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Comments on Regence BlueCross BlueShield's Proposal to Increase Health Insurance Rates

Filing #HL 0470 10

Health Insurance Rate Watch
A Project of OSPIRG Foundation

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The authors bear responsibility for any remaining factual errors. The views expressed in this report are those of the authors, and do not necessarily reflect the views of our funders, advisory committee, or those who provided analysis and review.

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Executive Summary

Regence BlueCross BlueShield of Oregon (Regence) is proposing to raise rates an average of 22.1% on individual plans. These are plans for people who do not have employer-based coverage. If approved, this rate increase will impact 59,477 Oregonians effective August 1, 2011.

OSPIRG Foundation's Rate Watch policy staff, consulting actuary, and advisory committee reviewed Regence's rate request, as filed with the Oregon Department of Consumer and Business Services (DCBS), as well as further information later provided by Regence.

After careful analysis of Regence's filing, we are concerned that Regence has not provided sufficient information to justify this rate increase. We are also concerned that a 22.1% average rate hike will drive Regence customers to drop coverage or decrease coverage with benefit buy-downs, destabilizing this pool and resulting in future rate increases.

Our key findings include:

1. Regence fails to acknowledge the impact of this rate increase on enrollment numbers, and fails to then account for the impact of ever-decreasing enrollment.

Regence does not project any meaningful change in enrollment, even though they have seen significant enrollment losses every year since 2007, when they began imposing double digit rate increases, and have lost 40% of the enrollment since that time. Absent a credible explanation for why they expect enrollment to remain steady, it is not realistic to believe that this trend will not continue, especially given the size of this increase. The proposed rate hike poses a significant risk to the stability of Regence's risk pool. An unstable risk pool would mean that Regence enrollees will face ever-higher premiums, as less healthy enrollees are stuck paying higher costs, while healthier enrollees drop their coverage or move to higher-deductible plans.

OSPIRG Foundation requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. Their response makes us even more concerned that Regence is failing to account for the impact that this rate hike will have on their enrollment and risk pool:

- Regence's response downplays the magnitude of its enrollment problem and the connection between enrollment and affordability of premiums.
- Regence's claim that there is no actuarial basis to project enrollment losses contradicts actuarial standards of practice.

Regence's reluctance to acknowledge this enrollment problem is puzzling, and refusal to build it into their rate filings is reason for concern. We recommend that DCBS only approve a rate change that ensures that consumers are protected from instability in Regence's risk pool in this market segment due to decreased enrollment and benefit buy-downs.

2. Regence fails to adequately justify their assumption that medical costs will increase at a rate of 12.6%.

- Regence's proposed medical trend of 12.6% a year is over six times higher than its actual claims experience of 2% in this market segment. According to the rate filing, the discrepancy is apparently due to the fact that Regence relies on models that it says correct for the impact of demographics and enrollees purchasing lower-benefit coverage. However, Regence fails to provide details of the methodology or underlying data supporting these models in the filing. Given the extraordinary gap between Regence's actual claims experience and their proposed medical trend, they should provide additional information.
- The medical trend appears to contain an inappropriate hidden profit margin in the form of a trend component labeled as "fluctuation."
- Regence does not appear to have taken into account the recent slowdown in medical costs reported by other insurers.

OSPIRG Foundation requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. In the response from Regence:

- Regence effectively refused to elaborate on how they arrived at the 12.6% figure, and strangely denied that their filing included an observed trend of 2% despite the filing listing the observed trend as 2% on page 3 of the Trend Information and Projection document.
- Regence confirmed that the "fluctuation" factor of 1.4% is indeed to factor in a margin of error[1]. This is in addition to the similar 1.1% "risk and contingency" factor elsewhere in the filing, and is worthy of careful scrutiny by DCBS.
- Finally, Regence's answer to the issue of the decreased medical claim trends of recent years[2] raised more questions than answers, and in fact, appeared to make the case for a much lower medical trend then Regence proposes.

