Evaluation of the

Oregon Department of Consumer and Business Services

Division of Insurance Rate Review Program

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I. Introduction

On May 18, 2012, the Insurance Division of the State of Oregon's Department of Consumer and Business Services ("the Division") issued a request for proposals to conduct an evaluation of the activities and impact of the Division's work that was funded by two grants ("the grants") awarded by the United States Department of Health and Human Services (HHS). The grants were awarded through HHS's Rate Review Grant Program, Cycle I (August 2010 – September 2011, with a no-cost extension through September 2012) and Cycle II (October 2011 – September 2014). On September 24, 2012, the contract was awarded to the Georgetown University Health Policy Institute ("Georgetown").

A. Work Plan

The work plan agreed upon between Georgetown and the Division included background research and review of applications for the Cycle I and II grants, as well as the quarterly and annual grant reports, OSPIRG input on selected rate filings, and other relevant documents. Individuals to be interviewed included the current and past Oregon insurance commissioners, the Division's actuarial and administrative staff, the OSPIRG Health Care Advocate, and persons involved with rate filing from Oregon insurance carriers that cover 5% or more of the individual or small group markets. Additional interviews added to the work plan later included the chair of the Oregon State Senate's Committee on General Government, Consumer, and Small Business Protection, and a former administrator of Cover Oregon, the state's Marketplace. Attempts made to contact the former director of OSPIRG were unsuccessful and it was later agreed that interviews with health care providers – which were originally part of the work plan – would not be useful.

Also included in the work plan was a review and report by an experienced state regulatory health insurance actuary of all rate filings and reviews received and conducted during the two grant cycles. The original work plan also included the review of filings filed with the Center for Medicaid and Medicare Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) for Oregon association plans (a segment of the market for which the Division did not have rate review authority), but it was later determined that CCIIO reviews would not inform an evaluation of the Division's rate review program.

Another facet of the work plan included a review of the transparency efforts funded by the grants. Initiatives reviewed included the Division's rate review web site and the public hearings held for each rate review filing.

B. Informal Progress Report

An informal progress report, submitted on September 19, 2013, provided an overview of progress to date on the work plan, including completion of the background research and additional activities completed or begun at the time the report was submitted. The progress report also included next steps as work on the evaluation proceeded.

C. Interim Report

An interim report was submitted on December 20, 2013. The interim report provided highlights of administrative and actuarial staff interviews completed at that point. The highlights were presented in three broad categories: rate review process, transparency, and public input. The three categories were broken down into subcategories, and the report included a discussion of the remaining evaluation activities.

II. Background

A. Pre-ACA Rating and Rate Review Requirements

Oregon's rate review program was considered by many in the regulatory and advocacy communities to be a top tier rate review program, even before the grants were awarded. The more progressive features of the program included modified community rating in the individual and small group markets and a requirement that rates could not vary from the geographic area average rate, except that rates could be adjusted based on age, family composition, and benefit design. Also prior to the grants, rates could not be based on an individual's health or claims history, or any other characteristics of the individual (e.g., gender).[1]

In the Oregon small group market, rates could vary from the geographic average rate by 50 percent based *only* on one or more of the following factors:[2] age of employees and covered dependents, family composition, benefit design, employer contributions, participation rates, employee and dependent tobacco use, participation in wellness programs, customer loyalty, and expected claims experience (not to exceed 5 percent).[3] Portability plan rates were reviewed to assure that the insurer followed the statutory formula for developing portability rates, which was based on the insurer's small and large group rates.[4]

The Division had prior approval authority over all individual and small employer rates before the grants were awarded and has since gained approval authority over association plan rates. All rate filings for individual and small group health plans were required to include: a filing description, a summary of the filing, an actuarial memorandum, rate tables, rating factors, plan relativities, an explanation of the development of the base rate and rate changes, trend information and projections, premium retention, and a worksheet for individual health benefit plan rates. Also required was information about covered benefit or plan design changes, cost containment and quality improvement efforts, insurer's financial position, certification of compliance, third-party authorization, and a statement of administrative expenses.

The standard for approval of rates, as defined in Oregon statute, has been that the rates must be reasonable and not excessive, inadequate, or unfairly discriminatory.[5] Division actuaries ask two fundamental questions about each rate filing: is the aggregate rate request justified and is the request fairly allocated among rate payers?

[1] ORS 743.767; OAR 836-053-0465.
[2] ORS 743.737; OAR 836-053-0065.
[3] Note: Oregon classified its small group market rating rules as adjusted community rating; however, the 5% adjustment for expected claims experience does not appear to be consistent with adjusted community rating.
[4] ORS 743.760; OAR 836-053-0780.
[5] ORS 742.005 and 743.018.

B. Legislation

HB 2009, a law reforming health insurance regulation in Oregon, was passed in 2009. The law made significant improvements to the rate review process by strengthening the Division's authority to develop an improved rate review process. Significant changes enacted include the addition of a public comment period, the Division's ability to require more detail about administrative expenses, allowing the Division to consider an insurer's cost containment and quality improvement efforts, and the Division's ability to consider an insurer's overall profitability, investment earnings, and surplus.[6] Additionally, the Division has explicit authority to consider an insurer's historical and projected loss ratios, historical and projected trend, historical and projected administrative costs, and net income targets.[7]

The authority to consider an insurer's overall profitability rather than just the profitability of a particular line of insurance, to take a deeper dive into administrative expenses, and to consider investment earning and surplus, are what set Oregon's rate review program apart from most other states. In addition to the factors explicitly listed in the statute, the Division also considers whether the request is for a closed block of business, previous rate changes, and anticipated changes in the number of enrollees. For example, in order to lessen the financial burden on consumers, the Division has denied requests for significant rate increases for very small closed blocks of business when those requests came on the heels of previous large rate increases.[8]

The 2011 legislative session produced a number of new laws that affected health insurance and/or rate review,[9] including SB 89, which made changes to Oregon statutes that were necessary to implement federal health care reform and SB 99, which authorized both the creation of the Oregon Health Insurance Exchange and the establishment of a Children's Reinsurance Program that spreads the cost of insuring high-risk children among all companies providing health insurance to Oregonians.

C. Cycle I Rate Review Grant

The one million dollar Cycle I federal rate review grant was awarded on August 9, 2010 and extended to September 30, 2011. A no-cost extension to September 30, 2012 was granted to conclude activities in progress on the original expiration date. The grant supported Oregon's efforts to implement major rate review improvements by providing funds to secure the resources necessary for the Division to establish the enhanced rate review process authorized by the 2009 legislation (which became effective in April 2010).[10] With Cycle I grant funds, the Division hired staff to allow expanded rate filing scrutiny, to increase IT capacity, to ensure complete and accurate rate filings, and to improve communications with and engagement of the public. These improvements resulted in more in-depth analyses of rate filings and significantly increased

[6] *See* Statement of Teresa Miller, Administrator Oregon Insurance Division Department of Consumer and Business Services On Affordable Care Act: Impact on Health Insurance Rate Review Before the Senate Committee on Health, Education, Labor & Pensions United States Senate, August 2, 2011.
[7] ORS 742.005 and 743.018.
[8] Oregon Rate Review Grant Cycle I Project Abstract, page 5.
[9] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 7.
[10] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 2.

responsiveness to consumer issues.[11] The former commissioner interviewed said, "The grants provided framework, discipline, and motivation to move rate review forward."

D. Cycle I Accomplishments:

With Cycle I funds, the Division hired five new people: two additional health insurance actuaries, a market analyst, a rate filing intake coordinator, and a project coordinator. Because of Oregon's competitive health insurance market, the Division was reviewing approximately 50 rate requests per year at the time the grant was awarded.[12] The increased staffing resulted in more complete filings at intake and more thorough analyses of filings; this added scrutiny led the Division to approve lower than requested rates for many of the filings reviewed during the Cycle I funding period.[13]

The Division also used grant funds to contract with Lewis & Ellis Actuaries & Consultants to identify ways in which the rate review process could be used to affect the costs of medical services.[14] Lewis & Ellis initially provided twelve potential strategies for employing the rate review process to affect the underlying costs of health care. In its final report, the firm boiled the list down to three strategies where the rate review process could be leveraged:

- Fundamental payment reform and integration of the healthcare system;
- An increase in primary care spending;
- Transparency and standardization of network contracts.

Initially, the Division "chose to delay additional follow-up on Lewis & Ellis study, pending several other major market changes, such as development of the Oregon health insurance exchange."[15] In October 2012, Oregon reported that "in Y[ear] 2 [the no-cost extension period] we will move forward with follow-up, evaluating how to more meaningfully include quality improvement and cost containment efforts in rate review and in information provided to the public."[16] ,

Other Cycle I accomplishments include improvements to the transparency of, and consumer engagement with, the rate review process. The Division held its first public hearing in two decades on a proposed health insurance rate change during Cycle I. Because of the amount of interest generated by the hearing, the Division decided to hold public hearings on most individual and small group rate hearings going forward.[17]

[11] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 2.
[12] See Statement of Teresa Miller, Administrator Oregon Insurance Division Department of Consumer and Business Services On Affordable Care Act: Impact on Health Insurance Rate Review Before the Senate Committee on Health, Education, Labor & Pensions United States Senate, August 2, 2011.
[13] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3.
[14] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3.
[15] Oregon Health Insurance Rate Review Grant Program Cycle II, Year 1, Quarter 4 Report (Includes Cycle I No-cost Extension Report), October 2012, page 3.
[16] Oregon Health Insurance Rate Review Grant Program Cycle II, Year 1, Quarter 4 Report (Includes Cycle I No-cost Extension Report), October 2012, page 3.
[17] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3-4.

