CONSUMER GUIDE
to Health Insurance Rate Review in Oregon

DFR | Division of Financial Regulation
Department of Consumer and Business Services

The Department of Consumer and Business Services' Division of Financial Regulation (DFR) reviews, and approves or disapproves, premium rates for small employer and individual health insurance plans. Consumer involvement in this process is critical and welcomed. This guide is intended to help explain the process and better enable and encourage consumer involvement in the rate setting process.

Health insurance rate review is just one way the division regulates the insurance industry. The division also protects consumers by:

- Making sure insurance companies are financially stable and able to pay claims.
- Reviewing all types of insurance policies to make sure they are clearly written, contain required benefits, and do not exclude items and services they must cover.
- Licensing insurance companies and agents (also called producers).
- Providing a help line where consumer advocates are available to answer insurance questions or help resolve complaints against an agent or insurance company.
- Investigating potential violations of insurance law.

Need help with an insurance question or complaint? Contact a consumer advocate:

Visit dfr.oregon.gov
Call 888-877-4894 (toll-free)
Email dfr.insurancehelp@dcbs.oregon.gov

Contents

Health insurance reform in Oregon

Since 2014, state and federal health reforms have strengthened consumer protections for health insurance. Some of these reforms include:

- The federal Patient Protection and Affordable Care Act, referred to as the ACA for short:
  - Prohibits preexisting health exclusions, increasing eligibility for coverage.
  - Provides federal tax subsidies to reduce the monthly premium of private insurance purchased through the health insurance marketplace.
  - Requires health insurance plans to cover basic (essential) benefits, including preventive services.
- The Oregon Reproductive Health Equity Act (RHEA):
  - Mandates coverage of sexually transmitted infection screenings, pregnancy screenings, tobacco-use counseling, and other enumerated benefits.

  - Mandates access to contraceptive coverage.
  - For more information: https://dfr.oregon.gov/insure/health/understand/coverage/Pages/reproductive-health.aspx

- The federal No Surprises Act:
  - Prohibits "surprise billing" in certain situations when a health care provider is out of network and an in-network provider was not an option.

Health benefit plans: Coverage and cost

Plans must cover essential health benefits

All health plans in the individual and small group markets offer coverage known as essential health benefits. The exact benefits differ by state and reflect services offered in a typical employer plan; however, all plans must offer benefits in these 10 categories:

- Emergency benefits
- Hospitalizations
- Laboratory services
- Maternity care
- Behavioral health and substance use disorder treatment
- Outpatient, doctors' office visits, and ambulatory surgical centers
- Pediatric care
- Prescription drugs
- Preventive care
- Rehabilitative and habilitative (helping maintain daily functioning) services

Coverage levels – "metal tiers "

Plan labels, such as "bronze," "silver," and "gold" show consumers that their cost share is different based on plan types. Some plans pay more medical costs than others. The plan labels also make it easier to compare plans across insurers.

Oregon requires all insurers to offer at least one bronze plan and one silver plan that are identical across companies and established by the Division of Financial Regulation. These are called standard plans. Standard plans cover the same benefits with the same cost share, allowing consumers to easily compare price, customer service, and the provider network.

Level	Actuarial value	HSA eligible
Bronze	60%	Possibly eligible
Silver	70%	Possibly eligible
Gold[1]	80%	Not eligible
Platinum[2]	90%	Not eligible

[1] Insurers in the marketplace are required to offer at least the standard gold plan. Insurers outside of the marketplace are not required to offer gold plans.

[2] Insurers are not required to offer platinum plans.

Making coverage affordable

Subsidies

Low- and moderate-income individuals and families are eligible for financial help to buy coverage through healthcare.gov. The amount of these tax credits and subsidies, which reduce premiums and out-of-pocket costs for deductibles, copayments, and coinsurance, depend upon the size of the consumer's family and household income. For example, a family of four making up to $120,000 (400 percent of the 2024 federal poverty level) may be eligible for tax credits to help lower their monthly premiums.

Oregon Reinsurance Program

The State of Oregon implemented a state-based reinsurance program using a federal Patient Protection and Affordable Care Act (ACA) 1332 waiver effective 2018. State innovation waivers (also referred to as section 1332 waivers) allow states to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.

This program is similar to the federal transitional reinsurance program that existed in the early years of the ACA. Moreover, the Oregon Reinsurance Program (ORP) partially reimburses health insurance companies on the individual insurance marketplace for an enrollee's accumulated health care claims under eligible ACA individual plans from the Oregon Health Insurance Marketplace. The parameters are set annually to help lower premium rates, stabilize the individual health insurance market, and expand coverage throughout Oregon. The parameters consist of a total value of health care cost per claimant, measured against a starting attachment point claim amount, below a maximum claim amount and coinsurance rate. The ORP shares the high-cost claims with the insurer, which lessens the burden for the claimant.

