

Rate Filing Decision Summary
June 1, 2011

Regence BlueCross BlueShield of Oregon
Small Employer Health Insurance

Basic Features of this Rate Filing

- Effective Date: July 1, 2011
- Requested Annual Average Increase: 10.8%
- Approved Annual Average Increase: 9.1%
- Number of Members Impacted on an Annual Basis: Approximately 54,299
- Applies to Non-Grandfathered Small Employer Health Plans

These Requested/Approved increase numbers are averages. Your plan's rate may change by a different percentage. Your insurer will notify you in writing of your plan's specific rate change.

Summary of Rate Filing Decision

DCBS approved a 9.1 percent average annual increase for Regence's non-grandfathered small employer group plans instead of the 10.8 percent requested. This rate change reduces a previously approved rate increase that became effective December 1, 2010. As a result of this filing, rates will be an average of 5.3 percent less than what they would have been without this request. The approved increase is intended to cover the projected rise in health care claims costs. The company has recently experienced lower than expected claims costs and reductions in the company's administrative costs and is requesting a reduction in previously approved rates to pass these savings on to consumers.

With this filing, Regence is joining other major insurers in Oregon that have recently sought decreases in previously approved rates. DCBS must evaluate if these decreases are sustainable and thus will not result in large increases at a later date. We must also consider whether the reduction is sufficient in light of declining claims costs or other factors. DCBS agreed that Regence's more recent data supported approving a reduction in previously approved rates but we determined that the average annual rate increase should be reduced to 9.1 percent, instead of the 10.8 percent requested. This further reduction from the requested rate change will result in an additional savings to members of approximately \$4.1 million per year, an average savings of \$6.34 for each member per month.

Recent medical and pharmacy claims costs were less than the company had predicted in their last filing. The history of claims paid is one of the factors companies consider when calculating expected claims paid. Known or expected changes in other factors such as payments to providers, how often members seek health care, and the type of health care services members use must also be considered. In this filing, Regence projected a 12 percent increase in medical claims costs and a 14 percent increase in prescription drug claims costs. However, DCBS disagreed and reduced the projected increases in medical claims costs to 11.1 percent and pharmacy claims costs to 13.1 percent.

With this 9.1 percent approved increase, Regence projects it will lose 2.2 percent on this business over the next year.

Regence reported no changes in their cost containment and quality improvement initiatives. The company gave more detail about existing efforts, including:

- Participating in a two-year pilot project, Medical Home Initiatives, which has contracts with 14 medical groups in the state to improve health care outcomes for people with complex chronic conditions. The project uses strategies such as RN-provided care management for these identified “high risk” patients and payment methods that reward the medical groups for specified measured improvements.
- Changing all contracts with major hospitals to require them to comply with the Oregon Association of Hospitals and Health Systems guidelines, “Non-Payment for Serious Adverse Events”, intended to reduce errors that harm patients.

Public comments submitted to DCBS related to rate filings indicate consumers are concerned about the impact of insurers’ top management compensation on premium costs. For 2010, the executive salary expense for the company’s senior executives was 0.16 percent of premiums. This represents approximately \$0.46 of a member’s premium each month.

The company decreased their projected administrative expenses so that administrative costs for these policies will be about 1.1 percent lower in 2011 than in 2010. This is less than the 3.9 percent annual increase in the U. S. government index that DCBS uses to determine whether changes in administrative costs are acceptable.

DCBS received comments regarding this filing, including detailed comments from the Oregon State Public Interest Research Group (OSPIRG). Using federal funds granted to the state to implement health care reform, DCBS contracted with OSPIRG to enhance consumer participation in the rate filing review process. DCBS comments regarding the feedback received from OSPIRG appear in the document that immediately follows this posting.

