



Department of Consumer and Business Services

Department of Consumer & Business Services
Oregon Division of Financial Regulation

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Standards for Filing Individual and Small Group Health Benefit Plan Rates

These standards are summaries, and review of the entire statute or rule may is strongly encouraged.

Category	Reference	Description of review standards requirements
SUBMISSION PACKAGE REQUIREMENTS	OAR 836-010-0011	Required forms are located on SERFF and on our Web site: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx
	OAR 836-053-0473 (2)(m)	Third party filer’s letter of authorization.
	OAR 836-053-0471 (2)(l)	Certification of compliance form signed and dated by an authorized persons.
REVIEW REQUESTED	ORS 742.003(1), OAR 836-010-0011(3), ORS 743.767, OAR 836-010-0021(1)	The following are submitted in this filing for review (select one): 1. New rate filing 2. Rate change 3. Continued use of existing rates The annual geographic average rate (GAR) filing is satisfied through the inclusion of GARs in the Rate Tables and Factors exhibit.
	ORS 743.018 (4), ORS 743.019	Acknowledgment of rate review request: The company acknowledges that the director may approve, disapprove, or approve a modification of this proposed premium request. Approval of this request will be given, provided that upon completion of an actuarial review, the rates are deemed actuarially sound, reasonable and not excessive, inadequate or unfairly discriminatory, and based on reasonable administrative expenses.
FORM NUMBERS	ORS 731.296	A list of policy form numbers to be listed on the Rate/Rule Schedule tab in SERFF.
HEALTHCARE REFORM ELEMENTS	PPACA Public Law 111-148 CFR Title 45	2015 Alignment of Individual Market <ul style="list-style-type: none"> All ACA compliant products issued on or after January 1, 2014 may only provide coverage through December 31 of that year. Rates and benefits for the same plan offered in and out of the Exchange must be identical

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HEALTHCARE REFORM ELEMENTS	Age Banding CFR 45 (A)(B) Part 147 sub part 147.102(a)(1)(iii)	<p>3 to 1 Age Banding Rating Restrictions:</p> <ul style="list-style-type: none"> Age factors will be standardized statewide and will be restricted to a 3 to 1 ratio. Note that this state-specific age curve is an approved variation from the federal age factors. <p>Details can be found on the CMS site: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf</p>
	Per Member Rating CFR 45 (A)(B) Part 147 sub part 147.102(c)(1)	<p>List bill (Individual ACA compliant filings):</p> <ul style="list-style-type: none"> All individual rates will be priced per member, with a maximum of 3 children under 21
	Composite Rating CFR 45 (A)(B) Part 147 sub part 147.102(c)(3)	<p>Composite rating (Small Group ACA compliant filings):</p> <ul style="list-style-type: none"> Per-member build-up of rates is required to determine group aggregate premium based on census at time of quote Standardized tier factors must be used for allocation of group aggregate to group members; changes from current tier factors must be revenue neutral Standardized tier factors: Employee Only: 1.0; Employee + Spouse: 2.0; Employee + Child = 1.85; Family: 2.85 (note that children include all dependent children ages 0 to 25)
	Tobacco Factors Composite Rating CFR 45 (A)(B) Part 147 sub part 147.102(a)(iv).	<p>Tobacco Rating Factors (Individual ACA compliant plans):</p> <ul style="list-style-type: none"> Tobacco factors may not exceed 1.5 The age band ratio for smokers may not exceed 3 to 1. <p>Children under 18 may not be charged a tobacco load.</p>
	Medical Loss Ratio CFR 45 (A)(B) Part 158 sub part B 158.210.	<p>Federal MLR:</p> <ul style="list-style-type: none"> Rates may not be set such that the anticipated federal MLR is under 80%. When determining reasonability of rates, Oregon does not recognize federal credibility standards in calculation of the Federal MLR The Federal MLR calculation is provided on the same line as the MLR value.
	FEDERAL REGULATIONS	<p>Fees and Assessments (General):</p> <p>Fees must reflect an average total cost over the plan year</p>

