

**PROPOSED AMENDMENTS TO  
SENATE BILL 684**

1 On page 1 of the printed bill, line 2, after the semicolon insert “creating  
2 new provisions; amending ORS 743.737 and 743.760;”.

3 Delete lines 6 through 30 and insert:

4 **“SECTION 2. (1) If, as part of the review of a rate filing under ORS**  
5 **743.018, the Department of Consumer and Business Services requests**  
6 **information from an insurer that the department intends to treat as**  
7 **confidential or otherwise not subject to public disclosure, the depart-**  
8 **ment shall:**

9 **“(a) Extend the public comment period prescribed by ORS 743.019**  
10 **for 30 days; and**

11 **“(b) Notify interested persons and publish a notice on the**  
12 **department’s website that information that may be relevant to a rate**  
13 **filing will be reviewed by the department without public disclosure.**

14 **“(2) No later than 14 days after publication of the notice described**  
15 **in subsection (1) of this section, a person may petition the department**  
16 **to have access to the information that will not be subject to public**  
17 **disclosure. The department shall grant the petition if:**

18 **“(a) The request meets the requirements established by the depart-**  
19 **ment by rule;**

20 **“(b) The person has an interest or represents a public interest that**  
21 **may be affected by the outcome of the rate review;**

22 **“(c) The person does not have any financial interest in the infor-**

1 **mation that will be reviewed;**

2 **“(d) The person has the knowledge or expertise to meaningfully and**  
3 **productively contribute to the review of the rate filing; and**

4 **“(e) The person enters into the agreement described in subsection**  
5 **(4) of this section.**

6 **“(3) The department shall prescribe by rule the form of the petition,**  
7 **the submission requirements and the procedure for sharing informa-**  
8 **tion with a petitioner under this section.**

9 **“(4) A petitioner must enter into a written confidentiality agree-**  
10 **ment with the department stipulating that the petitioner will:**

11 **“(a) Not use or disclose information obtained through the review**  
12 **of the rate filing for any purpose other than to participate in the re-**  
13 **view unless the insurer consents, in writing, to the use of the infor-**  
14 **mation for another purpose; and**

15 **“(b) Take all reasonable steps to keep secure and not disclose any**  
16 **confidential information obtained through the review.**

17 **“(5) Upon a finding that a petitioner has failed to comply with the**  
18 **terms of the agreement described in subsection (4) of this section, the**  
19 **Director of the Department of Consumer and Business Services or the**  
20 **director’s designee may:**

21 **“(a) Remove a petitioner from the review of the rate filing;**

22 **“(b) Prohibit a petitioner from participating in the review of future**  
23 **rate filings; or**

24 **“(c) Impose penalties under ORS 731.988.**

25 **“SECTION 3. ORS 743.737 is amended to read:**

26 **“743.737. (1) A preexisting condition exclusion in a small employer health**  
27 **benefit plan shall apply only to a condition for which medical advice, diag-**  
28 **nosis, care or treatment was recommended or received during the six-month**  
29 **period immediately preceding the enrollment date of an enrollee or late**  
30 **enrollee. As used in this section, the enrollment date of an enrollee shall be**

1 the earlier of the effective date of coverage or the first day of any required  
2 group eligibility waiting period and the enrollment date of a late enrollee  
3 shall be the effective date of coverage.

4 “(2) A preexisting condition exclusion in a small employer health benefit  
5 plan shall expire as follows:

6 “(a) For an enrollee, on the earlier of the following dates:

7 “(A) Six months after the enrollee’s effective date of coverage; or

8 “(B) Ten months after the start of any required group eligibility waiting  
9 period.

10 “(b) For a late enrollee, not later than 12 months after the late enrollee’s  
11 effective date of coverage.

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

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

24 “(b) An exclusion period for specified covered services, as established  
25 under ORS 743.745, applicable to all individuals enrolling for the first time  
26 in the small employer health benefit plan.

27 “(4) A health benefit plan issued to a small employer may not apply a  
28 preexisting condition exclusion to a person under 19 years of age.

29 “(5) Late enrollees in a small employer health benefit plan may be sub-  
30 jected to a group eligibility waiting period of up to 12 months or, if 19 years

1 of age or older, may be subjected to a preexisting condition exclusion for up  
2 to 12 months. If both a waiting period and a preexisting condition exclusion  
3 are applicable to a late enrollee, the combined period shall not exceed 12  
4 months.