We also received the following detailed questions about this filing and have included answers to these questions below:

1. *Why are certain cost factors not quantified, e.g. "administration, overhead, premium taxes, portability charges, and assessments for OMIP (Oregon Medical Insurance Pool)?" The Affordable Care Act requires insurance carriers "to provide details of administrative costs and executive compensation," not simply line item summaries.*

The public filing document “Premium Retention” quantifies Operating Expense, OMIP Assessment, Portability Charge, Premium Tax, Commissions, and Contribution to Surplus both as percentages of premium and as dollars per member per month. Also, the public filing document “Five Year Trend of Administrative Costs” quantifies these costs in ten different categories (salaries, depreciation, rent, advertising, etc.) for every year from 2006 through 2011. Executive compensation we take from the public statutory annual statement, which is audited annually by an independent firm and audited every

three years by the Insurance Division's auditors.

2. Insurance carriers typically do not make profits from underwriting (premiums collected minus claims paid out) but rather from the "float" (the time difference between collecting premium and paying a claim) and the interest and investment income it generates. What is Regence's investment income and why are they permitted to request rates that seek to ensure an underwriting profit?

Sometimes companies do make underwriting profits even when they do not intend to; the estimation of future claims is inherently uncertain. The underwriting equation is not only premiums minus claims but must also allow for administrative costs. In this filing, Regence does not seek an underwriting profit. They seek to move from a 3.5% underwriting loss, which is fairly severe and probably unsustainable over the long term, to a smaller 0.9% underwriting loss on this small group business. The company as a whole has had underwriting gains of 1.9% in 2010, minus 0.1% in 2009, minus 1.1% in 2008, minus 2.5% in 2007, and 1.0% in 2006, averaging to roughly minus 0.16% over the five years. They have had investment gains of 3.0% in 2010, 1.2% in 2009, 2.1% in 2008, 3.6% in 2007, and 2.1% in 2006, averaging to roughly 2.4% over the five years. Actually, little investment income is generated from "float." For some kinds of insurance, investment income can play a decisive role in overall profitability. For example, property and casualty insurers routinely have underwriting losses but remain profitable because they earn investment income based on long lag periods between when premiums are earned and when claims are incurred. Health insurers earn investment income, too, but the investment income is a smaller factor in the company's overall profitability because most claims incurred are settled within one year of earning the premium. By the way, most of the investment income is earned on the company's surplus.

3. Why is the referenced "experience period" only from July 1 to August 31 while the request rate increase is for 12 months? Shouldn't these two periods be roughly equivalent, i.e. the experience period should match in duration the period of any requested premium increase?

The public "Development of Rate Change" document in the filing states that the "experience period" is from September 1, 2009, to August 31, 2010, which is twelve months, and this is appropriate, even if the new rate period is for a much shorter duration, as adequate experience is needed to credibly project claims, regardless of the duration of the new rates. In this case, the new rate period is from July 1, 2011 to September 1, 2012. This means that these 3rd quarter 2011 rates will be effective for groups that renew in the 3rd quarter of 2011, until their next renewal. For example, a group renewing on 9/1/2011 would pay these 3rd quarter 2011 rates until 9/1/2012. The new rates may not be used for quoting purposes or for renewals after 6/30/2012. That is, groups renewing 9/1/2011 would indeed pay these rates until 9/1/2012, but groups renewing 7/1/2012 and later would get rates from a filing that is yet to be made. Our policy is to approve rates for no more than twelve months.

4. A payout ratio of 82.3% is below the 85% mandated by the Affordable Care Act for all not-for-profit Blue plans. Why is this not being enforced?

We are not aware of any ACA provision that singles out Blue Cross plans. However, Section 2718 does specify 80% for small group and individual plans; 85% is only for large group plans. Furthermore, the federal standard of 80% (or 85% for large groups) is allowed to include not only claims costs but also costs of “Deductible Fraud and Abuse Detection/Recovery Expenses” and “Health Care Quality Expenses”, and a further allowance is made for the costs of federal and state taxes. The medical loss ratio figure that you picked up from our filing is based on Oregon’s more stringent calculation and is not allowed to include these costs or make allowances for federal and state taxes. In other words, this filing easily meets the federal standard.

This Rate Filing Decision Summary is intended to be a tool for consumers and others to help explain the rate filing and the decision made by the Oregon Insurance Division and is not intended to describe or include all factors and information considered as part of the Oregon Insurance Division’s rate review process.

