# Health Insurance Rate Review Grant Program
## Cycle 1, Quarter 1 Report

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| **Submission Date:** | February 28, 2011 |
| **State:** | Oregon |
| **Project Title:** | 2010 Grants to States for Health Insurance Premium Review—Cycle 1 |
| **Project Quarter Reporting Period:** | 08/09/2010-12/31/2010 |
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## Introduction:

Oregon is using its federal grant funds to build on 2009 legislation and subsequent rulemaking that brought additional transparency and stronger standards to our rate review process. The department set two key goals for grant funds:

- Subject rate filing actuarial data to additional scrutiny and examine ways to use rate review to lower medical claims costs.
- Work to give consumers a better understanding of the costs of medical care and how premium dollars are spent.

To advance these goals, we identified five major grant objectives:

1. Expand the rate review process to include the review of unreasonable large group rates, as well as collect new data on the large group market. This objective is on hold, pending additional federal guidance on how large group rate increases are to be considered by both state and federal regulators.
2. Work with stakeholder groups to determine how rate filings should detail medical and pharmaceutical claims costs and how this information should be part of our rate review website.
3. Bolster consumer input by using grant funds to contract with a consumer advocacy organization to regularly provide meaningful comments on rate filings and to create a long-term strategy to increase consumer input.
4. Explore opportunities in the rate review process to affect health care cost containment or health care delivery system improvement, using grant funds to contract with a consulting firm to work with the department to conduct this study.
5. Improve the rate review page of our website to make it easier for consumers to find, understand, and use the myriad of data available on rate requests, our rate decisions, and the medical costs underlying health insurance rates.

To carry out the increased workload, we proposed and since hired the following four employees:

1. An *actuary* to review all filings, performing a second tier of review, paying special attention to rate filing impact on all policyholders.
2. A *project coordinator* to expand plain language decision summaries, organize grant reports, and coordinate responses to all inquiries and requests for rate filing information.
3. A *market analyst* to assist the actuaries in determining the accuracy of information provided in the rate filings.
4. A *rate filing intake coordinator* to improve actuarial efficiency by ensuring the all rate filings at intake are in compliance with required regulations.

**Program Implementation Status as of December 31, 2010**

| Objectives | Milestones & Progress | Challenges, Responses & Variations |
|---|---|---|
| 1. Expand the scope of rate review to include the review of unreasonable large group rates, as well as collect new data on the large group market. | This item is on hold pending additional federal guidance on how unreasonable large group rates will be reviewed. | |
| 2. Expand our current rate filing requirements to detail claims costs.<br><br>• Improve rate filing requirements by working with stakeholder groups to develop administrative rules and exhibits to better detail medical and pharmaceutical claims costs (medical loss ratio).<br><br>• Create systems enhancements to display medical loss ratio as part of our website's rate review page. | We formed an advisory group, seeking representatives of all stakeholders. Two meetings have been held including participants representing the top 7 insurers in Oregon, Archimedes (a "grassroots" health care advocacy group), OSPIRG (a consumer advocacy group), and the Oregon Health Policy & Research office.<br><br>Pending finalization of data to be collected regarding medical claims costs. | Positions responsible: add Gayle Woods, Operation Manager<br><br>Getting sufficient stakeholder participation has been a challenge. We are actively seeking input to assist us in developing reporting tools that are meaningful to consumers. |
| 3. Bolster consumer input in the rate review process.<br><br>• The department will support a consumer advocacy group to provide regular public comments for rate filings. | We issued a Request for Proposal and selected Oregon State Public Interest Research Group (OSPIRG) —a 40-year old nonprofit consumer advocacy group, which began work 11/16/2010. See *Public* | |

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| • Create a long-term strategy to increase consumer input in the rate review process. | *Access Activities* section of this Narrative Report. | |
| 4. Engage a consulting firm to conduct a study to explore opportunities within the rate review process to affect medical cost trends, improve the delivery system and control the growth of health care costs.<br><br>Track progress and assist the consulting firm. | As of December 31, 2010, we issued a Request for Proposal for this study. | Contract awarded February 2011.<br><br>Positions responsible: add Gayle Woods, Operations Manager, & D'Anne Gilmore, Project Coordinator |
| 5. Develop and implement changes to our rate review systems capacity, with focus on transparency and efficiency enhancements. | | Positions responsible: add D'Anne Gilmore, Project Coordinator & Cheryl Martinis, Public Information Officer |
| • Link Oregon Insurance Division website with the new Federal portal. | Completed in January 2011. | |
| • Create systems enhancements to put some information into exportable fields for consumers. | | |
| • Create new systems for future data collection efforts, work on automation of complete SERFF downloads & other systems enhancements. | Initial meeting with department's Information Management Division has been held and project is underway. | |