5 “(6) Each small employer health benefit plan shall be renewable with re-  
6 spect to all eligible enrollees at the option of the policyholder, small em-  
7 ployer or contract holder unless:

8 “(a) The policyholder, small employer or contract holder fails to pay the  
9 required premiums.

10 “(b) The policyholder, small employer or contract holder or, with respect  
11 to coverage of individual enrollees, an enrollee or a representative of an  
12 enrollee engages in fraud or makes an intentional misrepresentation of a  
13 material fact as prohibited by the terms of the plan.

14 “(c) The number of enrollees covered under the plan is less than the  
15 number or percentage of enrollees required by participation requirements  
16 under the plan.

17 “(d) The small employer fails to comply with the contribution require-  
18 ments under the health benefit plan.

19 “(e) The carrier discontinues offering or renewing, or offering and re-  
20 newing, all of its small employer health benefit plans in this state or in a  
21 specified service area within this state. In order to discontinue plans under  
22 this paragraph, the carrier:

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

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

29 “(C) May not cancel coverage under the plans for 90 days after the date  
30 of the notice required under subparagraph (A) of this paragraph if coverage

1 is discontinued in a specified service area because of an inability to reach  
2 an agreement with the health care providers or organization of health care  
3 providers to provide services under the plans within the service area; and

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

7 “(f) The carrier discontinues offering and renewing a small employer  
8 health benefit plan in a specified service area within this state because of  
9 an inability to reach an agreement with the health care providers or organ-  
10 ization of health care providers to provide services under the plan within the  
11 service area. In order to discontinue a plan under this paragraph, the carrier:

12 “(A) Must give notice to the department and to all policyholders covered  
13 by the plan;

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

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

21 “(g) The carrier discontinues offering or renewing, or offering and re-  
22 newing, a health benefit plan, other than a grandfathered health plan, for  
23 all small employers in this state or in a specified service area within this  
24 state, other than a plan discontinued under paragraph (f) of this subsection.

25 “(h) The carrier discontinues renewing or offering and renewing a  
26 grandfathered health plan for all small employers in this state or in a spec-  
27 ified service area within this state, other than a plan discontinued under  
28 paragraph (f) of this subsection.

29 “(i) With respect to plans that are being discontinued under paragraph (g)  
30 or (h) of this subsection, the carrier must:

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

4       “(B) Issue any such plans pursuant to the provisions of ORS 743.733 to  
5 743.737.

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

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

9       “(j) The Director of the Department of Consumer and Business Services  
10 orders the carrier to discontinue coverage in accordance with procedures  
11 specified or approved by the director upon finding that the continuation of  
12 the coverage would:

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

14       “(B) Impair the carrier’s ability to meet contractual obligations.

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

19       “(L) In the case of a health benefit plan that is offered in the small em-  
20 ployer market only through one or more bona fide associations, the mem-  
21 bership of an employer in the association ceases and the termination of  
22 coverage is not related to the health status of any enrollee.

23       “(7) A carrier may modify a small employer health benefit plan at the  
24 time of coverage renewal. The modification is not a discontinuation of the  
25 plan under subsection (6)(e), (g) and (h) of this section.

26       “(8) Notwithstanding any provision of subsection (6) of this section to the  
27 contrary, a carrier may not rescind the coverage of an enrollee in a small  
28 employer health benefit plan unless:

29       “(a) The enrollee or a person seeking coverage on behalf of the enrollee:

30       “(A) Performs an act, practice or omission that constitutes fraud; or

1 “(B) Makes an intentional misrepresentation of a material fact as pro-  
2 hibited by the terms of the plan;

3 “(b) The carrier provides at least 30 days’ advance written notice, in the  
4 form and manner prescribed by the department, to the enrollee; and

5 “(c) The carrier provides notice of the rescission to the department in the  
6 form, manner and time frame prescribed by the department by rule.