The Department of Consumer and Business Services approves health insurance rates in the individual and small group markets. Under Oregon law, the department considers actuarial documentation to ensure that rate increases are reasonable in relation to the benefits provided under the policy and that the rate requested is fairly allocated among the ratepayers. In that light, the department reviews multiple factors related to proposed rate changes including the insurer’s revenues, medical and prescription costs, administrative costs, actual and projected profits, and past rate changes as well as the impact the change will have on Oregon consumers.

Insurers request rate changes periodically. An insurer cannot increase rates of your health benefits plan more than once in a 12-month period. When an insurer requests a rate change quarterly, new customers pay the new rate immediately and the change accumulates over a 12-month period. Specific rate changes may vary from this summary, in part because insurers offer different benefit plans.

Glossary of Terms:

Administrative costs: Expenses the insurance company pays to operate this insurance plan. This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the company’s offices and equipment, commissions to agents to sell and service policies, subsidies to cover legally required plans such as portability, the Oregon Medical Insurance Pool, and taxes.

Medical and prescription costs: The portion of the premium that pays for medical services and prescriptions.

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.



**Response to OSPIRG Comments on
Regence BlueCross BlueShield of Oregon
Rate Filing #GH 0075 11 Non-Grandfathered Small
Employer Health Benefit Plans**

June 9, 2011

Oregon State Public Interest Research Group (OSPIRG) conducted a comprehensive analysis of this rate filing as part of its grant-funded contract with DCBS to review health insurance rates on behalf of consumers. OSPIRG identified some areas of concern that are shared by DCBS. This is our response to OSPIRG's key findings.

While OSPIRG's comments recognize that the 10.8% increase is less than some of the historical increases that have been approved for this market segment, the OSPIRG analysis does not clearly disclose that this rate change actually lowers the amount consumers will pay. The rate change modifies the previously approved rate increase that was implemented in December 2010. With this filing, rates will be an average of 5.3 percent less than what they would have been without this rate request.

Medical and Prescription Drug Cost Trends

OSPIRG questioned the basis for projected medical and prescription drug costs, which exceeded the company's actual claims experience and the rates some other major Oregon insurers report and project. OSPIRG especially questioned the increase in the company's projected medical and prescription drug trends that resulted from including a fluctuation factor to account for cost variation.

In all rate filing reviews, DCBS gives detailed consideration to how trends are calculated and used in the rate development. DCBS uses historical claims information for the plan under review and trend assumptions for other carriers writing this type of coverage. The claims paid table in Regence's filing does not display the effect of cost sharing, which must also be considered in order to capture the total cost of medical and prescription drug costs. Other factors must also be considered, such as known or expected changes in provider reimbursement and how much and what types of health care services members use.

DCBS also questioned Regence's introduction of fluctuation in the trend calculations. Regence defended factoring in fluctuation in claims costs as standard actuarial practice and a way to ensure consistent pricing over time. DCBS considered it to be potential margin built into the trend assumptions. After consultation with actuaries in other state insurance regulatory agencies, who agreed with our conclusion, DCBS disallowed using the fluctuation factor in projecting medical and prescription cost trends.

DCBS found that, with the exception of fluctuation, Regence's methods and conclusions are consistent with accepted actuarial practices and their medical and prescription drug cost trends were in line with other recent filings by other insurers.

DCBS is in the process of revising its filing requirements to include more detailed information regarding medical trend to be submitted with future rate requests.

Insurer's Efforts to Improve Quality and Reduce Medical Costs

OSPIRG stated that the cost containment and quality improvement programs Regence listed in the filing lacked sufficient detail to tell whether these measures worked as intended and whether patient health was protected.

Regence expects to spend about 85 cents out of every premium dollar on health care services, which is similar to other small group plans in the Oregon market. DCBS currently collects information on changes to every insurer's health care quality improvement and cost containment efforts with rate filings and makes that information public. Regence's filing met the standards of our current review practices. However, we are considering how to more meaningfully use quality improvement and cost containment filing information to affect where the majority of the premium dollar is spent. Using federal health care reform funds, we contracted with an independent actuarial firm to conduct a study to explore how our rate review process could be used to affect the underlying costs of medical services. Results of the study are due in the fall of 2011.

