State of Oregon
Department of Consumer & Business Services
Division of Financial Regulation

Health Benefit Plan (a.k.a. SB-501) Report Instructions
Effective: 2015 Reporting Year
Revised 3/18/2016

Purpose

- ORS 743.748 requires each carrier, as defined by ORS 743.730(6), offering a Health Benefit Plan in Oregon to submit information on an annual basis to the Director of the Department of Consumer & Business Services (DCBS).
- This information is used by DCBS to prepare reports on regulated health insurance market segments. Those segments are: individual (including portability plans), small employer groups, associations, trusts, multiple employer welfare association groups (MEWA), and large groups.

Information and Disclosure

- Reported information is compiled from the carrier's annual statement, as required by ORS 731.574.
- Information reported in Sections A and B of the report is available to the public via the Division of Financial Regulation's website.
- Instructions are provided for clarification and to facilitate accurate reporting to DCBS.
- OAR 836-053-1400 further clarifies the terms used in this report.
- For questions relating to the submission of data, contact ins.mrktsurv@state.or.us or 503.947.7201.

Federal MLR Calculations and Premium Rebates

- Earned premiums, incurred claims, and incurred loss ratios for Health Benefit Plan reporting remain consistent with the exhibit of premiums, enrollment and utilization that is part of the company's annual financial statement, as required in OAR 836-053-1400.
- Incurred loss ratios for Health Benefit Plan reporting purposes are not equivalent to federal MLR calculations. Please refer to the HealthCare.gov website for information pertaining to federal MLR calculations and required premium rebates.
- Premium rebates will be reported consistent with guidance provided by revision to SSAP 66. No additional reporting of premium rebate information is required for the Health Benefit Plan report.

Role of Carriers

- Carriers are responsible for the accuracy and timeliness of their report.
- The report must be submitted to DCBS by April 1 of each year via the Division of Financial Regulation's website at **https://www4.cbs.state.or.us/exs/ins/multifile/**
- Carriers must provide and maintain the following company contact information:
    - Name of contact person
    - Contact person's email and phone number
    - Mailing address
    - Fax number
    - Oregon certificate of authority number
    - NAIC number

Health Benefit Plan Report – General Information

Reporting Required:

ORS 743.748 requires each carrier offering a "Health benefit plan" to submit information pertaining to specific market segments to the Director of DCBS on or before April 1st of each year.

Per ORS 743.730(18)(a) "Health benefit plan" means any**:**
(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;
(B) Health care service contractor or health maintenance organization subscriber contract; or
(C) Plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended, to the extent that the plan is subject to state regulation.

The specific market segments are: individual (including portability plans), small employer groups, associations, trusts, multiple employer welfare association groups (MEWA), and large groups.

Exempt from Reporting - No exempt filing is currently required:

- Companies with no "Health benefit plans" in force or in run out during the reporting period are not required to report for that period. *No online exemption is currently required.*
- Per ORS 743.730(18)(b), the following are not included in the definition of "Health benefit plan" and should not be reported:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;
(B) Coverage of Medicare services pursuant to contracts with the federal government;
(C) Medicare supplement insurance policies;
(D) Coverage of TRICARE services pursuant to contracts with the federal government;
(E) Benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan;
(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;
(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;
(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;
(I) Dental only coverage;
(J) Vision only coverage;
(K) Stop-loss coverage that meets the requirements of ORS 742.065;
(L) Coverage issued as a supplement to liability insurance;
(M) Insurance arising out of a workers' compensation or similar law;
(N) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or
(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

- In addition to the exclusions noted above, the following coverage types are excluded from reporting:
  - Single-service benefit plans not specified above (i.e. prescription drug)
  - Supplemental medical plans
  - Medicare Advantage
  - Complementary medical plans (i.e. chiropractic, naturopathic, supplemental medical reimbursement)

Reporting Period

The Health Benefit Plan Reporting Year is the calendar year ending immediately prior to each April 1 report due date.

