

DIVISION 053

HEALTH BENEFIT PLANS

836-053-0000 (NEW)

Statutory Authority and Implementation

(1) OAR 836-053-0471 and 836-053-0475 are adopted under the authority of ORS 731.244, 743.018, 743.019 and 743.020, to aid in giving effect to provisions of ORS Chapters 742 and 743 relating to the filing of rates and policy forms with the Director. The requirements of OAR 836-053-0471 and 836-053-0475 are in addition to any other requirements established by statute or by rule or bulletin of the Department.

(2) OAR 836-053-0471 and 836-053-0475 apply to the following rate filings submitted or resubmitted to the Director on or after April 1, 2010:

(a) Health benefit plans for small employers;

(b) Individual health benefit plans.

Stat. Auth.: ORS 743.018, 743.019 and 743.020

Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020, 743.730, 743.767

Hist.: ID

836-053-0471 (NEW)

Required Materials for Rate Filing for Individual or Small Employer Health Benefit Plans

(1) Every insurer that offers a health benefit plan for small employers or an individual health benefit plan covering an Oregon resident shall file the information specified in subsections (2) and (3) of this rule when the insurer files with the director a schedule or table of premium rates for approval.

1 **(2) A schedule or table of base premium rates filed under subsection (1) of this section shall**
2 **include sufficient information and data to allow the director to consider the factors set**
3 **forth in ORS 743.018(4) and (5). The filing shall include all of the following separately set**
4 **forth and labeled as indicated:**

5 **(a) A filing description.**

6 **(A) Label: FILING DESCRIPTION.**

7 **(B) The filing description shall be submitted in the form of a cover letter. The filing**
8 **description must provide a summary of the reasons an insurer is requesting a rate change**
9 **and the minimum and maximum rate impact to all groups or members affected by the rate**
10 **change, including the anticipated change in number of enrollees if the proposed premium**
11 **rate is approved. The description also must include the name and contact information of**
12 **the filer and a description of any significant changes the insurer is making to the following:**

13 **(i) Rating factor changes;**

14 **(ii) Plan modification or discontinuance; and**

15 **(iii) Benefit or administration changes.**

16 **(b) A rate filing summary.**

17 **(A) Label: RATE FILING SUMMARY.**

18 **(B) This summary must explain the filing in a manner that allows consumers to understand**
19 **the rate change. The summary shall be in accordance with the form established in Exhibit 1**
20 **or Exhibit 2 to this rule. The information contained in this summary must match the**
21 **information provided elsewhere in the filing.**

22 **(c) An actuarial memorandum.**

23 **(A) Label: ACTUARIAL MEMORANDUM.**

24 **(B) This memorandum must include all of the following:**

25 **(i) A description of the benefit plan and a quantification of any changes to the benefit plan**
26 **as set forth in paragraph (2) (j) of this rule.**

27 **(ii) A discussion of assumptions, factors, calculations, rate tables and any other information**
28 **pertinent to the proposed rate.**

29 **(iii) A description of any changes in rating methodology supported by sufficient detail to**
30 **permit the department to evaluate the effect on rates and the rationale for the change.**

- 1 **(iv) The range of rate impact to groups or members including the distribution of the impact**
2 **on members.**
- 3 **(v) Signature of and date that a qualified actuary reviewed the rate filing.**
- 4 **(d) Rate tables and factors.**
- 5 **(A) Label: RATE TABLES AND FACTORS.**
- 6 **(B) The insurer must include base and geographic average rate tables, identify factors used**
7 **by the insurer in developing the rates and explain how the information is used in the**
8 **development of rates. The rate tables and factors must include a table of rating factors**
9 **reflecting ages of employees and dependents and geographic area. If base rates are not**
10 **provided by rating tier, the rate tier tables also must be provided.**
- 11 **(C) The document must indicate whether the rate increases are the same for all policies.**
12 **The document must clearly explain how the rate increases apply to different policies**
13 **including the entire distribution of rate changes and the average of the highest and lowest**
14 **rates resulting from the application of other rating factors.**
- 15 **(D) The geographic average rate table must include family type, geographic area and the**
16 **average of the highest and lowest rates resulting from the application of other rating**
17 **factors.**
- 18 **(E) The rate tables must contain at a minimum the base rates for each available plan. This**
19 **document must include information that would permit the determination of rates for each**
20 **benefit plan, each age bracket, each geographic area, each rate tier and any other variable**
21 **used to determine rates. If the rates vary more frequently than annually, separate rates**
22 **must either be provided for each effective date of change or information provided to permit**
23 **their determination and the justification for such variation in rates.**
- 24 **(F) If the filing is for a health benefit plan issued to a small employer, the insurer also shall**
25 **include the following factors if applied by the insurer as allowed under ORS 743.737:**
- 26 **(i) Contribution;**
- 27 **(ii) Level of participation;**
- 28 **(iii) Tobacco usage;**
- 29 **(iv) Participation in wellness programs;**
- 30 **(v) Duration of coverage in force; and**