3. Regence's estimates of the costs to comply with federal consumer protections may be inflated

Several consumer protections in the federal health care law that went into effect in September of 2010. These included requiring insurers to cover preventive care without requiring a co-pay, and preventing insurers from denying coverage to children with pre-existing conditions. To comply with these rules, Regence requests a cumulative 5.5% rate increase. This estimate is much higher than the 1-3% range independent analysts have suggested would be appropriate for these changes and higher as well than requests made by other insurers, but this discrepancy is not explained in the filing.

OSPIRG Foundation requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. In their response, Regence said that they believe the 1-3% range did not account for the law's requirement for insurers to cover essential benefits, but did not provide detail on how they developed the 5.5% estimate. Regence said that "These changes have been reviewed by

[1] See Regence response to OSPIRG item 10.

[2] See Regence response to OSPIRG item 3.

Milliman, an independent actuarial and consulting company." [3] Regence did not provide a copy of the Milliman review as part of the filing or supplemental information.

4. Regence should provide more detailed information about its efforts to reduce costs

The filing suggests that Regence is pursuing initiatives to lower health care costs while improving the quality of care. But in the filing, Regence provides only cursory information about these initiatives, the savings that have resulted so far and whether the savings are being returned to consumers in the form of lower rates. Given how critical these cost-saving measures are to the future of health care in Oregon, DCBS should request significantly more detailed information from Regence about its efforts.

OSPIRG requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. In its response, Regence writes: "It is all but impossible to break out specific savings on an item-by-item basis," and reiterated much of what was already outlined in the filing. Given the preponderance of encouraging studies from innovators such as the Cleveland Clinic and the Mayo Clinic, it is unclear why Regence is so pessimistic about their ability to track the effectiveness of each of their cost control efforts.

5. Growing surplus levels at a time when enrollment is spiraling down may be counter-productive.

Regence proposes to contribute 1.1% or more of premium to its surplus, even though its surplus is already ten times higher than its authorized control level risk-based capital. Especially given the concerns outlined above, this component of the rate increase proposal appears unnecessary.

Instead of imposing this sizable rate hike and sending dollars to surplus, it may make more sense to for Regence to redouble its investment in proven strategies to reduce medical costs, and forgo a growth in surplus in order to stabilize enrollment while those strategies have time to get results.

Before deciding to approve or deny this rate request, we urge the Insurance Division to scrutinize the details of this filing very carefully, and require Regence to outline a concrete plan to rein in costs and stabilize enrollment.

[3] See Regence response to OSPIRG item 4.

Key Features of the Proposal

State tracking # for this filing	HL 0470 10
Name of health insurance company	REGENCE BLUECROSS BLUESHIELD OF OREGON
Type of insurance	Major Medical Policy (individual)
Grandfathered under federal health reform?	Non-Grandfathered

Average rate increase	22.10%
Minimum rate increase	16.70%
Maximum rate increase	34.10%

Number of Oregonians affected	59,447
Anticipated enrollment if approved	59,447

Insurer's history of rate increases in this market	
2010	16.40%
2009	17.10%
2008	24.10%
2007	17.60%
2006	-16.00%

Proposed rate	
% premium to be spent on medical costs	79.20%
% premium to be spent on administrative costs	19.70%
% premium to be spent on profits	1.10%

Effective Date of rate increase	8/1/2011
Date rate filing posted	5/3/2011
Date comments due	6/15/2011
Link to rate filing:	http://tinyurl.com/3ctba9g

Basis for proposed increase	
Increase in medical costs	12.60%
Increase in Rx costs	12.60%

Insurer Information

For profit or non-profit:	Non-profit
State domiciled in:	OR
Parent company:	Regence Group

Insurer's financial position	
Year	2010
Surplus	$544,163,691
Investment earnings	$56,377,696

Surplus History Company-Wide	
Year	**Amount in Surplus**
2005	$466,860,469
2006	$533,543,425
2007	$552,188,131
2008	$486,124,238
2009	$565,197,607
2010	$544,163,691

Discussion of the Rate Filing

In each of the sections below, we discuss key questions about the rate filing and its impact on Oregonians.