Section A - Oregon-Only Data – Publicly Available

The market segments in Section A are:

1. Individual (including portability)
2. Small Employer Group
3. Associations and Trusts (including MEWAs)
4. Fully Insured Large Groups.

PLEASE NOTE: Information for student health plans that meet the definition of a health benefit plan will be included with the large group line of business (Section A, line 4). Include line item information of:

I. Year-end Members
II. Member Months
III. Premium
IV. Claims for those student health plans in the comment section.

Data required for Section A, lines 1 through 4 is obtained from the Exhibit of Premiums, Enrollment and Utilization, business in the state of Oregon ("State Page") that is part of the Health Annual Statement. If a carrier is not using the Health Annual Statement, then they will need to derive the data from their records using the instructions for the referenced health State Page.

Lines 1 through 4

Columns I. through VIII. are reported for each market segment:

I. Total Number of Members: The total number of members at end of current year (as of December 31 of the reported year), as reported by the carrier on the State Page. A member includes the subscriber and covered dependents, ***regardless of where they reside*.**
II. Total Number of Member Months: Current year member months as reported by the carrier on the State Page (the accumulated member months for the reporting period).
III. Total Amount of Premiums: Health premium as reported by the carrier on the State Page.
IV. Total Amount of Costs for Claims: Amount incurred for provision of health care services as reported by the carrier on the State Page. Amounts here will differ from amounts reported for federal MLR calculations due to differences in reporting of activities to improve healthcare.
V. Medical Loss Ratio: ***Calculated automatically***. The medical loss ratio is the Total Amount of Costs for Claims (column IV) divided by Total Amount of Premiums (column III) and is separate from the federal MLR. Information regarding the federal MLR may be found through the http://www.healthcare.gov/ website.
VI. Average Amount of Premiums per Member per Month - Reporting Year: ***Calculated automatically*** (column III divided by column II).
VII. Average Amount of Premiums per Member per Month—Prior Year: column VI from the carrier's prior year Health Benefit Plan Report. If no report was filed, this amount should be calculated from the prior year's State Page.
VIII. Percentage Change in Average Premium per Member per Month, measured from the previous year: ***Calculated automatically*** and equal to column VI less column VII divided by column VII.

Line 5 – Total for Columns I through IV Above: ***Calculated automatically.***

Section A - Oregon-Only Data (*Not* Publicly Available)

Line 4a was added for minimum premium and other large group business reported as partially insured on the carrier's Annual Statement. This information is not directly reported on the State Page. Please refer to the Guidance for Reporting Minimum Premium Plans Division of Financial Regulation's Memorandum released January 25, 2010. Data reported on line 4a is not included in line 4 and is not included in the total of lines 1 through 4.

Line 4a

Columns I through IV are reported for minimum premium and other partially insured large groups:

I. Total Number of Members: The total number of members at end of current year (as of December 31 of the Health Benefit Plan Reporting Year), enrolled under a Minimum Premium, or other partially insured, large group health benefit plan. A member includes the subscriber and covered dependents, ***regardless of where they reside*.**
II. Total Number of Member Months: Accumulated member months for the current year.
III. Total Amount of Premiums: Total earned contractual funding less any earned stop loss insurance premiums.
IV. Total Amount of Costs for Claims: Amount incurred for provision of health care services that does not exceed contractual stop loss insurance thresholds. The total amount of costs for stop loss claims are reported separately on the State Page and are excluded here.

Section A - Nationwide Data (Publicly Available)

Line 5

Report the total of all Comprehensive (Hospital and Medical) individual and group business nationwide as reported on the Analysis of Operations by Line of Business schedule in the carrier's Annual Statement.

NAIC Annual Statement defines Comprehensive (Hospital and Medical) as business that provides for medical coverage including hospital, surgical & major medical. Comprehensive includes State Children's Health Insurance Programs (SCHIP) Medicaid Program (Title XXI) risk contracts. Also includes medical only programs that provide medical only benefits without hospital coverage.

