Health Insurance Rate Review Grant Program
Cycle 1, Quarter 2 Report

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Introduction

As described in our Cycle 1, Quarter 1 Report, significant changes in Oregon laws in 2007 and 2009 gave the Insurance Division the legal authority necessary to conduct rigorous and transparent rate reviews for individual, small group, and portability health insurance. Unlike many states, Oregon law requires group health insurers to provide portability coverage for those who leave group coverage. As a result, portability rates represent over 20 percent of our rate reviews. We do not review or regulate rates in the large group health insurance market.

Insurers must submit rates for prior approval in the individual, small group, and portability markets before the policies are initially introduced in Oregon 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. All rate filings are public and posted on our website, with a 30-day opportunity for public comments, which are also posted. We post a detailed rate filing decision for every filing that is reviewed and is either approved or disapproved.

We have broad authority to ensure that 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.

However, we understand that even the most transparent and detailed rate review process alone will not make insurance significantly more affordable for businesses and individuals. With this federal grant we have begun to build on existing efforts to enhance our rate review process, better communicate the results of rate reviews, and explore ways to use rate review to affect underlying health care claims costs.

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 unreasonable large group rates and collect new large group market data. This objective is on hold, pending further federal guidance.
2. Expand our current rate filing requirements to detail health care claims costs.
3. Bolster consumer input in the rate review process.
4. Identify opportunities in the rate review process to affect health care costs.
5. Improve our rate review systems capacity, with a focus on efficiency and transparency.

We proposed hiring four new employees, since hired, to carry out the increased workload of objectives 1-5 and to be responsible for additional objectives 6-9:

6. An actuary to conduct enhanced rate review activities.
7. A project coordinator to improve rate review communications.
8. A market analyst to ensure that rate filings are complete and to conduct analyses.
9. A rate filing intake coordinator to improve rate filing intake efficiency.

We have modified the proposed objectives and tasks for the actuary, market analyst, and project coordinator in response to the demands of implementing state and federal health care reforms in Q1 and Q2. The changes to objectives 6-9 and the associated positions are described in the *Program Implementation Status* section. The reasons for the changes are discussed in the *Significant Activities Undertaken & Planned* and the *Operational Policy Developments & Issues* sections of this report.

Program Implementation Status

As of March 31, 2011

Table 1

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 objective is on hold pending additional federal guidance on how unreasonable large group rates will be reviewed.	
2. Expand our rate filing requirements to detail health care claims costs.	We continued to work with stakeholders to develop administrative rules and exhibits to better detail health care costs. We are currently pursuing using the Consumer Disclosure format developed by HHS for insurers proposing rate increases of 10% or more. The information collected, category breakouts, graphics and information displays appear to meet our needs and we would require this completed document to be submitted with all rate requests.	It was initially challenging to get sufficient stakeholder involvement, especially consumers. Our 7 largest insurers, insuring over 90% of Oregonians, are participating in the stakeholder group. They agreed with developing rules to require the use of the Consumer Disclosure format
Create systems enhancements to display claims data as part of the rate review page.	Based on decisions finalizing the health care claims data, the Information Management Division will move forward with systems enhancements intended to capture the data to use in a variety of ways, including tracking trends and to create the displays for web posting.	

3. Bolster consumer input in the rate review process.	We continued our contract with OSPIRG, a consumer advocacy group, to provide regular public comments for rate filings. They issued their second major report on a filing in Feb 2011. In April, OSPIRG selected a third health benefit plan rate filing for review.	We post OSPIRG's comments on our website rate filing page, along with our response. OSPIRG's comments are helpful to the rate review process and to increasing meaningful consumer input. One area of discussion continues to be the issue of premium affordability, defined in OSPIRG's comments as no more than 8% of monthly median household income.
4. Contract with a consulting firm to conduct a study identifying opportunities in the rate review process to affect health care costs.	The contract began in Q2 with Lewis & Ellis Actuaries & Consultants, Dallas TX office. In April, the study is launching with in-person and phone interviews with stakeholders and others, including: consumer and health care advocates, insurers, small business owners, health care providers, state health care policy administrators, department actuaries, and local and national experts in strategies for affecting health care costs.	The contractor has had to more persistently pursue getting adequate stakeholder participation to represent minority, rural, and low-income health care interests. We anticipate the draft report of recommendations to be delivered by June 20, 2011. We will select which recommendations to ask Lewis & Ellis to explore in greater detail for the final report to be delivered by September 20, 2011.
5. Improve our rate review systems capacity, with a focus on efficiency and transparency.	Our Information Management Division (IMD) developed a work plan for systems improvements, currently being implemented. To allow consumers and others to use and compare rate filing information, we are creating an exportable database. IMD is currently programming the database. To make it easier for consumers to find and understand the information in rate filing requests and in our decisions, we began work to make the website more accessible to consumers. We are	IMD work could not begin until we provided them with a clear set of expectations, some of which changed as we gained experience in the start-up of implementing state and federal reforms. The standard state webpage template, used by all units of state government, has some limitations. A new, more flexible, state webpage