7 “(9) Notwithstanding any provision of subsection (6) of this section to the  
8 contrary, a carrier may not rescind a small employer health benefit plan  
9 unless:

10 “(a) The small employer or a representative of the small employer:

11 “(A) Performs an act, practice or omission that constitutes fraud; or

12 “(B) Makes an intentional misrepresentation of a material fact as pro-  
13 hibited by the terms of the plan;

14 “(b) The carrier provides at least 30 days’ advance written notice, in the  
15 form and manner prescribed by the department, to each plan enrollee who  
16 would be affected by the rescission of coverage; and

17 “(c) The carrier provides notice of the rescission to the department in the  
18 form, manner and time frame prescribed by the department by rule.

19 “(10) A carrier may continue to enforce reasonable employer participation  
20 and contribution requirements on small employers applying for coverage.  
21 However, participation and contribution requirements shall be applied uni-  
22 formly among all small employer groups with the same number of eligible  
23 employees applying for coverage or receiving coverage from the carrier. In  
24 determining minimum participation requirements, a carrier shall count only  
25 those employees who are not covered by an existing group health benefit  
26 plan, Medicaid, Medicare, TRICARE, Indian Health Service or a publicly  
27 sponsored or subsidized health plan, including but not limited to the medical  
28 assistance program under ORS chapter 414.

29 “(11) Premium rates for small employer health benefit plans shall be  
30 subject to the following provisions:

1       “(a) Each carrier must file with the department the initial geographic  
2 average rate and any changes in the geographic average rate with respect  
3 to each health benefit plan issued by the carrier to small employers.

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

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

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

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

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

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

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

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

27       “(vi) The period of time during which a small employer retains uninter-  
28 rupted coverage in force with the same carrier; and

29       “(vii) Adjustments to reflect the provision of benefits not required to be  
30 covered by the basic health benefit plan and differences in family composi-



1 tion.

2 “(D)(i) The premium rates determined in accordance with this paragraph  
3 may be further adjusted by a carrier to reflect the expected claims experience  
4 of the covered small employer, but the extent of this adjustment may not  
5 exceed five percent of the annual premium rate otherwise payable by the  
6 small employer. The adjustment under this subparagraph may not be cumu-  
7 lative from year to year.

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

11 “(E) A carrier shall apply the carrier’s schedule of premium rate vari-  
12 ations as approved by the department and in accordance with this paragraph.  
13 Except as otherwise provided in this section, the premium rate established  
14 by a carrier for a small employer health benefit plan shall apply uniformly  
15 to all employees of the small employer enrolled in that plan.

16 “(c) Except as provided in paragraph (b) of this subsection, the variation  
17 in premium rates between different health benefit plans offered by a carrier  
18 to small employers must be based solely on objective differences in plan de-  
19 sign or coverage and must not include differences based on the risk charac-  
20 teristics of groups assumed to select a particular health benefit plan.

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

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

29 “(B) Any adjustment attributable to changes in age, except an additional  
30 adjustment may be made to reflect the provision of benefits not required to

1 be covered by the basic health benefit plan and differences in family com-  
2 position.

3 “(e) Premium rates for small employer health benefit plans shall comply  
4 with the requirements of this section.

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

8 “(a) The full array of health benefit plans that are offered to small em-  
9 ployers by the carrier;

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

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

14 “(d) Provisions affecting any preexisting condition exclusion.

15 “(13)(a) Each carrier shall maintain at its principal place of business a  
16 complete and detailed description of its rating practices and renewal under-  
17 writing practices relating to its small employer health benefit plans, includ-  
18 ing information and documentation that demonstrate that its rating methods  
19 and practices are based upon commonly accepted actuarial practices and are  
20 in accordance with sound actuarial principles.

21 “(b) A carrier offering a small employer health benefit plan shall file with  
22 the department at least once every 12 months an actuarial certification that  
23 the carrier is in compliance with ORS 743.733 to 743.737 and that the rating  
24 methods of the carrier are actuarially sound. Each certification shall be in  
25 a uniform form and manner and shall contain such information as specified  
26 by the department. A copy of each certification shall be retained by the  
27 carrier at its principal place of business.

28 “(c) A carrier shall make the information and documentation described  
29 in paragraph (a) of this subsection available to the department upon request.  
30 Except as provided in ORS 743.018 **and section 2 of this 2013 Act** and ex-

1 cept in cases of violations of ORS 743.733 to 743.737, the information shall  
2 be considered proprietary and trade secret information and shall not be  
3 subject to disclosure to persons outside the department except as agreed to  
4 by the carrier or as ordered by a court of competent jurisdiction.