Does not include self-insured business, federal employees health benefit programs (FEHBP), Medicare and Medicaid programs and dental only business. (See Health Quarterly and Annual Statement Instructions, Appendix, Definitions of Lines of Business) Also does not include non-comprehensive or other medical, such as: specified/named disease, limited benefit, student, accident only or AD&D, Disability Income, Long Term Care, Tricare, Medicare Part D Stand-Alone, Credit, Stop Loss/Excess Loss, Administrative Services Only, or Administrative Services Contracts. (See Health Annual Statement Blank, Accident and Health Policy Experience Exhibit, Other Medical (Non-Comprehensive) and Other Business).

Section B - Company Wide – Publicly Available

Carriers will provide the following information from their Annual Statement for the reporting year:

Total Revenue

Health Statement Blank: See Statement of Revenue and Expenses
Life & Accident & Health Statement Blank: See Statement of Operations

Total amount of surplus maintained:

Health Statement Blank: see the Liabilities, Capital & Surplus page
Life & Accident & Health Statement Blank: See the Liabilities, Surplus and Other Funds Page.

Total amount of reserves maintained for unpaid claims:
Health Statement Blank: see the Liabilities, Capital & Surplus page
Life & Accident & Health Statement Blank: See the Liabilities, Surplus and Other Funds Page.

Total net underwriting gain or loss
Health Statement Blank: see Statement of Revenue and Expenses page
Life & Accident & Health Statement Blank: See Statement of Operations page and subtract the following from the Net Gain from Operations after Dividends to Policyholders and Before Federal Income Taxes:

1. Net investment income
2. Amortization of Interest Maintenance Reserve
3. Separate Accounts net gain from operations excluding unrealized gains or losses
4. Miscellaneous Income

Net Income after taxes
Health Statement Blank: see Statement of Revenue and Expenses page
Life & Accident & Health Statement Blank: See Statement of Operations page

Oregon Reinsurance Program assessment
Cash paid during the reporting year and included in general expenses in the Annual Statement.

Total amount of general administrative expenses
Health Statement Blank: see Analysis of Operations by Lines of Business page
Life & Accident & Health Blank: Not a comparable line in this Blank. However, data may be derived from Exhibit 2 – General Expenses, column 3 by removing portions attributed to claims adjustment expenses.

Of total general administrative expenses, the five largest nonmedical administrative expenses of those shown below:
Health Statement Blank: Select from column 3 of the Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses, for the 10 items shown below.
Life & Accident & Health Blank: Select from column 3 of Exhibit 2 – General Expenses, for items 1-9, and column 2 of Exhibit 3 for item 10 below and remove those portions attributed to claims adjustment expense.

1. Rent (Hlth: Line 1) (L&H: Line 1)
2. Salaries, wages and other benefits (Hlth: Line 2)(L&H: Line 2)
3. Commissions (Hlth: Line 3)
4. Legal fees and expenses, other professional or consulting fees including: certifications and accreditation fees; auditing, actuarial and other consulting services (Hlth: Total of lines 4, 5 and 6)(L&H: Line 4.1)
5. Travel Expenses (Hlth: Line 7)(L&H: Line 5.1)
6. Marketing and Advertising (Hlth: Line 8)(L&H: Line 5.2)
7. General Office Expenses including: Postage, express and telephone; printing and office supplies; equipment (Hlth: Total of Lines 9, 10 and 12)(L&H: Total of Lines 5.3, 5.4, 5.6 and 6.6)
8. Cost or Depreciation of EDP equipment and software (Hlth: Total of lines 11 and 13)(L&H: Line 5.7)
9. Outsourced services including EDP, claims and other group services and administration fees (Hlth: Total of Lines 14 and 18)(L&H: Line 6.7)
10. Other taxes, licenses and fees (Hlth: Total of Lines 23.1, 23.2, 23.3, 23.4 and 23.5)(L&H: Exhibit 3, Column 2, Total of lines 2, 3, 4, 5 and 6)