Oregon Division of Financial Regulation - Health Filing Tips

- **Advertisements:** Any advertising that is attached to or mailed with an application must be submitted for prior approval.
- **Alcohol or Controlled Substance Use Exclusion:** ORS 743A.164 requires that an individual health insurance policy, other than disability income, provide coverage for medical treatment of injuries or illnesses caused in whole or in part by the insured's use of alcohol or a controlled substance that is equivalent to coverage for other injuries or illnesses.
- **Applications:** If revising, adding, or deleting language in an application or replacing an application, include a "redlined" copy of the previously approved version of the form in the submission support materials. The application will need a new form number or addition of an edition date/version date to the previously approved form number. If a new or revised application is to be used with a previously approved form, explain how the changes in the application may or may not affect the rating of the product previously approved.
- **Associations, Trusts, and Discretionary Groups - For Health ONLY:** Due to the passage of House Bill 3321 (2007), out-of-state exempt associations, trusts, and discretionary groups are no longer allowed. Revised product standards and new Oregon Administrative Rules (OAR) are available on the Oregon Division of Financial Regulation (DFR) website for submission and assignment of an DFR entity number. All associations, trusts, discretionary groups, and MEWAs must be reviewed and approved by the division prior to issuance.
- **Blanket Health:** The same coverage must be provided to everyone who is eligible for coverage under the group policy. Optional coverage added via endorsement or rider is at the option of the group policyholder (rather than the individual insured) and provides the same coverage for everyone. A pre-existing condition exclusion is not allowed because everyone under the policy must receive the same coverage.
- **Changes to Business Operations / Modification and Discontinuance of Health Benefit Plans:** These should be filed under H21.Health - Other. Do not use these TOI/Sub-TOI codes for any other type of filing or the submission will be disapproved without review. Filing checklist 440-2896 is used with these submissions. The proposed action will determine what notification requirements apply, and if withdrawing from Oregon, whether a five-year ban would be applicable. Include a list of affected policy forms, when they were approved, a copy of the notice sent to policyholders, a list of the changes that prove that the change in benefits constitutes less than 10 percent actuarial value change, and the number of policyholders affected by the change
- **Cover Letter:** For SERFF filings, attach the Cover Letter in the Supporting Documentation tab. Please list the form name and number for each form being submitted with the filing — the number and edition date must be listed exactly as they appear on the filed documents. If not using a cover letter on a SERFF submission, provide this form information in the Filing Description portion of the General Information tab.
- **See Guidelines for Filing Life & Health Policies, Riders, etc. regarding making changes to the base contract:**
  An endorsement, rider, or amendment changes previously approved policy provisions or benefits, and is issued separately from the original policy forms:

  Endorsements and amendments (changes):

  - Any endorsement or amendment must be filed and approved before delivery.
  - When filed in a separate document, an endorsement or amendment must contain a unique form number in the bottom left-hand corner.
  - The Oregon Division of Financial Regulation limits the number of changes to the base policy forms.

The analyst may require a company to file an entirely new version of the base policy if there are significant changes made by the endorsement or amendment.

- **Definitions:**
  - **Rider** - an optional benefit available for purchase (e.g. prescriptions, vision, dental)
  - **Endorsement or Amendment** - these are used to change specific contract provisions. These terms may be used interchangeably.
- **Filing in Pieces:** Insert pages are not allowed. The policy form or certificate form must have the same form number in the bottom left-hand corner of each page throughout the entire form. Any changes to the base contract/policy require that the policy be refiled with a new form number (such as adding an edition date) for all pages (see Filing Revisions).
- **Variability:** Items may be included as variable by bracketing the variable language in the policy form. All options (choices) and ranges (minimum to maximum benefit amounts) must be either shown in the policy form, or submitted in a separate document called a Statement of Variability (SOV) that explains in detail each variable item. Regardless of the method used, the form must have brackets around the variable data. Blank lines are not permitted. Also, fixed and maximum charges cannot be filed as variable.
- **Filing Revisions:** A "redlined" version showing where changes have been made is required to be included when revising any previously approved forms.
  - When revising, adding, or deleting language in a form, the form must be refiled with a new form number or with the addition of a revision date/edition date to the previously approved form number.

- **Health Form Numbering:** Individual health insurance statute ORS 743.405(7) states the form number must appear on the first page of the policy form. Insert pages are not allowed. The policy form number or certificate form number must have the same form number in the bottom left-hand corner of each page throughout the entire form/document.

  Any changes to the base contract/policy require the policy to be refiled with a new form number (such as adding an edition date) for all pages (see Filing Revisions). If variability is filed via a Statement of Variability, then it needs to be submitted as a form for approval, with its own unique form number in the bottom left-hand corner on each page of the document. This could be as simple as using the policy form number followed by -SOV.

- **Limited Benefit Plans:** When coverage in the base policy/contract is based on an event (rather than expenses), such as hospital confinement, and the benefit is a fixed dollar amount (rather than a percentage of expenses), then ALL benefits, including those in optional riders, must be flat dollar amounts. Benefits based on expenses (percentages) cannot be combined with benefits based on an event (fixed dollar amounts).
- **Long-Term Care (LTC) has a 10-year look-back limit on medical questions.**
- **Long-Term Care Provider Facilities:** Benefits must be payable from all of the treatment facilities (nursing home, assisted living, home care, and adult foster care) from ORS 743.656(1) (b) and (2).

  Rate filings: Tell us the form number to which the rate change applies.
  - Must include a fully completed Appendix A with any rate filings, showing the 10-year expected experience projection for individual and small groups (fewer than 50 employees).

- An actuarial memorandum is not required for large group (51 employees and greater) filings, except for certain association filings, Medicare Supplements and Long Term Care for which all rates must be filed and approved. The definition of small employer changes to not more than 100 employees in 2016.
- Must include complete actuarial support documentation whenever rates are part of a filing submission.
- Premiums must be reasonable in relationship to benefits.

Terrorism Exclusions: No terrorism exclusion language is allowed.