In response to OSPIRG's comment, Regence provided additional details. These include:

- Participating with four other health plans in a two-year pilot project, Medical Home Initiatives, which has contracts with 14 medical groups in the state to improve health care outcomes for people with complex chronic conditions. The project uses strategies such as RN-provided care management for these identified "high risk" patients and payment methods that reward the medical groups, which are accountable for specified measured patient improvements.
- Enhancing their oversight of hospital discharge planning for members with more complex health care needs. Regence staff begins coordinating with hospital staff earlier in members' hospital stays to identify those who need additional care management and to ensure that discharge plans are sound, reducing the likelihood of readmission.
- Beginning in 2010, all Regence contracts with major hospitals require the hospitals to agree to guidelines that preclude payment for additional medical services that are made necessary by certain medical errors, categorized as "never events" or "serious adverse events."
- The \$9.2 million estimated savings amount is a 12-month savings estimate. The estimated savings from each particular effort in the cost containment and quality improvements exhibit of the filing is not explicitly calculated due to the concurrent and complementary nature of some of the programs and the variability in outcomes from any particular effort in the timeframe since implementation.

DCBS asks insurers to quantify the dollar impact of their quality improvement and cost containment programs, where possible. However, we recognize that some initiatives may take several years of experience before reaching any reliable conclusions about improving patient health and containing costs. In addition, savings from some community-wide health care improvement initiatives, intended to improve patient outcomes and contain costs, are difficult to attribute to one insurer though insurer participation may be essential.

Determining Rate Impact on Consumers

OSPIRG found it difficult to determine the true maximum and minimum rate increases that consumers would have, if the requested average annual rate in the filing is approved. They also cited finding instances of contradictory numbers within the filing.

We appreciate OSPIRG's concerns and in our review we dug deeper to learn more about the range of impact. Here's a brief description of what we found:

The Regence filing provided an 18.2% maximum and 1% minimum range for base rate increases. DCBS asked for better detail about what would cause a group to be at the higher or lower end of that range, so that could be considered in our review. Regence explained the range of increases is due to benefit changes as a result of PPACA and realignment changes. In general, high deductible plans receive the largest percentage increase. High deductible plans receive larger PPACA increases because the addition of preventive care benefits has a large percentage increase on plans with lower premiums. In addition, the rate realignment impacts result in larger increases to high deductible plans due to deductible leveraging, i.e., the proportion of member cost sharing due to a fixed dollar deductible reduces as total claims increase.

Apparent numerical inconsistencies were resolved during the review process. For example, a table in the filing displayed the percent of rate increase and the percent of members affected, with 0 percent members in the above 15 percent increase group, despite the statement that 18.2 percent was the maximum base rate increase. This apparent numerical contradiction resulted from the fact that so few members (146) could expect to receive a rate increase above 15 percent they were only 0.3 percent of the members. Because the table rounded all percentages to the nearest whole number, 0.3 percent rounded to 0 percent.

DCBS agrees that although the range of impact the rate increase will have on consumers is contained within the filing, the information could be presented in a more consumer-friendly format. DCBS is currently making information systems programming changes and developing administrative rules to use a new consumer disclosure document to display filing information more clearly. This disclosure document will be used for all health benefit plan rate filings.

Administrative Costs

OSPIRG expressed appreciation for Regence's attempt to limit administrative growth, but also commented that Regence might be artificially subsidizing administrative costs for these plans, which would not be sustainable and result in consumers being hit by price spikes in the future.

OSPIRG commented that Regence might be paying agent commissions equivalent to a percentage of the overall premium paid. Earlier this year, in an effort to further reduce operating expenses, the company moved from a percent-of-premium to a per-employee-per-month or per-member-per-month commission structure. As a result, projected commissions as a percent of premium decreased from 5.0% in the 12/1/2010 filing to 4.2% in this filing.

Regence stated that another projected reduction in their administrative costs was attributed to reducing claims processing costs with greater efficiencies. DCBS found their projected administrative savings to be reasonable.

