.

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

32 **SECTION 13.** ORS 735.230 is amended to read:

33 735.230. The board of directors of the joint underwriting association shall engage the services
 34 of an independent actuarial firm to develop and recommend actuarially sound rates, rating plans,
 35 rating rules and classifications. The *[Director of the Department of Consumer and Business Services]*
 36 **Insurance Rate Review Board** shall approve rates filed by the joint underwriting association in
 37 accordance with ORS 737.310. All rates approved for the joint underwriting association shall be
 38 actuarially sound and calculated to be self-supporting.

39 **SECTION 14.** ORS 737.045 is amended to read:

40 737.045. (1) If the Director of the Department of Consumer and Business Services has reason to
 41 believe that a rate, rating plan or rating system filed or used by an insurer or filed by a rating or
 42 advisory organization on behalf of an insurer **and approved by the Insurance Rate Review Board**
 43 does not comply with the requirements and standards of this chapter, the director may issue an or-
 44 der directing the insurer or the rating or advisory organization to discontinue or desist from the
 45 noncompliance. An order issued under this subsection is subject to the provisions of ORS 731.252.

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

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

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

13 (5) If the director finds after a hearing under ORS 737.215 that the violation of any of the pro-
 14 visions of this chapter applicable to it by any insurer or rating organization that has been the sub-
 15 ject of a hearing was willful, the director may suspend or revoke the certificate of authority of such
 16 insurer or the license of such rating organization.

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

20 **SECTION 15.** ORS 737.205 is amended to read:

21 737.205. (1) Every insurer shall file with the [*Director of the Department of Consumer and Busi-*
 22 *ness Services*] **Insurance Rate Review Board** copies of the rates, rating plans and rating systems
 23 used by it. Except as provided in ORS 737.207, 737.209 and 737.320 (2), each filing shall become ef-
 24 fective [*immediately on the date specified therein but not earlier than the date such filing is received*
 25 *by the director*] **14 days after the board issues an order approving the filing.** This subsection does
 26 not apply to inland marine risks which by general custom of the business are not written according
 27 to manual rates or rating plans.

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

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

37 **SECTION 16.** ORS 737.207 is amended to read:

38 737.207. (1) As used in this section, a market may be a line, subline or classification of com-
 39 mercial liability insurance.

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

- 1 (a) The nature and extent of competition;
- 2 (b) The size and significance of the coverage provided;
- 3 (c) Reinsurance availability;
- 4 (d) The volume of cancellations and nonrenewals; and
- 5 (e) Changing conditions in the economic, judicial and social environment.

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

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

18 **SECTION 17.** ORS 737.209 is amended to read:

19 737.209. (1) The *[Director of the Department of Consumer and Business Services]* **Insurance Rate**
 20 **Review Board** may hold a hearing on a filing made pursuant to ORS 737.207 if the director deter-
 21 mines that *[such]* **holding** a hearing would aid the *[director]* **board** in determining whether to ap-
 22 prove or disapprove the filing. A hearing under this section may be held at a place designated by
 23 the *[director]* **board** and upon not less than 10 days' written notice to the insurer or rating organ-
 24 ization that made the filing and to any other person *[the director decides should be notified]* **that**
 25 **requests notification**. A filing that is the subject of a hearing under this section becomes effective,
 26 if approved, as provided in subsection (4) of this section.

27 (2) A hearing held pursuant to subsection (1) of this section must be conducted by an adminis-
 28 trative law judge assigned from the Office of Administrative Hearings established under ORS
 29 183.605. The administrative law judge shall report findings, conclusions and recommendations to the
 30 *[director]* **board** within 30 days of the close of the hearing. The insurer or rating organization pro-
 31 posing the rate filing shall have the burden of proving that the rate proposal is justified and shall
 32 pay to the *[director]* **board** the fair and reasonable costs of the hearing, including actual necessary
 33 expenses.

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

36 (4) An order issued under subsection (3) of this section may be reviewed as provided in ORS
 37 183.480 to 183.540 for review of contested cases. A filing approved by the *[director]* **board** under this
 38 section shall be effective *[10]* **14** days after the order issued under subsection (3) of this section and
 39 shall remain effective during any review of the order.