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HEALTHCARE REFORM ELEMENTS	<p>Insurer Fee CFR 45 (A)(B) Part 156 sub part B 156.50.</p> <p>(De minimis) CFR 45 (A)(B) Part 156 sub part 156.140(a)</p> <p>(Actuarial Value) CFR 45 (A)(B) Part 156 sub part 156.135(a)</p>	<p>Insurer’s Fee:</p> <ul style="list-style-type: none"> • This fee is not considered a deduction for tax purposes • The unique tax implications should be added to margin, since they do not reflect explicit costs associated with the health benefit plans <p>Actuarial Value (AV) Calculator:</p> <ul style="list-style-type: none"> • All metal tier plans, both inside and outside the exchange must meet the de minimis range (varies by metal tier) for one of the 4 metal tiers: bronze, silver, gold, platinum • Catastrophic plans do not have an AV requirement • Actuarial value is determined based on Essential Health Benefits only • Where appropriate, the AV calculator should determine the objective differences between plans • Where the AV calculator is not appropriate, methodology must be consistent across all plans • The AV calculator is not required for determining pricing relativities
	<p>FEDERAL REGULATIONS Public Law 111-148</p> <p>(Federal Risk Adjustment) CFR 45 (A)(B) Part 153 sub part(s) (D) 153.610</p>	<p>Risk Adjustment</p> <ul style="list-style-type: none"> • Carrier projected claims must be adjusted to reflect average experience for the market • Risk adjustment payments in the base period experience are <u>appropriate</u> adjustments for projecting future claims
FILING DESCRIPTION	OAR 836-053-0473 (2)(a)	<p>The document labeled FILING DESCRIPTION is submitted in the form of a cover letter summarizing the reasons for rate change and includes:</p> <p>Filing Information:</p> <ul style="list-style-type: none"> • Description of the benefit plan(s) <p>Prior Filing Information:</p> <ul style="list-style-type: none"> • Most recent prior SERFF filing number(s) and approval date(s) • Current HIOS Submission Tracking ID • Comparison of actual and expected results, including the following: <ul style="list-style-type: none"> ○ Projected claims, admin and profit percentages from the prior filing with the rating period that most closely matches the experience period of this filing (Rate Filing Summary, “to” percentages) ○ Actual claims, admin, and profit percentages from this filing (Rate Filing Summary, “from” percentages) ○ Identify whether these values include risk adjustment • Quantify primary differences between actual and expected results.

Category	Reference	Description of review standards requirements
RATE TABLES AND FACTORS	OAR 836-053-0473 (2)(a)	<p>Rate Change Summary:</p> <ul style="list-style-type: none"> • Type of rate change request: annual, quarterly, other (explain) • Identify the intended duration of rate change request (typically 12 months) • Effective dates of all rate change requests, if not annual • Confirm average annual rate change, minimum and maximum rate impact (do not include any impact from demographic shifts) • Briefly list key changes in the filing: <ul style="list-style-type: none"> ○ Rating factors ○ New and discontinued plans ○ Significant benefit changes
RATE TABLES AND FACTORS	OAR 836-053-0473 (2)(a)	<p>Filing Impact:</p> <ul style="list-style-type: none"> • Identify the total members, subscribers, and groups affected by this rate filing and source of the counts, typically a snapshot of the most recent enrollment (e.g. members effective January 1, 2021) • Identify how membership is projected to change between the experience period and rating period, as appropriate: <ul style="list-style-type: none"> ○ Anticipated membership on the effective date of the filing ○ Estimated average membership for the filing period <p>Projected membership for the end of the rating period, if the proposed premium rate is approved as filed</p>