Regence's Recent Changes to its Product Offerings

In 2010, Regence discontinued its existing line of individual health insurance products, the Blue Selections products, and introduced as replacements a new Evolve series of products, which Regence

argued would "better address the rising costs of care."[4] Compared to comparable previous products, the Evolve insurance products shift costs to enrollees through new deductibles, by increasing limits on prescription drug coverage, through increased coinsurance for preventive care, and by setting a limit on the number of medical office visits allowed before the deductible would apply and enrollees would have to pay coinsurance.[5]

Despite Regence's hopes that these changes would "better address" the rising cost of care, Regence's prediction of medical claims, remains unchanged from last year, at a steep 12.6%. OSPIRG Foundation requested additional information on this issue on May 16, 2011, and received Regence's response on June 1. Regence attributed the lack of Evolve's success to the federal health reform law, stating, "…the Patient Protection and Affordable Care Act (PPACA) required us to remove many of these cost-saving features."[6] Regence provided no additional explanation detailing what aspect of the PPACA prevented the implementation of exactly which cost saving features.

Absent a more clear explanation, it is not possible to determine whether the product changes resulted in lower claims and the claims assumption is inflated, or if the strategy to shift costs to enrollees failed to result in lower claims costs for the insurer. DCBS and the public deserve a more thorough explanation.

Medical cost trends

Are the projected medical trends, both cost and usage, supported by the data?

We are concerned that Regence's filing does not adequately support its projected medical and prescription drug trends. The claims experience data suggests that the trends Regence is using may be excessive, and the trends are higher than those used by other Oregon insurers. The additional information DCBS obtained from Regence about its trend calculations do not sufficiently address these concerns and we urge DCBS to further scrutinize this aspect of Regence's filing.

By applying DCBS's trend evaluation methods described in an earlier rate decision[7] to the information provided by Regence, we are concerned that the company's annualized medical and prescription drug trend of 12.6% may be excessive.

DCBS has previously indicated that it evaluates an insurer's projected medical trend by comparing it with (1) the insurer's own two year claims experience, and (2) the average medical trend reported by other insurers. DCBS has described this evaluation practice as actuarially acceptable.

[4] Notice of Benefit Plan Replacement, Regence Blue Cross Blue Shield, dated March 2010.
[5] Regence stated that enrollees in Blue Selections Plus products were shifted into Evolve Core products, while it appears that those with Blue Selections Premier coverage were moved into Evolve Plus products. These are the products that are compared in this discussion.
[6] See Regence response to OSPIRG item 1.

[7] DCBS evaluation methods as described in the February 16 DCBS rate decision on a United Health Plan small business rate increase.

1. Regence's two year claim experience

On the first criterion, Regence's "observed" medical trend over the last two years of claims experience data shows per-member per-month costs increasing at only 2.0% -- over six times smaller than Regence's proposed medical trend.[8]

Regence argues that this 2.0% trend is an underestimate because it does not reflect the demographic impact of aging, and changes in enrollee benefits. Over the course of the experience period, apparently many enrollees have shifted to plans with lower benefits. Regence says that by normalizing the experience data to account for these issues, the underlying trend increases from 2.0% to 10.6% (still short of the requested 12.6% trend).

This general approach to adjusting claims experience to account for these issues may be valid. However, Regence has not provided any documentation, supporting data, methodological explanation, or calculations explaining the specific adjustments it has made, making it impossible to determine whether their approach is reasonable.

Regence notes that it eliminated certain products in 2010 which led to temporarily decreased utilization, which would be consistent with expecting a higher medical trend in the future, but provides no further details of the expected impact of this change. The claims experience trend of 2.0% suggests that the medical trend could be significantly lower than the requested 12.6%. Without further information, it is impossible to determine whether the normalization is justified. Further, if in fact it is justified, it is unclear why Regence is not employing the 10.6% underlying trend they calculate, rather than the requested 12.6% trend, which is even higher.