	currently redesigning the rate filing search section of the website. We plan to have these pages available to the public by summer 2011.	template is under development and should be ready to use next year. At that point, we will be able to make further website enhancements. We have not had the staff resources to do web traffic analysis, but anticipate having reports on website visits in Q3. As we roll out new reports, tools and other website information, we will have a better idea of what is being used and how it is used. We will also consider developing other means of getting direct feedback from website visitors.
6. Hire an actuary to conduct enhanced rate review activities.	Hired in Q2 The actuary: • Conducts rate reviews for small group and individual filings, as an assigned primary actuary, from initial intake through final decision meeting. • Participates in peer consultation on other reviews with the other actuaries.	Due to workload demands described in the *Significant Activities* and *Operational, Policy Developments* sections, the actuary is currently conducting regular rate reviews, rather than performing only second tier reviews, as proposed. We will evaluate when and if second tier reviews are still the best strategy to pursue.
7. Hire a project coordinator to improve rate review communications.	Hired in Q2 The project coordinator: • Writes rate filing decision summaries • Facilitated creating the Rate Filing Snapshot (see *Attachments)*. • Monitors grant activities, including Objective 4 Lewis & Ellis study and coordinates grant communications. • Works on website and other projects to improve consumer communications.	The project coordinator is not currently coordinating all responses to inquiries about health insurance rates, as proposed. We have determined it is better to continue these communications through our usual channels: public information officer, consumer liaison, and consumer advocacy office.
8. Hire a market analyst to	Hired in Q1 The market analyst:	Due to workload and filing

ensure that rate filings are complete and to conduct analyses.	• Reviews every filing to determine if the contents meet the required state administrative rules. • Validates consistency of data. • Identifies problem areas and provides filers with technical assistance. • Completes an analysis of every small group and individual filing, comparing their administrative cost increases to the Producer Price Index (PPI).	accuracy problems, described in the *Operational, Policy Developments & Issues* section, the market analyst is not currently doing field audits to ensure that insurers are reporting accurate data in rate filings, as proposed. Instead, he is working to resolve problem areas with all filers. We will evaluate when and if field audits are still the best strategy.
9. Hire a rate filing intake coordinator to improve rate filing intake efficiency.	Hired in Q 1 The rate filing intake coordinator: • Reviews each filing at intake to ensure that every document required by state administrative rules is present in the filing. • Identifies problem areas and provides filers with technical assistance. • Maintains a detailed rate filing history of all ACA related filings in Excel format, which is accessible to and used by all staff involved in rate review of ACA filings. • Provides logistical support to the actuaries and technical support to the project coordinator for SERFF snapshot and report issues.	The rate filing intake coordinator is not solely ensuring that documents in the filing comply with state rules, as proposed. Instead, this responsibility is shared with the market analyst as part of his review of every filing. The workload burden, described in the Operational, Policy Developments & Issues section, forced the rate filing coordinator to temporarily set aside some duties in March 2011 to focus only on the rate filing intake process. Otherwise, the duties remain as proposed.

Significant Activities: Undertaken and Planned

Enhanced Rate Reviews
In 2007, Oregon law made health insurance rate filings public and required that we post the filings on our website. In August 2010, when the Cycle 1 grant began, we had four months earlier launched the enhanced rate review process required by new laws enacted in the 2009 legislature.

Oregon's 2009 health insurance rate review reforms:

- Added a public comment period.
- Required more detail about insurer administrative expenses.
- Allowed consideration of an insurance company's cost containment and quality improvement efforts.
- Gave the department the ability to consider an insurer's overall profitability, investment earnings, and surplus in determining whether to approve a rate request.

The changes in state law are intended to promote competition among carriers and curb excessive rate increases. The changes are also intended to foster public participation in and consumer understanding of the health insurance rate review process.

Oregon's new law also set a tight timeframe for performing rate reviews. Under Oregon Administrative Rules we must:

- Determine whether a filing is complete or not within 10 days of receiving a proposed rate table or schedule.
- Open a 30-day public comment period on the date the filing is deemed complete.
- Approve or disapprove a rate filing within 10 days of the end of the public comment period.

Prior to the 2009 statutory change, it was not uncommon for reviews to require 60 days or more to complete. During that time we worked with insurers to gather any missing information, get questions answered, and negotiate changes necessary to resolve the review.

Incorporating the federal Affordable Care Act reforms into the enhanced rate review process required us to ensure that the costs of federal reforms are included and appropriate in each filing. As described in our Quarter 1(Q1) Report, implementing the Oregon health reforms, along with incorporating the Affordable Care Act reforms in the fall of 2010, posed a number of challenges. As a result of state and federal reforms, our rate reviews became more complex, demanding analyses of a broader range of factors in more depth than ever before, and requiring more consideration of the weight to give to those factors. At the same time, the reviews and resulting decisions were expected to be concluded faster.

