

**STATE OF OREGON  
DEPARTMENT OF CONSUMER & BUSINESS SERVICES  
INSURANCE DIVISION**

**Quarterly Health Enrollment Report Instructions**

**Revised 1/27/2012**

**Effective 1st Quarter, 2012**

**A. PURPOSE**

- The Oregon Legislature has passed several health reform bills since 1996. Therefore, the Insurance Division has required various entities to submit enrollment information to the Department of Consumer and Business Services (DCBS) to assess the effect of those bills on individual and group health insurance markets. Reporting entities include:
  - Health insurers, health care services contractors and fraternal benefit societies authorized to transact health insurance business in this state (carriers);
  - Multiple Employer Welfare Arrangements (MEWAs)
  - Third Party Administrators (TPAs), and;
  - Oregon Special Districts (special districts)
- This information is used to prepare reports measuring the effects of the bills and to determine the number of insured and uninsured in Oregon by DCBS. The report is also used by:
  - The Oregon Medical Insurance Pool (OMIP) for assessment purposes.
  - The Oregon Health Authority (OHA) for All-Payer Healthcare Claims Data Reporting Program.
- Instructions are to provide clarification and to facilitate accurate reporting of this information to DCBS.

**B. ROLE OF CARRIERS, TPAs AND SPECIAL DISTRICTS**

- Carriers, TPAs and special districts are responsible for the completeness, accuracy and timeliness of their enrollment reports.
  - **Carriers:** Report fully insured members and self-insured members, with or without stop loss, where applicable, for which administrative services are provided, as described in the instructions that follow.
  - **Oregon Special Districts:** Report self insured enrollment when not otherwise reported by a carrier or TPA.
  - **TPAs:** Report enrollment for self insured medical plans for which administrative services are provided. Enrollment reports must be submitted to DCBS through the Insurance Division's [iReg website](#) via .txt or .dat file in the required [format](#).
- Questions or concerns regarding submission of this report may be directed to the Market Regulation Coordinator via e-mail: [ins.mrktsurv@state.or.us](mailto:ins.mrktsurv@state.or.us) or by telephone: (503) 947-7268.
- Each carrier, TPA and Special District must submit its information by:
  - May 1 for 1<sup>st</sup> Quarter - NEW
  - August 1 for 2<sup>nd</sup> Quarter - NEW
  - November 1 for 3<sup>rd</sup> Quarter - NEW
  - February 1 for 4<sup>th</sup> Quarter - NEW

**C. CARRIERS, TPAs AND SPECIAL DISTRICTS MUST VALIDATE CONTACT INFORMATION FOR ENROLLMENT OR EXEMPTION REPORTING PURPOSES, PROVIDING**

- Filing contact name and title
- E-mail address for contact person
- Mailing address
- Phone number
- Fax number

**D. EXEMPT FROM REPORTING ENROLLMENT**

Some carriers, TPAs and special districts may be exempt from filing enrollment. If so, then only an annual exemption request is required. To determine qualification for exemption, refer to the “Exempt from Reporting Enrollment” section below.

**NOTE:** Licensed carriers, TPAs and special districts exempt from reporting enrollment **must file an exemption once per calendar year describing reasons for the exemption.** Exemptions are filed via the Insurance Division’s [iReg website](#) and are normally due during the first quarter reporting period. Exemptions apply for the entire calendar year, unless a change in status occurs and the company or district then has lives to report. Then, a Quarterly Enrollment Report must be completed for the applicable quarter during which the change occurred.

**Not Exempt from Reporting Enrollment**

- Carriers and TPAs with lives under both reportable types of insurance and insurance exempt from reporting do not qualify for an exemption. In this case, submit only lives enrolled under reportable types of insurance and not lives covered by exempt types of insurance.
- Carriers and TPAs that do not write or have not issued contracts in Oregon may not qualify for exemption. Oregon members covered by reportable types of insurance are reported regardless of where the policy or contract was issued or written.
- Companies with no lives to report for a calendar year quarter following a quarter in which lives were reported must file a record of type 1. See [Company Record Layouts](#).

**Exempt from Reporting Enrollment**

- Exempt types of insurance include:
  - accident coverage only,
  - specific disease or condition coverage only,
  - credit coverage only,
  - disability income or short-term disability coverage only,
  - long-term care coverage only,
  - hospital income coverage only (plans that pay a specified dollar amount per day),
  - travel coverage only
  - other complementary coverage
- Exempt self-insured plans include:
  - dental only
  - vision only
- Exempt TPAs include those administering:
  - pharmacy benefit management only
  - standalone or carve-out mental health and chemical dependency only
  - standalone or carve-out radiology and imaging, or other single service administration
  - administration of FSAs or HSAs only

## E. QUARTERLY HEALTH ENROLLMENT REPORTING

The Quarterly Health Enrollment Report pertains to active licensed carriers, MEWAs, special districts, and TPAs authorized under ORS 744.702, and any other group or individual health insurance carrier licensed in Oregon. The report applies to health insurance coverage provided to residents of Oregon, regardless of where the policy or contract is issued.