The ORP is funded by grants from the U.S. Department of Health and Human Services and the U.S. Treasury and a 2 percent assessment imposed on commercial health premiums. Of the 2 percent assessment, 0.3 percent is retained by the ORP to reimburse eligible health insurers on the individual health insurance market. The remaining total assessment of approximately 1.7 percent is transferred to the Oregon Health Authority to fund Medicaid. As a result, the state's 1332 innovation waiver helps lower the cost of health insurance and expands health insurance plan options throughout Oregon's 36 counties, with at least four to six options per county.

The U.S. Department of Health and Human Services and the U.S. Treasury must determine that the waiver will provide coverage that is at least as comprehensive as the coverage provided without the waiver; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable without the waiver; provide coverage to at least a comparable number of residents as without the waiver; and not increase the federal deficit. This is done by calculating Advanced Premium Tax Credits, member enrollment, federal poverty levels, and comprehensive health plans cost per member. The federal agencies pass the net savings back to Oregon to help fund the ORP.

Health insurance rate review

About 13 percent of Oregonians are covered by plans requiring rate approval by the Division of Financial Regulation. These individual and small business buyers are considered the most vulnerable consumers because they lack the negotiating power of large groups.

The division reviews rates for:

- Small employers (50 or fewer employees), which account for about 6.5 percent of Oregon's market.

- Individuals or families who are self employed or, for other reasons, do not get insurance through an employer, which account for about 7 percent of Oregon's market
- Individuals account for 6.69 percent of Oregon's market.
- Small groups account for 6.66 percent of Oregon's market.

The division does not review rates for about 85 percent of the market, including:

- Large groups (more than 50 employees). These groups negotiate prices directly with the insurer.
- Self-insured employers who are subject to federal regulation.
- Government entities such as the Public Employees Benefits Board (PEBB) or the Oregon Education Benefits Board (OEBB).

What is a rate?

The base price for a health insurance plan is known as a base rate. A premium is calculated from the base rate and is the specific amount a policyholder pays for insurance coverage.

A policyholder's actual premium will be higher or lower than the base rate depending on tobacco use, age, and where one lives in Oregon. The health of one's family, however, is not a factor in how much one pays for health insurance – the only variations from the base rate allowed under the law are for tobacco use, age, and where one lives. The policyholder is part of an insurance pool, and the entire pool's medical costs do influence overall rate increases from year to year.

The division reviews proposed rates for new health insurance plans, as well as proposed rate changes for existing plans.

Factors that determine a premium

Individual plan (for those who do not get job-based coverage)

- Age
- Benefits chosen
- Number of family members on the plan
- Where one lives in Oregon
- Tobacco use

Small group (50 or fewer employees)

- Average age of enrolled employees and dependents
- Benefits the employer selects
- Number of family members on the plan
- Geographic location
- Tobacco use by employees

Age: Premiums for older people cannot be more than three times those charged to younger people in the same geographic area, not considering tobacco use.

Family rates: In individual health benefit plans, family rates are a combined total of the rate each family member receives; however, no more than three children may be factored into the total rate.

T**obacco**: People who use tobacco can be charged up to 50 percent more than people who do not. Insurance companies decide how and whether to consider tobacco use when setting rates.

Large group (more than 50 employees): Employers negotiate directly with the insurance company; rates for large group plans are not subject to prior approval.

When the policyholder buys insurance as an individual, the policyholder pays the premium. When the policyholder receives coverage through their job, the employer pays the premium or the policyholder and the employer share the premium cost.

Federal uncertainty: Insurers may be worried about the effects of possible federal changes to tax credit availability or other legal changes and include a buffer to reduce the risk of financial insolvency.

Rate review process

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.

Small group rate review

Small group ACA rates can have a renewal date throughout the year. This is different from individual rates, which must all have a Jan. 1 renewal date. The small group rate filings include "time adjustment factors" (the exact term may be different depending on the insurer) that are applied to the January rates to produce April, July, and October rates. These factors reflect the effect of inflation throughout the year on health care costs and are directly tied to the medical trends for the year.

What a premium covers

What does a rate cover?

An insurance rate covers:

- Medical claims costs (hospitals, doctors, pharmacy, lab, and other benefits)
- Insurer administrative costs
- Profit/margin

What drives claims costs?

Many factors influence actual and predicted claims costs. Two of the most important are unit cost and utilization.

Unit cost: This measures medical services inflation. How much more the same services cost one year versus the next is the single largest factor affecting claims costs. Inflation is largely caused by unit price changes in contracts that insurers have with doctors and hospitals, as a well as increased charges for laboratory services, diagnostic imaging, prescription drugs, and other medical services.

Utilization (use of medical services): Utilization describes underlying factors that influence the type and quality of medical services people use. Examples include:

- Aging population
- Increasing number of people in poor health (obesity, for example)
- Changes in how doctors and hospitals diagnose conditions (such as an increase in the use of CT and MRI diagnostic imaging)
- New technologies or treatment patterns
- New medical equipment to treat conditions

Where does one's premium dollar go?

