

# House Bill 2130

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## 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 data reporting requirements for carriers offering health benefit plans and for third party administrators. Requires insurers to include administrative expenses and explanation of changes in administrative expenses in rate filings. Requires Director of Department of Consumer and Business Services to approve increases in administrative expenses.

Authorizes director to establish by rule uniform statewide standards for administrative functions of licensed health insurers.

Authorizes Office for Oregon Health Policy and Research to collect and report changes in contracted prices for services provided by health benefit plan or administered by third party administrator. Authorizes office to adopt reporting requirements for capital projects proposed by hospitals and ambulatory surgical centers. Authorizes office to adopt rules to ensure full disclosure about expected impact of capital project to community served by hospital or ambulatory surgical center.

## A BILL FOR AN ACT

1  
2 Relating to health care cost information; creating new provisions; and amending ORS 743.018,  
3 743.737, 743.760 and 743.767.

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

5 **SECTION 1. Sections 2, 3, 4 and 5 of this 2009 Act are added to and made a part of the**  
6 **Insurance Code.**

7 **SECTION 2. "Covered life" means a subscriber, policyholder, certificate holder, spouse,**  
8 **dependent child or any other individual insured under an insurance policy or whose benefits**  
9 **are administered by a third party administrator licensed under ORS 744.702.**

10 **SECTION 3. (1) A carrier offering a health benefit plan as defined in ORS 743.730 and a**  
11 **third party administrator licensed under ORS 744.702 shall annually submit to the Depart-**  
12 **ment of Consumer and Business Services, in a form and manner prescribed by the depart-**  
13 **ment, data concerning the number of covered lives of the carrier or third party**  
14 **administrator, reported by line of business and by zip code.**

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

18 **SECTION 4. The Director of the Department of Consumer and Business Services may by**  
19 **rule establish uniform statewide standards for the administrative functions of all licensed**  
20 **health insurers in this state.**

21 **SECTION 5. (1) Insurers must include in their rate filings a statement of administrative**  
22 **expenses in such form and detail as the Director of the Department of Consumer and Busi-**  
23 **ness Services shall prescribe by rule, including but not limited to:**

24 **(a) A statement of administrative expenses on a per member per month basis; and**

25 **(b) An explanation of the basis for any proposed increases or decreases.**

**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       (2) The director may approve reasonable increases in administrative expenses but, with-  
 2 out sufficient justification by the insurer that the increases are necessary and appropriate,  
 3 may not approve increases in administrative expenses that exceed the cost of living for the  
 4 previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All  
 5 Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United  
 6 States Department of Labor.

7       **SECTION 6.** (1) An insurer offering a health benefit plan as defined in ORS 743.730 and  
 8 a third party administrator licensed under ORS 744.702 shall annually submit to the Office  
 9 for Oregon Health Policy and Research, in a form and manner prescribed by the office, data  
 10 on the contracted prices paid by the insurer or third party administrator for health services  
 11 for which the insurer or third party administrator directly indemnifies the person for pro-  
 12 viding the service.

13       (2) The office may publish reports, based on the data collected under subsection (1) of  
 14 this section, on the annual changes in contracted prices for health services.

15       (3) The office may contract with a private entity to collect and analyze the data required  
 16 by subsection (1) of this section.

17       (4) The data provided under subsection (1) of this section is proprietary and trade secret  
 18 information and is not subject to disclosure to persons outside of the office or the entity  
 19 contracting with the office under subsection (3) of this section except:

- 20       (a) To the Department of Consumer and Business Services;
- 21       (b) As agreed to by the carrier or third party administrator; or
- 22       (c) As ordered by a court of competent jurisdiction.

23       **SECTION 7.** Section 8 of this 2009 Act is added to and made a part of ORS chapter 442.