40 **SECTION 18.** ORS 737.310 is amended to read:

41 737.310. The following standards shall apply to the making and use of rates:

- 42 (1) Rates shall not be excessive, inadequate or unfairly discriminatory.
- 43 (2) As to all classes of insurance, other than workers' compensation and title insurance:
 - 44 (a) No rate shall be held to be excessive unless:
 - 45 (A) Such rate is unreasonably high for the insurance provided; and

1 (B) A reasonable degree of competition does not exist in the area with respect to the classi-
2 fication to which such rate is applicable.

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

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

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

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

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

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

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

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

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

32 (9) Due consideration shall be given, in the making and use of rates for all insurance, to in-
33 vestment income earned by the insurer, to insurer profits and to accumulated reserves for vocational
34 rehabilitation services and for claim costs related to orders or awards made pursuant to ORS
35 656.278.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32 **SECTION 19.** ORS 737.312 is amended to read:

33 737.312. Agreements may be made among insurers with respect to the equitable apportionment
 34 among them of insurance which may be afforded applicants who are in good faith entitled to such
 35 insurance but who are unable to procure such insurance through ordinary methods. Such insurers
 36 may agree among themselves on the use of reasonable rate modifications for such insurance, such
 37 agreements and rate modifications to be subject to the approval of the [Director of the Department
 38 of Consumer and Business Services] **Insurance Rate Review Board.**

39 **SECTION 20.** ORS 737.320 is amended to read:

40 737.320. (1) The [Director of the Department of Consumer and Business Services] **Insurance Rate**
 41 **Review Board** shall review title insurance filings[,] and each workers' compensation insurance
 42 filing[, *as soon as reasonably possible after they have been made in order*] to determine whether they
 43 meet the requirements of this chapter.

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

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

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

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

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

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

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

32 **SECTION 21.** ORS 737.322 is amended to read:

33 737.322. Notwithstanding any other provision of this chapter:

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

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

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

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

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

4 **SECTION 22.** ORS 737.325 is amended to read:

5 737.325. (1) Under [*such*] rules [*and regulations as the Director of the Department of Consumer*
 6 *and Business Services adopts, the director,*] **adopted by the Insurance Rate Review Board, the**
 7 **board**, by written order, may suspend or modify the requirement of filing as to any class of insur-
 8 ance, or subdivision or combination thereof, or as to classes of risks, for which the rates cannot
 9 practicably be filed before they are used. Such orders[,] **and** rules [*and regulations*] shall be made
 10 known to insurers and rating organizations affected [*thereby*] **by the orders and rules**. The
 11 [*director*] **board** may make such examination as the [*director*] **board** deems advisable to ascertain
 12 whether any rates affected by [*such*] **the** order meet the standards set forth in ORS 737.310.

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

16 **SECTION 23.** ORS 737.336 is amended to read:

17 737.336. (1) If within the waiting period or the extension thereof, if any, as provided in ORS
 18 737.320 (2), the [*Director of the Department of Consumer and Business Services*] **Insurance Rate**
 19 **Review Board** finds that a filing does not meet the requirements of this chapter, the [*director*] **board**
 20 shall send to the insurer or rating organization [*which*] **that** made [*such*] **the** filing written notice
 21 of disapproval of [*such*] **the** filing, specifying therein in what respects the [*director*] **board** finds
 22 [*such*] **the** filing fails to meet the requirements and stating that [*such*] **the** filing shall not become
 23 effective.

24 (2) If the Director **of the Department of Consumer and Business Services** has reason to
 25 believe that an insurer or rating or advisory organization is not complying with the requirements
 26 and standards of this chapter other than the requirements and standards dealing with rates, rating
 27 plans or rating systems, unless the director has reason to believe such noncompliance is willful, the
 28 director shall give notice in writing to such insurer or rating or advisory organization stating in
 29 what manner such noncompliance is alleged to exist and specifying a reasonable time, not less than
 30 10 days after the date of mailing, in which such noncompliance may be corrected.

31 **SECTION 24.** ORS 737.340 is amended to read:

32 737.340. [(1)] Any person aggrieved with respect to any filing that is in effect, other than the
 33 insurer or rating organization that made the filing, may make written application to the [*Director*
 34 *of the Department of Consumer and Business Services*] **Insurance Rate Review Board** for a hearing
 35 on the filing. The application shall specify the grounds to be relied upon by the applicant.