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	OAR 836-053-0473 (2)(b)	<p>A document labeled RATE TABLES AND FACTORS that includes:</p> <p>Introduction:</p> <ul style="list-style-type: none"> • Indicate whether the rate changes are the same for all policies • If the rate change is not uniform for all policies, clear explanation of how the rate changes apply to different policies <ul style="list-style-type: none"> ○ Identify the rate factors that are changing ○ Refer to table demonstrating a meaningful distribution of rate changes (Exhibit 4) • Clear instructions, including a calculation, so that any member or group can determine the rates for each benefit plan, each age bracket, each geographic area, each rate tier, and all other variables used to determine rates • Cross-reference supporting exhibits: Benefit changes (Exhibit 2), Plan Relativities (Exhibit 6) • Identify any rating factors that are not used to develop rates <p>Rate Tables:</p> <ul style="list-style-type: none"> • Rate tables containing, at a minimum, the base rates for each available plan • Geographic Average Rate (GAR) table containing family type, geographic area, and average of highest and lowest rates resulting from the application of other rating factors • (Small Group only) Provide a table of quarterly Premium Trend adjustments

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RATE TABLES AND FACTORS	OAR 836-053-0473 (2)(c)	<p>Rate Factors:</p> <ul style="list-style-type: none"> • Tables for all factors not already included in the rate tables: <ul style="list-style-type: none"> ○ Age ○ Tobacco ○ Family/Rating Tier ○ Geographic Area • The following factors are no longer allowed for plans issued on or after 2014 <ul style="list-style-type: none"> ○ Contribution ○ Participation ○ Wellness program participation ○ Duration of in-force coverage ○ Experience adjustments • Identify each rate factor that is changing as a result of this filing <ul style="list-style-type: none"> ○ Include the previous rate factors ○ Calculate the rate impact for each change

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ACTUARIAL MEMORANDUM	OAR 836-053-0473 (2)(c)	<p>This is the primary supporting document for the filing and should satisfy both state and federal memorandum requirements. All other supporting documentation should be provided as Exhibits to accompany the memorandum.</p> <p>A document labeled ACTUARIAL MEMORANDUM that includes:</p> <p>Company’s Identifying Information:</p> <ul style="list-style-type: none"> • Company Legal Name • State: Oregon • HIOS Issuer ID • Market: Individual or Small Group • Effective Date <p>Company Contact Information:</p> <ul style="list-style-type: none"> • Name and contact information of the filer • Name and contact information for secondary contact <p>Introduction:</p> <ul style="list-style-type: none"> • Identify the benefit plans impacted by the rate change request • Overview of the filing <ul style="list-style-type: none"> ○ Identify the base rate increase, as calculated in the Development of Rate Change exhibit. (Exhibit 1) ○ Quantify the impact of all rate factor changes and whether those changes are revenue neutral, as identified in the Rate Table and Factors exhibit ○ Quantify any impacts of the changes to the benefit plan, as described in the Covered Benefit Design Changes (Exhibit 2) ○ Demonstrate the calculation of the average annual rate change (Exhibit 3) • Fill out and include Summary of Filed Rating Assumptions (see template) in Actuarial Memorandum.

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ACTUARIAL MEMORANDUM	OAR 836-053-0473 (2)(c)	<p>Discussion:</p> <ul style="list-style-type: none"> • Description of any changes in rating methodology, supported by sufficient detail to permit the division to evaluate the effect on rates • Discussion of all assumptions and calculations pertinent to the proposed rate <ul style="list-style-type: none"> ○ (Small Group only) If rates vary more frequently than annually, provided information to justify such variation in rates ○ Provide justification and need for assumptions, identifying relevant sources if the assumption is data driven ○ Tie together the administrative costs presented in the Development of Rate Change (Exhibit 1) and Statement of Administrative Expenses (Exhibit 5) ○ Consideration of credibility of calculations and data • Demonstrate how projected claims on Exhibit 1 tie to the Index Rate shown on the URRT. • Demonstrate starting with the Index rate how the rates for each plan are calculated utilizing network/area, pricing relativity, age factors and admin only. • We expect use of HHS guidance or generally accepted actuarial principles <p>Mandates:</p> <ul style="list-style-type: none"> • Identify all mandated state and federal changes to the filing including, but not limited to: <ul style="list-style-type: none"> ○ New benefits (EHB), including effective dates and pricing methodology ○ New fees, including implementation and justification ○ Risk Adjustment ○ Exchange impacts: fees, reallocation impacts ○ Impact of cost sharing subsidies on plan pricing ○ Impact of market changes: Transitional and Small Group Expansion ○ Guaranteed issue

