

Department of Consumer & Business Services

Oregon Insurance Division – 5

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Standards for Filing Individual and Small Group Health Benefit Plan Rates

This checklist must be submitted with your filing in compliance with OAR 836-010-0011(2). These standards are summaries, and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certification of compliance form. “Not applicable” can be used only if the item does not apply to the rates being filed. Not including required information may cause this filing to be considered incomplete and returned without review. **These standards are subject to change as HHS releases more information.**

Insurer Name: _____

Date: _____

TOI (type of insurance):

- H15I – Individual Health - Hospital/Surgical/Medical Expense
- H16G – Group Health Major Medical

- H16I – Individual Health – Major Medical

Sub-TOI:

- H15I.001- Hospital/Surgical/Medical Expense
- H16G.001A – Any size group – PPO
- H16G.001B – Any size group – POS
- H16G.001C – Any size group – Other
- H16G.003A – Small Group only - PPO
- H16G.003B – Small Group only – PPO Basic
- H16G.003D – Small Group only – POS
- H16G.003E – Small Group only – POS Basic
- H16G.003G – Small Group only – Other
- H16I.005A – Individual – PPO
- H16I.005B – Individual – POS
- H16I.005C – Individual – Other

Product Type:

- HMO PPO EPO POS HSA HDHP FFS Other

GENERAL REQUIREMENTS FOR ALL SMALL GROUP AND INDIVIDUAL HBP RATE FILINGS				
Category	Reference	Description of review standards requirements	Answers	Page #
Submission package requirements	OAR 836-010-0011	Required forms are located on SERFF or on our Web site: http://insurance.oregon.gov/docs/serff/filing_requirements.html .		
		Paper filings: These items must be submitted with your filing for it to be accepted as complete: <ul style="list-style-type: none"> • NAIC transmittal form • Two self addressed stamped envelopes, one in which Insurance Division can return the approved filing • Complete copy of the filing on a CD, with each document as a separate PDF 	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
	OAR 836-053-0473 (2)(m)	Third party filer's letter of authorization	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
	OAR 836-053-0471 (2)(l)	Certification of compliance form signed and dated by an authorized person	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
	OAR 836-010-0011(2)	Product standards for rates with boxes checked. (this document)	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
	ORS 731.296	Draft letter to consumer advising them of the rate change will be provided before the rate review is complete.	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
Grandfathered Status		Effective for plan years on or after 1/1/2014, filings for "Grandfathered" status health plans must be pooled separately from "Non-Grandfathered" status health plans. Each filing must stand alone.	Confirm <input type="checkbox"/>	
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): <ol style="list-style-type: none"> 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.	Yes No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Form numbers	ORS 731.296	A list of policy form numbers to be listed on the Rate/Rule tab in SERFF.	Confirm <input type="checkbox"/>	

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HEALTHCARE REFORM ELEMENTS	Federal regulations	<p>2015 Alignment of Individual Market</p> <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 <p>Single Pool Rating:</p> <ul style="list-style-type: none"> All Grandfathered and Non-Grandfathered business must be pooled separately beginning in 2015 All associations (except student health plans available through a bona fide association) must be included in the base experience <p>Grandfathered plans:</p> <ul style="list-style-type: none"> Grandfathered plans are not subject to any of the new rating and benefit provisions effective in 2014 <p>3 to 1 Age Banding Restrictions:</p> <ul style="list-style-type: none"> Age factors will be standardized statewide and will be restricted to a 3 to 1 ratio The federal age factors will be used for small group and individual <p>List bill (Individual filings):</p> <ul style="list-style-type: none"> All individual rates will be priced per member, with a maximum of 3 children under 21 <p>Average rating for Small Group:</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) <p>Tobacco Rating Factors:</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>Federal MLR:</p> <ul style="list-style-type: none"> Rates may not be set such that the anticipated federal MLR is under 80%. 	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>	

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		<ul style="list-style-type: none"> When determining reasonability of rates, Oregon does not recognize federal credibility standards in calculation of the Federal MLR Fees and Assessments (General): <ul style="list-style-type: none"> Fees must reflect an average total cost over the plan year Insurer's Fee: <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 Actuarial Value (AV) Calculator: <ul style="list-style-type: none"> All plans, both inside and outside the exchange must meet the de minimis range (within 2%) for one of the 4 metal tiers: bronze, silver, gold, platinum 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, pricing must be consistent across all plans 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
HEALTHCARE REFORM ELEMENTS The "3 Rs"	Federal regulations	Reinsurance (Federal and State Supplemental): <ul style="list-style-type: none"> Use parameters and assessment provided by federal and state regulators Claims adjustments on individual filings must be consistent with average market risk Embedded pediatric dental qualifies for reinsurance Stand alone dental does not qualify for reinsurance Risk Adjustment: <ul style="list-style-type: none"> Carrier projected claims must be adjusted to reflect average experience for the market Risk Corridor: <ul style="list-style-type: none"> Health benefit plans should not be priced to anticipate an impact of the risk corridor program 	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
FILING DESCRIPTION	OAR 836-053-0473 (2)(a)	The document labeled FILING DESCRIPTION is submitted in the form of a cover letter summarizing the reasons for rate change and includes: Filing Information:	Yes N/A <input type="checkbox"/> <input type="checkbox"/>		