24       **SECTION 8.** The Office for Oregon Health Policy and Research may adopt rules requiring  
 25 hospitals and ambulatory surgical centers within the state to publicly report proposed capital  
 26 projects expected to incur costs greater than an amount prescribed by the office. Rules  
 27 adopted under this section shall:

28       (1) Require the hospital or ambulatory surgical center to publish notice of the proposed  
 29 capital project in a major newspaper serving the region in which the capital project will be  
 30 located;

31       (2) Require the hospital or ambulatory surgical center to hold a public meeting to fully  
 32 explain the proposed capital project and the expected impact of the project on the prices  
 33 charged by the hospital or ambulatory surgical center; and

34       (3) Establish other requirements the office deems necessary to allow for full disclosure  
 35 of the expected impact of the proposed capital project on the community served by the hos-  
 36 pital or ambulatory surgical center and to solicit feedback from interested stakeholders, in-  
 37 cluding but not limited to:

- 38       (a) Businesses and business associations that provide health care coverage in the com-  
 39 munity;
- 40       (b) Health insurers;
- 41       (c) Insurance agents and brokers serving the community; and
- 42       (d) Residents of the community.

43       **SECTION 9.** ORS 743.018 is amended to read:

44       743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015,  
 45 every insurer shall file with the Director of the Department of Consumer and Business Services all

1 schedules and tables of premium rates for life and health insurance to be used on risks in this state,  
2 and shall file any amendments to or corrections of such schedules and tables. **Premium rates are**  
3 **subject to approval, disapproval or withdrawal of approval by the director as provided in ORS**  
4 **742.003, 742.005 and 742.007.**

5 (2) Except as provided in ORS 743.737 and 743.760 and subsection (3) of this section, a rate filing  
6 by a carrier for any of the following health benefit plans subject to ORS 743.730 to 743.773 shall be  
7 available for public inspection immediately upon submission of the filing to the director:

8 (a) Health benefit plans for small employers.

9 (b) Portability health benefit plans.

10 (c) Individual health benefit plans.

11 (3) The director, upon request by a carrier, may exempt from disclosure any part of the filing  
12 that the director determines to contain trade secrets and that would, if disclosed, harm competition.  
13 The part that the director determines to be exempt from disclosure shall be considered confidential  
14 for purposes of ORS 705.137. The director may not disclose a part of a filing subject to a carrier's  
15 request pending the director's determination under this subsection.

16 **SECTION 10.** ORS 743.737 is amended to read:

17 743.737. *[Health benefit plans covering small employers shall be subject to the following*  
18 *provisions:]*

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

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

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

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

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

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

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

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

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

45 (4) Late enrollees may be excluded from coverage **by small employer health benefit plans** for

1 up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If  
2 both an exclusion from coverage period and a preexisting conditions provision are applicable to a  
3 late enrollee, the combined period shall not exceed 12 months.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 (k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider  
15 network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens  
16 the physical health or well-being of health care staff and seriously impairs the ability of the carrier  
17 or its participating providers to provide services to an enrollee. An enrollee under this paragraph  
18 retains the rights of an enrollee under ORS 743.804.

19 [(L)] **(6)** A small employer carrier may modify a small employer health benefit plan at the time  
20 of coverage renewal. The modification is not a discontinuation of the plan under [paragraphs (e) and  
21 (g) of this] subsection **(5)(e) and (g) of this section**.

22 [(6)] **(7)** Notwithstanding any provision of subsection (5) **or (6)** of this section to the contrary,  
23 any small employer [carrier] health benefit plan subject to the provisions of ORS 743.733 to 743.737  
24 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment  
25 by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrep-  
26 resentation or concealment by the enrollee.

27 [(7)] **(8)** A small employer carrier may continue to enforce reasonable employer participation and  
28 contribution requirements on small employers applying for coverage. However, participation and  
29 contribution requirements shall be applied uniformly among all small employer groups with the same  
30 number of eligible employees applying for coverage or receiving coverage from the small employer  
31 carrier. In determining minimum participation requirements, a carrier shall count only those em-  
32 ployees who are not covered by an existing group health benefit plan, Medicaid, Medicare,  
33 CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but  
34 not limited to the Oregon Health Plan.

35 [(8)] **(9)** Premium rates for small employer health benefit plans **require approval by the direc-**  
36 **tor under ORS 742.003 and** shall be subject to **section 5 of this 2009 Act and** the following pro-  
37 visions:

38 (a) Each small employer carrier issuing health benefit plans to small employers must file its  
39 geographic average rate for a rating period with the director at least once every 12 months.

40 (b)(A) The premium rates charged during a rating period for health benefit plans issued to small  
41 employers may not vary from the geographic average rate by more than 50 percent on or after  
42 January 1, 2008, except as provided in subparagraph (D) of this paragraph.