1 (vi) Any adjustment to reflect expected claims experience, which may not exceed the limits
2 established in ORS 743.737.

3 (e) Plan relativities.

4 (A) Label: PLAN RELATIVITIES.

5 (B) This document must explain the presentation of rates for each benefit plan, explain the
6 methodology of how the benefit plan relativities were developed and demonstrate the
7 comparison and reasonableness of benefits and costs between plans.

8 (f) A description of the development of the proposed rate change or base rate.

9 (A) Label: DEVELOPMENT OF RATE CHANGE OR BASE RATE.

10 (B) This document is the core of the rate filing and must explain how the proposed rate or
11 rate change was calculated. The calculation must be based on generally accepted actuarial
12 rating principles for rating blocks of business and should provide sufficient detail to allow
13 reasonable review. The development of rate change or base rate also should include actual
14 or expected membership information and identify a proposed loss ratio for the rating
15 period. A rate renewal calculation must begin with an assumed experience period of at
16 least one year ending within the immediately preceding year, or, if more recent data is
17 available for one-year period that concludes with the most recent period for which data is
18 available. The total premium earned during the experience period should be adjusted to
19 yield premium adjusted to current rates. A projection is made of premiums and claims for
20 the period during which the proposed rates are to be effective. Claims for a renewal
21 projection should reflect an assumed medical trend rate as well as other expected changes
22 in claims cost, including but not limited to the impact of benefit changes or provider
23 reimbursement.

24 (g) Trend information and projection.

25 (A) Label: TREND INFORMATION AND PROJECTION.

26 (B) This document must describe how the assumed future growth of medical claims (the
27 medical trends rate) was developed based on generally accepted actuarial principles. The
28 trend document also must include historical monthly average claim costs for at least the
29 immediately preceding two years when applicable. If the carrier's structure does not
30 include claims cost, the carrier shall submit this information based on allocated costs.

31 (h) Premium retention.

1 **(A) Label: PREMIUM RETENTION.**

2 **(B) This document must include a description of retention. As used in this paragraph,**
3 **“retention” means the amount to be retained by the insurer to cover all of the insurer’s**
4 **non-claim costs including expected profit or contribution to surplus for a nonprofit entity.**
5 **Retention must be reported on a percentage of premium basis.**

6 **(i) Worksheet for Individual Health Benefit Plan Rates (if applicable).**

7 **(A) Label: WORKSHEET FOR INDIVIDUAL HEALTH BENEFIT PLAN RATES.**

8 **(B) This standardized schedule for individual health benefit plan rates must include earned**
9 **premiums, incurred claims and membership totals for the past five years on an annual**
10 **basis as well as accumulated to the current date. The same elements must be projected and**
11 **reported for each of the next three years. If an active life reserve has been established, that**
12 **reserve also should be included.**

13 **(j) Changes to covered benefits or health benefit plan design.**

14 **(A) Label: COVERED BENEFIT OR PLAN DESIGN CHANGES.**

15 **(B) This document must explain benefit and administrative changes with rating impact,**
16 **including covered benefit level changes, member cost-sharing changes, elimination of plans,**
17 **implementation of new plan designs, provider network changes, new utilization or prior**
18 **authorization programs, changes to eligibility requirements, changes to exclusions, or any**
19 **other change in the plan offerings that impacts costs or coverage provided.**

20 **(k) Changes in the insurer’s health care cost containment and quality improvement efforts.**

