House Bill 3145

Sponsored by Representative SHIELDS; Representatives CLEM, DEMBROW, GALIZIO, KOTEK, TOMEI, Senator MONNES ANDERSON

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 criteria for Department of Consumer and Business Services to use in determination of whether to approve health insurance premium rates. Prescribes information that must be provided by insurer seeking approval of rates. Requires large employer group health insurers to submit premium rates to Director of Department of Consumer and Business Services for approval. Creates process for party adversely affected or aggrieved by approval of premium rates to challenge order in contested case and allows award of attorney fees against insurer in favor of prevailing party.

A BILL FOR AN ACT

Relating to regulation of insurance rates; creating new provisions; and amending ORS 743.018, 743.737, 743.760 and 743.767.

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

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

SECTION 2. (1) As used in this section, "consumer price index" means the Portland-Salem Consumer Price Index for All Urban Consumers for All Items as reported by the United States Bureau of Labor Statistics.

(2) Notwithstanding ORS 742.003, 742.005, 743.018, 743.737, 743.760 and 743.767, the Director of the Department of Consumer and Business Services may not approve increases in premium rates that exceed the rate of increase in the consumer price index, unless the director finds the rates to be:

(a) Fair, equitable, reasonable and justifiable;

(b) Based upon a reasonable allocation of administrative expenses;

(c) Based on the payment of reasonable rates to all categories of providers;

(d) Necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future; and

(e) Unrelated to insurer losses resulting from deliberate under-pricing or speculative or imprudent investment practices.

(3) In determining whether proposed premium rates are fair, equitable, reasonable and justifiable, the director shall consider all of the following:

(a) The insurer's financial position including, but not limited to, profitability, surplus, reserves and investment earnings.

(b) Historical and anticipated nonmedical, medical and hospital expenses.

(c) Any anticipated reduction in the number of enrollees if the proposed rate is approved.

(d) Changes to covered benefits or health benefit plan design that accompany the rate increases, including:

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.

(A) An expansion or reduction of the benefits covered under the health benefit plan;

(B) An expansion or reduction of benefits due to a change in the formulas, methodologies or schedules used in making benefit determinations;

(C) An increase or decrease in coinsurance, deductibles, copayments or other costs paid by enrollees; and

(D) Establishment of new requirements for coverage, including prior authorization or other methods of utilization control, or elimination of requirements.

(e) The insurer's efforts to contain costs while maintaining or improving quality, including:

(A) The extent to which the health benefit plan design reduces or waives copayments, coinsurance and deductibles for preventive health care, primary care and chronic disease management;

(B) Whether the insurer uses the Oregon Prescription Drug Program;

(C) The insurer's adoption of innovative provider contracting practices or payment methodologies that promote quality and efficiency and encourage providers to use evidence-based clinical standards established by the Health Resources Commission or the Health Services Commission; and

(D) The insurer's programs that identify and address excessive or inadequate utilization of covered services.

(f) Any other factors adopted by the director by rule.

(4) Increases in administrative costs as a portion of premiums may not exceed the rate of increase in the consumer price index unless justified by increased transparency, improved quality of health care or lower future costs.

SECTION 3. Notwithstanding ORS 742.003, 742.005, 743.736, 743.737, 743.760 and 743.767, the Director of the Department of Consumer and Business Services may not approve a health benefit plan, as defined in ORS 743.730, unless the director finds that:

(1) The health benefit plan promotes access to essential health services and does not impose unreasonable barriers to the utilization of essential health services; and

(2) The insurer is using the insurer's contracting, benefit design, utilization management, quality improvement and network composition to promote wellness and the delivery of quality affordable health care.

SECTION 4. An insurer that submits premium rates to the Director of the Department of Consumer and Business Services for approval shall include the following information in the form and manner prescribed by the director by rule:

(1) A statement accompanied by supporting facts of the insurer's anticipated reserves and surplus under the proposed rates.

(2) A summary of the insurer's nonmedical and medical expenses and investment income for the most recently ended fiscal year.

(3) A statement of increases or decreases in enrollment anticipated by the insurer under the proposed rates.

(4) A statement accompanied by supporting facts of the changes in utilization of medical services and provider reimbursement rates anticipated by the insurer under the proposed rates.

(5) An explanation of changes to the covered benefits or plan design under the proposed rates.

