Oregon Health Insurance Rates
Management Review

Introduction

We conducted preliminary work on the Oregon Insurance Division's (division) health insurance rate review process. We did not conduct a full audit because our preliminary review did not identify deficiencies or improvements to justify the commitment of additional audit resources. This report summarizes the areas we reviewed. Among our observations:

- Oregon's rate review process is performed by skilled staff and designed to be transparent and engage consumers.
- The division analyzes and approves rates for the individual and small group markets, about 10% of Oregon's health insurance market.
- Within this smaller group, Oregon's market includes 16 insurers offering coverage to over 390,000 people.
- Federal and state regulations require at least 80% of consumer premiums be spent on patient medical care, cost containment and quality improvement efforts.
- To protect consumers, the division reviews seek to ensure reasonable rates that are actuarially sound and companies are financially stable.
- In the past two years, nearly every rate request in Oregon was changed as a result of rate review, and most requests were decreased. Health insurance premiums continue to increase, but the increase has slowed in recent years.

Health Insurance Regulation in Oregon

Insurance regulation and rate review work together to further the division's goals to foster a financially sound and competitive insurance market place, promote affordability, and ensure fair treatment of consumers. The division regulates most types of insurance, including health, auto, homeowner, life, long-term care, and disability.

The division is accredited by the National Association of Insurance Commissioners (NAIC), which sets standards and accredits states for insurance regulation. All states are currently accredited.

Financial regulation, which includes financial examinations and ongoing financial analysis, provides the foundation for rate review. Initially, the division authorizes companies to sell

insurance in the state. Regulators then perform ongoing financial examinations and financial analysis to monitor and ensure companies are financially sound and able to pay insurance claims. The division examines the financial condition of companies domiciled in Oregon approximately every 3-5 years, or as needed. The examinations consist of site visits, interviews, analysis and other procedures to develop a robust risk assessment of the company. A standard financial examination also includes control testing and substantive tests covering several areas, including but not limited to: claim handling, claim reserves, underwriting, premiums, and expenses.

Regulators perform ongoing financial examinations and financial analysis to ensure companies are financially sound and able to pay insurance claims

Between examinations, the division's financial analysts conduct ongoing monitoring by reviewing insurance company annual and quarterly financial statements. Analysts look for prospective risks with the greatest potential to develop financial problems. If necessary, the division can take regulatory action including supervision, rehabilitation, or liquidation of the company.

Health Insurance Rate Review

About 10% of Oregonians participate in individual and small group health insurance plans. The division annually reviews and approves these rates, which typically experience greater volatility. In addition, individuals and small groups do not have the same capacity to negotiate rates with insurers as do businesses or government entities with large group plans. The division does not approve rates for large employers (those with 51 or more employees), self-insured employers, or government entities including Medicare and Medicaid programs.

The Division is responsible for reviewing and approving health insurance rates for about 10% of Oregonians

Companies use actuarial analysis to develop rates estimated to cover the anticipated costs of clinical services, administrative costs, and company profits. The actuarial analysis produces a range of answers based upon these estimates. If the estimates differ from what actually occurs, or costs change, the company may request a rate increase or decrease in the future.

The division reviews rate requests by conducting its own analysis and modifies most rates before approving them for use. The division reviews rates each summer that will take effect for the following calendar year.

Insurance companies begin preparing rates using the prior year's financial information submitted at the end of March. Once submitted, state law gives the insurance division up to 60 days to

review and approve rates. After the review, companies revise and submit new plan documents based on the approved rates. New plans must be ready in September to be included in the insurance exchange open enrollment as mandated by the Affordable Care Act (ACA).

Companies have the option to appeal rate decisions and have their appeal heard by an Administrative Law Judge. However, time is a limiting factor since companies must have their appeals concluded and rates approved to get on the insurance exchange and compete in the marketplace.

Rate review begins when companies submit their rate filings. The filing is an extensive document that includes financial data from the previous year such as claim information, premiums collected and administrative costs. It also includes an explanation of how the company created the rate, including assumptions about medical costs and utilization, projected enrollment, and projected profit margin if the rate is approved. The filing is initially reviewed for completeness. If there is something missing or if at any point during the process staff have questions, they submit written requests to the insurance company for information and/or an explanation. Companies can also provide further explanation during public rate review hearings.