In addition, the Cycle I grant enabled Oregon to contract with a consumer advocacy organization, the Oregon State Public Interest Research Group (OSPIRG), which elevated the level of consumer participation in the rate review process. OSPIRG was able to encourage broader and more informed consumer participation, not only in the form of written comments, but also in attendance at public hearings held on rate filings.[18] OSPIRG also provided recommendations for improvements to the rate review process.[19] Also, because OSPIRG subcontracts with seven other nonprofit organizations, the Division's relationship with OSPIRG has had the effect of broadening community capacity.[20]

Also during Cycle I, the Division participated in a collaborative effort through SERFF to make the consumer disclosure template part of the filing process.[21] Additional funds were used to create and publish a new rate review guide for consumers[22] and to create a seven-minute animated video to explain health insurance costs and the Division's role in regulating rates. The video was posted to the Division's website in both English and Spanish.[23] Division staff also participated in several legislative and congressional town halls, as well as meeting with civic groups, associations, or other organizations to engage stakeholders in the rate review process.[24]

System enhancements accomplished during Cycle I included working with the Central Services Division, formerly the Information Management Division (IMD), to develop a work plan for system improvements, begun during Cycle I. The improvements were completed during the no-cost extension period and included:

- Creating an exportable database to allow any visitor to the website to use and compare rate filing information;
- Creating the capability to coordinate SERFF with the Division's back office system to eliminate dual data entry;
- Completing website enhancements, including interactive components of the website, such as information on growth in premiums, enrollment in different market segments, financial and market data, and profiles of Oregon's major insurers.[25]

During Cycle I, the Division also began work to develop the consumer disclosure document generated from the preliminary justification data required by the federal rate review regulation and posted to the Division's website. Because of the no-cost extension, Oregon was able to complete the programming required for this document and, in Cycle II, began requiring that it be included with rate filings.[26] Additionally, during Cycle I, the Division began the process of purchasing and installing the video technology that would allow people to watch public hearings from their computers. During the no-cost extension period Division staff was able to complete this process, and they are now able to live stream and record all rate hearings.[27]

[18] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 2.
[19] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3-4.
[20] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 11.
[21] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3-4.
[22] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 7.
[23] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 3-4.
[24] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 8.
[25] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 5.
[26] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 5.
[27] Oregon's Health Insurance Rate Review Grant Program Cycle I Final Report Template, page 4.

E. Cycle II Rate Review Grant

Oregon's Cycle II rate review grant was awarded on September 20, 2011 in the amount of $4,040,777. The grant period extended from October 1, 2011 to September 30, 2014. In year 1 of Cycle II, funds were used to contract with Wakely Consulting Group, resulting in two initiatives: a report, *Actuarial Analysis: Impact of the Affordable Care Act on Small Group and Individual Market Premiums in Oregon*, and analyses for the Governor-appointed Essential Health Benefit Workgroup, which resulted in the recommendation to the Governor for Oregon's benchmark plan choice that was submitted to HHS.[28]

The Division hired two more staff members with Cycle II funds: a rate liaison and an Exchange coordinator. In addition to increased rate scrutiny, the additional staff members allowed greater collaboration with Cover Oregon, the developing health insurance Exchange, and its rate review needs.[29] The Exchange Coordinator position in particular is responsible for identifying and facilitating resolution of issues affecting both agencies and assuring that regulatory, policy, and operational decisions affecting Cover Oregon and the private market are consistently addressed between the Division and Cover Oregon. Examples of the duties of the position are serving as a member of the Cover Oregon actuarial workgroup, providing legal analysis and technical advice on existing Oregon ratemaking regulations, staffing a DCBS advisory committee (a committee established by SB 91) that would recommend standard plan designs for the individual and small group markets, and providing oversight of the contract with Wakely on the development and implementation of Oregon's risk adjustment and reinsurance programs.[30]

F. Cycle II Accomplishments

Twenty-one public rate hearings were held during first year of Cycle II. Some hearings covered both grandfathered and non-grandfathered plans or addressed several plans offered by a parent company in a single hearing.[31] The new rate review guide – describing the rate review process and educating the public about how to get involved – was posted to the Division's website during Cycle I and was made available in printed form during Cycle II. Nearly 400 copies of the guide were distributed at public forums, town halls, and public hearings.[32]

The consumer liaison – a permanent position at the Division – established an outreach program to inform consumers about and engage them in the rate review process. The consumer liaison conducted rate review presentations in a dozen legislative and congressional town halls during Cycle II, reaching hundreds of Oregonians.[33]

Also during Cycle II, the Division outfitted the conference room with the video equipment needed for live web streaming and to create a video archive of hearings and make it accessible

[28] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 3.
[29] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 3.
[30] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 12.
[31] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 4.
[32] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 4.
[33] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 4.

on the Division's website. From April to September 2012, 646 unique identified users logged on to ten hearings that were available via the internet.[34]

Additional improvements to the rate review website were made during Cycle II. They included interactive tools that allow site visitors to learn about the Oregon health insurance marketplace and to compare companies, access rate requests, and review public comments and decision documents. Other improvements provided enhanced access for the public to engage with e-notify and public hearings, and to make comments.[35]

As stated earlier, during Cycle I, the Division delayed recommendations from the Lewis and Ellis study, noting that they would move forward with them at a later date. And move forward they did. Late in Cycle II the Division determined that cost and quality metrics would be required to be included in 2015 rate filings. They also enhanced the quality improvement and cost containment information provided to the public. In the fourth quarter of Cycle II, the Division participated in Oregon Health Policy Board workgroups that began meeting to discuss topics such as sustainable healthcare expenditures and how to use Oregon's all payer, all claims data base (APAC) in rate review. These workgroups have been carried over into Cycle III.[36]

Additionally, the Central Services Division completed the programming to use the HHS consumer disclosure format for all filings in Oregon during the Cycle II period that overlapped with the Cycle I no-cost extension period.[37]

III. Overarching Impact of Grant-supported Activities

The Cycle I and Cycle II grants allowed significant enhancements to the Division's health insurance rate review program. The feedback on those enhancements, provided by those interviewed for this evaluation, fell into four broad areas: procedural changes, bolstered by additional manpower; quality of the rate filing reviews; transparency and consumer involvement; and predicted and actual changes in rates post-ACA enactment.

A. Front Door Improvements

Improvements to the rate review process that fall into the "front door" category include those related to the enhanced standards, expanded filing requirements, and the improved process for the intake of filings. Various Division actuaries made positive comments about the enhanced standards, such as, "The standards are more refined…We've used the grant money to enhance the standards." This actuary went on to say that the enhanced standards have "dramatically improved the process."

In regard to the expanded filing requirements, one actuary made this statement: "Now we closely look at the components that make up their administrative costs—their commission structure, their taxes and fees—and those have been reined in." One actuary noted that the Division was

[34] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 5.
[35] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 5.
[36] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 3, Quarter 4 Report, page 3.
[37] Oregon's Health Insurance Rate Review Grant Program Cycle II, Year 1, Annual Report, page 5.

aware of a downward push on recent profit margins, due to the economy. Another Division actuary made this comment about the enhancements: "We request a lot more information on all of the factors that influence rates by lengthening our list of requirements." Additional comments by actuarial staff about the enhanced standards included this one: "My understanding is that the filings are more complete and that the companies provide more information in the filing. As we've gone back and forth with the companies, the companies have gotten a better idea of what we want them to include in the filings," and this one: "As far as the filings I've seen, I guess that the companies are doing a better job of providing filings that are written in more accessible language."

In addition to two new actuaries to implement enhanced standards and expanded filings, the grant funded a position to handle the intake of the rate review filings, the intake coordinator, also significantly improved the rate review process. An administrative staff member, who once held the position, described the intake coordinator's responsibilities as follows: 1) the coordinator conducts initial reviews to ensure the filings were complete (no content review at this stage); 2) the coordinator gives the company 24 hours to fix any discrepancies and/or submit any missing documentation or withdraw the filing and resubmit when able. She explained, "My responsibility was to do the initial review, then the 24-hour turn around. After this, the actuaries would deem the filing complete, and then the intake coordinator posts the filing to the website and monitors comments received about the filing." Other grant-funded positions related to front door improvements include a Project Coordinator, Market Analyst, Exchange Coordinator, and Administrative Assistant.

Many of the insurers filed incomplete or otherwise incorrect filings in the months prior to and immediately following the Oregon and federal health reforms. After the Division implemented grant-funded strategies to identify and promptly address these filing problems, most of the insurers learned what is necessary to submit a complete and responsive filing.

Increased Manpower and Time

A significant operational concern throughout both grant periods was management of an increased workload. The documentation necessary to address the additional data points being reviewed per the 2009 legislation, along with inconsistent rate filing ebb and flow, presented major challenges. Like many states, Oregon law allows only 30 days to review a filing, followed by 10 days to make a determination. The initial 30 days is concurrent with the public comment period. The challenge became more daunting when it became necessary to coordinate the rate review process with the needs of Cover Oregon. The additional grant-funded staff equipped the Division to meet those demands and those presented later with the first exchange filing.

One Division staff member put it this way: "[Before the grants] everyone tried to be really objective and I think at the time felt that they were being really objective. But what I see now is, that there's enough people to really have a peer review process going on, and it's because of the new filing season with small group and individual that the ACA brought about, it's just a lot more thoughtful, consistent, whole-market kind of view."

IV. Quality of Reviews

A. Division Staff Perspective

The enhanced standards and additional data points required for a rate filing in Oregon have, in the opinion of Division staff, improved the quality of the reviews. One actuary said this about the reviews: "Now we closely look at the components that make up their administrative costs—their commission structure, their taxes and fees—and those have been reined in." The actuary noted that the Division was aware of a downward push on recent profit margins, due to the economy: "For example, the new Oregon Health Report outlines 2011 financials and the average profit margins for the seven largest health issuers was two percent." Due to their attention to administrative costs and profit margin trends, the actuary said that Oregon had "One of the lowest amounts of MLR rebates in the country, which show[s] that we are doing a better job of keeping the MLR ratios up." (Actually, according to CCIIO records, insurers in only six states returned higher average rebates per family to consumers across all markets in 2012 than those in Oregon – but there are a number of factors besides the rate review program that could be responsible for that.)

Another actuary noted that the process is prescribed by the enhanced product filing standards: "Essentially what we do is review each component of the filing and if they make sense we don't ask questions." However, the actuary noted that most filings require 10-20 questions for clarification. A few staff mentioned that the filings required fewer questions since issuers are becoming better educated about the enhanced process.

Another Division actuary said, "Once we reach a conclusion (e.g., trend is too high), we usually approve a modified rate. We rarely just disapprove a rate. Instead, we will conditionally approve it contingent on modification of certain factors." The same actuary noted that, on occasion, the insurance company comes back with additional clarification to support their initial request or to support a rate higher than the initial decision. When that happens, the Division actuary does not ordinarily change the decision, but may do so if deemed appropriate. Ultimately, the Division is the final arbiter in the rate making process.

The Division applies the generally applied standards of "reasonable, adequate, and nondiscriminatory" to its review of rates. It is important to note here that the degree of attention paid to business expenses, the examination of capital and surplus, and consideration of profitability as part of the routine rate review process are elements of only a very few state rate review processes and their inclusion define for many the "gold standard" of rate review.

Some of the comments made in the actuarial interviews pointed to the various ways that considering these factors enhance the rate review process. For example, the actuaries noted that they generally communicate to the carriers what the expectations are for administrative cost growth. Expectations are usually that the growth rate would fall under the CPI for health insurers. For the last several years that would be three and nine tenths percent. So, growth under that index would be acceptable. The Division would expect a reduction for anything filed above that percentage.