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ACTUARIAL MEMORANDUM	OAR 836-053-0473 (2)(c)	<p>Certification:</p> <ul style="list-style-type: none"> • Identify that the filing is consistent with the company’s internal business plans • Confirm all calculations are based on generally accepted actuarial rating principles for rating blocks of business • Signature of and date that a qualified actuary reviewed the rate filing • Contact information of peer review actuary (Per ASOP #8, definition 2.2, the peer review actuary is also a filing actuary, but Oregon is not requesting a signature from that actuary)
DEVELOPMENT OF RATE CHANGE OR BASE RATE (Exhibit 1)	OAR 836-053-0473 (2)(d)	<p>Please refer to provided template. A document labeled DEVELOPMENT OF RATE CHANGE OR BASE RATE including :</p> <ul style="list-style-type: none"> • Detailed calculation of how the proposed rate or rate change was determined: <ul style="list-style-type: none"> ○ Base period data appropriate for risk pool ○ All adjustments from base period claims to projected claims ○ Addition of all expenses and pre-income tax margin to costs ○ All adjustments from base period premiums to current premiums ○ Calculation of final required premium and rate increase ○ Loss ratio demonstrations ○ Federal MLR calculation with a calculation of that percentage • Sufficient detail to allow division to review and determine reasonability and actuarial soundness of assumptions, calculations, and estimates <ul style="list-style-type: none"> ○ Distinguish between data, assumptions, and calculations ○ Provide calculated aggregate and PMPM values ○ Provide all formulas • Cross-reference supporting exhibits: Trend (Exhibit 4), Admin (Exhibit 5)
COVERED BENEFIT OR PLAN DESIGN CHANGES (Exhibit 2)	OAR 836-053-0473 (2)(e)	<p>A document labeled COVERED BENEFIT OR PLAN DESIGN CHANGES that:</p> <ul style="list-style-type: none"> • Explains benefit and administrative changes with rating impact, including: <ul style="list-style-type: none"> ○ Covered benefit level changes ○ Member cost-sharing changes ○ Elimination of plans ○ Implementation of new plan designs ○ Provider network changes ○ New utilization or prior authorization programs ○ Changes to eligibility requirements ○ Changes to exclusions ○ Any other change in the plan offerings that impacts costs or coverage provided ○ Complete description of plan changes made due to federal healthcare reform including the total premium percentage increase attributed to these changes and a

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		<p>specific breakdown that shows the benefit change and percentage of rate increase for each benefit</p> <ul style="list-style-type: none"> ○ Percentage rating impact for each item, as well as the total impact ○ Members impacted by change and discontinuations ○ Identify new mandates and applicable law
<p>SUMMARY OF RATE INCREASES</p> <p>(Exhibit 3)</p>	<p>OAR 836-053-0473 (2)(f)</p>	<p>Please refer to provided template</p> <p>A document labeled SUMMARY OF RATE INCREASES including:</p> <ul style="list-style-type: none"> ● Table showing the following for all effective dates (quarterly for small group, for example): <ul style="list-style-type: none"> ○ Effective date ○ Membership count ○ Requested average annual rate change ○ Minimum annual rate impact ○ Maximum annual rate impact ○ Rate change from prior effective date (if not annual) ● If applicable, a table showing a meaningful distribution of rate increases across the entire pool. ● Estimate the contributing factors to the rate increase: trend, rating changes, margin changes, benefit changes, other

