A-Engrossed
House Bill 2605

Ordered by the House April 9
Including House Amendments dated April 9

Sponsored by Representative NOSSE (Presession filed.)

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.

[*Requires insurers to submit rate filings to Department of Consumer and Business Services no later than eight months prior to beginning of open enrollment period for health insurance exchange. Requires department to make preliminary decision on rate filing within 10 days after close of public comment period and to notify insurer in writing if preliminary decision is to disapprove rate filing. Allows insurer opportunity to meet with Director of Department of Consumer and Business Services and provide additional information if preliminary decision is to disapprove rate. Requires director to make final decision on rate filing within 30 days of close of public comment period.*]

[*If insurer contests denial of rate filing within 10 days of notice, requires final order in contested case hearing to be entered no later than 90 days prior to beginning of open enrollment period for plan for which rates were submitted.*]

Specifies procedures by which Department of Consumer and Business Services may approve, modify or disapprove rate filing. Specifies procedures for insurer or person affected by rate filing to contest department's approval, modification or disapproval of rate filing.

Requires department to convene work group to consider modifying standard used to review rate filings.

A BILL FOR AN ACT

Relating to insurance; creating new provisions; and amending ORS 742.003, 743.018 and 743.019.

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

SECTION 1. (1) The Department of Consumer and Business Services shall convene a work group of stakeholders and department staff to consider modifying the standard for reviewing a rate filing under ORS 743.018 (4) to allow the Director of the Department of Consumer and Business Services to disapprove a rate only if the rate falls outside of a range of rates that are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses.

(2) The department shall report the findings of the work group to the appropriate interim committees of the Legislative Assembly no later than September 15, 2016.

SECTION 2. ORS 743.018 is amended to read:

743.018. (1) Except for group life and health insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services 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 743.019**.

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.

(2) Except as provided in ORS 743.737 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) Individual health benefit plans.

(3) The director may by rule:

(a) Specify all information a carrier must submit as part of a rate filing under this section; and

(b) Identify the information submitted that will be exempt from disclosure under this section because the information constitutes a trade secret and would, if disclosed, harm competition.

(4) The director, after conducting an actuarial review of the rate filing, may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the director's discretion, the proposed rates are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses.

(5) In order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the director may consider:

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

(b) Historical and projected administrative costs and medical and hospital expenses.

(c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums.

(d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

(e) Changes to covered benefits or health benefit plan design.

(f) Changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(h) Any public comments received under ORS 743.019 pertaining to the standards set forth in subsection (4) of this section and this subsection.

[*(6) With the written consent of the insurer, the director may modify a schedule or table of premium rates filed in accordance with subsection (1) of this section.*]

[*(7)*] **(6)** The requirements of this section do not supersede other provisions of law that require insurers, health care service contractors or multiple employer welfare arrangements providing health insurance to file schedules or tables of premium rates or proposed premium rates with the director or to seek the director's approval of rates or changes to rates.

SECTION 3. ORS 743.019 is amended to read:

743.019. (1) When an insurer files a schedule or table of premium rates for individual or small employer health insurance under ORS 743.018, the [*Director of the*] Department of Consumer and Business Services shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The [*director*] **department** shall post all **of the** comments **received** to the **department's** website [*of the Department of Consumer and Business Services*] without delay.

[*(2) The director shall give written notice to an insurer approving or disapproving a rate filing or,*

with the written consent of the insurer, modifying a rate filing submitted under ORS 743.018 no later than 10 business days after the close of the public comment period. The notice shall comply with the requirements of ORS 183.415.]

(2) The department shall make a preliminary decision to approve, disapprove or modify a rate filing. The department shall notify the insurer of, and make available to the public, the preliminary decision, including:

(a) An explanation of the findings and rationale that are the basis for the decision; and

(b) Any actuarial or other analyses, calculations or evaluations relied upon by the department in arriving at the decision.

(3) The department shall provide the insurer or any person adversely affected or aggrieved by the preliminary decision the opportunity to meet with the department to discuss and respond to the preliminary decision. However, an insurer or other person may not substitute new facts or data for the facts or data submitted by the insurer in the filing. The meeting shall:

(a) Include a department employee who reviewed the rate filing; and

(b) Comply with the requirements of ORS 192.610 to 192.690.

(4)(a) The department may approve a modified rate filing only with the written consent of the insurer. An insurer's consent to the modified rate filing does not preclude the insurer from contesting the modified rate filing by requesting a reconsideration under subsection (6) of this section or by requesting a contested case hearing.

(b) If the modified rate filing is reversed as a result of a reconsideration or contested case hearing, the rate filing, as approved in the reconsideration or final order in a contested case, may take effect on or after the date of the reconsideration or final order, in accordance with rules adopted by the department.

(5)(a) The department shall issue an order, no later than 30 days after the close of the public comment period described in subsection (1) of this section, approving, disapproving or modifying the rate filing based on the information submitted during the public comment period. However, the department may not consider new facts or data that are offered as a substitute for the facts or data submitted by the insurer in the filing. The order shall be mailed to the insurer and posted to the department's website.

(b) The order must include:

(A) An explanation of the findings and rationale that are the basis for the order, including any actuarial or other analyses, calculations or evaluations relied upon by the department in its findings or rationale; and

(B) Notice of the right of the insurer or any person adversely affected or aggrieved by the order to contest the order by requesting:

(i) An expedited reconsideration in accordance with subsection (6) of this section; or

(ii) A contested case hearing in accordance with ORS chapter 183.

(6) If an insurer or a person adversely affected or aggrieved by an order approving, disapproving or modifying a rate filing submits to the department a request for reconsideration no later than 10 days after the date the order is issued under subsection (5) of this section:

(a) The requester may not substitute new facts or data for the facts and data that were submitted by the insurer in the filing, but may provide a brief, memorandum or analysis based on the evidence contained in the filing or received and considered by the department during the public comment period;

(b) The Director of the Department of Consumer and Business Services may not delegate the decision-making authority for the reconsideration request to any other individual;

(c) The director shall issue a decision on the request for reconsideration no later than 30 days after the request is received by the department; and

(d) The decision shall include:

(A) An explanation of the findings and rationale that are the basis for the decision; and

(B) Notice of the right to a contested case hearing in accordance with ORS chapter 183.

(7) Subsections (2) and (5) of this section do not require the department to perform any actuarial or other analyses, calculations or evaluations.

(8) The department may adopt rules modifying the procedures described in subsections (2) to (6) of this section, but only to the extent necessary to comply with 42 U.S.C. 300gg-94.

SECTION 4. ORS 742.003 is amended to read:

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

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

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

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

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

(2) **Except as provided in ORS 743.019,** the director shall within 30 days after the filing of any such form approve or disapprove the form. The director shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

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

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