The actuaries reported that, when examining submitted administrative expenses, they look at outliers among other issuers. They also look at the administrative expenses in light of a carrier's financial statements and at administrative expenses the carrier claims on its filings for other lines

of business. A Division actuary noted, "We've expanded this since 2010 by, for example, looking closely at the levels of surplus comparing to their levels of sales. We have several new applicants to our market and we want to make sure that carriers have enough surplus to handle the new business as they grow." Another actuary said, "We challenge assumptions where RBC [Risk Based Capital] is very high and there is a high profit and risk margin because we believe this is a redundancy."

In regard to profitability, one actuary noted that the Division does not allow any kind of risk margin trend to be used as a rating factor and that the entire margin should be easily visible as part of the profit. Although there is no hard and fast rule for the amount of profit that is allowed, there is a general consensus that profit can be reduced or eliminated if the proposed rate increase is high. Solvency is also considered, though it was noted that it is rarely a factor. Past profits are considered, as well.

The actuaries and other rate review staff were in agreement that both the Cycle I and Cycle II rate review grants made possible the enhanced reviews they are now able to conduct. In particular, that the additional staff, improved standards, and enhanced IT made available by grant funds have allowed them to spend more time examining assumptions on which rate filings are based. One administrative staff said, "We download information from SERFF nightly. A lot of the IT upgrade went into making our back office system more compatible with SERFF to avoid duplicative data entry."

One Division actuary observed that he and his colleagues are able to "...look at more factors and drill down to a finer level of detail than anyone else in the country because of the additional actuaries and other rate review staff." Another noted that because of the more rigorous and thoughtful rate reviews, they are able to conduct they are able to cut more rates and don't have to take the "machete" approach to do so.

B. External Stakeholder Perspectives

While both actuarial and administrative staff members interviewed agree that the additional staff, efficiency improvements and expanded review data points have made significant improvements to the quality of the Division's rate reviews, there are mixed opinions about the process from some of the external stakeholders interviewed.

Three of the seven industry representatives interviewed think the Division's reviews have gotten tougher since the enhancements. Three others opined that the Division has always been tough and they have not noted significant change. The seventh insurer representative was not involved with Oregon rate filings before 2014.

All of the insurers commented that the amount of documentation required is more burdensome than other states and a few thought that there is too much focus on non-actuarial requirements. One said that the trend exhibit and five-year administrative expense report history are not helpful documentation. One insurer said that the enhanced requirements added a week of work to prepare a filing; another said that it took 100 additional man hours to meet the additional requirements. One insurer said that, despite the additional time needed to prepare a filing, the process has become more consistent, and another commented that the Division actuaries are very

responsive to questions. Most carriers communicate with the Division primarily through SERFF, with some phone calls and fewer emails.

One insurer commented that the Division has not asked about the adequacy of rates and the rates approved sometimes seemed to be arbitrarily lowered from the initial rate submission. He noted that insurers need to use the best assumptions for each block of business in order to maintain adequate reserves. Another insurer was concerned that the Division seems to "not like" profit margins above three to four percent. That insurer also commented, "I have observed that some of the companies file negative profit margins like negative ten percent, negative eleven percent profit margin. This, as an actuary, I feel, if you're putting negative eleven percent profit margin, or in other words, an eleven percent loss, those rates are not adequate. And I would like the Department to push hard on those carriers and not allow them to use negative profit margins."

One insurer stated that his company now files lower assumptions because of pushback. Another has found that any trend filed above CPI requires a lot of justification, and sometimes trend and expenses would have to be squeezed in elsewhere. Another insurer similarly found that there was more scrutiny of assumptions and that the Division was more prescriptive. Most insurers felt that the Division did not negotiate rates; rather, the Division questions assumptions (although one carrier described this as negotiation on factors and assumptions) and either approves the requested rate or changes it.

The Senator who was interviewed thinks an examination of surplus should play a bigger part of the review. He said, "So I think surplus needs to be quantified to the degree that the insurance commissioner can actively use those [statutory] tools and say 'No, we're not going to go along with this because not only are you sitting on $150,000,000 more than any truth-based actuary will tell you that you need to pay claims, even in a disaster, but you also sent $50,000,000 from the individual market up to your holding company.'" He added, "You just never see that where surplus is taken into account in a significant way in the rate filings. So I think that could be a big advance, if they could take a look at how to quantify some of those things..."

The OSPIRG representative observed that the Division is pushing back more aggressively on rate increase requests. He added that he would like to see more questioning about the insurer's bad debt liability, since that should be decreasing as more people are covered. It is interesting to note here that one insurer said that answering OSPIRG's questions (per their contract with the Division) as well as those of the Division actuary makes working with an Oregon filing more time intensive.

V. Review of Filings

The actuary who served on the evaluation team reviewed all rate filings listed on oregonhealthrates.org that were submitted during three selected time periods: January 1 – June 30, 2010 (the "pre-reform" period), June 1 – August 31, 2011 (the "middle" period), and October 1, 2012 – March 31, 2013 (the "post-reform" period). His review focused on the types of support provided in the filing, the Insurance Division's questions and requests for further information, and the Division's decision regarding the filing. The review was based on

information posted on the System for Electronic Rate and Form Filings (SERFF) and on oregonhealthrates.org. The results of his reviews comprise the remainder of this section.

Thorough and competent rate reviews were performed during all three of the time periods considered. Nonetheless, there were some differences among the three periods. The reviews during the latter two periods were marginally more thorough than those during the pre-reform period, particularly with respect to claims trend analysis. More standardized exhibits were required during these periods. One result was that detailed trend data was available for all filings whereas such data was only provided for some of the pre-reform filings and usually only after requested by the reviewer.

Nearly all of the pre-reform filings were approved as filed. In contrast, nearly all of the rate increases reviewed for the middle period were reduced from the requested level, often based on the Division's claims trend analysis. When the reviewer's judgment differed from the carrier's judgment, the reviewer's judgment was imposed. In some cases, the initial decision was for an even smaller increase than was ultimately approved, but the carriers were allowed to submit further justification, resulting in acceptance of more, but not all, of the carrier's assumptions. The trend factor initially used was reduced in four of five individual reviews (grouping similar filings) and one of the three small group reviews during the middle period.

Another difference between reviews during the pre-reform and middle periods was institution of a more collaborative approach among Division actuaries, probably reflecting the increase in staffing. The SERFF record for many middle period filings include email strings through which the primary reviewer sought and received input from one or more other actuaries within the Division before finalizing a recommendation.

During the post-reform period, about half of rate increases were reduced from the amount initially requested. Claims trend assumptions did not play as central a role as during the middle period. It appears that in contrast to the middle period, the carrier's and the Division's expectations for future trends were similar during the post-reform period.

A. Filings reviewed

Based on the three time periods identified, the filings listed on oregonhealthrates.org, and the submission dates listed on SERFF, I identified 45 filings for review as summarized in the Table 1. As noted below the table, the third time period may be expanded to include more filings.

Table 1

	Individual		Portability		Small Group	
Time Period	Number of Filings	Members	Number of Filings	Members	Number of Filings	Members
1/1/10-6/30/10	2	53,033	5	2,144	10	315,985
6/1/11-8/31/11	8	64,810	1	4,882	5	94,832
10/1/12-3/31/13	5	23,821	6	6,111	4	107,097

Portability plans were available to those losing group coverage. Two plans are required to be offered, a "prevailing" plan and a "low" plan with a lower level of benefits and therefore lower premiums. Although they are individual plans, they are rated differently. Portability claims experience is pooled with large and small group experience. Due to adverse selection, claims per member are generally significantly higher for portability plans than for group plans. As a result, loss ratios are generally well over 100% for portability plans. Carriers can add a small pooling charge to their group rates to make up for the losses on portability plans. Another restriction on portability rates is that the rate increase cannot exceed the average increase for group plans.

The 46 filings reviewed are summarized in Table 2. In some cases, two or more filings were related and were reviewed together. These are indicated by dotted lines rather than solid lines separating the rows in the table. For example, the last four individual filings in the table are from John Alden and Time, which are affiliated companies that offer identical products and rates. Each company had one filing for non-grandfathered policies and one for grandfathered policies.

Table 2

Issuer	Effective Date	Date Submitted	Members	Days from submission to approval	Filed Increase	Approved Increase
1/1/10-6/30/10 ("Pre-reform" period)						
Individual						
Regence BlueCross BlueShield of Oregon	7/1/10	3/26/10	23,200	41	0%	0%
LifeWise Health Plan of Oregon	9/1/10	3/31/10	29,833	97	15%	15%
Portability						
PacifiCare of Oregon	7/1/10	3/8/10	309	59	-0.1%	-0.1%
UnitedHealthcare Insurance Company	7/1/10	3/10/10	122	27	6.3%	6.3%
LifeWise Health Plan of Oregon	8/1/10	3/26/10	500	18	11.9%	11.9%
Health Net Health Plan of Oregon	8/1/10	4/08/10	1,205	75	32.4%	20.6%
Connecticut General Life Insurance Company	4/1/10	4/8/10	8	78	0%	0%
Small Group						
Health Net Health Plan of Oregon	4/1/10	1/4/10	36,844	36	12.2%	12.2%
Regence BlueCross BlueShield of Oregon	7/1/10	2/9/10	57,390	37	12.9%	12.9%
ODS Health Plan	7/1/10	2/9/10	15,194	50	16.5%	16.5%

Issuer	Effective Date	Date Submitted	Members	Days from submission to approval	Filed Increase	Approved Increase
Kaiser Foundation Health Plan of the Northwest	7/1/10	1/22/10	31,700	96	9.9%	9.9%
Health Net Health Plan of Oregon	8/1/10	2/5/10	37,189	56	13.5%	12.5% (With-drawn after approval)
Aetna Life Insurance Company	7/1/10	3/29/10	189	122	9.4%	9.4%
Kaiser Foundation Health Plan of the Northwest	10/1/10	3/31/10	31,700	50	9.9%	9.9%
UnitedHealthcare Insurance Company	7/1/10	4/12/10	10230	43	0%	0%
PacificSource Health Plans	10/1/10	5/21/10	38,565	66	15.4%	15.4%
Regence BlueCross BlueShield of Oregon	10/1/10	6/10/10	56,984	N/A	13.7%	With-drawn
6/1/11-8/31/11 (Middle Period)						
Individual						
Providence Health Plan	11/1/11	6/2/11	11,186	78	-0.5%	-4%
Kaiser Foundation Health Plan of the Northwest	1/1/12	7/8/11	2,657	119	6.9%	4.9%
Kaiser Foundation Health Plan of the Northwest	1/1/12	7/8/11	6,813	119	8.8%	6.9%
Health Net Health Plan of Oregon	10/1/11	7/13/11	4,015 Rev: 2,310	68	6.3%	5.1%
Health Net Health Plan of Oregon	10/1/11	7/15/11	510	36	7.2%	With-drawn
Health Net Health Plan of Oregon	10/1/11	8/26/11	508	31	3.3%	2%
ODS Health Plan	11/1/11	7/29/11	26,333	69	9.94%	8.94%
PacificSource Health Plans	1/1/12	8/30/11	12788	50	5%	3.9%