Multiple division staff members contribute to reviewing the rate requests. Each rate filing is reviewed by a team of an actuary and a rate analyst. An actuary is a professional who analyzes the financial costs of risk and uncertainty using mathematics, statistics, and financial theory. The division's financial analysts, who perform ongoing monitoring of the companies, provide input on the company at the beginning and end of the rate review. In 2014, the actuaries, analysts, and their manager, held weekly meetings to discuss their process for evaluating plans and trends they were seeing across all of the rates filed.

By law, the director may approve an individual or small group rate if it is:

- actuarially sound;
- reasonable and not excessive, inadequate or unfairly discriminatory; and
- based on reasonable administrative expenses.

The division reported reviewing a greater number of rates in 2013 and 2014 as health insurance transitioned to ACA-compliant plans.

Rate review is not a mechanical function. Each insurance company develops its rates differently. The division's review team looks for reasonableness in the filings and checks the assumptions companies make. In the past two years, rate reviews have resulted in changes to nearly every ACA-compliant plan.

In the past two years, rate reviews have resulted in changes to nearly every ACA-compliant proposal.

During our review staff was able to describe the rate review process for the prior year and plans for the current year. However, we noted that the division does not have written policies and procedures for rate review, which would make its process more consistent and transparent. The division has recently begun work to develop written policies and procedures.

National Reforms Change Rate Review

Health care has historically been regulated at the state level. The Affordable Care Act, passed in March 2010, gave the federal government a role in private health insurance rate review, and began changing rates and the rate review process. Most of the ACA's rate review provisions were implemented in 2010 and 2011. Federal regulation outlined elements for effective rate review and the US Department of Health and Human Services (HHS) evaluated the effectiveness of state rate review programs. HHS deemed Oregon to have an effective rate review program.

The cost of insurance premiums is mostly comprised of the actual cost of care and services provided. The ACA set a standard to ensure premium dollars are spent on actual medical care. Beginning in 2011, insurers must spend at least 80% of premium dollars on clinical care and quality improvements. No more than 20% can be spent on administration, advertising, and profit. If an insurer spends less than the required 80% on clinical care, cost containment and quality improvement efforts, the company must rebate policy holders the difference. The division reports that Oregon's largest insurers generally spend more than is required. On average, the largest companies spent 90 cents of every premium dollar on medical costs between 2007 and 2012.

Insurers must spend at least 80% of premium dollars on clinical care and quality improvements.

The ACA reforms also require that individual or small group rates above an applicable threshold must be reviewed. Insurers must publicly disclose and justify rate increases. Rate increases are

reviewed for reasonableness by states, or by the federal government if the state does not have an effective rate review program. Oregon reviews all rate changes and publishes the rate documentation on the division's website.

The federal government and/or states established insurance exchanges to sell individual and small group insurance plans. These marketplaces also link qualified consumers to tax credits to help pay for insurance coverage. All companies selling insurance on or off the exchange are required to sell a standard "bronze" and "silver" plan so consumers can compare costs across companies. On average, a bronze plan is estimated to pay for 60% of normally expected medical costs and a silver plan is estimated to pay for 70% of normally expected medical costs.

The ACA reforms included grant funding for states to transform rate review processes and increase transparency. Oregon was awarded grants in each of three grant cycles, totaling $8.6 million. These grants were generally used to improve the rate review process, hire staff, increase transparency and consumer advocacy, and enhance data.

Notable Features of Oregon's Rate Review

There is no template for rate review and state law and rate review processes vary across the country. However, Oregon's laws and rate review process include some desired features. These are described below.

Prior approval authority

The division has "prior approval authority" over individual and small group plans for all types of carriers, meaning the division must approve an insurer's rate before it can be marketed to consumers. This makes the state better positioned to negotiate reductions in rates. Not all states have this authority.

Transparency

The division has made robust efforts to be transparent, including providing the public access to rate filing information and avenues for public comment. Specific details on these efforts include:

- The division maintains a consumer-oriented website, http://www.oregonhealthrates.org/, devoted to rate review. All new, recent, and historical rate decisions and documentation can be found on the site. The documentation includes the correspondence between the division and the insurance company. The information for requested rates is

available online during the rate review process so the public can access the information and provide comments before a decision is made. The website also includes basic information on the rate review process and information on grant funding.