21 **(A) Label: COST CONTAINMENT AND QUALITY IMPROVEMENT EFFORTS.**

22 **(B) This document must explain any changes the insurer has made in its health care cost**
23 **containment efforts and quality improvement efforts since the insurer’s last rate filing for**
24 **the same category of health benefit plan. Significant new health care cost containment**
25 **initiatives and quality improvement efforts should be described and an estimate made of**
26 **potential savings together with an estimated cost or savings for the projection period. The**
27 **insurer shall provide information about whether the cost containment initiatives reduce**
28 **costs by eliminating waste, improving efficiency, by improving health outcomes through**
29 **incentives, or by elimination or reduction of covered services or reduction in the fees paid**
30 **to providers for services.**

31 **(l) Information about the insurer’s financial position.**

1 **(A) Label: INSURER'S FINANCIAL POSITION.**

2 **(B) This document must include information about the insurer's financial position,**
3 **including but not limited to profitability, surplus, reserves and investment earnings. This**
4 **document also must include a discussion of whether the proposed change in the premium**
5 **rate is necessary to maintain the insurer's solvency or to maintain rate stability and**
6 **prevent excessive rate increases for the line of business in the future. In providing this**
7 **information, the insurer may reference documents filed with the department as part of the**
8 **annual statement or other requisite filings. The referenced material must be available to**
9 **the public.**

10 **(m) Certification of compliance.**

11 **(A) Label: CERTIFICATION OF COMPLIANCE.**

12 **(B) The certificate must comply with OAR 836-010-0011 and must certify that the filing**
13 **complies with Oregon statutes, rules, product standards and filing requirements.**

14 **(n) Third party filer's letter of authorization (if applicable).**

15 **(A) Label: THIRD PARTY AUTHORIZATION.**

16 **(B) If the filing is submitted by a person other than the insurer, the filing must include a**
17 **letter from the insurer that authorizes the third party to submit and correspond with the**
18 **department on matters pertaining to the rate filing.**

19 **(3) (a) For each schedule or table of premium rates filed, the insurer shall separately**
20 **include a statement of administrative expenses for the line of business and complete the**
21 **chart displaying the five-year trend of administrative costs included as Exhibit 3 to this**
22 **rule. The chart must break down the insurer's administrative expenses relating to:**

23 **(A) Salaries, wages, employment taxes and other benefits;**

24 **(B) Commissions;**

25 **(C) Cost depreciations including but not limited to depreciation for equipment, software or**
26 **furniture;**

27 **(D) Rent or occupancy expenses;**

28 **(E) Marketing and advertising;**

29 **(F) General offices expenses, including but not limited to sundries, supplies, telephone,**
30 **printing and postage;**

31 **(G) Third party administration expenses or fees or other group service expense or fees;**

1 **(H) Legal fees and expenses and other professional or consulting fees;**

2 **(I) Other taxes, licenses and fees; and**

3 **(J) Travel expenses.**

4 **(b) The statement of administrative expenses required under this subsection must include:**

5 **(A) As set forth in Exhibit 3, a statement of administrative expenses on a per member per**
6 **month basis set forth separately for claim-related and non-claim expenses;**

7 **(B) As set forth in Exhibit 3, an explanation of the basis for any proposed premium rate**
8 **increase or decrease related to changes in the administrative expenses of the insurer; and**

9 **(C) An explanation of how the insurer allocates administrative expenses for the filed line of**
10 **business.**

11 **(4)(a) Within 10 days after receiving a proposed table or schedule of premium rate filing,**
12 **the director shall:**

13 **(A) Determine whether the proposed table or schedule of premium rate filing is complete.**
14 **If the director determines that a filing is complete, the director shall review the proposed**
15 **schedule or table of premium rate in accordance with ORS 742.003, 742.005, 742.007 and**
16 **743.018. If the director determines that the filing is not complete, the director shall notify**
17 **the insurer in writing that the filing is deficient and give the insurer an opportunity to**
18 **provide the missing information.**

19 **(B) If the filing is complete, the director shall open the 30-day public comment period. For**
20 **purposes of determining the beginning of the public comment period, the date the carrier**
21 **files a proposed schedule or table of premium rates shall be the date the director**
22 **determines that the filing is complete.**