(6) A report of the insurer's efforts to contain costs, including efforts to:

(a) Reduce or eliminate copayments, coinsurance or deductibles for primary care or chronic disease management;

(b) Use the Oregon Prescription Drug Program, or the reasons for not using the plan;

(c) Require participating providers to use evidence-based clinical standards established by the Health Resources Commission or the Health Services Commission;

(d) Negotiate favorable rates for health services; and

(e) Identify and address excessive or inadequate utilization of covered services.

(7) Other information the director deems necessary.

SECTION 5. (1) The Director of the Department of Consumer and Business Services may approve premium rates submitted under ORS 742.003, 742.005, 743.018, 743.737, 743.760 or 743.767 only by issuing a written order that:

(a) Includes findings of fact, conclusions of law and sufficient legal analysis to explain how the ultimate facts support the legal conclusions;

(b) Is signed by the director; and

(c) Is posted to the website of the department upon service of the order on the insurer.

(2) Any person adversely affected or aggrieved by the order issued under subsection (1) of this section is entitled to a contested case hearing in accordance with ORS chapter 183 before the order becomes effective, if a hearing is requested no later than 60 days after the service of the order on the insurer or the posting of the order to the department's website, whichever occurs last.

(3) In a contested case proceeding under this section:

(a) The director has the burden of establishing compliance with the requirements of section 2 of this 2009 Act;

(b) Parties are entitled to discovery of all nonprivileged written communications and other materials, including communications and materials in electronic format, of the insurer and the Department of Consumer and Business Services that are relevant to the director's determination; and

(c) A party may depose any state employee or contractor whose testimony may be material to the director's determination of approval, including actuaries, department managers, the Administrator of the Insurance Division and the director.

(4) A party that prevails in a contested case hearing under this section or on judicial review of the contested case order may be awarded reasonable costs and attorney fees against the insurer.

SECTION 6. ORS 743.018 is amended to read:

743.018. (1) Except for **group health insurance policies that have been agreed upon as a result of negotiations between a policyholder and an insurer and** group life [*and health*] insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. **Premium rates are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007 and section 2 of this 2009 Act.**

(2) Except as provided in ORS 743.737 and 743.760 and subsection (3) of this section, a rate filing by a carrier for any [*of the following*] health benefit plans [*subject to ORS 743.730 to 743.773*] shall

be available for public inspection immediately upon submission of the filing to the director[*:*]**.**

[*(a) Health benefit plans for small employers.*]

[*(b) Portability health benefit plans.*]

[*(c) Individual health benefit plans.*]

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

SECTION 7. ORS 743.737 is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

holder.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[*(8)*] **(9)** Premium rates for small employer health benefit plans **require approval by the director under ORS 742.003 and 743.018 and section 2 of this 2009 Act and** shall be subject to the following provisions:

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

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

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on the factors specified in subparagraph (C) of this paragraph. A small employer carrier may elect which of the factors specified in subparagraph (C) of this paragraph apply to premium rates for small employers. The factors that are based on contributions or participation may vary with the size of the employer. All other factors must be applied in the same actuarially sound way to all small employers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Provisions affecting any preexisting conditions provision.

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

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

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except as provided in ORS 743.018 and except in cases of violations of ORS 743.733 to 743.737, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

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

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

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

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

SECTION 8. ORS 743.760 is amended to read:

743.760. (1) As used in this section:

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

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

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

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

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include an individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of

1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

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

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

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

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

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

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

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

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

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

(7) Premium rates for portability plans **require approval by the director under ORS 743.003, this section and section 2 of this 2009 Act and** shall be subject to the following provisions:

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

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

(A) For each plan, the variation between the lowest premium rate and the highest premium rate

shall not exceed 100 percent of the lowest premium rate.

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

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

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

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

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

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

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

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

(b) For fraud or misrepresentation by the policyholder;

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

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

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

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

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

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

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

competent jurisdiction.

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

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

SECTION 9. ORS 743.767 is amended to read:

743.767. Premium rates for individual health benefit plans **require approval by the Director of the Department of Consumer and Business Services under ORS 742.003, 742.005 and 743.018, this section and section 2 of this 2009 Act and** shall be subject to the following provisions:

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

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

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

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

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

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

SECTION 10. Sections 2 to 5 of this 2009 Act and the amendments to ORS 743.018, 743.737, 743.760 and 743.767 by sections 6 to 9 of this 2009 Act apply to increases in premium rates proposed on or after the effective date of this 2009 Act.