The average breakdown of the premium dollar in Oregon:

- 89 cents – medical claims (payments to doctors, labs, and facilities for the services provided)
- 10 cents – costs of running the company , that is, salaries for staff and agreements with third parties to administer specific benefits
- 1 cent – insurance company profit

These numbers include all of an insurance company's business, even large employers. However, the breakdown varies significantly based on the line of business (small group plans versus individual plans, for example). Every rate request filed with the division, along with the division's decision, includes a projection of how the company will spend the premium dollar if its rate is approved.

Health insurance premiums reflect the cost of health care. Controlling health care costs is key to stabilizing health insurance rates.

Health care cost containment

The Oregon Legislature through Senate Bill 889 (2019) and House Bill 2081 (2021) established a target for health care cost growth. The target is set at 3.4 percent and applies to insurers, hospitals, and other health care providers. The target does not prevent insurers from requesting a higher rate during division rate review; instead, it serves as a discussion point about the drivers of health care costs across the market. For more information on health care cost containment, visit https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx.

Evaluating rate requests

By law, the Division of Financial Regulation:

- **Disapproves** rates if "benefits … are not reasonable in relation to the premium charged."
- **Approves** rates that are "reasonable and not excessive, inadequate, or unfairly discriminatory."

Key principles:

The approved rate and rating factors must generate premiums that are fairly priced considering the benefits provided. Reasonable rates are usually adequate to cover the costs of paying for medical services claims and for operating the company. Rates cannot be excessive. That is, insurers should not gouge the public.

The Division of Financial Regulation will not allow rates to be unfairly discriminatory. That means people in similar circumstances should pay similar rates and that rate increases should be shared appropriately between different groups of policyholders.

The division fosters a marketplace that keeps more people insured and also ensures that insurance companies continue to operate and pay claims. The division must balance the consumers' interest in having affordable, comprehensive health care coverage with our role in ensuring companies remain financially secure.

The division cannot control larger economic forces that also affect the marketplace, like inflation, but it attempts to navigate in the public's best interests as it reviews rate requests.

The division seeks to assess and balance the assumptions and projections of insurance company actuaries. For example, the

division scrutinizes company assumptions about increasing medical claims costs and administrative costs to ensure they are reasonable and not overinflated.

Rates must cover the cost of benefits plus the insurance company's costs to operate without being overpriced.

Key factors

In weighing a rate request, the division considers such factors as an insurance company's:

- Recent and projected medical care and prescription drug costs, including any benefit changes
- Past and future loss ratios (how much of every premium dollar goes to pay health care claims)
- Recent history of rate changes
- Overall financial strength (profitability, investment income, surplus)
- Premiums (how they compare to those of competitors)
- Administrative costs

Medical services costs

Recent and future costs of medical care and prescription drugs drive insurance rates. Thus, the division closely examines the assumptions behind insurance company estimates about future claims costs, particularly:

- How much will any benefit changes increase or decrease costs?
- Are new contracts with hospitals, doctors, or other providers increasing the unit costs? Why do companies expect policyholders to use more or fewer medical services or different types of service in the coming year?

- How many policyholders are likely to switch to a higher deductible plan so they can still afford coverage (resulting in less premium to the company)?
- Is there a "margin" or padding in the company's projections?
- To what extent are a company's members aging or are other demographic characteristics changing? How will those changes affect claims?
- What are the average Oregon and national trends in medical claims costs?

Profit

Oregon's seven largest health insurance companies averaged less than 2 percent profit in the five years ending in 2022. This profit is generated by their companywide business; it includes everything generated by Medicare and commercial health plans to investment income.

In some years a company may be profitable in some lines of business but not others. To maintain market stability, insurance companies are to price individual and small group rates so that they are not subsidized by the profitability of other lines of business.

Surplus

Insurance companies have minimum amounts of capital and surplus available so they can pay policyholders' claims. A surplus includes profits accumulated by for-profit and nonprofit companies.

Companies might use their surplus to invest in new technology, protect against adverse conditions such as unexpected claims, or take on additional enrollment and new risk.

Depending on the circumstances, the division has reduced rate requests to levels that would require companies to use their surplus to cover expected losses. However, always using surpluses to keep rates artificially low could create a volatile rate situation in the future, or endanger the solvency of a company, which could put consumers at risk of harm. If rates do not usually cover expected ongoing increases in health care costs, consumers may face steep rate increases in future years if rates suddenly need to be raised to catch up to the actual medical claims costs.

Administrative costs

The division looks at a company's administrative costs as well as its projected growth in administrative costs. Companies must report these costs by types of insurance (individual or small employer health plans, for example). They must break out what they spend on salaries, agent commissions, marketing, advertising, and other expenses.

Administrative costs are generally higher for individual and small group health insurance compared to large groups. They are typically higher for insurance companies that write fewer policies or that write several lower-premium, low-benefit policies.

Insurance companies must pay rebates to individual and small group policyholders when they fail to spend at least 80 percent of premiums collected on medical care and quality improvement versus administrative costs. For more information about the medical loss ratio requirements, visit https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/medical-loss-ratio.

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