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| 6. Hire an *actuary* within six months of receiving grant funds to review all filings, performing a second tier of review, paying special attention to rate filing impact on the entire block of business. | As of December 31, 2010, recruitment process under way. | New actuary started on January 31, 2011. |
| 7. Hire a *project coordinator* within three months of receiving grant funds to expand plain language decision summaries, organize grant reports, and coordinate responses to all inquiries and requests for rate filing information. | As of December 31, 2010 an offer was extended. | Project coordinator started on January 18, 2011. |
| 8. Hire a *market analyst* within three months of receiving grant funds to assist the actuaries in determining the accuracy of information provided in the rate filings. | Hired; began December 1, 2010 | |
| 9. Hire a *rate filing intake coordinator* within three months of receiving grant funds to improve actuarial efficiency by ensuring the all rate filings at intake are in compliance with required regulations. | Hired; began November 1, 2010 | |

## Significant Activities: Undertaken and Planned

Oregon's process for reviewing small employer, individual and portability health insurance rates is one of the most aggressive in the country. However, until we focus on the costs of health care itself, even the most transparent and detailed rate review process will fail to make insurance significantly more affordable for businesses and individuals. Thus, we plan to build on improvements we have already made in conducting rigorous and transparent rate reviews while looking for ways to use rate review to tackle medical claims costs.

**Oregon's rate review authority**

Thanks to legislation in 2007 and 2009, we have the legal authority we need to conduct rigorous and transparent rate reviews. Rates are submitted for prior approval before the policies are initially introduced in the Oregon market and on an annual basis thereafter, even if no increase or decrease is requested. Rates cannot be increased more often than annually for any given policyholder. We do not review or regulate rates in the large group health insurance market.

Rate filings in the markets we regulate are public and posted on our website. There is a 30-day public comment period on all rate requests and we explain each and every rate decision we make and post this on our website, as well. We plan to continue to improve the decision summaries that we generate for consumers.

We have broad authority to ensure rates are reasonable. Today, Oregon's rate review statutes require the department to ensure that the proposed rates are reasonable and not excessive, inadequate, or unfairly discriminatory. To assist in making this determination, the department has explicit authority to consider factors such as an insurer's investment income, surplus, and cost containment and quality improvement efforts. The department now considers an insurer's overall profitability rather than just the profitability of a particular line of insurance. Companies must also separately report and justify changes in administrative expenses by line of business and must provide more detail about what they spend on salaries, commissions, marketing, advertising, and other administrative expenses. We believe these improvements to our rate review process give the department the clear authority it needs to protect consumers from excessive rate increases and provide additional transparency around our rate review process.

We plan to provide consumers with additional information on how their premium dollar is used. In Oregon, 91 cents of every premium dollar (85 cents in the small group and individual markets) goes to pay medical claims costs. We are expanding our current rate filing requirements to include detailed information about medical claims costs and this information will be posted to our website so consumers can learn how increasing costs of health care impact their premiums.

Meanwhile, Oregon's competitive health insurance market helps mitigate unreasonable rate increases but also makes it harder for insurers to negotiate prices in the less competitive provider markets outside the Portland urban area. This offers an opportunity to look at how we might use rate review to influence the insurer-provider contracting process to benefit consumers.

Seven Oregon-based insurers, many of them non-profits, account for 92 percent of the Oregon health insurance market, and no single carrier garners more than 28 percent of the market in

Oregon. This is in contrast to a number of other states where a single carrier dominates the market.

Prior to the end of the Cycle 1 grant we should have a draft report from L&E Actuaries & Consultants of Dallas, Texas, the grant-funded consultants, on possible ways to use rate review to reduce health care costs. This study, for example, might explore such issues as whether Oregon should require insurers to spend a minimum amount on primary care or reject proposed rate increases if certain provider costs go up by more than a certain percentage each year.