Issuer	Effective Date	Date Submitted	Members	Days from submission to approval	Filed Increase	Approved Increase
Portability						
Kaiser Foundation Health Plan of the Northwest	1/1/12	8/26/11	4,882	46	15.5%	8%
Small Group						
UnitedHealthcare Insurance Company	12/1/11	6/15/11	13,021	118	6.6%	1.2%
UnitedHealthcare Insurance Company	12/1/11	6/15/11	13,021	118	6.6%	1.2%
Kaiser Foundation Health Plan of the Northwest	1/1/12	6/16/11	32,642	99	8.68%	8.68%
Health Net Health Plan of Oregon	10/1/11	6/30/11	36,148	70	3.1%	2.7%
Health Net Health Plan of Oregon	10/1/11	8/5/11	0	67	3.1%	2.7%
10/1/12-3/31/13 ("Post-reform" period)						
Individual						
Pacific-Source Health Plans	4/1/13	12/11/12	15,391	62	9.39%	9.39%
John Alden Life Insurance Company	7/1/13	3/21/13	82	75	14%	10.9%
John Alden Life Insurance Company	7/1/13	3/21/13	216	75	7%	6.6%
Time Insurance Company	7/1/13	3/21/13	3,609	75	14%	10.9%
Time Insurance Company	7/1/13	3/21/13	4,523	75	7%	6.6%
Portability						
The Mega Life and Health Insurance Company	1/15/13	11/29/12	0	N/A	0%	With-drawn
PacificSource Health Plans	4/1/13	12/26/12	346	42	3%	3%
Regence BlueCross BlueShield of Oregon	5/1/13	1/2/13	4,983	54	9.1%	6.2%
ODS Health Plan	6/1/13	1/28/13	439	44	7.6%	7.6%
UnitedHealthcare Insurance Company	7/1/13	3/29/13	182	48	6.2%	6.2%
UnitedHealthcare of Oregon	7/1/13	3/29/13	161	48	7.4%	7.4%

Issuer	Effective Date	Date Submitted	Members	Days from submission to approval	Filed Increase	Approved Increase
Small Group						
Health Net Health Plan of Oregon	1/1/13	10/10/12	27,596	71	5.9%	5.9%
Kaiser Foundation Health Plan of the Northwest	4/1/13	12/14/12	32,221	117	5.0%	4.5%
Providence Health Plan	8/1/13	3/22/13	29,773	56	5.7%	3.7%
UnitedHealthcare Insurance Company	3/30/13	7/1/13	17,507	47	6.6%	6.6%

The number of days from submission to approval provides a rough measure of efficiency. However, some delays may be due to the company being slow to respond to questions rather than to limited resources at Insurance Division. A short time between submission and approval could indicate the lack of a thorough review rather than efficiency, but that is not the case for these filings, all of which appear to have been reviewed thoroughly. Based on this sample, there is no significant difference among the three periods with respect to the time between submission and approval. It's important to note that the relatively long review period for the two individual Kaiser Foundation Health Plan filings during the middle period was due a company request for an extension on a related form filing. Excluding these filings, the average review periods were 59 days for the pre-reform filing, 67 days for the middle period and 62 days for the post-reform period.

The difference between the requested increase and the approved increase may be a crude indication of the effectiveness of the review process. Some differences among the three periods are apparent. The pre-reform filings were nearly all approved as filed, while nearly all rate increases requested during the middle period and about half during the post-reform period were reduced from the amount initially requested. However, a filing approved as filed does not indicate an ineffective review. If review standards have been clearly communicated the initial filing is more likely to be appropriate and not need to be changed than if review standards are inconsistent or not communicated prior to the filing. Also, reducing or denying a reasonable rate request, resulting in inadequate rates, does not indicate an effective review and may have negative consequences in the form of solvency problems, market withdrawals, or the need for much larger rate increases the following year.

Because, as described above, the statistics do not necessarily provide a meaningful comparison of the review process during different time periods, it is necessary to look at the specifics of each filing, the issues that were identified and how they were resolved, as well as any issues that were not identified but perhaps should have been. While this analysis is necessarily somewhat subjective, I believe it results in a more meaningful comparison.

B. Pre-reform filings

Nearly all of the filings from the "pre-reform" period were approved as filed, but only after what appears to be a thorough review. Public comments were received on several of the filings but did not appear to affect the review. The comments were mainly general objections to the rate increase that did not raise substantive issues regarding the filing.

Individual:
The **Regence** filing was not a rate increase for existing benefits but was an additional rate to cover expanded maternity benefit. The filing indicated that the benefit expansion was pursuant to an agreement with the Insurance Division. The impact on rates varied from 1.4% to 6.2%. The 0% shown on oregonhealthrates.org apparently excluded the rate change due to benefit changes. The reviewer requested and received clarifications and additional information before approving the filing. Two exhibits as well as the response to the objection were marked confidential by the company, but all documents were marked for public access by the reviewer in the SERFF Disposition. There was no discussion of this in the correspondence, so it is not clear whether the company had an opportunity to defend its claim of confidentiality. Oregon has very broad public access standards, so perhaps it was clear to both parties that confidentiality could not be provided.

The **LifeWise** filing was for a 15% average rate increase. In addition to requesting clarifications and additional information, the reviewer asked detailed questions concerning the claims trend assumption. Only three months of trend were provided in response to the reviewer's request for numerical support. The filing was approved.

Portability:
PacifiCare, a subsidiary of UnitedHealthcare, requested a 0.1% rate decrease, determined using the pooling mechanism prescribed by the Division. The reviewer asked several questions. Satisfactory responses were provided and the filing was approved. The company had requested that certain information in the filing be held confidential and submitted redacted versions of the relevant documents for public use as well as unredacted versions for the Division's use. However, the Division denied the request. The company initially requested a hearing to contest the decision, but later withdrew that request.

UnitedHealthcare requested a 6.3% rate increase. The reviewer asked several questions. Satisfactory responses were provided and the filing was approved. The company had requested that certain information in the filing be held confidential and submitted redacted versions of the relevant documents for public use as well as unredacted versions for the Division's use. However, the Division denied the request. The company initially requested a hearing to contest the decision, but later withdrew that request.

LifeWise requested an 11.9% rate increase. The reviewer asked several questions. Satisfactory responses were provided and the filing was approved.

Health Net had two types of plans, "managed care" and "PPO," each with prevailing and low options. The company requested a 32.4% increase in its new business rates. The filing stated

that its portability rates were among the lowest of all carriers, and therefore wanted to switch from its previous methodology to the methodology approved for Providence, which produced higher rates. The company requested a smaller 15% rate increase for renewing plans to cushion the effect of the 32.4% increase. They stated that if the state required less than a 32.4% for new business rates, they would have to raise the 15% to mitigate the cost burden. Two rounds of questions were asked and answered. In SERFF, rather than the responses being posted by the company, they were apparently provided by email and the reviewer posted them in SERFF as Reviewer Notes. However, the responses referred to "tables below" that were not posted. The company then amended the filing "based on our discussions with the OID" indicating that the proposed two-tier increase was unacceptable. Instead, they requested a 20.6% rate increase for both new and renewing members, "commensurate with our rate increases in our Group business." The amended increase was approved.

Connecticut General did not request any rate change, but submitted a filing because annual portability filings were required. The "Actuarial Demonstration" table was blank. Instead, an explanation was provided saying that the rates were based on large group rates, adjusted only to comply with 2 to 1 limit on age variation. Questions were asked and answered and the filing was approved.

Small Group:
The **Health Net** filing for April 1, 2010 was for a 12.2% average rate increase. The company asserted that an 18.22% would be needed to achieve an 80% loss ratio but requested the smaller increase, which reflected a 1% profit margin. The Division asked several questions, which the company answered, although it provided only a general explanation of how the 13.25% claims trend factor was developed. The proposed rates were approved only after the filing was modified to limit the "non-demographic" portion of the rate increase to no more than 30% for any group. This change apparently did not change the average increase rounded to one decimal place. The company requested confidentiality for some elements of the filing based on trade secret. This request appears to have been granted as the documents on the public website are redacted.

The **Regence** filing for July 1, 2010 requested a 12.9% average rate increase. This company also requested redactions of portions of the filing, but the request was denied and the company did not contest the decision. Also similar to the Health Net filing, only a general description of the development of the claims trend factor was provided in response to the reviewer's request, but in this case, the reviewer followed up, asking for more detail, which the company provided. The filing was then approved.

ODS requested a 16.5% average rate increase, which was approved after satisfactory responses were provided to the Division's questions. As in the case of Regence, the company's request for confidentiality was denied and the denial was not contested.

The **Kaiser** filing for July 1, 2010 requested a 9.9% average rate increase. As in the case of Health Net, only a general description of the development of the claims trend factor was provided in response to the reviewer's request and no follow-up questions were asked. The trend factor used was a relatively low 6.6%. The company stated that the 0.7% profit margin included in the filing was a step between the 2.9% loss in 2008 and the company's goal of 4%. The reviewer noted that the gain for the first three quarters of 2009, the most recent data available,

was already 0.7% and asked why a rate increase equal to trend plus the new premium tax would not be sufficient to maintain the margin. The company responded that they take a longer view in forecasting and that the gain in the second quarter had been unusually positive, which they considered an aberration. They also stated that they wanted to keep rate increases stable to avoid adverse selection and that the 0.7% margin was below their goal. The Division pushed back, stating that the fourth quarter loss has turned out to be quite small; that they were not convinced by the argument about uneven rate levels by quarter causing anti-selection, and that the company had not justified the need for a target profit margin above 0.7%. The Division said it estimated that an annual increase of 8% rather than 9.9% would be appropriate. This apparently led to discussion by telephone as the company's response said "Per our discussions, I have updated the Rate Filing Summary with our 2009 actual experience and added a reference to the new mandated child hearing aid benefit. As clarification to the power point page we submitted as a note to the reviewer; the 1.1% increase in retention is referring to the change in the admin plus commission load that we are charging groups excluding premium tax. In 2009 our non-POS 4-step charge was $61.54 and our 2010 charge is $62.19." The updated exhibit shows a 2009 loss of 0.8%. Another new exhibit justifies the proposed rate increase based on 6.7% for trend, 1% for the new premium tax, 0.15% for the new hearing aid mandate, and 1.85% to improve the margin. The requested increase was then approved.