Table 2, (on page 10), gives a year-over-year comparison of small group, individual and portability health insurance rate filings between January-March of 2010 and January-March 2011 and for the period from April-December 2010. Noteworthy changes include:

- A dramatic increase in the number of rejected and withdrawn filings. This pattern begins in the April-Dec 2010 time period, following the implementation of state reforms in April and federal reforms in September, and continues through March 2011.
- A big timing shift in when the rate increases were filed in January-March. In 2011 nearly the entire quarter's filings came in March, while in 2010 the filings arrived more evenly spaced over the entire quarter. While the total number of rate filings in January-March 2010 and in January-March 2011 is nearly identical, the time to deal with these filings was not.
- In January 2011 eight filings were still pending from the previous quarter. January 2010 began with only one pending filing and an approved filing to amend; all other filings were received, reviewed and disposed of within the quarter.

The operational and policy implications of doing more, better and faster, and our strategies for managing this workload are discussed in the *Operational, Policy Developments & Issues* section of this report.

TABLE 2

Notes:

No 2010 filings or filings in the January-March 2011 period were disapproved. However, to-date 45% of all filings approved between April 2010 and March 2011 were approved at lower rates than initially requested by the insurers. The average reduction was about four percentage points. Of the Small Group and Individual filings, 50% of the approved filings to-date were approved at lower rates than initially requested, with an average reduction of about four percentage points.

COMPARING 2010 & 2011 FILINGS							
Filing Status as of March 31, 2011	**TOTAL FILINGS**	**Rejected**	**Withdrawn**	**Approved**	**Approved at Lower Rate**	**Disapproved**	**Pending**
Jan-Mar 2010							
Small Group, Individual & Portability	25		2	23			
Small Group & Individual	21		2	19			
Mar 2010 alone							
Small Group, Individual & Portability	15			15			
Small Group & Individual	12			12			
Apr-Dec 2010							
Small Group, Individual & Portability	84	37	9	30	13		8
Small Group & Individual	60	27	7	19	9		7
Jan-Mar 2011							
Small Group, Individual & Portability	26	13	1	1	1		11
Small Group & Individual	21	12	1	1	1		7
Mar 2011 alone							
Small Group, Individual & Portability	23	10	1	1	1		11
Small Group & Individual	18	9	1	1	1		7

Improving Consumer Information & Bolstering Consumer Participation

We are committed to providing the public with better information about the factors that underlie health care costs and offering meaningful ways for public participation in the rate review process.

Understanding all the variables that contribute to driving the cost of health insurance is difficult. Consumer comments at our website often regard affordability. Consumers write about their frustration with increases in premiums and out-of-pocket health care costs, usually far exceeding cost increases for other goods and services. However, even some health care professionals have posted skeptical comments, questioning whether claims costs for health care really increased, as their own unit cost reimbursement from insurers has not increased significantly.

Major activities in Q2, which are intended to improve consumer information, communication and participation in the rate review process, included:

- *Contracting with OSPIRG,* a consumer advocacy group, to provide regular public comments for selected rate filings.

  OSPIRG continued to track all rate filings, examining filings they regarded as significant in more detail. OSPIRG selected a filing and completed their second rate review filing analysis in Q2. Their report and our response were posted to our website (see *Attachments* section). In addition to OSPIRG staff responsible for writing the report, they used the services of a contract actuary. To conduct the analysis OSPIRG also relied on a project advisory committee with representatives from small business, AARP, the Consumers Union, and Oregon Health Action Campaign.

  As part of the work of refining their methodology, OSPIRG evaluated the division's comments on their first filing analysis (United Health Care small group, reported in Q1) and our filing decision, in order to incorporate lessons learned for future filing analyses. OSPIRG gave us a response on the process with their first filing review, as they intend to do with the second filing, which they analyzed in Q2.

  OSPIRG communicates regularly with members, as well as with a broader group of consumer and community based organizations concerned with health care. OSPIRG's reviews are helpful to both engage consumers and provide a meaningful voice for consumers in the division's rate review process.

- *Refining rate filing decision summaries*. We post plain language rate filing decision summaries on our website at the same time that the decision is posted. These summaries are part of the division's efforts to improve public understanding of our role in rate review and the basis for approving or disapproving health insurance rate requests. Our website allows visitors to access all rate filings and decisions made since 2008.

  As noted in our Q1 report, these decision summaries have grown in length and detail for most of the filings. The content of these summaries varies, as filings vary, and as we try

to select the most relevant information for each particular rate filing decision summary.

The rate filing decision summaries, along with all rate filing documents for each filing, are public information and posted to our website.

- *Improving public communication about rates and premiums.* The relationship between approved rates and insurance premiums, as well as understanding what premiums actually pay for can be confusing to the public.

  We intend to begin using the *HHS Consumer Disclosure*[1] format (see Attachments Section). This appears to meet our need to make it simpler for website visitors to find important information, such as what percentage of the premium dollars are used by each insurer to pay health care claims, cover administrative costs and profit or loss. We also appreciate the efficiency of using a format that insurers will eventually be required to use otherwise. Our seven largest insurers, insuring over 90 percent of Oregonians, are participating in the stakeholder group that is considering how a breakdown of claims costs should be presented in a rate filing. They agreed that the use of the *Consumer Disclosure* format would be an efficient way to achieve our goal of providing better claims data information. We will develop Administrative Rules to implement the Consumer Disclosure format. When those rules are in place and the necessary programming and system changes are made by our Information and Management Division, every filing accepted for review will have a *Consumer Disclosure* posted.

