A-Engrossed
Senate Bill 717

Ordered by the Senate April 27
Including Senate Amendments dated April 27

Sponsored by COMMITTEE ON GENERAL GOVERNMENT, CONSUMER AND SMALL BUSINESS PROTECTION

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.

Authorizes Director of Department of Consumer and Business Services to conduct [*hearing*] **public meeting** on insurer's request for approval of premium rates **for individual or small employer health benefit plan**. [*Makes Attorney General party to hearing. Provides that decision following hearing be issued as contested case order.*]

Requires director to conduct public meeting on rate request if filing proposes seven percent or greater increase in rates and affects 1,000 or more policyholders. Requires director to certify intervenor that meets specified criteria for purposes of proceedings. Authorizes director to conduct public hearing and requires public hearing on request of certified intervenor. Provides that insurer has burden of proving that rate filing satisfies requirements. Requires that director act on rate filing by 90th day after beginning of public comment period or filing is deemed disapproved.

A BILL FOR AN ACT

Relating to health insurance rate review; amending ORS 742.003, 743.018, 743.019 and 743.020.

Whereas the State of Oregon, through its regulation of health insurance, has an obligation to balance the needs of individual and small group policyholders and the needs of insurers; now, therefore,

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

SECTION 1. 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.

(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 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.

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.

(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*] **shall** 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) 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 2. ORS 743.019 is amended to read:

743.019. (1) When an insurer files **for approval by the Director of the Department of Consumer and Business Services** a schedule or table of premium rates for **an** individual, portability or small employer health [*insurance under ORS 743.018*] **benefit plan, as defined in ORS 743.730**, 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 shall post all comments to the website of the Department of Consumer and Business Services without delay.

(2) The director may conduct a public meeting, in accordance with the provisions of ORS 192.610 to 192.690, on any filing with respect to an individual or small employer health benefit plan submitted under subsection (1) of this section.

(3)(a) The director shall conduct a public meeting, in accordance with the provisions of ORS 192.610 to 192.690, on any filing with respect to an individual or small employer health benefit plan submitted under subsection (1) of this section if:

(A) The filing proposes an average annual increase to the premium rates charged by the insurer of seven percent or greater; and

(B) The rate increase affects 1,000 or more policyholders.

(b) The purpose of a public meeting conducted under this subsection is to obtain additional information necessary for the director to determine if the proposed premium rates meet the requirements of ORS 743.018 (4) and that there are no grounds for disapproval under ORS 742.005. An actuary for the insurer or other representative of the insurer who is knowledgeable about the details of the filing must appear at the public meeting to answer questions.

(4) The director shall certify any of the following individuals or groups to formally participate in any proceedings under this section as intervenors:

(a) A group of 10 or more policyholders who will be affected by the premium rates in the filing and who jointly apply, in writing, to intervene.

(b) An association with 10 or more members who are policyholders who will be affected by the premium rates in the filing and who jointly apply, in writing, to intervene.

(c) An office of health insurance consumer assistance or ombudsman described in 42 U.S.C. 300gg-93 or similar consumer assistance organization or ombudsman.

(5) A certified intervenor shall have access to all information described in ORS 743.018 (3), 743.737 (10) and 743.760 (10) to the same extent as and subject to no greater restrictions on access than are imposed on the department. An insurer must respond to any requests for information from the director or a certified intervenor no later than the 20th day after the beginning of the public comment period on the filing.

(6) No later than 10 days after the close of the public comment period and with at least 10 days' advance notice to the insurer, the director may, or upon the request of a certified intervenor shall, conduct a public hearing. At any public hearing held under this subsection, the insurer shall have the burden of proving that the proposed premium rates meet the requirements of ORS 743.018 (4) and that there are no grounds for disapproval under ORS 742.005.

[*(2)*] **(7)** 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*] **90 days after the beginning** of the public comment period **if the insurer has provided all necessary information to the director**. The notice shall comply with the requirements of ORS 183.415. **If the director does not approve or modify a rate filing by the 90th day after the beginning of the public comment period, the rate filing shall be deemed disapproved.**

(8) The director shall give written notice of the approval, modification or disapproval of a rate filing to:

(a) Any certified intervenors in the proceedings; and

(b) Any person that submitted public comments during the public comment period for the filing.

(9) A certified intervenor shall be reimbursed by the insurer for reasonable expenses incurred for expert testimony presented at proceedings under this section, not to exceed $10,000 for each filing.

SECTION 3. ORS 743.020 is amended to read:

743.020. An insurer licensed by the Department of Consumer and Business Services shall include [*in*] **with** any [*rate filing under ORS 743.018*] **schedule or table of premium rates filed for approval by the Director of the Department of Consumer and Business Services** with respect to individual and small employer health [*insurance policies*] **benefit plans, as defined in ORS 743.730,**

a statement of administrative expenses in the form and manner prescribed by the department by rule. The statement must include, but is not limited to:

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

(2) An explanation of the basis for any proposed premium rate increases or decreases.

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 with respect to rate filings,** 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*] **approval or disapproval** to the insurer proposing to deliver [*such*] **the** form and when a form is disapproved the notice shall [*show wherein such*] **explain why the** 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*] **the** 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.