- Reporting is determined by the presence of “**Insured Oregon lives**” under reportable types of insurance, or self-insured medical plans, **at the end of a reporting quarter.**
- Reporting is not determined by premium volume, or current or new business written or issued within Oregon.
- Reportable types of insurance are not limited to “health benefit plans” as defined under ORS 743.730(17). See Section F.
- **Insured Oregon lives** include:
  - All residents of Oregon enrolled as subscribers or eligible dependents of a subscriber.
  - Oregon residents of an employer group covered by stop loss insurance.
- Plan enrollment is reported by the subscriber’s 5-digit postal zip code.

**NOTE: Carriers, TPAs and special districts should NOT double count lives in any listed categories (#1-13 below).** Lives counted in one category should not be counted in another category. However, counts reported under subcategories (i.e. 2.a., 3.a., 3.b., 4.a., 5.a., 5.b., 8.a., 8.b., 8.c.) should also be included in their respective categories.

## F. REPORTABLE TYPES OF INSURANCE

Report the number of lives insured (subscriber and/or eligible dependent) in the plans identified. Each life shall be reported by the subscriber’s five digit postal zip code. Dependents shall utilize the same zip code as the subscriber.

A “life” (Lives) is a person enrolled as a subscriber or an eligible dependent of a subscriber in a plan.

### 1. Individual

Report the number of lives enrolled in all individual medical plans, include individual short-term policies.

### 2. Small Employer Groups

Report the total number of lives enrolled in all small employer group plans (Indemnity and HMO type) including HIPAA small employer groups. A small employer group is defined in ORS 743.730(30). Do not include lives enrolled in small employer group plans provided through an association or a trust.

**2. a. Basic Plan.** Report the number of lives enrolled in a Basic Plan provided to all small employer groups. The count provided here should also be included in the count under the primary Small Employer Groups category (2.).

### 3. Associations, Trusts and MEWAs

Report the number of lives insured in all association, trust and/or fully insured MEWA group plans. The count reported here should equal the total of 3.a. and 3.b.

**3.a. Subject to small employer laws**

Report the number of lives enrolled in a health benefit plan issued to a small employer group through an association health plan and that is subject to ORS 743.734(1).

**3.b. Not Subject to small employer laws**

Report the number of lives enrolled in a health benefit plan issued to a small employer group or a large employer group through an association plan that is exempt from ORS 743.734(1).

**4. Large Groups**

Report the number of lives under all fully insured, alternately funded, and partially self-insured groups that do not meet the definition of a small employer group. These include blanket policies (ORS 743.534), student health plans (ORS 743.550) and discretionary groups (ORS 743.522(2)). If the policyholder of a blanket policy is located outside of Oregon then use the zip code "97710" for reporting lives. If the policyholder of a blanket policy is located in Oregon then use the zip code of the policyholder.

**4.a. Discretionary Groups not subject to small employer laws**

Report the number of lives enrolled in a health benefit plan issued to a discretionary group that is exempt from ORS 743.734(1). (e.g. a discretionary group with small employer members).

**5. Self-Insured**

This category includes both self insured groups not covered by and, to the extent consistent with federal law, covered by the Employee Retirement Income Security Act of 1974, as amended, that provide health care benefits in this state.

Report the number of lives covered in all self insured group medical plans for which you provide administrative services, with or without stop-loss. Membership reported in this category should not include small employer groups. If administrative services are limited, please note the services provided in the comment box, prior to uploading data files.

Do not report self-insured dental, vision, or other standalone or carve-out benefit membership. Carriers providing administrative services and stop loss coverage to Oregon special districts should report those lives under both subcategories 5.a. and 5.b. but should only report special district lives **once** under the category 5 total.

**5.a. Stop Loss – Reporting under this sub-category is limited to carriers that provide both administrative services and stop loss insurance.**

Report the number of lives covered under a self-insured group for which you provide administrative services with stop-loss. Stop Loss refers to Specific (Individual) or Specific and Aggregate stop loss coverage (ORS 742.065). If the stop loss policyholder is located outside of Oregon, then utilize the zip code "97710" for reporting lives. If the policyholder is located in Oregon then utilize the zip code of the policyholder.