  We intend to add an interactive presentation on our website that would explain health insurance costs and the role of the division in regulating rates, including the factors we consider during rate review and how consumers could be involved. This would include an explanation about how much of the premium dollar is used for medical services costs, administrative costs and insurance company profit. We are considering whether a university or community college class might help with an animated presentation or whether we will produce a flash presentation in-house. We are developing a script for this 6-7 minute presentation, aiming to have it on our website by summer 2011.

Affecting the Underlying Costs of Health Care

We are seeking specific recommendations on how we might use the rate review process to lower premium costs for individuals and small employers, by affecting the underlying costs of health care. Historically, the division's rate review has been focused on ensuring that rate requests are justified, based on claims costs, administrative costs, and profit. We also considered whether the rates were reasonable in view of the benefits offered. However, as in most of the country, Oregonians have seen health insurance premiums ramping up at a rate far exceeding increases in the costs of other goods and services, as well as the growth in personal or business income.

As described in the *Introduction* of this report, state health reforms that went into effect April 2010 expanded our authority and the scope of rate reviews. We collect and analyze much more

[1] The *Consumer Disclosure* was developed by HHS to be used with any rate filing request that exceeded a 10 percent increase.

information about an insurer's administrative costs and profits and have used the rate review process to question and challenge the amounts insurers are building into rates to cover these expenses. However, the bulk of the premium is spent on medical services. In Oregon's individual and small group markets our seven largest insurers already spend an average of 85 cents out of every premium dollar on medical services claims for hospital inpatient, hospital and facility outpatient, physicians and other providers, prescription drugs, medical equipment and other costs associated with delivering health care services.[2] We collect information on every insurer's health care quality improvement and cost containment efforts. We make their quality and cost containment statements public information, but are considering how to more meaningfully impact the vast majority of the premium dollar spending.

Following federal health care reforms and the availability of this Cycle 1 grant, we decided it was time to conduct a study to explore whether our rate review process could be used to affect the underlying costs of medical services. We recognize that there are numerous efforts underway nationally and in Oregon that are intended to improve quality, improve efficiency, and contain medical services costs. We are interested in how we might use the rate review process to promote the most promising approaches to contain or even, as a recent Institute of Medicine report[3] also points to, the potential to reduce medical services claims costs.

We contracted with Lewis & Ellis Actuaries & Consultants (Dallas, TX office) in February 2011 to conduct a study to identify ways in which the rate review process could be used to affect the underlying costs of medical care. In April they began meeting with stakeholders, including consumer and business representatives, the seven largest health insurers in Oregon, and health care provider representatives.

By the end of June, Lewis & Ellis will produce a report of draft recommendations of the most promising ways for the division to use the rate review process to affect medical services claims costs. We will select the recommendations for Lewis & Ellis to explore in more detail and provide a final report by September 2011.

This study report will be tailored for Oregon. As noted in our Q1 report, we have a highly competitive health insurance marketplace with the seven largest insurers covering more than 90 percent of the market and none of them dominating the market. In addition to private sector quality improvement and cost containment work, we also have some significant state-sponsored programs, which will be described in the *Collaborative Efforts* section of this report.

[2] Oregon Department of Consumer & Business Services, Insurance Division, *Health Insurance in Oregon, January 2011* report, compiled from data in the NAIC filings database including data through June 30, 2010.

[3] National Academy of Sciences, Institute of Medicine, Roundtable on Evidence-Based Medicine, Pierre L. Young and LeighAnne Olsen, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary*

Systems Enhancements

Our Information Management Division (IMD) developed a work plan for systems improvements, which is currently being implemented. Continuing work includes:

- Creating an exportable database, which will allow any visitor to the website to use and compare rate filing information. IMD is currently programming the database.
- Putting system enhancements in place that will increase our ability to efficiently use SERFF (the System for Electronic Rate and Form Filing)[4] with our back office system to eliminate dual data entry.

[4] SERFF is the online system operated by the National Association of Insurance Commissioners and used by insurers to file rate requests.

Operational, Policy Developments & Issues

Enhanced Rate Reviews

In the Quarter 1 Report we described how the expanded scope of rate review authority with state and federal health care reforms has increased the complexity and amount of time needed to evaluate a rate filing. Trying to accomplish this within the shorter timeframe for rate review set by Oregon's health care reforms has propelled us to devise new strategies and tools.

Challenges and responses to date:

1. *Substantial Increase in Required Information* As a result of state and federal reforms, we require much more detail about the insurers' claims costs, administrative expenses, cost containment and quality improvement efforts, as well as more specifics about the company's profits, sources of profits and surplus. We must rapidly analyze and weigh these factors in order to reach a decision.

   Responses To help make the best use of actuarial time, we have made some major changes in rate review responsibilities.

   We intended for the HHS grant-funded actuary to perform second-tier reviews of all filings, which the other actuaries had conducted. However, due to the unanticipated increase in the level and complexity of the workload, this actuary is currently performing regular rate filing reviews.