## Operational/Policy Developments/Issues

During C1-Q1 (August 8, 2010 through December 31, 2010) we were continuing to implement Oregon health reforms (HB 2009), which passed during the 2009 Legislative session, in concert with Affordable Care Act reforms.

HB 2009 makes a variety of reforms to Oregon's health care system to contain costs and improve quality. A major component of the bill, effective April 1, 2010, strengthened insurance rate review by:

- Adding a public comment period.
- Requiring more detail about insurer administrative expenses.
- Allowing consideration of an insurance company's cost containment and quality improvement efforts.
- Giving DCBS more ability to consider an insurer's overall profitability, investment earnings, and surplus in determining whether to approve a rate request.

Implementing these federal and state reforms concurrently requires that we take an evolving approach to enhanced rate review, as we identify the best processes for conducting reviews, as well as communicating the filings and decisions with the public. The grant-supported activities are intended to help expedite this development.

The department's expanded scope of rate review authority has increased the amount of time we need to evaluate a rate filing. Here are some of the reasons:

- We are asking more questions and requiring a greater level of detail regarding insurers' administrative expenses, cost containment and quality improvement efforts, and surplus.
- We are more closely reviewing filings when submitted to ensure all required information is included with the initial rate filing. It is extremely important that complete and valid data be included with the original filing since this documentation is posted to the web for public comment. Educating insurers on how to prepare and submit a rate filing that complies with our new administrative rules has been challenging.
- Another step has been added to our process with the contract awarded to OSPIRG for performing comprehensive reviews of selected rate filings. We carefully consider OSPIRG's comments and post a department response to the OSPIRG remarks when a decision has been made on a filing.

- We are experiencing new delays in our decision-making process for rate review as a result of our attempt to provide better information to the public. We spend a significant amount of time gathering the most pertinent information on a rate filing so we can provide meaningful information to consumers in our rate filing decision summaries. Drafting these summaries is a time-consuming process since converting elements of the complex rate review process to a consumer-friendly document is not easy. Increasing public demand for more information about companies and their rates has caused these summaries to grow in length from one page to four-page documents and the amount of time needed to prepare the summaries has also increased with the level of information provided.

OSPIRG's comments received on the first filing reviewed by this consumer advocacy group included a significant section on affordability of rates. The department considers the impact on consumers when reviewing rates but must also consider a company's ability to pay claims. For example, if a company is losing money in one line of insurance but is profitable overall, the department might approve a smaller increase than the company needs to cover costs, to lessen the burden on consumers. However, rates ultimately must be sufficient to cover medical claims costs and the reasonable costs of operating the insurance company. As medical claims rise, so do insurance rates. We appreciate public concerns about affordability of health insurance; however this approach to reviewing rate requests doesn't consider one of the key factors we are required to evaluate: whether premiums are appropriate for the level of benefits provided. The underlying cost of the benefit is the foundation for the premium charged. One way insurers today are addressing the affordability concern is through modification of benefit design where consumers pay a larger share of the claims cost. We are concerned about continued affordability of health insurance and with our rate review grant we've contracted to have a study done to learn how the rate review process can be used to reduce claims costs

## Public Access Activities

In recent years, amid annual double-digit increases in rates, Oregon policymakers and insurance regulators increased public access to rate filings and armed regulators with additional tools to curb rate increases in the rate-regulated markets.

The Oregon Department of Consumer and Business Services, through its Insurance Division, must approve rates for individual, small group, and portability health insurance before they can be used in this state. About 12 percent of Oregonians hold these types of policies. The department does not review or regulate rates in the large group health insurance market.

The 2007 Legislature made rate filings public and required the department to post the filings on its website. In 2009, as part of a major bill on health care reform, the Legislature added a 30-day public comment period for every rate request.