23 **(b) The director shall issue a decision approving, disapproving or modifying the proposed**
24 **table or schedule of premium rate filing within 10 days after the close of the public**
25 **comment period.**

26 **(5) The director shall post on the Insurance Division website all materials submitted under**
27 **subsections (2) and (3) of this rule at the beginning of the public comment period.**

28
29 **Stat. Auth.: ORS 743.018, 743.019 and 743.020**

1 **Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020,743.730,**
2 **743.767**
3 **Hist.: ID**

4
5 **836-053-0475 (NEW)**

6
7 **Approval, Disapproval or Modification of Premium Rates for Individual or Small**
8 **Employer Health Benefit Plan**

9
10 **(1) The materials submitted under OAR 836-053-0471 shall include sufficient information**
11 **to allow the director to evaluate the proposed schedule or table of premium rates for**
12 **approval, disapproval or modification. After conducting an actuarial review of the rate**
13 **filing, the director may approve a proposed premium rate for a health benefit plan for**
14 **small employers or for an individual health benefit plan if, in the director’s discretion, the**
15 **proposed rates meet the requirements of ORS 742.003, 742.005, 742.007 and 743.018.**

16 **(2) The director may approve reasonable increases or decreases in administrative expenses**
17 **supported by the information provided under OAR 836-053-0471. In addition to the**
18 **materials submitted under OAR 836-053-0471, in order to determine whether the proposed**
19 **increase or decrease in administrative expenses is reasonable, the director may consider the**
20 **cost of living for the previous calendar year, based on the Producer Price Index for Direct**
21 **Health and Medical Insurance Carriers Industry, as published by the Bureau of Labor**
22 **Statistics of the United States Department of Labor.**

23 **Stat. Auth.: ORS 743.018, 743.019 and 743.020**

24 **Stats. Implemented: ORS 742.003, 742.005, 742.007, 743.018, 743.019, 743.020, 743.730,**
25 **743.767**

26 **Hist.: ID**

27
28 **836-053-0465**

29 **Rating for Individual Health Benefit Plans**

1 (1) Individual health benefit plans shall be rated in accordance with the geographic areas
2 specified in OAR 836-053-0065. A carrier shall file a single geographic average rate (GAR) for
3 each health benefit plan that is offered to individuals within a geographic area. The GAR must be
4 determined on a pooled basis and the pool shall include all of the carrier's business in the Oregon
5 individual market.

6 (2) The variation in geographic average rates among different individual health benefit plans
7 offered by a carrier must be based solely on objective differences in plan design or coverage. The
8 variation shall not include differences based on the risk characteristics or claims experience of
9 the actual or expected enrollees in a particular plan.

10 (3) A carrier shall implement premium rate increases for an individual health benefit plan in a
11 consistent manner for all enrollees in the plan. A carrier may use either of the following methods
12 to schedule premium rate increases for all enrollees in a plan:

13 (a) A rolling schedule that is based on the anniversary of the date coverage is issued to each
14 enrollee or on another anniversary date established by the carrier; or

15 (b) A fixed schedule that applies concurrently to all enrollees in a plan. If a fixed schedule is
16 used, a carrier may adjust an enrollee's premium during the rating period if the enrollee moves
17 into a higher age bracket or has a change in family composition.

18 (4) A carrier shall file its geographic average rates for individual health benefit plans in
19 accordance with the rate filing requirements of OAR **836-053-0471 and** 836-053-0910.

20 (5) A carrier may use the same geographic average rate for multiple rating areas.

21 (6) A carrier shall offer its insureds the opportunity to pay premium on a monthly basis for an
22 individual health benefit plan in addition to any other mode offered by the carrier.

23 Stat. Auth.: ORS 731.244, ORS **743.019, 743.020,** 743.769

24 Stats. Implemented: ORS **743.019, 743.020,** 743.766 - ORS 743.769, ORS 746.015, ORS
25 746.240

26 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; Renumbered from 836-053-0420, ID 5-1998, f. & cert.

