

1 **DEPARTMENT OF CONSUMER AND BUSINESS SERVICES,**
2 **INSURANCE DIVISION**

3
4 **DIVISION 53**

5
6 **Health Benefit Plans**

7
8 **836-053-0007 Approval and Certification of Associations, Trusts, Discretionary Groups**
9 **and MEWAs**

10 (1) An insurer must obtain approval of an association, trust, discretionary group or
11 MEWA when an association, trust, discretionary group or MEWA applies for coverage if the
12 association, trust, discretionary group or MEWA is not an approved group policyholder as
13 defined in ORS 743.522.

14 (2) An insurer must certify that an association, trust, discretionary group or MEWA
15 continues to meet the requirements of ORS 743.522 when an association, trust, discretionary
16 group or MEWA applies for coverage if the association, trust, discretionary group or MEWA is
17 an approved group policyholder as defined in ORS 743.522.

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19 Stat. Auth.: ORS 731.244

20 Stats. Implemented: ORS 743.522

21
22 **836-053-0081**

23 **Association Health Plans; Requirements Regarding Small Employer Group Members**

24 (1) The carrier of an association health plan shall determine whether the plan maintains
25 the 95 percent retention rate required by ORS 743.734(7) not less than once in any 12-month
26 rating period or plan year. The carrier shall report to the Director any association health plan for
27 which the retention rate is less than 95 percent not later than the end of the first quarter following
28 the 12-month rating period or plan year. The carrier of an association health plan shall also
29 provide additional information regarding the association health plan pursuant to ORS 731.296,
30 when requested by the Director.

31 (2) The carrier of an association health plan shall determine whether the plan maintains
32 the 95 percent rate of retention of member employers of an association health plan required by
33 ORS 743.734(7) according to the following formula, in the following sequence:

34 (a) By determining the total number of member employers covered by the association
35 health plan on the date one year prior to the plan year anniversary date;

36 (b) By determining the number of member employers covered by an association health
37 plan on the date one year prior to the determination date that terminated coverage during the year
38 preceding the determination date for a reason stated in ORS 743.734(8);

39 (c) By subtracting the number determined in subsection (b) of this section from the
40 number determined in subsection (a) of this section;

41 (d) By determining the number of member employers covered by an association health
42 plan on the date one year prior to the determination date that terminated coverage during the year
43 preceding the determination date for any reason other than those stated in ORS 743.734(8);

44 (e) By subtracting the number determined in subsection (d) of this section from the
45 number determined in subsection (c) of this section; and

1 (f) Determining the retention rate by dividing the number determined in subsection (e) of
2 this section by the number determined in subsection (c) of this section.

3 (3) When an association offers coverage to member employers through two or more
4 association health plans issues by two or more carriers, the association may maintain the 95
5 percent retention rate required by ORS 743.734(7) either with respect to the association health
6 plan provided by each carrier or with respect to all association health plans offered through the
7 association.

8 (4) For the purpose of ORS 743.734(7)(b)(A), the initial premium rate requirement is the
9 rate that applies to each small employer member group upon its initial enrollment in the
10 association health plan.

11 Stat. Auth.: ORS 731.244

12 Stats. Implemented: ORS 731.296, 743.734 and 743.748
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1 **DEPARTMENT OF CONSUMER AND BUSINESS SERVICES**
2 **INSURANCE DIVISION**

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4 **DIVISION 53**

5
6 **Health Benefit Plans**

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8 **Annual Reporting Requirements**
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10 **836-053-1400**

11 **Format and Instructions for Report Required by [ch. 765, Oregon Laws 2005] ORS 743.748**

12 (1) A carrier shall submit the information required by [section 2(1), chapter 765, Oregon
13 *Laws 2005*] **ORS 743.748** electronically in the format and according to the directions established
14 by the Director of the Department of Consumer and Business Services and made available on the
15 website of the Insurance Division, and according to the provisions of this rule.

16 (2) The following terms used in [section 2(1), chapter 765, Oregon Laws 2005] **ORS**
17 **743.748** have the following meanings for the purpose of the information required [*thereunder*]
18 **by ORS 743.748**. References in this section to specific schedules and instructions are to
19 schedules and instructions for the NAIC health annual statement blank. The terms are defined as
20 follows:

21 (a) "Average amount of premiums per member per month" means total earned premiums
22 as reported on the exhibit of premiums, enrollment and utilization divided by the total member
23 months for the required reporting year.

24 (b) "Carrier's annual report" is the carrier's annual statement submitted as required by
25 ORS 731.574.

26 (c) "Medical loss ratio" means the total medical claims cost divided by the total
27 premiums earned, both as reported on the exhibit of premiums, enrollment and utilization.

28 (d) "Percentage change in the average premium per member per month" means the
29 average amount of premiums per member per month for the reporting year less the average
30 premium per member per month for the preceding reporting year divided by the average
31 premium per member per month for the preceding reporting year.

32 (e) "Total amount of costs for claims" means incurred claims as reported by the carrier on
33 the exhibit of premiums, enrollment and utilization in its annual statement. If the annual
34 statement blank used by a carrier does not include an exhibit of premiums, enrollment and
35 utilization, the carrier shall derive the answer from its records, using the instructions for the
36 exhibit of premiums, enrollment and utilization for reporting the information.

37 (f) "Total amount of premiums" means earned premium as reported by the carrier on the
38 exhibit of premiums, enrollment and utilization in its annual statement. If the annual statement
39 blank used by a carrier does not include an exhibit of premiums, enrollment and utilization, the
40 carrier shall derive the answer from its records, using the instructions for the exhibit of
41 premiums, enrollment and utilization for reporting the information.

42 (g) "Total number of members" means total number of members as of December 31 of
43 the reporting year, as reported by the carrier in its annual statement. If the annual statement blank
44 used by a carrier does not include an exhibit of premiums, enrollment and utilization, the carrier
45 shall derive the answer from its records, using the instructions for the exhibit of premiums,
46 enrollment and utilization for reporting the information.

1 (3) A carrier shall submit the following information by total for all comprehensive
2 hospital and medical products nationwide, *[and by total]* for all such products in each Oregon
3 market segment **and for the carrier's association health plans as described in ORS**

4 **743.734(7)**:

5 (a) Number of members.

6 (b) Number of member months.

7 (c) Premiums earned.

8 (d) Medical claims costs.

9 (e) Medical loss ratio.

10 (f) Average premium per member per month for the reporting year.

11 (g) Average premium per member per month for the preceding reporting year.

12 (h) Percentage change in premium per member per month from the preceding reporting
13 year.

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15 Stat. Auth.: ORS 731.244, [*Sec. 2, Ch. 765, OL 2005*] **743.748**

16 Stats. Implemented: [*Sec. 2, 3, 4, Ch. 765, OL 2005*] **ORS 743.748**

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