- The division has public education reports on health insurance in Oregon and consumer guides to health insurance and health insurance rate review, which go into more detail about many topics. It also publishes consumer friendly charts depicting rates.
- Rate review hearings are public. The hearings are also streamed online for those who are unable to attend in person.
- The public can sign up to receive email notifications from the division about rate filings for their particular insurance company, or other companies, and a variety of other insurance topics.

Actuarial staff

States vary in their staffing and actuarial resources for rate review. Oregon has three health actuaries on staff to review and question company assumptions on behalf of the public.

Oregon has 3 health actuaries on staff to review and question company assumptions on behalf of the public.

Consumer advocacy

ACA grant funding allowed the Insurance division to contract with Oregon State Public Interest Research Group (OSPIRG) to provide consumer advocacy during the rate review process. OSPIRG does not review every rate. It reviews a selection of the rates in consultation with an independent actuary, and provides comments during the rate review hearings on behalf of the public. It is unclear if there will be further funding for this work after September 2015.

Recent Rate Review Results

In the past two years, nearly every rate request in Oregon was changed as a result of rate review. Most rate requests were decreased while others were increased. On average, the overall effect of these changes was a reduction in the requested rates for the individual and small group markets. Figure 1 shows the 2014 and 2015 rates. The prices displayed are the estimated monthly rate for a Silver Plan for a 40-year-old Portland resident. Actual premiums may vary based on whether you use tobacco, where you live, your age, and the specific plan you choose.

Figure 1: ACA-complaint Individual and Small Group Monthly Rates

	2014			2015		
Individual	**Requested**	**Approved**	**Change**	**Requested**	**Approved**	**Change**
LifeWise Health Plan of OR	$ 252	$ 248	-1.6%	$ 216	$ 222	2.8%
Oregon's Health CO-OP	$ 278	$ 271	-2.5%	$ 202	$ 230	13.9%
Providence Health Plan	$ 342	$ 272	-20.5%	$ 227	$ 233	2.6%
Health Net Health Plan of OR	$ 221	$ 215	-2.7%	$ 233	$ 234	-16.1%
Moda Health Plan, Inc.	$ 225	$ 221	-1.8%	$ 249	$ 245	-1.6%
Atrio Health Plans[1]	$ 371	$ 293	-21.0%	$ 259	$ 245	20.7%
Kaiser Foundation Health Plan	$ 291	$ 256	-12.0%	$ 257	$ 246	-4.3%
Health Republic Ins Co	$ 299	$ 256	-14.4%	$ 231	$ 251	8.7%
Regence BlueCross BlueShield	$ 280	$ 270	-3.6%	$ 263	$ 259	-1.5%
PacificSource Health Plans	$ 257	$ 252	-1.9%	$ 290	$ 261	-10.0%
BridgeSpan Health Company	$ 288	$ 278	-3.5%	$ 270	$ 266	-1.5%
Time Insurance Co	$ 251	$ 351	0.0%	$ 318	$ 273	-14.2%
Trillium Community Health Plan, Inc	$ 486	$ 329	-32.3%	$ 352	$ 290	-17.6%

	2014			2015		
Small Group	**Requested**	**Approved**	**Change**	**Requested**	**Approved**	
LifeWise Health Plan of OR	$ 292	$ 289	-1.0%	$ 291	$ 286	-1.7%
Oregon's Health CO-OP	$ 338	$ 335	-0.9%	$ 287	$ 290	1.0%
Health Republic Ins Co	$ 298	$ 269	-9.7%	$ 294	$ 297	1.0%
Trillium Community Health Plan, Inc	$ 401	$ 381	-5.0%	$ 361	$ 298	-17.5%
Providence Health Plan	$ 375	$ 331	-11.7%	$ 278	$ 299	7.6%
Regence BlueCross BlueShield	$ 316	$ 310	-1.9%	$ 307	$ 302	-1.6%
Samaritan Health Plans, Inc[2]	$ 518	$ 346	-33.2%	$ 308	$ 302	-1.9%
PacificSource Health Plans[2]	$ 358	$ 358	0.0%	$ 319	$ 308	-3.4%
Health Net Health Plan of OR	$ 301	$ 297	-1.3%	$ 318	$ 310	-2.5%
Kaiser Foundation Health Plan	$ 299	$ 293	-2.0%	$ 311	$ 315	1.3%
Moda Health Plan, Inc.	$ 306	$ 306	0.0%	$ 340	$ 333	-2.1%
Atrio Health Plans[1]	$ 368	$ 360	-2.2%	$ 345	$ 339	-1.7%
UnitedHealthcare of OR, Inc	$ 340	$ 323	-5.0%	$ 364	$ 356	-2.2%
UnitedHealthcare Ins Co	$ 348	$ 330	-5.2%	$ 372	$ 363	-2.4%