1 ef. 3-9-98; ID 5-2000, f. & cert. ef. 5-11-00; ID 7-2001(Temp), f. 5-30-01, cert. ef. 5-31-01 thru
2 11-16-01; ID 14-2001, f. & cert. ef. 11-20-01

3 **836-053-0780**

4 **Rating for Portability Health Benefit Plans**

5 (1) Portability health benefit plans shall be rated in accordance with the geographic areas
6 specified in OAR 836-053-0065. A carrier shall file a single geographic average rate (GAR) for
7 each health benefit plan that is offered to eligible individuals within a geographic area. The GAR
8 must be determined on a pooled basis in accordance with ORS 743.760.

9 (2) Except for portability health benefit plans issued in accordance with ORS 743.761, the
10 variation in geographic average rates between a carrier's portability health benefit plans and the
11 carrier's group health benefit plans must be based solely on objective differences in plan design
12 or coverage. The variation shall not include differences based on the risk characteristics or
13 claims experience of the actual or expected enrollees in a particular plan.

14 (3) For portability health benefit plans issued in accordance with ORS 743.761, the premium
15 rates that apply to portability policyholders in the individual health benefit plan shall be identical
16 to the rates that apply to non-portability policyholders.

17 (4) A carrier shall implement premium rate increases for a portability health benefit plan in a
18 consistent manner for all policyholders in the plan. A carrier may use either of the following
19 methods to schedule premium rate increases for all policyholders in a plan:

20 (a) A rolling schedule that is based on the anniversary of the date coverage is issued to each
21 policyholder or on another anniversary date established by the carrier; or

22 (b) A fixed schedule that applies concurrently to all policyholders in a plan. If a fixed schedule is
23 used, a carrier may adjust a policyholder's premium during the rating period if the policyholder
24 moves into a higher age bracket or has a change in family composition.

25 (5) A carrier shall file its geographic average rates for portability health benefit plans in
26 accordance with the rate filing requirements of OAR 836-053-0910.

1 (6) A carrier may use the same geographic average rate for multiple rating areas.

2 **(7) A carrier shall submit with a filing under OAR 836-053-0910 (4) for a portability health**
3 **benefit plan a rate filing summary that explains the filing in a manner that allows**
4 **consumers to understand the rate change and how it may impact them. The summary shall**
5 **be in accordance with the form established in Exhibit 1 or Exhibit 2 to this rule or in other**
6 **substantively similar wording. The information contained in this summary must match the**
7 **information provided elsewhere in the filing.**

8 **(8) (a) Within 10 business days after receiving a proposed table or schedule of premium rate**
9 **filing, the director shall:**

10 **(A) Determine whether the proposed table or schedule of premium rate filing is complete.**
11 **If the director determines that a filing is complete, the director shall review the proposed**
12 **schedule or table of premium rate in accordance with ORS 742.003, 742.005, 742.007 and**
13 **743.018. If the director determines that the filing is not complete, the director shall notify**
14 **the carrier in writing that the filing is deficient and give the insurer an opportunity to**
15 **provide any missing information.**

16 **(B) If the filing is complete, the director shall open the 30-day public comment period. For**
17 **purposes of determining the beginning of the public comment period, the date the carrier**
18 **files a proposed schedule or table of premium rates shall be the date the director**
19 **determines that the filing is complete.**

20 **(b) The director shall issue a decision approving, disapproving or modifying the proposed**
21 **premium rate within 10 days after the close of the public comment period.**

22 **(9) The director shall post all materials submitted as part of the proposed schedule or table**
23 **of premium rates filing at the beginning of the public comment period.**

24 Stat. Auth.: ORS 731.244, **743.019, 743.020,**

25 Stats. Implemented: ORS **743.019, 743.020,** 743.731 & ORS 743.760

26 Hist.: ID 12-1996, f. & cert. ef. 9-23-96; ID 5-1998, f. & cert. ef. 3-9-98; ID 5-2000, f. & cert. ef.
27 5-11-00

28 **836-053-0910**

29 **Rate Filing**

1 (1) A carrier shall file with the Director:

2 (a) The appropriate checklists and certification statements, as established in OAR 836-010-0011;

3 **and**

4 (b) **For portability health benefit plans,** an actuarial demonstration of the basis for the
5 differences in the geographic average rates of the various plans offered in the marketplace. This
6 demonstration shall be certified by a member of the American Academy of Actuaries both at the
7 initial submission and subsequently when the rate relativities between plans are changed.