43 (B) The variations in premium rates described in subparagraph (A) of this paragraph shall be  
44 based solely on the factors specified in subparagraph (C) of this paragraph. A small employer carrier  
45 may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium

1 rates for small employers. The factors that are based on contributions or participation may vary  
2 with the size of the employer. All other factors must be applied in the same actuarially sound way  
3 to all small employers.

4 (C) The variations in premium rates described in subparagraph (A) of this paragraph may be  
5 based on one or more of the following factors:

6 (i) The ages of enrolled employees and their dependents;

7 (ii) The level at which the small employer contributes to the premiums payable for enrolled  
8 employees and their dependents;

9 (iii) The level at which eligible employees participate in the health benefit plan;

10 (iv) The level at which enrolled employees and their dependents engage in tobacco use;

11 (v) The level at which enrolled employees and their dependents engage in health promotion,  
12 disease prevention or wellness programs;

13 (vi) The period of time during which a small employer retains uninterrupted coverage in force  
14 with the same small employer carrier; and

15 (vii) Adjustments to reflect the provision of benefits not required to be covered by the basic  
16 health benefit plan and differences in family composition.

17 (D)(i) The premium rates determined in accordance with this paragraph may be further adjusted  
18 by a small employer carrier to reflect the expected claims experience of a small employer, but the  
19 extent of this adjustment may not exceed five percent of the annual premium rate otherwise payable  
20 by the small employer. The adjustment under this subparagraph may not be cumulative from year  
21 to year.

22 (ii) Except for small employers with 25 or fewer employees, the premium rates adjusted under  
23 this subparagraph are not subject to the provisions of subparagraph (A) of this paragraph.

24 (E) A small employer carrier shall apply the carrier's schedule of premium rate variations as  
25 approved by the director [*of the Department of Consumer and Business Services*] and in accordance  
26 with this paragraph. Except as otherwise provided in this section, the premium rate established for  
27 a health benefit plan by a small employer carrier shall apply uniformly to all employees of the small  
28 employer enrolled in that plan.

29 (c) Except as provided in paragraph (b) of this subsection, the variation in premium rates be-  
30 tween different small employer health benefit plans offered by a small employer carrier must be  
31 based solely on objective differences in plan design or coverage and must not include differences  
32 based on the risk characteristics of groups assumed to select a particular health benefit plan.

33 (d) A small employer carrier may not increase the rates of a health benefit plan issued to a  
34 small employer more than once in a 12-month period. Annual rate increases shall be effective on the  
35 plan anniversary date of the health benefit plan issued to a small employer. The percentage increase  
36 in the premium rate charged to a small employer for a new rating period may not exceed the sum  
37 of the following:

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

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

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

44 [(9)] (10) In connection with the offering for sale of any health benefit plan to a small employer,  
45 each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales

1 materials of:

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

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

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

6 (d) Provisions affecting any preexisting conditions provision.

7 [(10)(a)] (11)(a) Each small employer carrier shall maintain at its principal place of business a  
8 complete and detailed description of its rating practices and renewal underwriting practices, in-  
9 cluding information and documentation that demonstrate that its rating methods and practices are  
10 based upon commonly accepted actuarial practices and are in accordance with sound actuarial  
11 principles.

12 (b) Each small employer carrier shall file with the director at least once every 12 months an  
13 actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the  
14 rating methods of the small employer carrier are actuarially sound. Each such certification shall be  
15 in a uniform form and manner and shall contain such information as specified by the director. A  
16 copy of such certification shall be retained by the small employer carrier at its principal place of  
17 business.

18 (c) A small employer carrier shall make the information and documentation described in para-  
19 graph (a) of this subsection available to the director upon request. Except as provided in ORS  
20 743.018 and except in cases of violations of ORS 743.733 to 743.737, the information shall be con-  
21 sidered proprietary and trade secret information and shall not be subject to disclosure by the di-  
22 rector to persons outside the Department of Consumer and Business Services except as agreed to  
23 by the small employer carrier or as ordered by a court of competent jurisdiction.

24 [(11)] (12) A small employer carrier shall not provide any financial or other incentive to any  
25 insurance producer that would encourage the insurance producer to market and sell health benefit  
26 plans of the carrier to small employer groups based on a small employer group's anticipated claims  
27 experience.

28 [(12)] (13) For purposes of this section, the date a small employer health benefit plan is contin-  
29 ued shall be the anniversary date of the first issuance of the health benefit plan.