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

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

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

44 **SECTION 25.** ORS 737.505 is amended to read:

45 737.505. (1) Every rating organization and every insurer [*which*] **that** makes its own rates,

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

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

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

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

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

22 **SECTION 26.** ORS 737.526 is amended to read:

23 737.526. (1) Reasonable rules and plans may be promulgated by the Director of the Department
 24 of Consumer and Business Services for the interchange of data necessary for the application of
 25 rating plans.

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

31 **SECTION 27.** ORS 737.535 is amended to read:

32 737.535. No person shall willfully withhold information from or knowingly give false or mis-
 33 leading information to the Director of the Department of Consumer and Business Services, to any
 34 statistical agency designated by the director, **to the Insurance Rate Review Board**, to any rating
 35 organization, or to any insurer, which will affect the rates or premiums chargeable under this
 36 chapter.

37 **SECTION 28.** ORS 737.600 is amended to read:

38 737.600. (1) As used in this section, "fictitious grouping" means a grouping by way of member-
 39 ship, license, franchise, contract, agreement or any method other than common ownership, or use
 40 and control.

41 (2) No insurer shall:

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

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

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

7 (3) Nothing in this section applies:

8 (a) To policies of life or health insurance;

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

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

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

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

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

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

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

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

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

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

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

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

34 (4) Under ORS 731.244, the director shall make rules necessary for implementation of this sec-
 35 tion.

36 **SECTION 29.** ORS 742.003 is amended to read:

37 742.003. (1) Except where otherwise provided by law, [no] a basic policy form, or application
 38 form where written application is required and is to be made a part of the policy, or rider, in-
 39 dorsement or renewal certificate form [shall] **may not** be delivered or issued for delivery in this
 40 state until the form has been filed with and approved by the Director of the Department of Con-
 41 sumer and Business Services. This section does not apply to:

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

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

1 and benefits thereunder;

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

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

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

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

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

16 **SECTION 30.** ORS 742.490 is amended to read:

17 742.490. (1) Any rate, rating plan or rating system filed with the [*Director of the Department of*
18 *Consumer and Business Services*] **Insurance Rate Review Board** for a motor vehicle insurance
19 policy offering liability, personal injury protection or collision coverage, shall provide an appropri-
20 ate reduction in premium charges for such coverage if:

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

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

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

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

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

34 **SECTION 31.** ORS 742.706 is amended to read:

35 742.706. (1) If an insurer offers or purports to renew a commercial liability policy, but on terms
36 less favorable to the insured or at higher rates, the new terms or rates may take effect on the re-
37 newal date, if the insurer provides the insured, and the insurance producer if any, 45 days' written
38 notice. If the insurer does not provide such notice, the insured may cancel the renewal policy within
39 45 days after receipt of the notice or delivery of the renewal policy. Earned premium for the period
40 of time the renewal policy was in force shall be calculated pro rata at the lower of the current or
41 previous year's rate. If the insured accepts the renewal, any premium increase or changes in terms
42 shall be effective immediately following the prior policy's expiration date.

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

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

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

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

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

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

10 **SECTION 32.** ORS 743.015 is amended to read:

11 743.015. (1) All credit life and credit health insurance policies subject to ORS 743.371 to 743.380,
12 and all certificates of insurance, notices of proposed insurance, applications for insurance, indorse-
13 ments and riders used in connection with such kinds of policies, delivered or issued for delivery in
14 this state and the schedules of premium rates pertaining thereto shall be filed with the [*Director of*
15 *the Department of Consumer and Business Services*] **Insurance Rate Review Board**. Such forms are
16 subject to approval, disapproval or withdrawal of approval by the [*director*] **Director of the De-**
17 **partment of Consumer and Business Services or the board** as provided in ORS 742.003, 742.005
18 and 742.007.

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

23 (3) If a group policy of credit life or credit health insurance has been or is delivered in another
24 state, the insurer shall file only the group certificate, the individual application and the notice of
25 proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and
26 (4). The [*director*] **board** shall approve the group certificate, the individual application and the no-
27 tice of proposed insurance if the forms conform with the requirements specified in ORS 743.377 (2)
28 and (4) and the schedules of premium rates applicable to the insurance evidenced by the certificate
29 or notice are not in excess of the insurer's schedules of premium rates filed with the [*director*]
30 **board**.