Key features of Oregon's transparent rate review process include:

- The department posts rate filings for individual, portability, and small employer plans on its website. All information submitted as part of an insurance company's rate request is posted. No portion of the rate filing submitted is kept confidential.
- A required feature of the filing is a plain language summary highlighting the insurer's request and its five-year history of rate increases for that line of insurance.
- Consumers can sign up on the Oregon Insurance Division website to be notified when an insurer files a rate request and when the division makes a decision in a case.
- Once the entire filing is posted, a 30-day public comment period begins and all comments received are also posted to the website.
- With funding from the Cycle 1 rate review grant, the department contracted with a consumer advocacy group, Oregon State Public Interest Research Group (OSPIRG), to analyze significant health benefit plan rate requests and to comment on the filings selected for review. OSPIRG's comments are posted to the department's website within the 30-day public comment period and are a part of the documentation considered during the department's rate review.
- Because every rate change has its own story, the department develops and posts on the website a plain language summary describing key factors underlying each rate filing decision. Over time, the content of the summaries has changed in response to public feedback. For example, the rate filing decision summaries now posted by the department may also include information about an insurer's administrative expenses, quality and cost-containment initiatives, and the amount the cost of highly paid executives' salaries adds to a consumer's monthly premium. We expect to continue to develop these summaries to provide the best possible information to consumers.

OSPIRG began work under this grant-funded contract on Nov.16, 2010. During this quarter OSPIRG:

- established its program to offer comments as well as expand the number of consumers involved in the process;
- developed the methodology for tracking and determining significant rate filings;
- contracted with an actuary to review filings and advise them;
- tested their methodology and "rate alert" process to consumers, coalition partners, businesses and others; and
- provided detailed comments on one significant rate filing. A second set of comments was submitted in the grant's second quarter.

(See the *Enclosures/Attachments* Section of this report for OSPIRG's first rate filing comments and our response, both available on our website.)

While the department believes these are significant changes, we note that efforts to make insurance more accessible and affordable will not succeed unless health care costs are brought under control. Because many people find it difficult to understand what drives health insurance costs and why insurance regulators nationwide approve double-digit rate increases, we emphasize transparency in our strengthened rate review process. We are expanding our current rate filing requirements to include detailed information about medical claims costs and this

information will be posted to our website so consumers can see how their premium dollars are being spent for medical care.

## Collaborative efforts

The grant is furthering our efforts to reach out to a variety of stakeholders in multiple ways. In addition to ensuring consumer comment on the key issues involved in rate review, the grant is funding a consultant that will meet with a variety of stakeholders, including insurance companies and consumer advocacy organizations, to find ways we can use rate review to get at the medical costs that drive health insurance rates.

In Oregon, our governor, a separate state agency charged with health care reform in this state, and insurance regulators understand that controlling health care costs is key to making health insurance more affordable for businesses and individual consumers. We anticipate that our study will produce ideas that we can take to Oregon legislators.

**Consumer comment**
OSPIRG (Oregon State Public Interest Research Group), the consumer advocacy group selected to analyze our significant health benefit plan rate filings, began work under this grant-funded contract on Nov. 16, 2010. Over the past quarter, OSPIRG has established weekly conference calls, sought additional organizations for its advisory committee, worked on a webpage for its rate review project, and drafted materials for consumer outreach. OSPIRG sends "Rate Alert" e-mails to its advisory committee and to consumers, coalition partners, businesses, and others. This e-mail encourages participants to read the rate filing and submit comments. OSPIRG also sends a "Rate Alert" to its network of stakeholders with a link to each comment OSPIRG submits to the department regarding a rate filing. OSPIRG has now submitted detailed comments on two key rate filings.

**Medical costs study**
The department realizes that even the most open and detailed rate review process will fail to make insurance significantly more affordable for businesses and individuals unless we focus on the costs of health care itself.

Toward that end, the department recently selected L&E Actuaries & Consultants of Dallas, Texas, to perform a study on possible ways to use rate review to lower premium costs by addressing the underlying costs of health care. Historically, rate review processes have focused on medical trend (annual increase in claims costs), administrative expenses and proposed net income (profit). Agency actuaries review an insurer's assumptions in each of these categories to determine whether proposed increases are justified. Typically, after ensuring that medical cost trends are supported by claims data, insurance regulators do not drill further into the key factors affecting medical costs. One reason is that trend is based largely on negotiated contracts between insurers and providers.

However, given Oregon's unique and competitive market, we are interested in ways we might be able to influence the insurer-provider contracting process to benefit consumers. This study, for example, might explore such issues as whether Oregon should require insurers to spend a minimum amount on primary care or reject proposed rate increases if certain provider costs go up by more than a certain percentage each year.