   The market analyst and the rate filing intake coordinator have assumed non-actuarial duties previously done by the actuaries (see *Incomplete Information* below).

   After the actuaries determine that a filing is complete, the market analyst does an expense analysis of each filing, especially focusing on administrative expenses, comparing their filing expense statements with other data. To-date, the market analyst has identified a consistency problem in detailing administrative expenses as required by state health care reform rules. Reporting administrative expenses in the detail now required is new to the insurer's actuaries. The administrative expense reports are usually prepared by the insurer's cost-accounting or finance staff. Starting in April 2010, carriers are required to track these expenses by line of business. However, the historical information in the reports are best estimates, since insurers have not previously tracked administrative expenses in the categories and by group, as we now require them to be reported. As a result, we anticipate that inconsistencies in reporting administration may take some time to resolve.

   Only the primary actuary for a filing now attends the final decision meeting discussion with the director, rather than the actuarial team attending and discussing the filing.

However, the actuaries continue to provide each other with peer review of written documents and consult with each other, as necessary. This change was made to allow our actuarial team more time to focus on specific filing review.

We have created a two-page Rate Filing Snapshot template to organize filing information that is currently being used in the final decision meeting. Page one of the Snapshot displays tables that summarize rate filing data; page two is a bullet point list narrative description. The actuaries complete the Snapshot, which also functions as a checklist for them to ensure that all factors are considered and included. (See *Attachments* Section) The actuaries also now provide a one-page decision recommendation.

We plan to create a template for the initial filing meeting. We will continue to monitor the workload and the effectiveness of our tools and staff changes.

2. *Incomplete Information* We cannot accept inadequate filings as complete and then work with the insurer to answer questions or gather missing information over the course of weeks, as we once could. Meeting the statutory deadline for completing a review does not allow us the time to engage in extensive back-and-forth information gathering. In addition, the original filing is posted to the web for public comment, increasing the importance of having complete and correct filings in order for the public to have a meaningful chance to participate.

   Responses We have revamped our rate filing intake process to more closely examine filings at the time they are submitted, to ensure that the required information is there. The rate filing coordinator verifies that every required document is filed and requests any missing documents that must be received before the filing can be considered.

   The next review step is done by the market analyst, who determines whether the contents of the submitted documents meet the standards set out in the Oregon Administrative Rules for an insurance filing. A frequent problem in filing documents is incomplete or omitted information in the quality improvement and cost containment section of the filing.

   Finally, the actuaries review the filing in detail before determining that they are complete. Since early March 2011, every filing has been thoroughly vetted in this manner before it is posted to our website.

   As Table 2 (on page 10) shows, since Oregon health care reform took effect in April 2010, nearly one-half of filings have been rejected. When the rejected and withdrawn filings are added together, more than one-half of filings are not considered. The pattern of rejected and withdrawn filings has continued in Q2, after the market analyst began reviewing the contents of the filings and the actuaries began to strictly enforce the time period for responses. However, in Q2 the filings were rejected or withdrawn more quickly than in April-December 2010.

   We believe rejecting incomplete rate filings may save time, which was previously spent

on bringing insufficient rate filings to a level that allowed decisions to be based on valid data. However, there is a significant workload associated with rejecting a filing and then having to review a re-submitted correct and complete filing later. We hope that our thorough review process will be part of an education effort that will ultimately result in most filings meeting the new filing standards and being considered in a timely manner while providing the public with accurate and complete information about the rate request. We know that most insurers are interested in getting it right, as rejected and resubmitted filings also increase their workload.

3. *Filing Clusters & More Frequent Filings* Currently it appears that the March surge in rate filings is not continuing in April. But it is possible that we may see a new pattern of filings, with upticks in the number of filings toward the end of each calendar quarter. With a limited number of actuaries and tight timeframes to review and reach a decision on each filing, our ability to manage is already stretched. Clusters of filings would add to the difficulty, but it is too soon to know if this cluster is a one-time problem or an on-going pattern.

   We may also see an increase in filings done quarterly or semi-annually, rather than annually. Because of lower than expected health care claims costs, driven in part by members using fewer services, we have already had insurers requesting decreases in their year over year rates in quarterly or semi-annual filings. One insurer attributed this decline to benefit changes that shifted costs to members and to general economic conditions resulting in more members postponing some health care services. This same insurer stated their intention to monitor their claims costs on a quarterly basis and file rate changes, if necessary, quarterly. If many insurers do this, it could result in more competitive rates in our market, but would also compound current workload issues.

   Responses We are unsure if our responses, described in *Substantial Increase in Required Information* and *Incomplete Information* sections above, will be adequate to solve those problems, as well as deal with filing clusters. We will continue to monitor the effectiveness of our responses and the pace of filings and decide whether we need to devise other strategies.

Improving Consumer Information & Bolstering Consumer Participation

1. *Additional Steps in the Rate Review Process* In the Q1report, we described the steps added to our rate review process to improve public information and participation. These steps include: posting filings for public comment, gathering more pertinent information for consumers to include in the rate filing decision summaries, responding to and interacting with OSPIRG on filings selected for review, and writing the rate filing decision summaries. These steps continue to add to the time pressures described in the *Enhanced Rate Review* section above.