The **Health Net** request for August 1, 2010 was for a 13.5% average rate increase. The company requested confidentiality for some portions, but the request was denied. The filing included a brief and general description of the claims trend development. Questions were posted on SERFF, but responses were not. The Division approved a 12.5% average increase, based on a reduction of the profit margin from 2% to 1%, the same as had been used in the previous filing. However, the company later withdrew the filing before it was implemented, saying, "After the rate filing described below was approved, Health Net chose to withdraw the filing because the company decided not to implement the planned changes to benefits outlined in this summary at this time."

Aetna requested a 2.93% increase for third quarter of 2010 and 3.2% per quarter thereafter. This would be 12.6% annual increase for third quarter renewals. A request for confidentiality was denied. The Division's first request for additional support began, "We have a few more questions than we had for your filing last year. Please understand that we are tending to ask similar questions for all rate filings now." This indicates that even this "pre-reform" period represented a more thorough review process than earlier periods. The company provided a brief and general response to the reviewer's question as to how the claims trend factor was developed. A follow-up response referencing "our email conversation on 7-12-2010" (which was not attached on SERFF) includes an exhibit showing 54 months of claims data yielding 19 months of rolling 12-month normalized trends. The data was not split between utilization and cost although another response indicates that cost trend was estimated separately based on provider contracting.

A few weeks after the initial filing, the company amended the filing, saying that "due to our recent notification of intent to withdraw from the Oregon Small Group market effective 3/1/2011," they were removing the trend increases for the third quarter and later based on a recommendation from the Division. This meant that the rates would remain at the second quarter level, but because those rates were higher than the rates in effect for the third quarter the

previous year, third quarter renewals would still receive a rate increase, averaging 9.4%. It is not clear whether the initially requested 12.6% increase would have been approved if filing had not been amended.

The **Kaiser** filing for October 1, 2010 requested a 9.9% average rate increase. This filing was very similar to Kaiser's July 1 filing discussed above. The questions from the Division were mostly to confirm that responses provided for the July 1 filing applied to the October 1 filing as well. The filing was approved as filed.

UnitedHealthcare's filing did not request a rate change but modified benefits for existing plans and added new ones. Questions were asked for clarification and the filing was approved.

PacificSource requested a 15.4% average rate increase. A graph showing 24 months of rolling 12-month claims trends was included in the filing and no questions were asked regarding trend. Questions were asked for clarification of other parts of the filing and to request revisions to exhibits where they were completed the way the Division wanted. The filing was approved.

The **Regence** filing for October 1, 2010 requested a 13.7% average rate increase. A claims trend exhibit was included in the filing, similar to the one provided on request for the July 1 filing. The company withdrew the filing 12 days after filing. No explanation for the withdrawal was provided on SERFF. No questions were posed by the Division, but this may have been because the filing was withdrawn before the review was completed.

C. Middle Period Filings

The middle period consists of the three month immediately before the federal rate review rule took effect. It also represents a time when initiatives under Oregon's Cycle 1 grant had been implemented and Cycle 2 had not begun. Public comments were received on many of these filings but did not appear to affect the review. The comments were mainly general objections to the rate increase or to rate increases in general, or comments on the rate review process, and generally did not raise substantive issues regarding the filing.

Individual:
The **Providence** filing requested a 0.5% average rate decrease. Despite the fact that the requested rates represented a decrease, the Division questioned several aspects of the filing. The Division's initial decision called for a 7% decrease based on three adjustments:

1. Elimination of a charge for guaranteed issue to children because of a new reinsurance facility to cover this risk; in response, the company explained that the savings from the reinsurance mechanism would be offset by the assessment to support the facility, but offered to reduce its base rate by 1.05% to assume some benefit from pooling
2. Reduction of claims trend assumption form 9.7% to 7.9%; in response, the company defended its trend assumption and proposed a middle ground of 8.8%.
3. Elimination of a 2% profit margin; in response, the company proposed a compromise 1% profit margin.

In its final decision, the Division approved a 4% rate decrease.

The two **Kaiser** filings proposed a 6.9% average rate increase for non-grandfathered policies and an 8.8% average rate increase for grandfathered policies. The Division's initial decision called for a smaller increases of 3.9% and 5.9% respectively, based on four adjustments:

1. Initial filing reflected combined Oregon and Washington experience. The Division required it to be based on Oregon experience only. The company argued that its Oregon experience supported the requested increase, but the demonstration did not reflect savings due to benefit changes while the comparable increase in the initial filing was after this adjustment. Therefore the Division rejected this argument.
2. The Division required a reduction in claims trend assumption from 6.5% to 5.5%. The company response requested 5.75%, but this was denied.
3. The Division's initial decision required a reduction of the trend in administrative expenses from 4% to 0%. Based on the company response, 3.5% was allowed.
4. The Division required 0.1% reduction to remove an adjustment for child only plans no longer being offered.

In its final decision, the Division approved rate increases averaging 4.9% for non-grandfathered policies and 6.9% for grandfathered policies.

Health Net initially filed a request for a 6.3% average rate increase on grandfathered policies followed two days later by a request for a 7.2% average rate increase for "tweeners," meaning policies issued between March 23, 2010 and September 23, 2010. These are non-grandfathered policies that had to be amended at renewal to meet certain ACA requirements. The company subsequently withdrew the latter request and replaced it with a combined filing requesting a 3.3% average rate increase on both the "tweeners" and other non-grandfathered policies. The Division approved smaller increases of 5.1 on grandfathered policies and 2% on non-grandfathered policies, based on two adjustments:

1. The medical trend assumption was reduced from 12.4% to 11.7% to reflect smaller adjustment for underwriting wear-off.
2. The adjustment for new ACA benefits was lowered by 1/12 because one month of experience period already reflected these benefits. This reduced the benefit adjustment from 1.25% to 1.15% for grandfathered policies and from 1.85% to 1.70% for non-grandfathered policies.

ODS initially proposed a 9.94% average rate increase. The Division's initial decision said, "We would like to see an annual decrease of 8.23%." However, based on a spreadsheet showing the development of the recommended increase, it is clear that it was intended to say an 8.23% increase. The adjustments were:

1. A reduction of unit cost portion of the claims trend from 6.8% to 5.8%, resulting in a 1% decrease in the annual medical trend to 10.3%, based on a comparison to other companies and continuing weakness in the economy. The company disagreed, but proposed 6.6% unit cost trend, the same as approved for Regence. The Division responded that they could not accept this just based on what was approved for another carrier. The company then provided evidence of higher trends on its large claims due to underwriting wear-off. The Division's final decision accepted the 6.6% unit cost trend proposed by ODS.

2. A reduction of the administrative expense trend from 4.1% to the Division's 3.9% benchmark.

The Division's final decision approved a rate increase averaging 8.94%, reflecting these adjustments.

I noted that the claims experience used in the filing reflected claims incurred through April 30 processed through May 31, which is only one month runout. This is less than typically used and therefore relies relatively heavily on an estimate of unpaid claims. The filing shows that 25% of the last month's incurred claims and 3.9% of last 12 months' incurred claims reflects an estimate of future runout. Since the filing was dated July 29, at least another month of runout could have been used. However, the Division did not request this. A Division actuary did review the completion factors and found them reasonable, indicating that the estimate was not biased. However, actual experience is likely to be higher or lower than the estimate, so it would have been prudent to look at another month of actual runout.

OSPIRG participated in this review, submitting questions, testifying at the hearing, and presenting a 16-page report. They raised issues regarding the company's relatively low medical loss ratio, the rate of growth in commissions, medical trend assumption, and cost containment and quality improvement efforts. Their report indicated that in some areas, they did not have sufficient information to draw a conclusion. They stated that it was not clear whether the company's cost containment and quality improvement efforts were sufficient. Given that they did submit written questions to the company, it is not clear why they did not ask for more information in this area. They did ask how the company's completion factors (used to estimate incurred but not paid claims) were developed, but complained that the response was general and did not provide supporting data or calculations. It is not clear whether OSPIRG had an opportunity to ask follow-up questions. It is not clear what impact, if any, OSPIRG's input had on the Divisions rate review process and decision.

PacificSource requested a 5% average rate increase. The Division's initial decision called for a smaller increases of 3%, based on two adjustments:

1. The Division rejected the company's assumption that the utilization trend would change from a 1.7% decreasing trend to 0%, citing a continued weak economy. The company responded that a 0% trend would continue the lower utilization of the last year. They also pointed to the possibility of pent-up demand. The Division apparently accepted this, as the approved increase does not appear to reflect any change to the original assumption.
2. The Division concluded that the leveraging factor was overstated. The company responded that they had explained how the factor was calculated and asked for clarification as to what concerns the Division had with it. The SERFF record cites a phone call during which the Division referred the company to another company's filing that used a lower factor based on Milliman guidelines. The company defended its approach as more accurate and also reiterated its expectation that utilization will revert to a higher level within two years. The Division's final decision made some changes to company's leveraging calculation, reducing it from 2.8% to 2.1%.

In its final decision, the Division approved a 3.9% average rate increase.

The filing specified a relatively low target loss ratio of 74.8%, prompting the Division to ask whether the company anticipated paying rebates. The company responded that they did not expect to pay rebates in 2011 or 2012, based on adjustments for taxes, quality improvement, and credibility. The Division then asked for a breakdown of these adjustments, which indicated that the credibility adjustment was 3.8%. The federal MLR would be 78.2 before the credibility adjustment and 82% after. Although the Division approved a smaller rate increase than requested, this reflected changes to the projected claims, not retention, so the MLR would stay at this level. This seems contrary to the Division's stated policy of requiring rates to prospectively meet the MLR standard without a credibility adjustment.

Portability:
Kaiser requested a 15.5% rate increase. The Division asked several questions, through which it was discovered that the company had inadvertently double-counted the premium tax in its rate development and that the request did not comply with the requirement that portability rate increases not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age. The average group increase was 6.8% and the age adjustment was 1.1%. The portability rate increase was therefore limited to 8.0% (1.068 x 1.011 - 1).

Small Group:
UnitedHealthcare filed 161 new plans. Although, as new plans, they would not be grandfathered, the Division directed them to submit two companion filings, one for non-grandfathered plans and one for grandfathered plans, because the plans would be available to both grandfathered and non-grandfathered current policyholders. The proposed rates were based on previously approved trend factors. In an objection, the reviewer noted that the previously approved 12% trend factor seemed high relative to recent experience and recent falling trends for other carriers and nationwide. The company responded that they (and other carriers, according to published articles) believed that the recent low claims trends were at least in part due to consumers delaying care because of the current economic situation. They expected that when the economy began to improve, they would see not only a return to previous higher levels of utilization, but perhaps additional utilization to make up for elective services that were put off.