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<p>TREND INFORMATION AND PROJECTION</p> <p>(Exhibit 4)</p>	<p>OAR 836-053-0473 (2)(g)</p>	<p>A document labeled TREND INFORMATION AND PROJECTION that includes:</p> <ul style="list-style-type: none"> • Presentation of all significant variables of trend by these categories, if used. <ul style="list-style-type: none"> ○ Utilization trend ○ Cost trends by major service category, with a distribution of claims <ul style="list-style-type: none"> ▪ Hospital ▪ Physician ▪ Pharmacy ▪ Other ○ Deductible leveraging, if not reflected in the Plan Relativity exhibit ○ Technology/intensity ○ Other factors (please specify) • Cost trends should be supported by known contractual increases in hospital and professional agreements. Support needs to be quantitative and specific. • Quantify savings from the reduction of “bad debt” due to ACA coverage expansion. Show where this savings is reflected in the trend and/or rate development. • Mathematical development of the pricing trend used in the Development of Rate Change • Historical monthly average allowed claim costs for at least the immediately preceding three years when applicable <ul style="list-style-type: none"> ○ This information based on allocated costs if the insurer’s structure doesn’t include claims cost ○ Both un-normalized and normalized monthly average claim costs for same period. Claims should be normalized for applicable premium rating factors ○ Explanation of normalization method used and discussion of impact on trend <p>Notes:</p> <ul style="list-style-type: none"> • Carriers may not include a trend margin, or fluctuation factor in the development of trend.

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STATEMENT OF ADMINISTRATIVE EXPENSES (Exhibit 5)	OAR 836-053-0473 (2)(h)	<p>Please refer to provided template.</p> <p>Please complete the document labeled STATEMENT OF ADMINISTRATIVE EXPENSES including:</p> <ul style="list-style-type: none"> • A chart illustrating a breakdown of the insurer’s administrative expenses including: <ul style="list-style-type: none"> ○ 5 years of historical data tying to financials ○ Projected expenses for the filing effective date • A detailed breakdown of fees and taxes • Target pre-income tax margin for the projected period • Total retention for the base period and projected period • Reports retention on a percentage of premium basis broken down by operating expenses, commissions, state assessments and tax, and profit • Reports retention on a per member per month (PMPM) basis • Identify fixed or variable expenses (or a combination of both) • Reflect actual assessment of fees (ACA insurer fee, Exchange fees, other). The cost charge to the premium must cover the cost for that period, and not a projection of expected future fees. <p>In addition to the completed Statement of Administrative Expenses template, provide a description, in plain language, of the contributing costs of premium retention, including:</p> <ul style="list-style-type: none"> • Explanation of the basis for any proposed premium rate increase or decrease related to changes in the administrative expenses • Explanation of how administrative expenses for the filed line of business are allocated including whether state specific or national data is used • Includes a description of retention – “retention” means the amount to be retained by the insurer to cover all of the insurer’s non-claim costs including expected profit or contribution to surplus for a nonprofit entity
PLAN RELATIVITIES (Exhibit 6)	OAR 836-053-0473 (2)(i)	<p>Please refer to provided template.</p> <p>A document labeled PLAN RELATIVITIES that:</p> <ul style="list-style-type: none"> • Explains the presentation of rates for each benefit plan • Explains the methodology used to develop the benefit plan relativities