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		<ul style="list-style-type: none"> • 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 is 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 ○ “3 R’s”: Reinsurance, Risk Adjustment, Risk Corridor ○ Exchange impacts: fees, reallocation impacts ○ Impact of cost sharing subsidies on plan pricing ○ Guaranteed issue <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 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
DEVELOPMENT OF RATE CHANGE OR	OAR 836-053-0473 (2)(d)	<p>Please refer to provided template.</p> <p>A document labeled DEVELOPMENT OF RATE CHANGE OR BASE RATE</p>	Yes N/A	

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BASE RATE (Exhibit 1)		including : <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 margin to costs ○ All adjustments from base period premiums to current premiums ○ Calculation of final required premium and rate increase ○ Loss ratio demonstrations • 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) 	<input type="checkbox"/>	<input type="checkbox"/>	
COVERED BENEFIT OR PLAN DESIGN CHANGES (Exhibit 2)	OAR 836-053-0473 (2)(e)	A document labeled COVERED BENEFIT OR PLAN DESIGN CHANGES that: <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 specific breakdown that shows the benefit change and percentage of rate increase for each benefit ○ Percentage rating impact for each item, as well as the total 	Yes	N/A	

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		impact		
SUMMARY OF RATE INCREASES (Exhibit 3)	OAR 836-053-0473 (2)(f)	<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 	<p>Yes N/A</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	
TREND INFORMATION AND PROJECTION (Exhibit 4)	OAR 836-053-0473 (2)(g)	<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 	<p>Yes N/A</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>	

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		<p>quantitative and specific.</p> <ul style="list-style-type: none"> 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. Effective 1/1/2015, underwriting wear-off no longer applies to individual health plans. 	<input type="checkbox"/>	<input type="checkbox"/>	
STATEMENT OF ADMINISTRATIVE EXPENSES (Exhibit 5)	OAR 836-053-0473 (2)(h)	<p>Please refer to provided template.</p> <p>A 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 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 	Yes	N/A	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

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		<ul style="list-style-type: none"> • Reflect actual assessment of fees (Reinsurance assessment, 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. • A description in plain language of the contributing costs of premium retention <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 ○ 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 	<input type="checkbox"/> <input type="checkbox"/>	
PLAN RELATIVITIES (Exhibit 6)	OAR 836-053-0473 (2)(i)	Please refer to provided template. A document labeled PLAN RELATIVITIES that: <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 • 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 	Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

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		<ul style="list-style-type: none"> This exhibit should be identical between the plan filing and the rate filing. The plan name, issuer plan identification number, 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) 	<input type="checkbox"/>	<input type="checkbox"/>	
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"> Information about the company's financial position including but not limited to profitability, surplus, reserves, and investment earnings 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 Although public documents filed with the department as part of the annual statement or other requisite filings may be referenced in this item, information about the company's profitability, surplus, reserves, and investment earnings must still be included in the Insurer's Financial Position document; if such references are made, include copies of the supporting documents with this filing The last 5 years of RBC and a statement regarding the need for surplus 	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>	
COST CONTAINMENT AND QUALITY IMPROVEMENT EFFORTS (Appendix II)	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 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 	Yes <input type="checkbox"/>	N/A <input type="checkbox"/>	

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		<ul style="list-style-type: none"> 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 	<input type="checkbox"/> <input type="checkbox"/>	
STANDARD REVIEW QUESTIONS (Appendix III)		<p>Please refer to provided template.</p> <p>A document labeled STANDARD REVIEW QUESTIONS that answers the questions provided in the template.</p>	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	
Cost and Quality Metrics	Oregon Health Policy Board	<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 Kitzhaber</p> <ol style="list-style-type: none"> 1. Utilization per 1,000 members and per member per month costs for <ol style="list-style-type: none"> a. Inpatient Admissions/Days b. Outpatient Visits c. Emergency Department Visits d. Primary Care Visits e. Specialty Care Visits f. Rx Scripts g. Other Claims 2. Quality metrics for CY2013, as reported to the following entities <ol style="list-style-type: none"> a. NCQA: <ol style="list-style-type: none"> i. Breast Cancer Screening ii. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing b. CCO Metrics: <ol style="list-style-type: none"> i. Follow-Up After Hospitalization for Mental Illness* ii. Developmental Screening in the First Three Years of Life* iii. CAHPS: Access to Care* 	Yes N/A <input type="checkbox"/> <input type="checkbox"/>	