   We believe this open process is starting to positively affect the scope of information submitted by insurers in filings and the way the filing information is presented using a

consumer-friendly writing style. We noticed a recent change in a few filings, with clearer descriptions of what they were requesting to do with rates, why, and how that would affect individuals and small employers. One filing openly acknowledged that cost-shifting to consumers was part of the reason their medical services claims had declined, so that this decrease was not entirely good news for all consumers, and might change with an improving economy

2. *Consumer Advocates and Health Care Affordability* Many of OSPIRG's comments on the Health Net filing analyzed in Q2 were useful. Besides giving consumers meaningful representation in the process, their comments prompted us to better explain the factors considered for a rate decision. OSPIRG also reminded us of the importance of insisting that filings comply with the letter of the law, described in the *Lessons Learned* section below.

   However, OSPIRG again included a significant section on affordability of rates, just as they did with the filing analysis in Q1. And we continue to disagree with OSPIRG's conclusions about how to consider affordability in the rate review process. Their definition of affordability is that the monthly premium should not exceed 8 percent of the median[5] monthly income for households. While limiting premiums to that level might be a desirable public policy goal, to meet the standard of not exceeding 8 percent of income, a household with a $1000 monthly premium would require a $12,500 per month income.

   We are concerned with affordability and the effect of increases on consumers and bring that into every filing decision. However, given the constraints of health coverage currently purchased by employers or individuals, without large public subsidies, OSPIRG's definition of affordability is difficult to address. As stated in our previous grant report, the department considers the impact on consumers when reviewing rates. But we must also consider whether rates are appropriate for the level of benefits provided, cover the insurer's operating costs, and will be sufficient to cover paying medical services claims costs.

   As frustrating as this discussion about affordability may be for consumers, advocates and—at times—for us, we believe having an open discussion with consumers and advocates is an important part of considering how to expand health insurance coverage to everyone in our state and nationally. It also directly relates to the study we contracted for with Lewis & Ellis to give us recommendations for what part our rate review process may play in lowering claims costs for medical services.

[5] Median is the midpoint of any group, with half of the group above and half below that point. So median household income would be the income level where half of the households are below that level and half above. OSPIRG cites US Census data for 2009 that shows the median household annual income is: $25,531for individuals, $38,787 for two persons, and $67,264 for households with three or more persons. Restricting premiums to no more than 8% of household income would translate into annual insurance premiums of no more than: $2,042 for individuals, $3,103 for two-person households, and $5,381 for households with three or more persons.

Collaborative Efforts

Much of the grant-supported work involves collaboration.

We are engaging a range of stakeholders, including small employers, consumers and consumer advocacy organizations, insurance companies, and health care providers. As described in more detail in other sections of this report, stakeholders are invited to participate in:

- The study to identify ways the rate review process might affect underlying health care costs.
- State rule development to determine how each insurer will collect and display health care costs, describing how the premium dollar is spent and detailing the portion of the premium spent on medical services claims.
- Rate filings by commenting, as individuals and through advocacy organizations, including the OSPIRG analyses of filings.

We collaborate with the Oregon Health Authority (OHA), the department charged with leading the state's health care reforms that are intended to lower and contain costs, improve quality and increase access to health care services. Oregon Health Policy & Research (OHPR), a part of OHA responsible for research and evaluation, is participating in the Lewis & Ellis study on affecting the underlying costs of health care. Some of OHPR's existing analyses will be helpful to this study. We also engage in on-going collaboration with OHPR's work, such as an existing program that gathers data from insurers on hospital payments and a new initiative to establish an all-payers, all-claims data reporting program.[6] Although having all of this claims data will not alone affect health care costs, it should be a useful tool as we develop future strategies for using the rate review process to affect the underlying costs of health care.

In addition to our own collaborative efforts, both of our grant-funded contractors are involved in engaging stakeholders. OSPIRG, as noted in our last report, 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. Lewis & Ellis is meeting with and interviewing many stakeholders during the course of the study into how the rate review process might affect heath care costs.

[6] The Oregon Health Authority was given broad statutory authority to collect all medical services claims data for payment from Medicare, Medicaid, Portability, Individual, Small and Large employer group, Associations and Trusts; and self-insured plans. There are both mandatory and voluntary reporters involved in creating the all-payers, all-claims database. This is in the early stages of development. In March 2011 they began to receive test files from mandatory reporters.

Lessons Learned

Challenge of Public Participation As we reported previously, inviting public participation in the rate review process poses challenges. Rate review is guided by statutory requirements and actuarial standards; both of which can strike members of the public, struggling with paying for health insurance premiums, copays and deductibles, as irrelevant. We are continuing to learn how we can educate the public and listen to their concerns. Even when consumers and other members of the public may submit comments that reveal they do not understand our role or the requirements of rate review, we are trying to learn from these comments so that we can better engage and educate.