8 **(c) For health benefit plans for small employers and for individual health benefit plans, the**
9 **materials set forth in OAR 836-053-0471.**

10 (2) A carrier shall not offer a subject health benefit plan until the Director has determined that
11 the filed geographic average rate meets the applicable statutory requirements.

12 (3) An approved geographic average rate shall not be modified by a carrier until the Director has
13 determined that the filed modification meets the applicable statutory requirements.

14 (4) Rate filings pursuant to requirements specified in OAR 836-010-0011, *[and]* 836-010-0021
15 **and 836-053-0471** for any of the following health benefit plans subject to ORS 743.730 to
16 743.773 must be submitted to the Director in electronic format:

17 (a) Health benefit plans for small employers.

18 (b) Portability health benefit plans.

19 (c) Individual health benefit plans.

20 (5) Forms of acceptable electronic filing format under section (4) of this rule are:

21 (a) Filings submitted using the National Association of Insurance Commissioner's System for
22 Electronic Rate and Form Filings (SERFF); or

1 (b) Filings with documentation attached in pdf format that is under 3MB in size. For the purpose
2 of this subsection, each filing requirement, such as an exhibit, an actuarial memorandum or a
3 certificate of compliance, must be in a separate pdf format under 3MB in size. These filings may
4 be submitted via email with documents attached in pdf format, or the filings may be submitted
5 on a compact disc (CD) with documents attached in pdf format. If submitting via email, the
6 combined size of the email plus attached documents being transmitted must be less than four
7 megabytes.

8 *[(6) A carrier shall submit with a filing under section (4) of this rule a statement that explains the*
9 *filing in plain language for the purpose of public information, according to the form established*
10 *in Exhibit 1 or Exhibit 2 to this rule or in other substantively similar wording.]*

11 *[(7) The following apply to an insurer requesting exemption from disclosure:]*

12 *[(a) The insurer must submit the part or parts of the filing requested to be exempt in a separate*
13 *pdf format from the portion of the filing for which exemption is not requested.]*

14 *[(b) The insurer must accompany the exemption request by a clear and detailed explanation of*
15 *the following:]*

16 *[(A) How the part or parts of the filing meet the requirement of a trade secret; and]*

17 *[(B) How public disclosure of the trade secret would harm competition in the Oregon health*
18 *insurance market, with particular attention to the effects of disclosure on Oregon consumers,*
19 *along with evidence that demonstrates likely consequences.]*

20 *[(c) The insurer must submit the request with the rate filing.]*

21 *[(8)](6) Contents of rate filings described in section (4) of this rule and [~~statements~~] **rate filing***
22 ***summaries** described in [section (6) of this rule] **OAR 836-053-0471 and 836-053-0780(7)** will*
23 *be posted for public inspection on the Oregon Insurance Division website. [A carrier that*
24 *submits a request for exemption may respond to the Director not later than the fifth day after the*
25 *carrier receives the Director's decision to grant or deny the exemption. A request for exemption*
26 *in compliance with this section will stay disclosure of the part of a filing to which the request*

1 *applies, pending the Director's decision on the request. Similarly, a request for a hearing on a*
2 *decision by the Director will also stay disclosure of the part of a filing to which the request*
3 *applies.]*

4 [~~(9) Violation of any provision of this rule is an unfair trade practice under ORS 746.240.~~]

5 [(10)] **(7)** Sections (4) to [(8)] **(6)** of this rule, **as amended**, apply to a rate filing made on or after
6 [May 11, 2008] **April 1, 2010**.

7 Stat. Auth.: ORS 731.244, **743.019, 743.020**

8 Stats. Implemented: ORS **743.019, 743.020**, 743.730 - 743.773

9 Hist.: ID 13-1996(Temp), f. & cert. ef. 9-23-96; ID 2-1997, f. & cert. ef. 3-28-97; ID 5-1998, f.
10 & cert. ef. 3-9-98, Renumbered from 836-053-0185; ID 13-2007(Temp), f. & cert. ef. 12-21-07
11 thru 5-10-08; Administrative correction 5-20-08; ID 8-2008, f. & cert. ef. 6-18-08

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13