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# OREGON INSURANCE DIVISION BULLETIN INS 2003-9

DATE: December 23, 2003

TO: All Health Insurers and Health Care Service Contractors

RE: Reporting Procedures for House Bills 2987 and 3431

## I. Purpose of Bulletin

House Bills 2987 and 3431 require health insurance carriers to submit information requested by the Director so that the Department may assess the effect of each bill on the individual and small employer group health insurance markets. The purpose of this bulletin is to provide instructions that will facilitate the reporting of this information.

## II. Summary and Requirements Relating to HB 2987 and 3431

### A. HB 2987, Individual and Small Employer Group Coverage

1. Individual Policies

HB 2987 authorizes insurers to impose waivers of individual health insurance coverage on preexisting conditions for up to 24 months. A carrier may impose a waiver of coverage for one or more preexisting conditions, and each condition must be identified by the carrier when the individual is enrolled for the first time in the health plan.

Unlike current preexisting condition waivers, which are not required to be specifically defined, waivers imposed under HB 2987 must be limited to specific diseases according to the appropriate disease codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9 code). The waiver may not be less than six months or greater than 24 months and must be agreed to in writing by the carrier and the individual.

Each preexisting condition must be identified on an addendum to the individual health benefit plan and must include the appropriate 3-, 4-, or 5-digit ICD-9 Code including the disease category and a written description of the condition. (For example, 428.0 Congestive heart failure **BUT NOT** 428 Heart Failure.) Each addendum must be limited to the specific disease code and may not extend to include any other disease code or secondary condition directly or indirectly related to the preexisting condition.

2. Small Employer Policies

HB 2987 authorizes a carrier in the Small Employer Health Insurance (SEHI) program to charge the highest-rated group up to 2.5 times the amount the carrier charges its lowest rated group.

### B. HB 3431, Individual Coverage

HB 3431 authorizes a carrier to limit the number of individual health benefit plans in which an individual may elect to enroll. This change enables a carrier to offer coverage to an individual under any of the carrier's individual plans for which the individual qualifies, rather than requiring the carrier to accept or reject coverage of an individual on the basis of the carrier's richest plan. It is anticipated that a carrier will allow an individual to choose from among all of the carrier's individual plans for which the individual qualifies.

A carrier may impose the conditions of both HB 2987 and HB 3134 on a single individual. A carrier may limit the individual health benefit plan or plans in which an individual may elect to enroll and impose waivers of individual health insurance coverage for the same individual health insurance plan.

### C. Requirements Applicable to Both Bills

When a carrier offers an individual health benefit plan that imposes a waiver under HB 2987 or limits the plans in which an individual may enroll under HB 3431, or both, the carrier must provide a letter to the applicant that indicates all of the following:

- Whether the carrier declined coverage, offered a plan with a preexisting condition waiver or limited the applicant’s choice of plans.
- That any such declination, waiver or limitation constitutes an “adverse decision” for purposes of acceptance for OMIP coverage.
- If one or more waivers are offered, the appropriate ICD-9 code for each waiver and the length of the waiver.
- If the choice of plans is limited, a description of the benefit options for each plan offered to the applicant, including deductible amounts, coinsurance and coinsurance/out-of-pocket maximums.
- That the applicant may apply for coverage with OMIP and that a copy of the carrier’s letter should be submitted with the OMIP application.

## III. Data Collection Requirements for HB 2987 and HB 3431

### A. Generally

DCBS and OMIP will prepare reports measuring the effects of changes by HB 2987 in the individual and small group health insurance markets and HB 3431 in the individual health insurance market. For the purpose of these reports:

- *Member* means a person enrolled as a subscriber or an eligible dependent of a subscriber in a health plan (ORS 743.730(4)).
- *Health plan* means any health benefit plan as defined in ORS 743.730(18).

Collection of data and preparation and accuracy of these reports necessarily depend on the information that carriers provide to DCBS. Carriers must ensure that quarterly enrollment reports are accurate in order for the Division to establish appropriate starting points for evaluating the data to be reported. The following explains the data collection and reporting responsibilities of carriers and OMIP.

## B. Data Collection Requirements for Individual Health Insurance Market

The following reports will assess whether the number of individuals rejected for individual coverage has increased or decreased because of the legislation. The reports will also assess whether health coverage options in the individual market have become more limited because of the legislation.