Opportunity in Meaningful Consumer Participation OSPIRG's comments on filings have been helpful for reasons described elsewhere in this report. They have pushed for greater detail on how trend is developed and the impact that will have on members, which has been helpful for us as we try to communicate better with the public. Their focus on holding companies to complying with the letter of the law has resulted in reminding us of the importance of doing so, in keeping with public transparency.

For example, the law requires that rate tables must be submitted. However, we did not always follow up and insist on this when the tables were missing from a filing, as our actuaries could extrapolate from the information the insurer provided in the filing. But consumers and advocates could not easily do those calculations. As part of our filing review process we are now ensuring that all documentation required by law or rules is submitted and available to the public for each complete filing received.

Pause to Check Progress On any given day it can be difficult to see that our rate review process is making any difference in the health care marketplace. However, when we reviewed our own data for rate reviews done since the Oregon health care reforms went into effect April, 2010, we were surprised to see some of the early results.

As noted in Table 2 of this report, no 2010 filings or filings in the January-March 2011 period were disapproved. However, to-date 45% of all filings approved between April 2010 and March 2011 were approved at lower rates than initially requested by the insurers. The average reduction was about four percentage points. Of the Small Group and Individual filings for that same time period, 50 percent of the approved filings were approved at lower rates than initially requested, with an average reduction of about four percentage points. We calculated that the reductions made during the review process resulted in $25 M in savings—an average of $9.69 per member per month for Oregonians covered by those individual and small group health plans.[7] Health insurance affordability is a complex issue, as discussed earlier in this report, and this level of reduction is not going to solve that problem. However, we start to get a glimmer of the possibilities that effective rate review can have in balancing market stability with increasing affordability.

[7] These results are to-date through March 31, 2011. We have pending filings from that period, which will have their disposition in Q3 that will be reported in the next HHS report.

Additional challenges

Earlier sections of this report describe many challenges, including:

- The increasing the complexity, amount of detailed information, and shorter timelines for conducting rate reviews.
- The difficulties and opportunities found in meaningfully engaging and communicating with the public.
- Getting standardized filing documents that use the same title, format and include required and consistent content.
- The overarching challenge will be to identify how the rate review process might affect the causes that underlie the costs of medical services.

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:

- *Comments on Health Net Health Plan of Oregon's Proposal to Increase Health Insurance Rates*, GH 0664 10, February 2011. **http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzNxA**

- *Response to OSPIRG Comments on Health Net Health Plan of Oregon's Rate Filing #GH 0664 10 Non-Grandfathered Small Employer Health Benefit Plans* **http://www4.cbs.state.or.us/ex/ins/filing/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzN4E**

- To illustrate the information that we consider in rate filing decisions, see the attached *Rate Filing Decision Final Meeting Snapshot* pages 1 & 2.

Because some of the functionality in SERFF was not available until late December, Rate Review *Volume/Market Data Tables B-C* is included in *Attachments.* Table A was generated by SERFF upload.

HIPR Budget & Expenditure Report, Section B—By Grant Program Function or Activity Report for C1, Q2.

Rate Review Volume/Market Data
Quarter 2, 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 January 1, 2011-March 31, 2011 and is generated from the same filings as what is summarized in Tables B and C on the following page.

Rate Review Volume/Market Data

Tables B-C

Cycle 1, Qtr 2

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

Because some of the functionality in SERFF was not available until late December and post-submission updates were not requested from filers, these Tables are incomplete for number of policy holders. Oregon created Tables B & C for this report. We anticipate Qtr 3 Tables B&C will be populated by the SERFF upload.

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

HIPR Table B (Individual) Summary

Product Type	Covered Lives	Policy Holders
H161-Other	9,500	*
H06-Conversion	8,849	524*
*As noted above, this figure was not reported by most filers.		

HIPR Table C (Small Group) Summary

Product Type	Covered Lives	Policy Holders
H16G-Other	52,115	*
*As noted above, this figure was not reported by most filers.		

Rate Filing Snapshot

Rate Filing Posted:
Insurer:

Effective Date:
Rate Change Requested:
Requested Year over Year Rate
TOI/GF or NGF:

State Tracking #:
Rate change request period, if not annual
From:
To:

Year	Rate Change	Claims Trend
2010		
2009		
2008		
2007		

% of Premium	From	To
Claims		
Profit/Loss		

Administrative Costs	
Prior Year End PM/PM	
Projected Year PM/PM	
% Change	
PPI	
If % change exceeds PPI, see pg 2 notes.	