The Division requested a breakdown of trend and the breakdown provided showed a margin for adverse deviation. The Division also stated that the administrative expense trend from 2010 to the rating period was 6.7%, whereas they generally expected this trend to approximate the annual increase in the Producer Price Index for the Direct Health and Medical Insurance Carriers Industry from the Bureau of Labor Statistics, which was 3.9%. The company responded that the Division had incorrectly calculated the annual trend. Because the rating period was December 12, 2011 to November 30, 2012, the annual trend was 3.4%. The SERFF record included an extensive email string and additional technical questions and responses relating to a "wear-off" adjustment to reflect the additional claims increase resulting from the wearing off of initial underwriting.
The Division's initial decision called for a 0.3% decrease from the rate level one year earlier rather than the requested 6.6% increase based on three adjustments:

1. Remove the margin for adverse selection.

2. Remove the "other" component of the claims trend because part of this was for health reform benefits, which the Division said should not be in trend and the rest was for "flu epidemics" and "changes in utilization due to economic conditions," which the Division considered to be in the nature of a margin, which they did not allow in claims trends.
3. Remove the wear-off adjustment. In this regard, the Division stated, "If we accept your hypothesis that new business group experience will deteriorate over time, we would expect such deterioration to be gradual. We also believe, if there is deterioration, it will be reflected in claims experience used to develop and justify the medical trend. Your approach would appear to double-count this possible effect. We have not seen any other carrier attempt to justify SEHI 'wear off.' However, we are willing to accept your adjustment for catastrophic claims."

Regarding the first two issues, the company responded that (a) the trend was previously approved and remained reasonable; (b) flu and uncertainty were mentioned in other carriers' approved filings; and (c) "Two recent examples of why we believe these components are appropriate are the release of the new Hepatitis C medications as well as the women's health initiatives, which we estimate will increase trends approximately 1.5% due to increased costs and utilization. These items were not explicitly accounted for in our previously approved trends. … Models from actuarial consulting firms show how the upcoming flu seasons will be different from prior years. It is a recognized fact throughout the industry that the prior flu seasons were understated and that there is an expectation to return to higher levels." Regarding the third issue, the wear-off adjustment, the company responded (a) that there may be a misunderstanding, that this adjustment was used to determine manual, undiscounted premium and therefore the proper comparison is to compare that premium to a mature claim level; and (b) durational wear-off is an actuarially accepted principle in small group.

Two rounds of follow-up questions and answers ensued to clarify the information provided and explore certain technical issues. After this, a second decision was issued allowing a 1.2% average rate increase. This change was based on:

1. The company's argument concerning Hepatitis C medications and women's health initiatives;
2. The company's argument that models from actuarial consulting firms showed that the upcoming flu seasons would be different from prior years.

The company responded with a request for an additional 3%. Arguing that since the wear-off adjustment was not being allowed, the comparison should be to average discounted rate level, which was 0.97 times manual rate. The Division responded that it was not persuaded and the company complied with the second decision.

Kaiser requested an 8.68% average rate increase effective January 1, 2012. The reviewer asked several questions relating to claims trend as well as other issues. The company was unable to provide some requested information, such as a breakdown of the 5.5% claims trend between utilization, unit costs, and other factors. Several questions also resulted in the company making corrections to the documents in the filing.

Emails between two Division actuaries, posted on SERFF, show concerns about the company's inability to provide the requested data and the number and magnitude of "corrections" to the filing. Follow-up questions pursued these areas. The company's responses included the following statements: "Though we do have data on our unit costs and utilization, our trend and rate development are not developed using this data. We are developing the capability to use both of these data sources in our future rate developments." "Our access to this information is limited, as Kaiser's medical professionals are employed by Northwest Permanente, PC, a distinct corporate entity. However, we did learn from our medical group that in 2011, we provided an average increase on the order of 3% to our Northwest Perm clinicians. There had been no significant increases for 3 years prior. On the external side, the annual increase for provider contracts for non-employees ranges between 5% and 6%." "The error was simply a link to an older version of the data source."

In response to a question regarding administrative expenses, the company said it had limited its administrative expense trend factor to 3.5%, the same as had been used in a previous filing after the Division objected to a higher trend. The company's actual administrative expense trend was about 8%. Another question noted that the company's projections had consistently forecasted positive profit but that results had consistently been negative and asked why. The company's response provided only a listing of general reasons that could cause this with no specifics as to what assumptions were wrong.

An internal Division email dated September 23, 2011, posted on SERFF, noted that the reviewer had spoken to a company actuary who noted that because some plans were being discontinued, a 90-day notice would need to be given once rates were finalized and that if approved rates were different from what was requested, it would add an additional five to ten business days to the time needed to get the notices out, making a January 1 implementation problematic. Nonetheless, the email included the reviewer's recommendation to management for smaller rate increase based on shaving the claims trend factor and the profit margin. Despite this recommendation, the rate increase was approved as filed. A note from the reviewer in SERFF stated that during a telephone conversation with then Commissioner Teresa Miller on September 23, 2011, the decision was made to approve this rate filing. The reason not stated, although the timing issue noted above may have been a factor. Other factors might have been the history of worse results than projected and the low claims trend relative to other carriers.

The first **Health Net** filing for October 1, 2011 requested a downward revision of the rates previously approved for the fourth quarter due to improving experience, reduced commissions. The company noted the need to retain market share in a very competitive environment and included a negative profit margin in the rates. While a decrease from the previously approved rates, this was a 3.1% average increase from the fourth quarter 2010 rates then in effect for these groups. The Division rejected the portion of the annual increase (0.4%) reflecting changes in plan relativities to allocate retention as a flat amount across all plans, instead of as a percentage of premium. This change should have been revenue neutral but was not. The company agreed to retain the old rate relativities and the filing was approved.

The second **Health Net** filing for October 1, 2011 was a new $1,500 deductible plan, rated on the same basis as the existing plans. The annual rate increase displayed was changed consistent

with what was approved on the renewal filing, but because the change in plan relativities only affected deductibles over $3,000, rates for the new $1,500 plan were approved as filed.

D. Post-reform filings

The post-reform filings reflect new standards under the Affordable Care Act (ACA). For example, the federal Preliminary Justification template was included and the federal medical loss ratio (MLR) standards were in effect. While the use of the MLR standard in rate review is optional for states with effective rate review programs, Oregon did apply this standard. As with the pre-reform period, these reviews appear to have been thorough based on the questions raised.

Individual:
The **PacificSource** filing requested a 2.27% trend increase for second-quarter rates over the first-quarter rates. This represents a 9.39% annualized increase. The filing applied to products introduced in the first quarter. Since the company adjusts rates only at renewal, the filing did not affect any existing policyholders but only new business rates. Presumably for this reason, it appears that no public hearing was held and no public comments were received. The most significant issue raised was that the projected experience met the 80% MLR standard only if a credibility adjustment was included. The company responded:

> The projected MLR is based on the rebate based definition of MLR and is included to illustrate that we do not expect to issue rebates even if we achieve our target loss ratio of 75.4%. The credibility adjustment of 2.4% is identical to what was filed in the approved January 1, 2013 rate filing.

The rates were then approved as filed. As in the case of the earlier PacificSource filing discussed above, this seems contrary to the Division's stated policy of requiring rates to prospectively meet the MLR standard without a credibility adjustment.

The **Time** and **John Alden** filings requested a 14% increase for non-grandfathered policies and a 7% increase for grandfathered policies. The request was based on combined grandfathered and non-grandfathered experience. The reason for the larger increase on non-grandfathered policies was that the rates had not previously been adjusted for new benefits added pursuant to the ACA. A public hearing was held but no members of the public testified or submitted written comments. Two issues resulted in changes to the proposed rates before they could be approved. First, the proposed rates reflected trending to January 1, 2014, the midpoint of the rating period assuming the rates would remain in effect for 12 months, but the company planned to terminate all non-grandfathered policies on December 31, when members would have to switch to new 2014 plans. Therefore the Division required the rates to reflect the earlier October 1, 2013 midpoint for the actual rating period.

The second issue did not affect the overall average increase but affected how it was allocated by plan and therefore affected the relative increases for grandfathered and non-grandfathered policies. The company had proposed changes in its plan relativity factors based on claims experience. The Division questioned this because rating based on claims experience is not permitted. The company responded that they had interpreted the prohibition as only prohibiting rate variations based on the claims experience of any particular policyholder, but expressed

willingness to spread the increases over all plans if the Division interpreted it differently. At the public hearing, Michael Sink explained that any changes to plan relativities would have to be based on objective differences. Changes based only on claims experience may be due to selection (health status) and therefore were not permissible. The company was required to eliminate the changes in plan relativities but was permitted to do so in a revenue-neutral way. This reduced the average increase for grandfathered policies from 7% to 6.6%. The resulting increase in the increase for non-grandfathered policies was more than offset by the adjustment to the trending period, resulting in a reduction in that increase from 14% to 10.9%.

Portability:
Mega Life filed new forms to comply with ACA benefit requirements. The company had no portability plans in force. The filing indicated a rate change of 0%, but for reasons that were unclear, the Rate Detail in SERFF indicated a weighted average increase of 3.5%. The rate reviewer asked questions, but they were not answered because the filing was withdrawn at the recommendation of the forms reviewer, who indicated that due to multiple problems with the filing, it would need a complete overhaul to comply with federal and state regulations. Withdrawal was recommended because portability plans would not be offered as of 2014.

PacificSource requested a 3% rate increase, which was its average group rate increase after adjusting for benefit changes. The reviewer asked several questions. Satisfactory responses were provided and the filing was approved.

Regence requested a 9.1% rate increase. The Division's Decision stated that this "exceeded the average rate increase for their group business, 6.2 percent." However, the company's response to the reviewer's questions showed an average group rate increase of 5.7%. It is not clear what adjustments resulted in 6.2%.

ODS requested a 7.6% rate increase. The request would have been more if not for being limited to the carrier's average group rate increase. The reviewer asked several questions. Satisfactory responses were provided and the filing was approved.

UnitedHealthcare Insurance Company requested a 6.2% rate increase and **UnitedHealthcare of Oregon** (formerly PacifiCare of Oregon) requested 7.4%. These increases were determined using the methodology prescribed by the Division for portability rates and did not exceed the carrier's average group rate increase. The reviewer asked several questions, which were answered, and the filings were approved.