1. Carriers

Each health insurance carrier must compile and report the following data to DCBS quarterly on its *Quarterly Enrollment Reports*:

A. Total number of members enrolled in individual health plans issued by the carrier.

B. Total number of new individual health plans issued by the carrier; and:

- The number of new individual health plans issued in which the individual's choice of plans was limited by the carrier.
- The number of new individual health plans issued with preexisting condition waivers.
- The number of new health plans issued with more than one preexisting condition waiver of 6 to 24 months.
- The number of new individual health plans issued in which the individual's choice of plans was limited by the carrier and in which the plan was issued with one or more preexisting condition waivers.

C. Calculations of the following matters relating to individual health plans:

- Percentage of new book of business that represents individual health plans with preexisting condition waivers of 6 to 24 months.
- Percentage of new book of business that represents individual health plans in which the individual's choice of plans was limited by the carrier.
- Percentage of new book of business that represents new individual health plans in which the individual's choice of plans was limited by the carrier and in which the plan was issued with one or more preexisting condition waivers.

D. Rejection rate (subscriber and dependent) for individual health plans (applications

accepted/applications accepted + applications declined for health reasons):

- Number of applications for individual health plans received.
- Number of applications for individual health plans accepted.
- Number of applications for individual health plans declined for health reasons.
- Number of applications for individual health plans declined for pregnancy.
- Number of applications for individual health plans declined for other than health reasons.

E. Individual preexisting condition waivers:

- Number of waivers and corresponding ICD-9 code identified on the addendum to the health plan.
- For the purposes of this report, a carrier may limit the ICD-9 coding to the 3-digit disease group code; however, each preexisting condition waiver must be identified on an addendum to the individual health plan and must include the appropriate disease 3-, 4-, or 5-digit code, including the disease category and a written description of the condition.

2. OMIP

OMIP will compile on a quarterly basis the total number of individuals enrolling in OMIP:

- Number of individuals enrolling in OMIP as a result of carrier declination.
- Number of individuals enrolling in OMIP because the health plan was offered with preexisting condition waiver of 6 to 24 months.
- Number of individuals enrolling in OMIP because the carrier limited the individual's choice of health plans.

## C. Data Collection Requirements for Carriers in the SEHI Market

Data reporting from carriers will enable the Department of Consumer and Business Services to assess the effects of HB 2987 on the SEHI Market. By tracking the number of younger employees who elect to enroll in SEHI plans, DCBS will be able to determine whether more younger employees are electing coverage. The data will also allow DCBS to track the number of older employees and dependents electing to enroll in SEHI plans in order to determine whether those numbers decrease. Carriers shall provide the following data:

1. Each carrier shall compile and report data using the following standardized age bands: 0-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70+.

2. Each carrier must compile and report the following data to DCBS quarterly for SEHI (2-25) groups on its *Quarterly Enrollment Reports*:

- Total members enrolled in 2-25 groups (Small employer groups with 2-25 eligible employees, ORS 743.730 (12) and (30)).
- Average member age of SEHI (2-25) pool.

- Average member age of all new SEHI (2-25) groups.
- Percentage of all SEHI (2-25) group members in each age band (based on difference in ages of participating employees) as provided in HB 2987.

## IV. Filing your Quarterly Enrollment Reports

The first *Quarterly Enrollment Report*, in which each carrier shall report the required data for the first quarter of 2004, is due May 15, 2004. Along with the first *Quarterly Enrollment Report*, each carrier shall report the following data for the fourth quarter of 2003. These fourth quarter data will enable the Director to establish appropriate and consistent starting points for evaluating all of the information contained in the *Quarterly Enrollment Reports.*

- Individual health plans: Total number of members enrolled in individual health plans issued by the carrier, from page 3 of this bulletin; and the rejection rates as specified on page 4.
- SEHI Market: All data required under III.D.2. above, this page.

Each carrier must complete its *Quarterly Enrollment Reports* in Microsoft Excel file provided by the Oregon Insurance Division and must email the reports to: Healthun.web@state.or.us. A copy of the *Quarterly Enrollment Report* form is included with this bulletin.

Each carrier must submit its *Quarterly Enrollment Reports* by:

- May 15 for 1st Quarter
- August 15 for 2nd Quarter
- November 15 for 3rd Quarter
- February 15 for 4th Quarter

**NOTICE**

This bulletin is intended only to announce reporting requirements for HB 2987 and HB 3431 and does not otherwise modify current reporting requirements of other data in a carrier's *Quarterly Enrollment Report*.

This bulletin is dated the 23rd day of December 2003, at Salem, Oregon.

_____(Signed)_____
Joel Ario, Insurance Administrator