**5.b. Special Districts** – Report the number of lives covered under an individual or jointly self-insured program. Examples are Oregon cities, counties, school districts, community college districts, community college service districts or districts as defined in ORS 198.010 and 198.180. Please note total Oregon special district membership with stop loss in the comment box prior to uploading data files. Example Comment: Category 5.b. special district membership with stop loss 5,000.

**6. Stop Loss Only**

This category is limited to carriers providing Stop Loss coverage only (i.e. no administrative services) and not any of those under a Self-Insured plan with Stop Loss. Stop Loss refers to Specific (Individual) or Specific and Aggregate stop loss coverage provided by a carrier. If the stop loss group policyholder is located outside of Oregon, then utilize the zip code “97710” for reporting lives. If the policyholder is located in Oregon then utilize the zip code of the policyholder. Casualty insurers are not currently required to report. Please note total Oregon special district membership in the comment box prior to uploading data files.

Example Comment: Category 6: special district membership 5,000.

**7. TRICARE/FEHBP/CHAMPUS**

This category is limited to those lives covered under a Federal Employees Health Benefits Program (FEHBP)/TRICARE/Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

**8. Portability**

Report the number of lives enrolled in all plans offered as portability coverage. These include all those issued under prevailing, low-cost, and all other health benefit plans for Portability. The count reported here should be the total of 8.a, 8.b., and 8.c.

Oregon residents whose group insurance is under a self-funded plan must exhaust their COBRA prior to obtaining Portability coverage, which is provided through OMIP.

Oregon residents whose group insurance is under a fully-insured plan do not have to exhaust COBRA prior to obtaining Portability coverage. Therefore, they can choose between COBRA and Portability coverage, but they cannot have both COBRA and Portability at the same time.

**8.a. Prevailing**— A prevailing plan is a type of Portability plan that reflects the benefit coverage that is prevalent in the group health insurance market. Therefore, report the number of insured lives enrolled in a prevailing Portability plan.

**8.b. Low-Cost**— A low cost plan is a type of Portability plan that emphasizes affordability for eligible individuals. Therefore, report the number of insured lives enrolled in a low-cost Portability plan.

**8.c. Other**— A type of Portability plan that is not either Prevailing or Low-Cost. Therefore, report the number of insured lives enrolled in any individual plan that is being offered for Portability and is not either a Prevailing or Low-Cost plan.

**9. Medicare Advantage**

Report the number of lives enrolled in a Medicare Advantage plan. This was formerly referred to as Medicare + Choice and includes all plans provided under Medicare Advantage, even those that are **not** HMO plans. Do not include lives insured under Medicare HMO Cost plans under this category.

**10. Medicare HMO Cost**

Report the number of lives enrolled in all Medicare HMO Cost plans.

**11. Medicare PACE (Programs of All Inclusive Care for the Elderly)**

Report the number of insured lives enrolled in Medicare PACE plans.

**12. Medicare Supplement**

Report the number of insured lives enrolled in all Medicare Supplement (Medigap) plans they offer.

**13. Medicaid**

Report the number of lives enrolled in Medicaid plans. Report dual-eligible lives under the appropriate Medicare plan only. Carriers should NOT report Medicaid enrollment of subsidiary companies.

**14. Dental Only**

Report the number of lives enrolled in stand-alone policies or riders that provide dental only coverage. Do not include those lives where coverage is provided through a self-funded plan. The lives reported here could be reported elsewhere within this table. Please note in the comment section if the coverage is provided through a stand-alone policy or rider.

**15. Vision Only**

Report the number of lives enrolled in stand-alone policies or riders that provide vision only coverage. Do not include those lives where coverage is provided through a self-funded plan. The lives reported here could be reported elsewhere within this table. Please note in the comment section if the coverage is provided through a stand-alone policy or rider.

**16. Total Lives**

For each zip code, report the total of lives under categories 1 through 13 as described above.

**G. COMMENTS FOR SIGNIFICANT ENROLLMENT CHANGES**

If numbers within a category vary by more or less than (+/-) 10% or greater than 1,000 lives from the previous quarter, provide a brief explanation as to why the change occurred and add to the comments box within iReg prior to data file submission. Example: Enrollment gains attributed to entrance into Clatsop, Columbia and Hood River counties.

**H. SMALL EMPLOYER GROUP GEOGRAPHIC AVERAGE RATE (GAR) INFORMATION**

Provide the number of groups and lives for all small employer group policies issued in Oregon for the Current Reporting Quarter

Provide the total number of groups and lives for the current reporting quarter. The Geographic Average Rate (GAR) does not include premium differences that are due to differences in benefit design or family composition.