Stability of Regence's Risk Pool

OSPIRG is also concerned that Regence small employer plans have had double-digit increases every year since 2007, which OSPIRG worries may lead to fewer healthier members in the risk pool. They cite as evidence that Regence has recently seen declining enrollment in these small employer plans. OSPIRG also notes that introduction of new plans with higher deductible limits will encourage healthier members to migrate to those plans and leave less healthy members in the standard cost sharing plans. OSPIRG encouraged DCBS to work with Regence to assess these possible issues with the risk pool.

DCBS considers the effect of rate changes on members and market stability as part of all rate filing analyses. DCBS shares concerns about migration of healthier members leaving plans. However, this filing made no benefit changes to existing plans; it requested a reduction in the rates for those plans. DCBS concluded that the rate decrease for existing plans would promote market competitiveness and could help the company attract new small group members.

Affordability

As in previous comments submitted by OSPIRG, this analysis addresses the affordability of coverage. DCBS recognizes that this is a high priority for consumers and appreciates OSPIRG's concern. The purpose of this filing was to reduce previously approved rates and, had this filing not been approved, rates would have been about 5% higher.

SERFF Tracking Number: *RGAC-127078860* *State:* *Oregon*
Filing Company: *Regence BlueCross BlueShield of Oregon* *State Tracking Number:* *GH 0075 11*
Company Tracking Number:
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.003A Small Group Only - PPO*
Product Name: *BCBSO July 2011 Small Group Filing*
Project Name/Number: */*

SERFF Tracking Number: RGAC-127078860 State: Oregon
Filing Company: Regence BlueCross BlueShield of Oregon State Tracking Number: GH 0075 11
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
Product Name: BCBSO July 2011 Small Group Filing
Project Name/Number: /

Disposition

Disposition Date: 06/01/2011

Implementation Date: 07/01/2011

Status: Approved

HHS Status: HHS Approved

State Review: Reviewed by Actuary

Comment: Approved annual increase is 9.1% for policy renewals (described below as the "impact").

Approved annual increase is 5.3% less than rates than were otherwise in effect for renewals (described below as the "impact").

The company asserted they could justify an annual increase of 10.8% (described below as the "indicated").

=====

Department of Consumer and Business Services

Oregon Insurance Division

Quality of service from the Oregon Insurance Division

We strive to provide excellent customer service at all times. Our performance objective is to complete the review process for rate and form filings within 30 calendar days of receipt. In order to meet this goal, we need your help.

Instructions for submitting a filing are on our Web site. Filings that contain errors may be returned without having been accepted for review. If we contact you about compliance-related concerns or correction that need to be made to the accepted filings, we must receive your complete response within 10 calendar days.

SERFF Tracking Number: *RGAC-127078860* State: *Oregon*
 Filing Company: *Regence BlueCross BlueShield of Oregon* State Tracking Number: *GH 0075 11*
 Company Tracking Number:
 TOI: *H16G Group Health - Major Medical* Sub-TOI: *H16G.003A Small Group Only - PPO*
 Product Name: *BCBSO July 2011 Small Group Filing*
 Project Name/Number: */*

Any disapprovals for reasons other than filing errors must be supported by our product standards unless accompanied by written Insurance Division management authorization.

If you believe we have failed to meet our performance objectives, please let us know how. We value your comments and will use this information to improve our service.

You may request that your comments be kept confidential; however, be aware that confidential feedback limits our ability to follow up, as your concerns cannot be shared with staff.

Please include the filing number with your response. Thank you.

Rhonda.I.Saunders-Ricks
 Oregon Insurance Division
 Manager, Rates and Forms
 Telephone: 503-947-7983
 Fax: 503-378-4351

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
----------------------	--	-----------------------------------	---	---	--	---	---

<i>SERFF Tracking Number:</i>	<i>RGAC-127078860</i>	<i>State:</i>	<i>Oregon</i>
<i>Filing Company:</i>	<i>Regence BlueCross BlueShield of Oregon</i>	<i>State Tracking Number:</i>	<i>GH 0075 11</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.003A Small Group Only - PPO</i>
<i>Product Name:</i>	<i>BCBSO July 2011 Small Group Filing</i>		
<i>Project Name/Number:</i>	/		
Regence BlueCross BlueShield of Oregon	10.800% 9.100%	\$ 54,299	\$225,809,081 16.500% -0.700%
Percent Change Approved:			
Minimum:	-0.7%	Maximum:	16.5%
		Weighted Average:	9.1%