Claims Basis of Rate Request

Trend	
Experience	
Medical Trend	
Rx Trend	

Detail	Medical	Rx
Utilization		
Unit Cost		
D Leveraging		
Other		

Projected	
PPACA aggregate	
Lifetime limits	
Guaranteed < 19	
Coverage to 26	
No cost-share PC	
Other PPACA Changes	
Other Benefit Changes	

Margin Built into Trend?	
Experience Period	

Consumer Impact

Plan Membership	
Number of Members	
Membership Change	
Change Since	
Projected Membership Change	

Rate & Premium Ranges	
Minimum Rate Change	
Maximum Rate Change	
Min Premium Change	
Max Premium Change	
Avg Premium Change	

Financial Position

Company Business 20__	% of Business	Underwr. Gain
Comprehensive		
Medicare Supplement		
Medicare		
Medicaid		
Federal Employees		
Other		

Company Overview	
Most Recent Yr Profit as % of Premium	
Source of Recent Profit	
Underwriting	
Investment	
Other Income	
Increase in Capital & Surplus	

RBC	
2010	
2009	
2008	
2007	

Sr. Executives Compensation		
	% Premium	PMPM
Prior Yr		

Background & Other Basic Features of Their Request:

- New plans?
- Changes in benefits, copays, deductibles?
- Are they are making any changes in various actuarial assumptions?
- Are they making any significant changes in the methods used to develop rates or premiums?
- Note if the filing received any consumer comments, including OSPIRG.
- Other?
- Any changes since initial filing?

Points in Favor of Rate Change, Against Rate Change or Neutral:

Claims--Medical & Rx Trends

- Is there adequate information to support these trends?
- How do their trends compare in the marketplace?
- Comment, if any margin is built into trend.
- Is target claims cost reasonable?
- Any changes since initial filing?

Administrative Costs

- Is the rate of change = or< PPI? If more than PPI, how does the company support this? If more than PPI, review entire administrative expenses reported.
- Does the projected amount of admin cost calculated from the PMPM info submitted match or closely track with the amount of admin expense built into the premium from the rate development page? If not, what is the reason for the difference?
- What is contributing to any increase or decrease?
- Any changes since initial filing? If decreased, calculate the pm/pm savings.
- Report the "top 10 highest paid employees".

Profit/Loss

- Is it reasonable in relation to their financial position?
- Reasonable when compared with other insurers?
- Any changes since initial filing?

Financial Considerations

- The company's financial position?
- How will this rate change affect the company's financial position?

Requested Rate

- How does the proposed increase compare with trend, PPACA benefit costs, non-PPACA benefit changes & proposed profit?
- If proposed rate is above or below what would be anticipated from these factors (bullet above), why?
- Do we have a comparison of proposed rates vs. the competition?
- Any changes since initial filing?

Immediate Impact

- How many members are scheduled to renew in coming quarter?

HIPR Budget & Expenditure Report

Section B - By Grant Program Function or Activity Report

Cycle 1, Quarter 2 -- page 1 --

REGION: X
STATE: OREGON
NUMBER 1 IPRPR100057-01-00
BEGINNING DATE: 1/1/2011
ENDING DATE: 3/31/2011

	Activity 1 Objectives 1, 6, 8 & 9			Activity 2 Objectives 2, 7 & 8			Activity 3 Objective 3		
Object Class Categories	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE
a. Personnel	172,362.00	33,298.44	43,785.24	84,846.00	15,778.14	15,778.14			
b. Fringe Benefits	66,181.88	13,141.67	17,392.69	39,709.12	4,374.88	4,374.88			
c. Travel	2,500.00			1,500.00					
d. Equipment	12,798.12			7,678.88					
e. Supplies	15,327.50		206.43	9,196.50					
f. Contractual							100,000.00	36,130.38	36,130.38
h. Other	98,400.00	23,232.18	28,728.53	91,649.00					
h. Other–Objective 5									
Total Direct Charges	367,569.50		90,112.89	234,579.50			100,000.00		
INDIRECT COSTS	19,925.50	10,475.28	12,519.68	19,925.50	4,489.40	4,489.40			
TOTAL FEDERAL SHARE	387,495.00	80,147.57	102,632.57	254,505.00	24,642.42	24,642.42	100,000.00	36,130.38	36,130.38

Notes: The year-to-date Expense report reflects: 1)Adjustments made after the Q1 report, correcting the distribution between Personnel & Fringe.
2) Correction in YTD Supply expense.

HIPR Budget & Expenditure Report

Section B - By Grant Program Function or Activity Report

Cycle 1, Quarter 2 -- page 2 --

REGION: X
STATE: OREGON
NUMBER 1 IPRPR100057-01-00
BEGINNING DATE: 1/1/2011
ENDING DATE: 3/31/2011

	Activity 4 Objective 4			Activity 5 Objective 5			Total		
Object Class Categories	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE	BUDGETED	EXPENSES THIS PERIOD	EXPENSES YEAR TO DATE
a. Personnel							257,208.00	49,076.58	59,563.38
b. Fringe Benefits							105,891.00	17,516.55	21,767.57
c. Travel							4,000.00		0.00
d. Equipment							20,477.00		0.00
e. Supplies							24,524.00		206.43
f. Contractual	150,000.00						250,000.00	36,130.38	36,130.38
h. Other							190,049.00	23,232.18	28,728.53
h. Other--Obj 5 IMD				108,000.00	14,266.19	21,366.69	108,000.00	14,266.19	21,366.69
Total Direct Charges							960,149.00	140,221.88	167,762.98
INDIRECT COSTS							39,851.00	14,964.68	17,009.08
TOTAL FEDERAL SHARE	150,000.00		0.00	108,000.00	14,266.19	21,366.69	1,000,000.00	155,186.56	184,772.06