31 **SECTION 33.** ORS 743.018 is amended to read:

32 743.018. [*Except for group life and health insurance, and except as provided in ORS 743.015,*] Ev-
33 ery insurer shall file with the [*Director of the Department of Consumer and Business Services*] **In-**
34 **surance Rate Review Board** all schedules and tables of premium rates for life and health insurance
35 to be used on risks in this state, and shall file any amendments to or corrections of such schedules
36 and tables.

37 **SECTION 34.** ORS 743.405 is amended to read:

38 743.405. An individual health insurance policy must meet the following requirements:

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

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

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

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

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

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

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

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

25 **SECTION 35.** ORS 743.527 is amended to read:

26 743.527. (1) Every group health insurance policy delivered or issued for delivery in this state
 27 shall contain in substance the following provisions, applicable to the coverage for hospital or med-
 28 ical services or expenses provided under the policy:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

44 **SECTION 36.** ORS 743.737 is amended to read:

45 743.737. Health benefit plans covering small employers shall be subject to the following pro-

1 visions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 ness Services and to all policyholders covered by the plans;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 retains the rights of an enrollee under ORS 743.804.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (d) Provisions affecting any preexisting conditions provision.

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

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

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

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

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

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

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

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

1 743.737. Health benefit plans covering small employers shall be subject to the following pro-
2 visions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (A) Must give notice of the decision to the Director of the Department of Consumer and Busi-
 2 ness Services and to all policyholders covered by the plans;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (ii) 33 percent on October 1, 1999.

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

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

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

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

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

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

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

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

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

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

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

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

14 (d) Provisions affecting any preexisting conditions provision.

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

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

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

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

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

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

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

41 **SECTION 38.** ORS 743.760 is amended to read:

42 743.760. (1) As used in this section:

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

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

1 (i) Has left coverage that was continuously in effect for a period of 180 days or more under one
2 or more Oregon group health benefit plans, has applied for portability coverage not later than the
3 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident
4 at the time of such application; or

5 (ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as
6 amended and in effect on January 1, 1998, has applied for portability coverage not later than the
7 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident
8 at the time of such application.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 (b) For fraud or misrepresentation by the policyholder;

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

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

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

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

42 (10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of
43 business a complete and detailed description of its rating practices and renewal underwriting prac-
44 tices relating to its portability plans, including information and documentation that demonstrate that
45 its rating methods and practices are based upon commonly accepted actuarial practices and are in

1 accordance with sound actuarial principles.

2 (b) Each such carrier shall file with the director annually on or before March 15 an actuarial
3 certification that the carrier is in compliance with this section and that its rating methods are
4 actuarially sound. Each such certification shall be in a form and manner and shall contain such in-
5 formation as specified by the director. A copy of such certification shall be retained by the carrier
6 at its principal place of business.

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

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

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

20 **SECTION 39.** ORS 743.767 is amended to read:

21 743.767. Premium rates for individual health benefit plans shall be subject to the following pro-
22 visions:

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

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

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

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

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

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

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

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

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

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

14 **SECTION 41.** Notwithstanding the term of office specified by section 2 of this 2007 Act,
 15 of the members first appointed to the Insurance Rate Review Board under section 2 of this
 16 2007 Act:

- 17 (1) One shall serve for a term ending July 1, 2009;
- 18 (2) Two shall serve for terms ending July 1, 2010; and
- 19 (3) Two shall serve for terms ending July 1, 2011.

20 **SECTION 42.** Sections 3 to 6 of this 2007 Act and the amendments to ORS 83.580, 183.457,
 21 654.176, 731.260, 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312,
 22 737.320, 737.322, 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490,
 23 742.706, 743.015, 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781,
 24 Oregon Laws 2003, by sections 7 to 40 of this 2007 Act become operative on January 1, 2008.

25 **SECTION 43.** Sections 3 to 6 of this 2007 Act and the amendments to ORS 83.580, 183.457,
 26 654.176, 731.260, 731.754, 731.804, 735.230, 737.045, 737.205, 737.207, 737.209, 737.310, 737.312,
 27 737.320, 737.322, 737.325, 737.336, 737.340, 737.505, 737.526, 737.535, 737.600, 742.003, 742.490,
 28 742.706, 743.015, 743.018, 743.405, 743.527, 743.737, 743.760 and 743.767 and section 6, chapter 781,
 29 Oregon Laws 2003, by sections 7 to 40 of this 2007 Act apply to all policies of insurance issued
 30 or renewed on or after January 1, 2008.

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