5 “(14) A carrier shall not provide any financial or other incentive to any  
6 insurance producer that would encourage the insurance producer to market  
7 and sell health benefit plans of the carrier to small employer groups based  
8 on a small employer group’s anticipated claims experience.

9 “(15) For purposes of this section, the date a small employer health ben-  
10 efit plan is continued shall be the anniversary date of the first issuance of  
11 the health benefit plan.

12 “(16) A carrier must include a provision that offers coverage to all eligi-  
13 ble employees of a small employer and to all dependents of the eligible em-  
14 ployees to the extent the employer chooses to offer coverage to dependents.

15 “(17) All small employer health benefit plans shall contain special en-  
16 rollment periods during which eligible employees and dependents may enroll  
17 for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on  
18 February 17, 2009.

19 “(18) A small employer health benefit plan may not impose annual or  
20 lifetime limits on the dollar amount of the essential health benefits pre-  
21 scribed by the United States Secretary of Health and Human Services pur-  
22 suant to 42 U.S.C. 300gg-11, except as permitted by federal law.

23 “(19) This section does not require a carrier to actively market, offer, is-  
24 sue or accept applications for a grandfathered health plan or from a small  
25 employer not eligible for coverage under such a plan as provided by the Pa-  
26 tient Protection and Affordable Care Act (P.L. 111-148) as amended by the  
27 Health Care and Education Reconciliation Act (P.L. 111-152).

28 **“SECTION 4.** ORS 743.760 is amended to read:

29 “743.760. (1) As used in this section:

30 “(a) ‘Carrier’ means an insurer authorized to issue a policy of health in-

1 surance in this state. ‘Carrier’ does not include a multiple employer welfare  
2 arrangement.

3 “(b)(A) ‘Eligible individual’ means an individual who:

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

9 “(ii) Meets the eligibility requirements of 42 U.S.C. 300gg-41, has applied  
10 for portability coverage not later than the 63rd day after termination of  
11 group coverage issued by an Oregon carrier and is an Oregon resident at the  
12 time of such application.

13 “(B) Except as provided in subsection (12) of this section, ‘eligible indi-  
14 vidual’ does not include an individual who remains eligible for the  
15 individual’s prior group coverage or would remain eligible for prior group  
16 coverage in a plan under the federal Employee Retirement Income Security  
17 Act of 1974, as amended, were it not for action by the plan sponsor relating  
18 to the actual or expected health condition of the individual, or who is cov-  
19 ered under another health benefit plan at the time that portability coverage  
20 would commence or is eligible for the federal Medicare program.

21 “(c) ‘Portability health benefit plans’ and ‘portability plans’ mean health  
22 benefit plans for eligible individuals that are required to be offered by all  
23 carriers offering group health benefit plans and that have been approved by  
24 the Director of the Department of Consumer and Business Services in ac-  
25 cordance with this section.

26 “(2)(a) In order to improve the availability and affordability of health  
27 benefit plans for individuals leaving coverage under group health benefit  
28 plans, the director shall develop two portability health benefit plans pursu-  
29 ant to ORS 743.745. One plan shall be in the form of insurance and the sec-  
30 ond plan shall be consistent with the type of coverage provided by health

1 maintenance organizations. For each type of portability plan, the director  
2 shall establish standards for:

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

5 “(B) A low cost benefit plan, which shall emphasize affordability for eli-  
6 gible individuals.

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

10 “(3) The standards for portability health benefit plans established by the  
11 director under subsection (2) of this section must provide for appropriate  
12 accessibility and affordability of needed health care services and comply with  
13 all other provisions of this section.

14 “(4) Each carrier offering group health benefit plans shall submit to the  
15 director the policy form or forms containing at least one low cost benefit and  
16 one prevailing benefit portability plan offered by the carrier that meets the  
17 standards established by the director under subsection (2) of this section.  
18 Each policy form must be submitted as prescribed by the director and is  
19 subject to review and approval pursuant to ORS 742.003.