In conducting this study of the factors driving medical trends (unit costs, use and long-term prevention), the contractor will engage insurance carriers and consumer advocacy groups, nationally and locally, as well as survey other state regulators.

Finally, in an effort to better educate consumers about how their premium dollars are spent, the department is working with an advisory committee of stakeholders to discuss rules that will require insurers to disclose more information on medical claims. The committee, which has met twice, will also advise us on how to display this information on our website. We are working to involve more consumer representatives in this process.

## Lessons Learned

Inviting consumers to participate in highly technical health insurance rate reviews poses challenges ranging from soliciting comments relevant to the factors the department uses to make decisions to translating actuarial terms into plain language.

Affordability is the key issue for the vast majority of citizens who provide comments to the department on rate requests. It is also a factor that OSPIRG, the consumer group the department funds to offer rate review comment, raises in its reviews.

While the department considers the impact on consumers when reviewing rates, it must balance that against a company's ability to pay claims. For example, if a company is losing money in one line of insurance but is profitable overall, the department might approve a smaller increase than the company needs to cover costs, to lessen the burden on consumers.

However, rates ultimately must be sufficient to cover medical claims costs and the reasonable costs of operating the insurance company. As medical claims rise, so do insurance rates. The underlying cost of the benefit is the foundation for the premium charged. This is a difficult concept to convey to people who struggle to afford health insurance and is a reason we are focusing on ways we might use rate review to get at medical costs.

Overall, as Oregon's process has become more transparent and seeks to involve more consumers, the expectation is that rates will be lowered significantly. Yet, because insurance rates largely reflect health care costs, this expectation is not met.

**Additional challenges**

Standardized filings: Achieving standardized rate filing documents has been time-consuming and requires significant follow up with insurers. Oregon rules mandate that each of the required documents use the same title and include specified content. The goal is to make rate filings easier to understand for both regulators and consumers because each insurer files the same information in the same format for each rate filing.

Decision summaries: The department provides a plain-language explanation of every rate decision it makes. However, translating complex actuarial terms into plain language that is accurate, concise, and easy to understand is a challenge. Although this is not an easy process, the time invested in developing summaries that explain the reason for approved rates has been worthwhile. As each rate filing is completed, the summaries prepared by the department continue to evolve. The summaries are designed to furnish consumers with a clear understanding of the reason for the rate change and the impact the new rate will have on both the insurer and consumers. These documents have become useful tools for department staff as well as the public.

Seeking additional claims cost data: Our efforts to work with stakeholder groups to develop exhibits to better detail medical and pharmaceutical claims costs have proven to be surprisingly difficult. We continue to meet with an advisory committee to determine the type of information that would be meaningful for consumers and that is also readily available from insurers. We've had two meetings with the stakeholder groups and are now reaching out to carriers and consumer groups on another level in order to collect information that will assist us in developing the related administrative rules. We believe that transparency of these costs should help educate consumers on the direct impact health care costs have on their insurance premiums.

## Enclosures/Attachments

To illustrate the use of OSPIRG, the consumer advocacy contractor, in commenting on rate filings, please see these attachments, which are posted on our rate filing web page:

- OSPIRG analysis *Rate Review Comment, United HealthCare Insurance Company filing GH 0393 10, December 16, 2010*.
- Oregon Insurance Division's *Rate Filing Decision Summary, United Healthcare Insurance Company, Small Employer Health Insurance, February 16, 2011*

Because most of the functionality in SERFF was not available until mid-December 2010, we generated *Rate Review Volume/Market Data; Cycle 1, Qtr 1; Tables B-C*, which is included as an attachment here.

## Rate Review Volume/Market Data
**Quarter 1, Cycle 1**
**Table A**

This report was generated from data uploaded directly from SERFF (System for Electronic Rate and Form Filing, operated by the National Association of Insurance Commissioners) to the federal Health and Human Services reporting system.