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		<ul style="list-style-type: none"> • CCIIO has provided an Actuarial Value (AV) calculator to be used to determine the metal tier/level of benefits for each plan. • If the AV calculator was not used to determine the metal level for any plan, a supporting exhibit must be included explaining the methodology used to develop the AV. • Most, but not all benefit differences, are expected to be priced based on the AV calculator. If the plan relativities differ from the AV (for example, network differences), identify the factors resulting in the difference. • Demonstrates the comparison and reasonableness of benefits and costs between plans • If a plan includes benefit substitutions that are over 1% of total claims, then data must provide data supporting the calculation. • Compares plan relativities to the last filing, when relativities change, including deductible leveraging • The plan name, • issuer plan identification number (HIOS plan ID), • metal level or catastrophic plan, • List of Geographic areas that plan will be offered (1-7) • whether the plan will be sold: <ul style="list-style-type: none"> ○ inside the Exchange only, (in) ○ outside the Exchange only. (out) ○ both inside and outside the Exchange, or (both) • Whether or not pediatric dental is embedded (yes/no)
INSURER'S FINANCIAL POSITION (Appendix I)	OAR 836-053-0473 (2)(j)	<p>A document labeled INSURER'S FINANCIAL POSITION that includes:</p> <ul style="list-style-type: none"> • Discussion of whether the proposed change in the premium rate is necessary to maintain the company's solvency or to maintain rate stability and prevent excessive rate increases for the line of business in the future.
INSURER'S FINANCIAL POSITION (Appendix I)	OAR 836-053-0473 (2)(j)	<ul style="list-style-type: none"> • Specifically provide the following pages from the Annual Statement: <ul style="list-style-type: none"> ○ Supplemental Healthcare Exhibit (Part 1, for business in the State of Oregon)
COST CONTAINMENT AND QUALITY	OAR 836-053-0473 (2)(k)	<p>A document labeled COST CONTAINMENT AND QUALITY IMPROVEMENT EFFORTS that:</p> <ul style="list-style-type: none"> • Identifies new health care cost containment efforts and quality improvement efforts since the last rate filing for the same category of health benefit plan, with estimated savings for the projection period

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IMPROVEMENT EFFORTS (Appendix II)		<ul style="list-style-type: none"> • Describes significant changes to existing health care cost containment initiatives and quality improvement efforts, with estimated savings for the projection period, savings realized over the prior experience period, and a description of how the company is measuring the impact of its initiatives • Includes information about whether the cost containment initiatives reduce costs by eliminating waste, improving efficiency, by improving health outcomes through incentives, or by elimination or reduction of covered services or reduction in the fees paid to providers for services
STANDARD REVIEW QUESTIONS (Appendix III)		<p>Please refer to questions provided by the division, see the division’s website for the current list of Standard Review Questions.</p> <p>A document labeled STANDARD REVIEW QUESTIONS that answers the questions provided in the template is included as a Supporting Document.</p>
COST AND QUALITY METRICS	OREGON HEALTH POLICY BOARD CFR 45 (A)(B) Part 158 sub part 158.150 ORS 743.018 (5)(f)	<p>Fill out the following information on the provided template.</p> <p>Provide, for public review, the following metrics, as recommended by the Oregon Health Policy Board:</p> <p>Recommendation to Governor</p> <ul style="list-style-type: none"> • Utilization per 1,000 members and per member per month costs for <ul style="list-style-type: none"> ○ Inpatient Admissions/Days ○ Outpatient Visits ○ Emergency Department Visits ○ Primary Care Visits ○ Specialty Care Visits ○ Rx Scripts ○ Other Claims • Quality metrics for CY2021, as reported to the following entities <ul style="list-style-type: none"> ○ NCQA: <ul style="list-style-type: none"> ▪ Breast Cancer Screening ▪ Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing ○ CCO Metrics: <ul style="list-style-type: none"> ▪ Follow-Up After Hospitalization for Mental Illness* ▪ Developmental Screening in the First Three Years of Life* ▪ CAHPS: Access to Care*

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PROPOSED STANDARD PLAN RATES		Use provided template to show proposed standard plan rates, by metal and age tier, for each covered rating area.
HIOS URRT SUBMISSION	CFR Part 154.200 CFR Part 156.80	<ul style="list-style-type: none"> • All ACA Compliant plans (even off exchange only plans) must be submitted on HIOS when this rate filing is submitted via SERFF. • The filing tracking number should be the Rate Filing SERFF Tracking number. • The URRT must be updated after the rate filing is approved.