20 “(5) No later than 180 days after the director establishes standards for  
21 portability plans, as a condition of transacting group health insurance in  
22 this state, each carrier offering group health benefit plans shall make avail-  
23 able to eligible individuals the prevailing benefit and low cost benefit por-  
24 tability plans that have been submitted by the carrier and approved by the  
25 director under subsection (4) of this section.

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

1 of the portability plan.

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

4 “(a) Each carrier must file with the director the carrier’s initial ge-  
5 ographic average rate and any changes in the geographic average rate with  
6 respect to each portability health benefit plan issued by the carrier.

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

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

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

18 “(c) Premium variations between the portability plans and the rest of the  
19 carrier’s group plans must be based solely on objective differences in plan  
20 design or coverage and must not include differences based on the actual or  
21 expected health status of individuals who select portability health benefit  
22 plans. For purposes of determining the premium variations under this para-  
23 graph, a carrier may:

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

25 “(B) Pool all portability plans for eligible individuals leaving small em-  
26 ployer group health benefit plan coverage with all plans offered to small  
27 employers and pool all portability plans for eligible individuals leaving other  
28 group health benefit plan coverage with all health benefit plans offered to  
29 such other groups.

30 “(d) A carrier may not increase the rates of a portability plan issued to

1 a policyholder more than once in any 12-month period. Annual rate increases  
2 shall be effective on the anniversary date of the plan issued to the  
3 policyholder. The percentage increase in the premium rate charged to a  
4 policyholder for a new rating period may not exceed the average increase in  
5 the rest of the carrier's applicable group health benefit plans plus an ad-  
6 justment for age.

7 “(8) A portability plan under this section may not contain preexisting  
8 condition exclusions, waiting periods or other similar limitations on cover-  
9 age.

10 “(9) Portability health benefit plans shall be renewable with respect to  
11 all enrollees at the option of the enrollee unless:

12 “(a) The policyholder fails to pay the required premiums;

13 “(b) The policyholder or a representative of the policyholder engages in  
14 fraud or makes an intentional misrepresentation of a material fact as pro-  
15 hibited by the terms of the policy;

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

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

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

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

23 “(10)(a) A carrier offering a group health benefit plan shall maintain at  
24 its principal place of business a complete and detailed description of its  
25 rating practices and renewal underwriting practices relating to its portabil-  
26 ity plans, including information and documentation that demonstrate that its  
27 rating methods and practices are based upon commonly accepted actuarial  
28 practices and are in accordance with sound actuarial principles.

29 “(b) A carrier offering a group health benefit plan shall file with the  
30 Department of Consumer and Business Services annually on or before March

1 15 an actuarial certification that the carrier is in compliance with this sec-  
2 tion and that its rating methods are actuarially sound. Each certification  
3 shall be in a form and manner and shall contain such information as speci-  
4 fied by the department. A copy of each certification shall be retained by the  
5 carrier at its principal place of business.

6 “(c) A carrier offering a group health benefit plan shall make the infor-  
7 mation and documentation described in paragraph (a) of this subsection  
8 available to the department upon request. Except as provided in ORS 743.018  
9 **and section 2 of this 2013 Act** and except in cases of violations of the In-  
10 surance Code, the information is proprietary and trade secret information  
11 and shall not be subject to disclosure to persons outside the department ex-  
12 cept as agreed to by the carrier or as ordered by a court of competent ju-  
13 risdiction.

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

18 “(12) An individual who is eligible to obtain a portability plan in ac-  
19 cordance with this section may obtain such a plan regardless of whether the  
20 eligible individual qualifies for a period of continuation coverage under fed-  
21 eral law or under ORS 743.600 or 743.610. However, an individual who has  
22 elected such continuation coverage is not eligible to obtain a portability plan  
23 until the continuation coverage has been discontinued by the individual or  
24 has been exhausted.

25 “(13) Subject to the provisions of ORS 743.894 (2) and (4), a carrier may  
26 rescind a portability health benefit plan issued to a policyholder only if the  
27 policyholder or a representative of the policyholder:

28 “(a) Performs an act, practice or omission that constitutes fraud; or

29 “(b) Makes an intentional misrepresentation of a material fact as pro-  
30 hibited by the terms of the policy.”.



1 On page 2, delete lines 1 through 17.

2 In line 18, delete “3” and insert “5”.

3 \_\_\_\_\_