[1] Estimate is for Salem area
[2] Estimate is for Eugene area

Health insurance premiums continue to increase, but the increase has slowed in recent years. Figure 2 shows the average annual increase in Oregon rates declining in the years since the ACA reforms were enacted. There is no data for 2014 because it is the first year of ACA rates and the rates are not comparable to prior years.

Figure 2: Average Annual Rate Increase by Market, 2008 to 2015

Year	Individual Increase	Small Group Increase
2008	21.34%	13.44%
2009	14.92%	10.47%
2010	15.57%	11.68%
2011	9.05%	6.63%
2012	7.00%	4.13%
2013	7.19%	5.87%
2014	-	-
2015*	5.70%	2.80%

Source: Oregon Insurance Division
* ACA-compliant plans only; does not include "grandfathered" or "transitional" plans

Consumers will likely see a market with more similar prices as a result of rate review. The range of prices shrank in the past two years making prices more competitive across the market. Figure 3 illustrates the range of rates requested and approved for a 40 year old on a silver plan living in the Portland area. The range of requested rates was larger for 2014, the first year of ACA-compliant rates, and shrank considerably in the second year.

Figure 3: Range of Approved Rates by Market and Year

The new health exchange allows consumers to compare rates across insurance companies. It is too early to tell how this will affect consumer choices or the competitiveness of the market in

the long run. In the initial year of the exchange, the individual market had more dramatic changes than the small group market. Individual enrollment increased from the prior year. Most consumers chose the lowest cost individual ACA-compliant plan. One company, Moda, captured the largest share of consumers who changed providers or enrolled for the first time. It more than tripled its individual plan enrollment and captured over 50% of the individual market. The individual and small group market enrollment is shown in Figures 4 and 6. These figures include enrollment in both ACA and non-ACA compliant plans and are based on preliminary data provided by the companies.

The individual market in 2014 looked less competitive and more concentrated than the prior year. The number of companies with more than 5% market share decreased and the largest market share held by a company increased from 29% to 54%. Figure 5 provides basic information on the individual and small group markets.