Small Group:
Health Net requested a downward revision of the rates previously approved for groups renewing in the first two quarters of 2013 because Providence facilities were no longer included in its PPO provider network. This resulted in a decrease in the PPO area factors in the two areas where these facilities were located. While a decrease from the previously approved rates, this was a 5.9% average increase from the then current rates for these groups. The Division requested and the company provided additional support for the new area factors, after which the filing was approved. Some of the information provided was redacted because, as stated in the Division's

Decision, "it includes calculations and assumptions that showed explicit differences in contracted reimbursement rates and variations in provider network efficiency."

Kaiser filed rates to reflect the addition of coverage for Applied Behavior Analysis (ABA) for autism and for the federal reinsurance assessment. They did not request any change to the previously approved rates for the second and third quarters of "due to internal systems limitations," but did request higher rates for fourth quarter renewals. They also requested increased participation discounts for groups over 35 eligible employees with at least 75% enrollment with Kaiser, which had an estimated average impact is -0.35%. The reviewer said they had not approved filings that requested significant ACA taxes be implemented prior to 2014 and asked the company to explain its rationale. The company responded that (a) rules had now been released, providing less uncertainty about the fees; (b) the proposed charge reflected only the portion of the plan year in 2014; (c) without it, rates will be inadequate; and (d) the company's margin was negative even with it. The reviewer then requested that the fee be removed and the company complied, reducing the average rate increase from 5.0% to 4.5%.

Providence requested an average 5.7% rate increase effective August 1, 2013, based in part on 2014 ACA fees that would be in effect for part of the rating period. As in the case of the Kaiser filing, the Division required the fees to be removed, reducing the average rate increase to 3.7%.

I noted that the claims experience used in the filing reflected claims incurred through December 31, 2012 paid processed through December 31, 2012, which means no runout was included even though the filing was submitted nearly 3 months later. This is very unusual and relies relatively heavily on an estimate of unpaid claims. The filing shows that 8.4% of the incurred claims are based on an estimate of future runout based on completion factors. The reviewer did ask for the completion factors and how they were developed, but as in the case of the ODS filing discussed above, did not request runout data.

UnitedHealthcare requested a downward revision of previously approved rates for one product in one area for groups renewing in the last two quarters of 2013 to reflect to reflect improved provider contracts. They also expanded availability of this product to an additional county in the one area and of another product to two counties in another area. After the reviewer's questions were answered, the filing was approved.

E. Review of Filings Conclusion

As noted above, nearly all of the pre-reform filings were approved as filed. The only exceptions were one portability filing and two small group filings. The portability filing requested different rate increases for new and renewing members, which the Division found unacceptable. One of the small group filings was withdrawn by the company for reasons unrelated to the review. The other was reduced by 1% because the requested 2% profit margin was considered to be excessive in comparison to the company's previous filing and to profit margins approved for other carriers. The approval of most of these filings as filed does not reflect a cursory review. From the detailed questions asked of the carriers, it is clear that a thorough analysis was performed. However, in the end, the Division accepted the carriers' judgment with respect to trend factors and other assumptions.

Perhaps more noteworthy, nearly all of the rate increases reviewed for the middle period were reduced from the requested level. More standardized exhibits were required during this period. When the reviewer's judgment differed from the carriers' judgment, the reviewer's judgment was imposed. In some cases, the initial decision was for an even smaller increase than was ultimately approved, but the carriers were allowed to submit further justification, resulting in acceptance of more, but not all, of the carrier's assumptions. By far the biggest difference between the judgments of the reviewer and the carrier were in the claims trend assumptions. During the pre-reform period, the amount of support required to support the trend assumption varied from one review to another and in no case did the reviewer require a reduction in the trend assumption. In the middle period, a standardized trend exhibit was required. The reviewer observed that recent trends had moderated, both in Oregon and nationally. Several carriers argued that they considered this a temporary moderation due to the poor economy and they expected future trends to revert to past levels, or even higher levels due to pent-up demand. However, the reviewer apparently did not share this view and approved smaller rate increases based on lower trend factors. A reduction in the trend factor caused some or all of the reduction in the requested rate increase for four of the five individual reviews (grouping similar filings) and one of the three small group reviews. The one portability rate request was reduced for reasons unrelated to the trend factor.

Another difference between reviews during the pre-reform and middle periods was institution of a more collaborative approach among Division actuaries, probably reflecting the increase in staffing. The SERFF record for many middle period filings include email strings through which the primary reviewer sought and received input from one or more other actuaries within the Division before finalizing a recommendation.

During the post-reform period, about half of the requested rate increases were reduced from the amount initially requested. For the post-reform rate increases that were reduced from the requested level, claims trend assumptions did not play as central a role as during the middle period. While in some cases the changes included technical changes to the trend calculation, the differences between the carrier's and the Division's expectations for future trends that were apparent during the middle period were no longer evident in the post-reform period. One of the individual filings was approved as filed; however, this filing affected only new business rates and therefore did not result in any rate increase to existing policyholders. Three of the portability filings were also approved as filed. The prescribed methodology for portability rates leaves less room for judgment that is the case with other individual and small group filings. If the carrier followed the methodology correctly, the filing was generally approved. Two of the small group filings during this period were also approved as filed, but both were downward revisions to rates approved previously. In other words, the companies requested to implement smaller rate increases than had previously been approved for the rating period in question. The previously approved filings did not occur during the time periods covered by this report, so I do not know whether those filings were approved as filed.

VI. Transparency Initiatives

A. Perspectives on the Rate Review Web Page

Division staff, both actuarial and administrative, saw great value in the transparency efforts made possible by the grants. Oregon's rate review web site is generally considered by those in the health insurance regulatory and policy worlds as among the most transparent sites, notably because the Division does not redact information simply because an issuer claims it is "confidential." Division staff noted that there are some instances where information is not made public because the issuer is able to make a case that it is a "trade secret," but that is a rare event. The website posting also includes a consumer-friendly filing summary that is easier for consumers to understand than the issuer's version of the filing. Staff members said that CCIIO's frequent revisions of required rate filing documentation have made it difficult to initiate the filing summaries they eventually want to use. Those summaries will illustrate important points with chart and graphs.

Additionally, Oregon is one of very few states that include in the public-facing posting of the filing much of the correspondence between the Division actuary and the issuer actuary. Often this correspondence will demonstrate the reason behind a rate review decision and has significant value to an observer – whether an advocate or a consumer.

Other observations by actuarial and administrative staff about enhanced transparency efforts include one staff member who said, "Basically we went from 'no transparency to full transparency.'" And another who noted, "With regard to the rate filings, everything we receive from the time the rate is filed to the decision is posted to our website—the rate filings, our correspondence with the issuer, the hearings, public comments, the written decision...we try to get all of the specific information to the filing, as well as general information regarding rate review, to the public."

Additionally, a staff member said, "We wanted consumers to be able to see the breakdown of medical expenses. Now consumers can see that we actually have a process. Before, it was just a black box to them. I'm not sure how big of a difference this is, but now they can see all of the correspondence we do with the companies and they can see that we are probing the filings." And another said, "When you put all of the things we have done to increase public access together the difference is pretty considerable. People can see the filings and comment on them. There are several points where the public can be involved in the rate review process."

External stakeholders, while recognizing that Oregon's transparency efforts are above average, did have suggestions. The OSPIRG representative commented that he would like to see more transparency around the underlying data that results in trend assumptions and claims data presented in the filings. OSPIRG was instrumental in adding the communications between the reviewing actuary and the insurer's actuary to the website's filing data.

The State Senator interviewed noted that one insurer uses a "veil of transparency" by having a third party submit its findings. He would like to see something done to prevent that practice. He also believes that insurers should be required to send notices to their policyholders when they submit a rate increase proposal to the Division, so the policyholders would be made aware of the filing and could access the web site to see what was filed.

Insurers interviewed did not have much to say about the Division's transparency efforts, but one did comment that it is very difficult to have any documentation considered "proprietary."

Insurers generally did not think that giving consumers the ability to comment, either in person or through the website, is helpful nor did they believe that it resulted in many changed rates.

B. Web Site Transparency Comparisons

In an attempt to quantify the transparency efforts, the evaluators compared the transparency of Oregon's web site to those of the five states just below it and five states just above it in terms of population. Metrics for comparison were:

1) Where the state's rate review site falls in the results of a Google Search using the search term "(Name of State) Rate Review."
2) Number of clicks from the state insurance regulator's home page to rate review information.
3) Whether the web site includes a list of rate filings.
4) Whether the web site includes a search function.
5) Whether the complete filing is posted on the site, along with correspondence.

Each metric was scored, with lower scores indicating better quality rate review web sites. The results appear on the chart below:

State Name	Google search for "_(state)_ Rate Review" placement	Google search points	Clicks from landing page to rate review information	List of filings available? Yes=1, No=5	Personalized policy search available? Yes=1, No=5	Complete filing w/ communication Yes=1, No=5	**Total Score**
CO	First	1	3	1	5	3** unsure	13
AL	First	1	5	5	5	5	21
SC	First	1	4* "file not found"	5	5	5	20
LA	First	1	2	1	1	1	6
KY	First	1	5 No information	5	5	5	20
OR	First	1	2	1	1	1	6
OK	First	1	5 No information	5	5	5	21
CT	First	1	1	1	1	1	5
IA	Third	3	1* "file not found"	5	5	5	19
MS	First	1	1	1	1	5	9
AR	First	1	1* "file not found"	5	5	5	12

***Link to rate review page works, then message appears: "File not Found"**

****Could not view file without a plan name**

As the chart indicates, Oregon's (and Louisiana's) web sites place a close second to Connecticut's, with just one additional click necessary to reach Oregon's rate review filings. Several states had non-functioning links to their rate filings, possibly because the links originally led to the state's filings on Healthcare.gov and CCIIO is no longer posting that information. The metric remains valid because it demonstrates that states that post their own filings can avoid being subject to the actions of another entity and those states' consumers can rely on consistent availability of rate filing information. Also relevant is the fact that the presence of rate filings on state websites are largely due to the transparency requirements of the ACA and the federal rate review grants that helped many of the states build their rate review pages.

VII. Consumer Engagement

A. Public Hearings

In 2011, the Insurance Division began been holding public hearings on rate changes and now holds a hearing on every rate filing it reviews. The hearings consist of a meeting between Division staff and representatives from the insurer, in which the Division staff asks clarifying questions about the rate filing. The public can attend these hearings and can comment during the hearing or may sign up in advance to provide a comment via telephone. In addition to individual citizens testifying, a representative from OSPIRG or a special interest consumer group might testify. The equipment and staff that make the hearings possible, including technical upgrades to the hearing room to provide live streaming and video recording, were provided by the grants.

There are varied, and even some changing, opinions on the value of the hearings from Division staff and stakeholders. Some individuals indicated that they felt the hearings would not be worthwhile, but they eventually came to see their value, and some individuals who once favored the hearings now believe that they may not be necessary for every filing, particularly for very small rate changes, including decreases.