30 [(13)] (14) A small employer [carrier] **health benefit plan** must [*include a provision that offers*]  
31 **offer** coverage to all eligible employees and, **if** [*to all dependents to the extent*] the employer chooses  
32 to offer coverage to dependents, **to all dependents**.

33 [(14)] (15) All small employer health benefit plans shall contain special enrollment periods dur-  
34 ing which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C.  
35 300gg as amended and in effect on July 1, 1997.

36 **SECTION 11.** ORS 743.760 is amended to read:

37 743.760. (1) As used in this section:

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

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

41 (i) Has left coverage that was continuously in effect for a period of 180 days or more under one  
42 or more Oregon group health benefit plans, has applied for portability coverage not later than the  
43 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident  
44 at the time of such application; or

45 (ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as

1 amended and in effect on January 1, 1998, has applied for portability coverage not later than the  
2 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident  
3 at the time of such application.

4 (B) Except as provided in subsection (12) of this section, "eligible individual" does not include  
5 an individual who remains eligible for the individual's prior group coverage or would remain eligible  
6 for prior group coverage in a plan under the federal Employee Retirement Income Security Act of  
7 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected  
8 health condition of the individual, or who is covered under another health benefit plan at the time  
9 that portability coverage would commence or is eligible for the federal Medicare program.

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

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

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

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

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

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

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

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

38 (6) A carrier offering group health benefit plans shall issue to an eligible individual who is  
39 leaving or has left group coverage provided by that carrier any portability plan offered by the car-  
40 rier if the eligible individual applies for the plan within 63 days of termination of prior coverage and  
41 agrees to make the required premium payments and to satisfy the other provisions of the portability  
42 plan.

43 (7) Premium rates for portability plans **require approval by the director under ORS 743.003**  
44 **and** shall be subject to **section 5 of this 2009 Act and** the following provisions:

45 (a) Each carrier must file the geographic average rate for each of its portability health benefit



1 plans for a rating period with the director on or before March 15 of each year.

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

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

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

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

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

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

20 (d) A carrier may not increase the rates of a portability plan issued to an enrollee more than  
 21 once in any 12-month period. Annual rate increases shall be effective on the anniversary date of  
 22 the plan issued to the enrollee. The percentage increase in the premium rate charged to an enrollee  
 23 for a new rating period may not exceed the average increase in the rest of the carrier's applicable  
 24 group health benefit plans plus an adjustment for age.

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

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

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

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

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

33 (d) 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 its contractual obligations.

37 (10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of  
 38 business a complete and detailed description of its rating practices and renewal underwriting prac-  
 39 tices relating to its portability plans, including information and documentation that demonstrate that  
 40 its rating methods and practices are based upon commonly accepted actuarial practices and are in  
 41 accordance with sound actuarial principles.

42 (b) Each such carrier shall file with the director annually on or before March 15 an actuarial  
 43 certification that the carrier is in compliance with this section and that its rating methods are  
 44 actuarially sound. Each such certification shall be in a form and manner and shall contain such in-  
 45 formation as specified by the director. A copy of such certification shall be retained by the carrier

1 at its principal place of business.

2 (c) Each such carrier shall make the information and documentation described in paragraph (a)  
 3 of this subsection available to the director upon request. Except as provided in ORS 743.018 and  
 4 except in cases of violations of the Insurance Code, the information is proprietary and trade secret  
 5 information and shall not be subject to disclosure by the director to persons outside the Department  
 6 of Consumer and Business Services except as agreed to by the carrier or as ordered by a court of  
 7 competent jurisdiction.

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

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

16 **SECTION 12.** ORS 743.767 is amended to read:

17 743.767. Premium rates for individual health benefit plans **require approval by the Director**  
 18 **of the Department of Consumer and Business Services under ORS 740.003 and** shall be subject  
 19 to **section 5 of this 2009 Act and** the following provisions:

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

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

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

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

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

38 (4) Notwithstanding any other provision of this section, a carrier that imposes an individual  
 39 coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for  
 40 a period not to exceed six months and in an amount not to exceed the percentage by which the rates  
 41 for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon  
 42 Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge  
 43 shall be approved by the Director of the Department of Consumer and Business Services and, in  
 44 combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting  
 45 conditions provision.