Figure 4: Individual Enrollment as of June 30, 2014

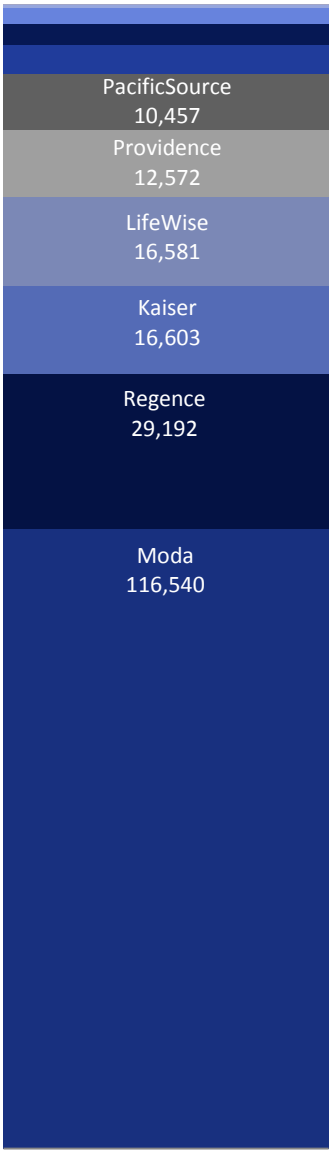


Figure 5: Market Information as of June 30, 2014

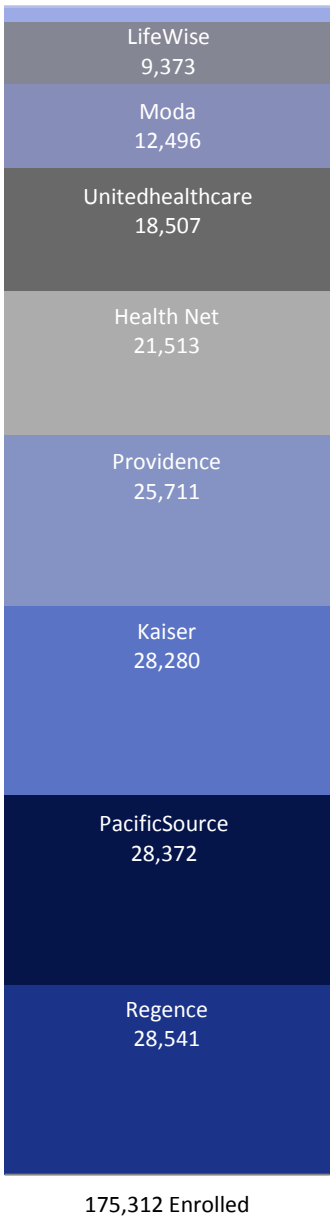
	Individual	Small Group
Enrollment as of Prior Year	151,189	193,961
Enrollment	216,662	175,312
Number of Companies	13	14
Number of Companies over 5% Market Share	5	8
% Market Share of Largest Company	54%	16%
% Enrolled in ACA Plans	74%	14%
Market Concentration as of Prior Year	Moderate	Moderate
Market Concentration	Highly	Unconcentrated

There were less dramatic shifts in the small group market. Small group enrollment decreased. Overall, the market became less concentrated and looked more competitive, with 8 companies obtaining 5-16% of the market share each. While most of the individual market (74%) is enrolled in ACA-compliant plans, only 14% of the small group market has switched to ACA plans. There could be additional shifts in the market as members move to ACA compliant plans in the future.

Surplus Regulation

The division has authority to consider a company's surplus as it reviews rates and can raise or lower requested rates based on surplus.

Figure 6: Small Group Enrollment as of June 30, 21014



A company's surplus can be derived from many insurance plans and is a cushion for its entire business, not just related to the rates approved by the division. Surplus is comprised of profits accumulated by the insurer as well as capital received from issuing stock, and can be used at the company's discretion. In general, surplus is used to fund new technology and infrastructure projects, and cover unexpected costs, losses or enrollment.

Regulators want to see a sufficient surplus to ensure the company can continue to operate and pay claims in the event of unexpected losses or increased costs. Surplus funds can benefit the consumer by reducing sharp price fluctuations year to year.

The predicted profit margin for a rate can indicate whether a rate may increase or decrease surplus funds and the extent of its impact. Rates that are kept artificially low by relying on surplus funds could lead to sharp fluctuations in the future. There is currently no state or national standards defining excessive, or even sufficient, levels of surplus. The majority of health insurance companies maintain a surplus that represents 2-4 months worth of operating expenses. Surplus is an element considered by financial regulators as they perform ongoing monitoring and by actuaries and analysts reviewing rates. Regulators check to see that there are minimum levels of surplus and Risk Based Capital (RBC) in place. Surplus that is less than 10% of yearly premiums requires additional scrutiny or review.

Risk Based Capital is a national formula for measuring the minimum amount of capital a company should hold given the risk involved in the company's business. Regulatory action is triggered when RBC levels drop to certain levels. The minimum levels function as an early warning system so that regulators and the company can take action and remedy issues before a company becomes insolvent. These actions can range from monitoring the company and setting a plan of action, to liquidating a company. RBC levels vary across Oregon companies.

Scope of Work

We limited our work to general review of the division's health insurance rate review process and insurance regulation, as we did not identify a topic that warranted a full audit.

We gathered information on the federal Affordable Care Act and its impacts on health care and state health insurance rate review, as well as Oregon's health reform efforts. We researched health insurance rate review practices and financial regulation.