It covers the period from August 9, 2010 to December 31, 2010 and is generated from the same filings as what is summarized in Tables B and C on the following page.

| TABLE A: Quarterly Reporting Summary | |
|---|---|
| Number of Submitted Rate Filings | 31 |
| Number of Policy Rate Filing Requesting Increase in Premiums | 27 |
| Number of Filings Reviewed for Approval/Denial, etc. | 17 |
| Number of Filings Approved | 11 |
| Number of Filings Denied | 0 |
| Number of Filings Deferred | 6 |

## Rate Review Volume/Market Data

## Tables B-C

**Cycle 1, Qtr 1**

Table A is in the HIOS Report generated by the SERFF upload.

Because most of the functionality in SERFF was not available until 12/16/10 and post-submission updates were not requested from filers, other data (e.g., number of policy holders) are not included in Cycle 1, Qtr 1 report. We anticipate Qtr 2 will include these additional displays.

Tables D&E are not included, as the Large Market component of the grant has not been implemented.

| Table B: Individual Market | |
|---|---|
| Product Type | H161.005A PPO |
| Number of Covered Lives | 95,475 |
| Product Type | H161.005C Other |
| Number of Covered Lives | 19,537 |
| Product Type | H06 Health Conversion |
| Number of Covered Lives | 14,341 |

| Table C: Small Group Market | |
|---|---|
| Product Type | H16G.003A Small Group Only - PPO |
| Number of Covered Lives | 67,322 |
| Product Type | H16G.003B Small Group Only - PPO |
| Number of Covered Lives | 6,235 |
| Product Type | H16G.003B Small Group Only - Other |
| Number of Covered Lives | 135,623 |

# HIPR Budget & Expenditure Report

## Section B - By Grant Program Function or Activity Report

Cycle 1, Quarter 1 09/09/10-12/31/10

| | |
|---|---|
| REGION: | X |
| STATE: | OREGON |
| NUMBER | 1 IPRPR100057-01-00 |
| BEGINNING DATE | 8/9/2010 |
| ENDING DATE | 9/30/2011 |

| | Activity 1 Objectives 1, 6, 8 & 9 | | Activity 2 Objectives 2, 7 & 8 | | Activity 3 Objective 3 | | Activity 4 Objective 4 | | Activity 5 Objective 5 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Object Class Categories | BUDGETED | SPENT THIS PERIOD | BUDGETED | SPENT THIS PERIOD | BUDGETED | SPENT THIS PERIOD | BUDGETED | SPENT THIS PERIOD | BUDGETED | SPENT THIS PERIOD | BUDGETED | SPENT THIS PERIOD |
| a. Personnel | 172,362.00 | 9,909.30 | 84,846.00 | | | | | | | | 257,208.00 | 9,909.30 |
| b. Fringe Benefits | 66,181.88 | 4,828.52 | 39,709.12 | | | | | | | | 105,891.00 | 4,828.52 |
| c. Travel | 2,500.00 | 0.00 | 1,500.00 | | | | | | | | 4,000.00 | 0.00 |
| d. Equipment | 12,798.12 | 0.00 | 7,678.88 | | | | | | | | 20,477.00 | 0.00 |
| e. Supplies | 15,327.50 | 277.23 | 9,196.50 | | | | | | | | 24,524.00 | 277.23 |
| f. Contractual | | | | | 100,000.00 | | 150,000.00 | | | | 250,000.00 | 0.00 |
| g. Construction | | | | | | | | | | | 0.00 | |
| h. Other | 98,400.00 | 5,496.35 | 91,649.00 | | | | | | | | 190,049.00 | 5,496.35 |
| h. Other--Obj 5 IMD | | | | | | | | | 108,000.00 | 7,100.50 | 108,000.00 | 7,100.50 |
| Total Direct Charges | 367,569.50 | 20,511.40 | 234,579.50 | | 100,000.00 | | | | | | 960,149.00 | 27,611.90 |
| INDIRECT COSTS | 19,925.50 | 2,044.40 | 19,925.50 | | | | | | | | 39,851.00 | 2,044.40 |
| **TOTAL FEDERAL SHARE** | 387,495.00 | 22,555.80 | 254,505.00 | | 100,000.00 | | 150,000.00 | 0.00 | 108,000.00 | 7,100.50 | 1,000,000.00 | 29,656.30 |

Note: Two charges were incurred and authorized during C1, Q1; one for the SERFF agreement and one for the consumer advocacy organization. Both invoices were processed in C1, Q2, so are not included in this report.