The first public hearing in two decades, held in June 2011, was on a Regence Blue Cross Blue Shield rate filing. The insurer requested a 22.1 percent rate increase, impacting more than 59,000 Oregonians. Attendance at the hearing was very high, estimated at between 100 and 300 people. Based on the attendance at the first hearing, the Division felt the hearings would be a mechanism to increase transparency, public participation, and consumer understanding of rate review. However, since then, hearings have not been very well attended. Division staff praised the ability to both live stream and record the hearings. Individuals interested in the proceeding, but unable to attend in person, can stream the hearing or watch it later. Despite low physical attendance at the hearings, virtual attendance has been higher.

Some Division staff and stakeholders interviewed suggested a number of potential reasons for low attendance at hearings. Some suggested that the low attendance could be due, in part, to the location and time of the hearings. The first, well-attended hearing was held in Portland in the evening. The subsequent hearings have been held in Salem during the afternoon. Portland is Oregon's largest city by a large margin and, as one individual interviewed noted, many of the most proactive citizens live in Portland. That same individual noted that it is likely that people living in Portland would not be inclined to travel to Salem for a hearing. Some individuals

interviewed also postulated that rate review was simply too technical a process to really create much public interest in the hearings.

Several insurers cited the low attendance as one reason why the hearings have increased the work involved in filing their rates, while providing relatively little benefit. Some insurers also cited additional time needed to prepare for the hearing and the time and money necessary to travel to Salem. Some Division staff and insurers alike suggested that they should perhaps consider a less resource intensive way to meet if attendance continues to be low. It was also suggested that the Division not hold hearings for every filing, but rather hold them only for filings that meet a certain rate increase threshold.

There may be value in the hearings whether or not they are well attended by the public. Several individuals from the Division expressed a belief that the hearings have increased transparency and that increased transparency was worthwhile in itself. They cited feedback indicating that open, accessible hearings are important to consumers, even if they do not attend. Furthermore, several Division staff and stakeholders noted that the hearings have educated the media and OSPIRG about the rate review process. The better educated media and OSPIRG ultimately may lead to better information disseminated to the public and to more informed consumers. Division staff also expressed a feeling that there is inherent value in having public, in-person discussions with the insurers, particularly because they increase communication between the Division and the insurers, and because both the Division staff and the insurers do not know who might be watching the hearing, so they must express themselves clearly.

The State Senator interviewed expressed a concern that the hearing was not nearly adversarial enough, and consisted of "softball questions." He suggested that asking questions about access to primary care and bending the cost curve, and requiring evidence on those issues, would be an appropriate and meaningful use of the Division's power during hearings. He said "Ideally, OSPIRG would have enough information to say, 'Carrier asked for 22%. We think it should be 12%.' Carriers block that every chance they get. Ideally OSPIRG would have time/opportunity to get discovery, cross exam – make it more 'adversarial.'"

Ultimately, it is not clear whether having a public hearing for every rate filing or the number of individuals attending the hearings has a direct impact on the approved rates. However, as many interviewed individuals expressed, the increase in transparency in the rate review process may, alone, be worth the time and expense of holding the hearings. Furthermore, the increased conversation between Division actuaries and insurers, the motivation provided for all parties to hit their time frame targets for review, increased carrier preparedness for the hearing, and perhaps even improved quality of filings, are all potential positive impacts of the hearings.

B. OSPIRG

As with most improvements to the rate review program made possible by grant funds, the general consensus on the contract with OSPIRG is that the group makes a valuable contribution. The commissioner made this statement about the value OSPIRG adds to the rate review process: "I look at OSPIRG in much the same way I look at the hearings. Having that third party representative has added a level of independent review and public awareness of the rate review

program, which is very important." However, she added, "OSPIRG's role and their effectiveness has evolved in the process. Part of this is that they've taken seriously the need to actively engage with actuaries. And they bring the public policy into the process, although we would really like it if they could 'beef up' their comments by giving us more concrete examples."

Several staff members said that OSPIRG has matured and its staff has become much more knowledgeable since they were first awarded the contract. At that time, they said, the OSPIRG actuary had only property and casualty (P&C) insurance experience. One staff member noted that the actuary expected the same kind of supportive documentation with their filings as is seen in P&C filings, when the data required with a health insurance filing is quite different. Staff noted the many contributions OSPIRG makes to the rate review process, including review of rates, questioning of insurers and speaking for consumers during public hearings, and consumer education. However, one administrative staff person noted that, while the Division followed OSPIRG's recommendation about posting Division actuaries' correspondence with insurers on the web site, they are not able to operationalize all of OSPIRG's recommendations. She said, "We've listened to them about posting to the web and the level detail of supporting documentation, but we have not changed our administrative rules and we have not been able to address the affordability issue yet." She added, "They are very helpful but they do create a lot of work for us. OSPIRG has set the bar a little higher for us...."

The OSPIRG Health Care Advocate noted that his organization would have been involved in the rate review process even if they hadn't been awarded the Division contract, but he added that their involvement would have been minimal and the contract allows OSPIRG to participate to a far greater extent. And the State Senator interviewed said that OSPIRG's involvement "absolutely has improved the consumer experience."

One Division staff member characterized the need for OSPIRG's continued involvement by citing an example from a public hearing. She said, "OSPIRG has really been very helpful in trying to get more and more people to understand. And it is confusing for people. We have a fragmented system. And so at one public hearing I was moderating, we had an older gentleman who sat patiently waiting to talk and when the time came he was there to protest an increase in his Medicare Advantage program. And so, you know, boy I had to be so diplomatic and really tell him, 'Gosh, you've waited so long and we'd be really happy to hear what you have to say about that, it didn't relate to this particular filing,' but you know it's so confusing for people."

VIII. Conclusions/Going Forward

A. Sustainability

As discussed throughout this report and demonstrated by the actuary's findings, Oregon has been able to make significant improvements to its rate review process over the past several years due, in large part, to the federal grant funds the state received. The grant money funded additional staff, cited as critically important to the improved rate review process. In addition to improving

the speed and effectiveness of the rate review process, the grant funds were used to increase transparency and consumer engagement.

The Division increased its technological capacity to conduct and stream hearings, updated the website to include all rate filing materials and receive public comment, and contracted with OSPIRG to represent consumers in the rate review process. Grant funding for OSPIRG has been continued through Cycle III and Cycle IV, which will end September 2016 unless there is an opportunity for a no cost extension. The Division has not yet considered whether it would seek funds for continuing OSPIRG's activities in its 2017-19 budget request. However, consumer outreach is available through the Division's Consumer Liaison and will continue to be funded in the Division's budget. The Division intends to continue funding its website and hearings, so as to maintain Oregon's status as an effective rate review state. The cost of the equipment necessary to record and stream hearings was included in grant funds and the Department foresees that any future cost will be within the Department's current budget.

Eight positions were funded by the Cycle II grant: a project coordinator, a market analyst, an intake coordinator, two health actuaries, a health rate liaison, an administrative specialist, and a health reform/exchange coordinator. One position was added with Cycle III grant funds, an operations and policy analyst. Many of the individuals interviewed indicated that the enhanced rate review would not have been possible without the new staff, particularly the additional actuaries. Similarly, staff indicated that filings came to the actuaries more complete because of the work of the intake coordinator. The Division staff noted that they felt that many of the new hires would be necessary to continue enhanced rate review into the future and maintain Oregon's status as an effective rate review state, past the expiration of grant funds.

Two of the grant-funded positions, the health rate liaison and the administrative specialist, have already been eliminated or not filled. An additional three positions; the project coordinator, the health reform/exchange coordinator, and the operations and policy analyst are limited in duration. The project coordinator position will end at the conclusion of grant activities. The health reform/exchange coordinator is slated to end in September 2015. The operations and policy analyst position will expire September 2016.

Ultimately, four of the grant-funded positions, the market analyst, intake coordinator, and two health actuaries, will become permanent positions. Permanent status has been achieved for these positions and they will be funded by the Division's operating assessment levied against insurers. Therefore, positions and functions that staff has identified as most critical to maintaining Oregon's status as an effective rate review state will be extended past the expiration of the grants funds through the Division's budget.

B. Going Forward - Conclusions

The improved rate review functions have, according to the former Cover Oregon staff member, been a significant help to Cover Oregon. He believes that operating in a state with such a strong rate review program has served to control premium rates, as evidenced by the competition among insurers to keep the 2014 rates affordable.

He said, "… from the exchange perspective we loved that we had robust rate review in Oregon because it satisfied all those requirements. We could essentially look to them to satisfy all of those pieces of the exchange responsibilities, in terms of looking at rates, and just the process itself; they were able to collect all the information that we needed. It was a boon to us, really, as an exchange, because it took a lot of those things off of our plates. I know that's sort of self-interested, but it was one less thing we had to worry about."

There is no reason to think that the Division's rate review process won't continue to provide this high level of service to Cover Oregon going forward. Similarly, the Division is working with the Governor's Triple Aim[38] program and the Division is exploring ways that rate review authority can be leveraged to promote affordability.

The significant improvements made to the Oregon rate review program due to funding from the rate review grants have touched every area of the rate review program from the quality of the reviews, to the high functioning web site, to the OSPIRG contract, and public hearings. The Division's efforts have applied these public funds in a manner that epitomizes good public service. The Division has made every grant dollar work to help Oregonians not only understand how their health insurance premiums are developed, but also to benefit from premiums that are reasonable and affordable.

Interviews with stakeholders yielded a few complaints and many suggestions, some rooted in the self-interest of the commenter and others rooted in a sincere interest in making the rate review program function more efficiently, or provide improved service to consumers. While all suggestions may not be feasible, given the leadership demonstrated in bringing the Division's rate review program to its current status, it is likely that many of the suggestions can and will be incorporated as the program evolves.

This statement by insurance commissioner Laura Cali sums it up best: "We set a baseline set of expectations when we began our new process and it has been an evolution since then. We started with what we thought a rate filing should look like, and in particular what a post-reform rate filing should look like. We had to evolve and think about the level of detail we wanted to collect. We've improved and expanded what we've collected. This is a work in progress; we still have more we'd like to do."

[38] Triple Aim is an approach to optimizing health system performance. The goals are: 1. Improving patient quality and satisfaction, 2. Improving population health, and 3. Lowering per capita health care costs. The "Triple Aim" was developed by the Institute for Healthcare Improvement and adopted by the Centers for Medicare and Medicaid Services (CMS).

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PacificSource Health Plans
Providence Health Plan
Regence BlueCross BlueShield of Oregon
UnitedHealthcare Insurance Company