We interviewed Insurance Division managers, staff, external stakeholders, and officials from other states. We obtained rate filings and observed rate review hearings. We also reviewed national financial regulation and actuarial practice standards, reports on health reforms, and laws and rules at the state and national level.

We focused our work on health insurance rate review processes and did not cover other lines of insurance, such as property and casualty or life insurance. We also did not review specific rate decisions or perform financial or actuarial analysis to evaluate the appropriateness of rate decisions or the financial position of insurance companies.

Because we limited our work to a general review and did not proceed with a full audit, we were not required to and did not follow generally accepted government auditing standards. Had we found a topic warranting an audit, the work would have been conducted to meet those standards.

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State, Kate Brown, shall be, by virtue of her office, Auditor of Public Accounts. The Audits Division, under the direction of Gary Blackmer, exists to carry out this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division audits all state officers, agencies, boards, and commissions and oversees audits and financial reporting for local governments.

Audit Team

Will Garber, CGFM, MPA, Deputy Director

Sheronne Blasi, MPA, Audit Manager

Amelia Eveland, MBA, Senior Auditor

Roy Jackson, Staff Auditor

This report, a public record, is intended to promote the best possible management of public resources. Copies may be obtained from:

website: sos.oregon.gov/audits

phone: 503-986-2255

mail: Oregon Audits Division
255 Capitol Street NE, Suite 500
Salem, Oregon 97310

The courtesies and cooperation extended by officials and employees of the Oregon Insurance Division during the course of this audit were commendable and sincerely appreciated.

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Director's Office
350 Winter Street NE, Room 200
Salem, OR 97301-3878
Voice: 503-378-4100
Fax: 503-378-6444
dcbs.oregon.gov

November 25, 2014

The Honorable Kate Brown
Secretary of State
Oregon Audits Division
255 Capitol Street NE, Suite 500
Salem, OR 97310

RE: Response to Management Review, Report Number 2014-2x

Dear Secretary Brown:

Thank you and your performance audit team for evaluating the Insurance Division's rate review program. We appreciate the diligence, professionalism, and thoroughness of the process and your team's dedication to learning about a complex and important consumer protection function.

As your report suggests, Oregon's rate review process is incredibly important to consumers and their families. More than 390,000 Oregonians rely upon health insurance sold in the markets regulated by rate review. As you also note in your report:

- Insurance regulation and rate review work hand in hand to achieve a financially sound and competitive insurance market, promote affordability, and ensure fair treatment of consumers.

- In the past two years, nearly every rate request in Oregon was changed as a result of Oregon's rate review process, and most requests were decreased. Oregon's 2015 approved rates for individuals increased at a rate of 5.7% as compared to an average annual increase of 14% for states in the federally-facilitated marketplace. In fact, Oregon's average individual and small group health insurance premiums were lower in 2015 than in 2014.

- Oregon has an unusually competitive and robust market, which includes 16 companies selling health insurance in the individual and small group markets.

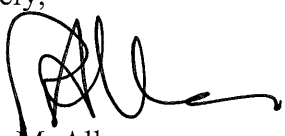
- The cost of insurance premiums is mostly comprised of the actual cost of care and services provided. The Affordable Care Act (ACA) set a standard to ensure premium dollars are spent on actual medical care. Beginning in 2011, insurers must spend at least 80 percent of premium dollars on care and quality improvements. On average, Oregon's largest companies spent 90 cents of every premium dollar on medical costs between 2007 and 2012. Oregon's review process helps ensures insurers meet this requirement.

- Oregon's rate review laws and process contain some desired features not required by federal law or always found in other states. Those attributes include: prior approval authority of rates before products are marketed to Oregonians, complete process transparency so that any Oregonian can follow a rate from filing to approval in real time, a well-resourced and qualified staff as well as a partnership with the Oregon State Public Interest Research Group (OSPIRG) to provide an additional layer of consumer advocacy during the rate review process.

Your report also recommends that our office prepare process and procedure manuals to document the methodology behind the rate review program. We believe this is an excellent suggestion and have begun developing formalized documentation of procedures.

Again, thank you for your efforts in evaluating this important program. We are pleased that your findings are consistent with the consumer protection goals we strive to accomplish.

Sincerely,



Patrick M. Allen
Director