SERFF Tracking Number: RGAC-127078860 State: Oregon
 Filing Company: Regence BlueCross BlueShield of Oregon State Tracking Number: GH 0075 11
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
 Product Name: BCBSO July 2011 Small Group Filing
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	4872 - Individual and Small Group Health Benefit Plan Rate Filings	Reviewed-No Action	Yes
Supporting Document (revised)	HBP - Filing Description	Approved	Yes
Supporting Document (revised)	HBP-Rate Filing Summary Options	Approved	Yes
Supporting Document	HBP-Rate Filing Summary Options	Replaced	Yes
Supporting Document	HBP-Rate Filing Summary Options	Replaced	Yes
Supporting Document (revised)	HBP- Actuarial Memorandum - Small Employer	Approved	Yes
Supporting Document (revised)	HBP - Rate Data	Approved	Yes
Supporting Document (revised)	HBP-Covered Benefit or Plan Design Changes	Approved	Yes
Supporting Document	HBP-Cost Containment and Quality Improvement Efforts	Approved	Yes
Supporting Document (revised)	HBP- Insurer's Financial Position	Approved	Yes
Supporting Document	3894 Certification of Compliance	Approved	Yes
Supporting Document	Third party filers letter of authorization	Not Applicable to filing	Yes
Supporting Document (revised)	HBP-Statement of Administrative Expenses	Approved	Yes
Supporting Document (revised)	HBP - Draft notice to policyholder	Approved	No
Supporting Document	2896 Benefit Modification & Discontinuance of Health Benefit Plans	Approved	Yes
Supporting Document	HBP - Draft notice to policyholder	Approved	Yes
Supporting Document	Response to Questions Dated 4-13-2011	Approved	No
Supporting Document	Response to Questions Dated 4-25-2011	Approved	No
Supporting Document	Response to Questions Dated 5-3-2011	Approved	No
Supporting Document	Response to Question Dated 5-6-2011	Approved	No
Supporting Document	HBP - Filing Description	Replaced	Yes
Supporting Document	HBP-Rate Filing Summary Options	Replaced	Yes
Supporting Document	HBP-Rate Filing Summary Options	Replaced	Yes
Supporting Document	HBP- Actuarial Memorandum - Small Employer	Replaced	Yes
Supporting Document	HBP- Actuarial Memorandum - Small Employer	Replaced	Yes
Supporting Document	HBP- Actuarial Memorandum - Small Employer	Replaced	Yes
Supporting Document	HBP - Rate Data	Replaced	Yes

SERFF Tracking Number: RGAC-127078860 State: Oregon
 Filing Company: Regence BlueCross BlueShield of Oregon State Tracking Number: GH 0075 11
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.003A Small Group Only - PPO
 Product Name: BCBSO July 2011 Small Group Filing
 Project Name/Number: /

Supporting Document	HBP - Rate Data	Replaced	Yes
Supporting Document	HBP - Rate Data	Replaced	Yes
Supporting Document	HBP - Rate Data	Replaced	Yes
Supporting Document	HBP - Rate Data	Replaced	Yes
Supporting Document	HBP-Covered Benefit or Plan Design Changes	Replaced	Yes
Supporting Document	HBP- Insurer's Financial Position	Replaced	Yes
Supporting Document	HBP- Insurer's Financial Position	Replaced	Yes
Supporting Document	HBP-Statement of Administrative Expenses	Replaced	Yes
Supporting Document	HBP - Draft notice to policyholder	Replaced	No
Rate (revised)	Plan Relativities, Base Rates, GAR Rates	Approved	Yes
Rate	Plan Relativities, Base Rates, GAR Rates	Replaced	Yes
Rate	Plan Relativities, Base Rates, GAR Rates	Replaced	Yes