Role of DCBS as regulator

DFR approves rates that are “reasonable and not excessive, inadequate, or unfairly discriminatory”

Consumer interest in having affordable, comprehensive health care coverage

DFR’s role in ensuring that insurance companies remain financially stable

Rate Review Timeline

Fall Year 1

- Insurers begin reviewing claims experience from previous plan years.
- Insurers consider if new plans should be changed to meet consumer needs.

January – April Year 2

- Insurers review enrollment statistics, claims experience, and market factors and finish developing their rate request.

May Year 2

- Rates are filed with the division.
- A public comment period is opened.
- Division actuaries begin reviewing filed rates.

June Year 2

- The division reviews rate filings.
- Division actuaries meet weekly to determine if insurer follow-up is needed to understand the rate requests.

July Year 2

- Rate hearings are held. Visit oregonhealthrates.org
- The public comment period concludes, and public comments are considered as part of the rate decision.
- Preliminary rate decisions are made by the division and are uploaded to oregonhealthrates.org.
- The preliminary orders are released.

August Year 2

- The division finalizes rate orders and other administrative requirements.
- Plans and rates are transmitted to the U.S. Centers for Medicare & Medicaid Services by the Oregon Health Insurance Marketplace after approval for display during open enrollment on healthcare.gov.

November Year 2

- Open enrollment begins for Year 3 plan year individual and small group health benefit plans.

January Year 3

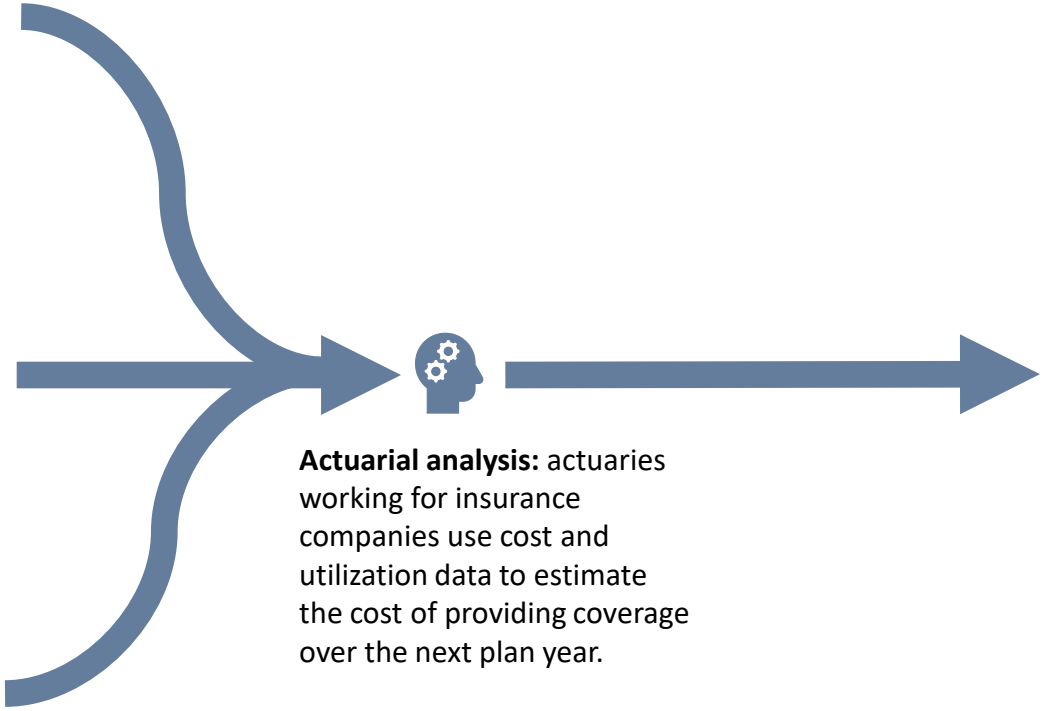
- New plans and rates are effective.

What's in a rate?

Cost trend: the cost of providing health care based on the price insurers can negotiate with health care providers, or the required rate of reimbursement in statute or rule where applicable.

Utilization trend: the extent to which members of a health plan use covered services. This could be driven by life events like pregnancy, accidents, global events like an epidemic, or by addition of new covered services.

Administrative cost: the cost of administering the health plan. Under the ACA's "medical loss ratio," this must be **20% or less** of collected premium.



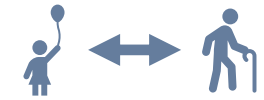
Actuarial analysis: actuaries working for insurance companies use cost and utilization data to estimate the cost of providing coverage over the next plan year.

Base rate: actuaries produce a "base rate," This is the rate that DCBS reviews for small group and individual plans.

What's in a rate?

The **base rate** is adjusted for each individual consumer based on the permissible rating factors on this slide.

The ACA prohibits the consideration of any other individual characteristics, such as gender, race, or preexisting medical conditions as rating factors.



Age: As people age, they tend to require more care, and more expensive care.

Tobacco use: The ACA expressly allows consideration of a person's tobacco use in rating.

Family size: Covering a spouse or dependents under a plan will increase premium and may also change cost-sharing limits.

Geography: The cost of care may vary across different areas of the state, depending on the availability of providers and the insurer's ability to negotiate.

Actuarial value: Monthly premium is adjusted relative to how generous the coverage is.

These adjustments determine the **monthly premium** owed by each consumer (not considering PTC, which may lower the consumer's actual out-of-pocket premium).