Carriers need to report the number of groups and lives (include dependents) they have in a plan that was recently or previously issued within the following specific premium rate ranges for the current reporting quarter:

- 41% or + above (or below) the GAR
- 21%-40% above (or below) the GAR
- 1%-20% above (or below) the GAR
- 0% variance to the GAR

**NOTE:** This data is not limited to new policies but all policies in-force. Therefore, this information must be provided as long as a carrier has any insured lives under a small employer group plan during the quarter being reported and regardless of whether it has new business or not.

## I. SUBSCRIBER DATA FOR ALL SMALL EMPLOYER GROUP, INDIVIDUAL AND MEDICARE LINES OF BUSINESS FOR THE CURRENT REPORTING QUARTER

Provide data related to lives (no dependents) insured under policies for the current reporting quarter. Carriers are to report this data as long as they have any insured lives regardless of whether or not it is new or current business in this state.

- Average small employer group “subscriber” age for new small employer groups. For the reporting quarter, provide the average age of all subscribers insured under all new small employer groups at the end of the reporting quarter. Do not include dependents. These should be subscribers actually currently enrolled in the group plan for the reporting quarter and not those in process.
- Average small employer “subscriber” age for all small employer groups. For the reporting quarter, provide the average age of all subscribers insured under all small employer groups at the end of the reporting quarter. This includes both existing and new groups. Do not include dependents. These should be subscribers actually currently enrolled in the group plan for the reporting quarter and not those in process.
- % of all small employer group “subscriber” in each of the following age bands. For the reporting quarter, provide the percentage of lives in all small employer groups within the specified age bands at the end of the reporting quarter. This includes both existing and new groups. Do not include dependents. These should be subscribers actually currently enrolled in the group plan for the reporting quarter and not those in process.

- ✓ 0-19
- ✓ 20-29
- ✓ 30-39
- ✓ 40-49
- ✓ 50-59
- ✓ 60-69
- ✓ 70-79
- ✓ 80-89
- ✓ 90+

- For all individual health plans,  
For the reporting quarter, provide the percentage of lives enrolled in all individual health plans within the specified age bands at the end of the reporting quarter. This includes both existing and new policyholders but not those in process. Do not include dependents.

- ✓ 0-19
- ✓ 20-29
- ✓ 30-39
- ✓ 40-49
- ✓ 50-59
- ✓ 60-69
- ✓ 70-79
- ✓ 80-89
- ✓ 90+

**NOTE:** The percentages recorded within each of the above age bands for each type of coverage for the reporting quarter must total 100%. Do not use more than 2 decimal places.

#### **J. DATA FOR ALL INDIVIDUAL HEALTH PLAN APPLICATIONS FOR THE CURRENT REPORTING QUARTER**

Provide data related to all Individual Health Plan applications for the end of the current reporting quarter. This is regardless of whether a carrier has current or new business in this state.

**NOTE:** If this information is not applicable to your company because it is a closed block of business, please enter a 0 and make a note in the comment section of the report.

All carriers who have insured lives under any of its individual health plans must report this data. Carriers must also provide this data even if the choice of plans is not limited or plans with pre-existing condition waivers are not issued.

- a. Rejection Rate (Formula:  $d/(d+c)$ )** – Provide the rejection rate for all individual health plan applications received at the end of the reporting quarter. The formula:  $d/(d+c)$  = the number of lives declined for health reasons in all applications for individual health plans, **NOT** including those declined for pregnancy, *divided* by the number of lives declined for health reasons in all applications for individual health plans, **NOT** including those declined for pregnancy, *plus* the number of lives accepted in all applications for individual health plans.

This is a calculated field based on data provided under #c and #d below. If the field does not automatically calculate, manually calculate this information and provide the rejection rate based on the formula for the reporting quarter.

- b. Number of Lives in all Applications for Individual Health Plans “Received”**  
Report the number of lives (subscriber and dependents) in all applications for individual health plans “received” at the end of the reporting quarter.
- c. Number of Lives “Accepted” in all Applications for Individual Health Plans**  
Report the number of lives (subscriber and dependents) in all applications “accepted” for individual health plans at the end of the reporting quarter.
- d. Number of Lives “Declined” for Health Reasons in all Applications for Individual Health Plans**  
Report the number of lives (subscriber and dependents) “declined” for health reasons in all applications for individual health plans at the end of the reporting quarter. Do **NOT** include those declined for pregnancy.
- e. Number of Lives “Declined” for Pregnancy in all Applications for Individual Health Plans**  
Report the number of lives (subscriber and dependents) “declined” for pregnancy in all applications for individual health plans at the end of the reporting quarter.