2. Comparison to other insurers' approved trends

In the Oregon individual market, the weighted average approved medical trend was 13.6%, somewhat higher than Regence's proposed 12.6% trend.[9] However, we have previously voiced concerns that using the overall industry approved medical trend as a benchmark is flawed, and tends to self-perpetuate the status quo, rather than push each insurer to hold down medical costs. This is especially the case where, as here, Regence makes up a significant portion of the individual market, meaning that holding them to the market standard de facto allows them to set their own benchmark. A far better approach would be to analyze each insurer's efforts on their own merit, relative to their recent history.

3. Additional concerns

In contrast to DCBS' stated approach, Regence does not appear to calculate their medical trend by comparing to those used by other insurers, or even directly deriving it from their claims experience as adjusted and normalized. Indeed, Regence argues that claims experience has "little predictive value" (p. 19). Instead, in setting their medical trend, they note that they look to the change in the per-unit cost of

[8] Claims experience data is the amount the insurer has historically spent on medical claims in the market segment (see p. 20 of Regence's filing for month by month claims experience).
[9] Industry-wide annualized trend information is derived from data provided by DCBS to OSPIRG in March 2011.

services; the change in services used, including both overall utilization increases and shifts in what treatments are used; and the leveraging impact of deductibles and other fixed cost-sharing elements.

In additional information provided to DCBS after its initial filing, Regence provided a breakdown of these elements of its trend. These are reimbursement, at 5.7%; utilization, at 1.2%; mix and intensity, at 2.2%; leverage at 2.1%; and "fluctuation" at 1.4%. Regence did not provide details of how the specific values were chosen, and if they were derived from actual claims experience or from a mathematical model.

We have two additional concerns about Regence's approach. First, we are concerned that Regence's medical trend does not account for the recent slowdown in the rate of increase of health care costs. Regence has used the same medical trend of 12.6% in individual market filings going back as far as January 2010. However, recent press releases from numerous large insurers have indicated that in the first quarter of the year, they have found that their actual medical trends are lower than their projections, in part due to consumers decreasing their utilization of medical services, presumably due to the state of the economy.[10] Because Regence's medical trend has remained unchanged for so long, we are concerned that it does not reflect this recent trend towards decreased utilization and more slowly rising per unit costs.

Second, we are concerned that Regence may be building a hidden profit margin into their medical costs. We are concerned that the medical trend's provision for "fluctuation" may in fact be a hidden profit margin. Regence did not provide information on this fluctuation factor regarding this filing. But according to Regence's communication to DCBS about the recent small group filing regarding, this fluctuation factor, it is "based on the standard deviation of the rolling 12-month claim costs."

The standard deviation of monthly claim costs will reflect the extent to which claims are either higher than or lower than average over the course of the year. That is, any months in which claims were higher than average will be balanced by those with lower claims costs. Thus, it appears unreasonable to increase medical trend to account for fluctuations that will as often lead to lower costs as higher ones. If Regence's projections are accurate, this fluctuation margin will directly add to its surplus.

The rate filing already contains a 1.1% margin for risk and contingency, and this "fluctuation" factor is in addition to that margin. Further, by including this profit margin as part of its medical costs, Regence may be inflating its loss ratio. The supplemental information provided by Regence does not provide methodological details of how this fluctuation component was calculated, and thus we urge DCBS to examine it carefully to ensure that its inclusion is not inappropriate.

Regence's response to medical trend concerns

OSPIRG requested additional information on these issues on May 16, 2011, and received Regence's response on June 1.

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[10] See Aetna Reports First-Quarter 2011 Results, http://www.aetna.com/news/newsReleases/2011/pr_1stquarter2011_earnings.html; UnitedHealth Group Reports First Quarter Results, http://www.unitedhealthgroup.com/invest/2011/UNH-Q1-2011-release.pdf; Health Net Reports First Quarter 2011 GAAP Net Loss of $108.2 Million, or $1.16 a Share, http://healthnet.tekgroup.com/article_display.cfm?article_id=5538; see also Reed Abelson, *Health Insurers Making Record Profits as Many Postpone Care*, N.Y. TIMES, May 13, 2011, http://www.nytimes.com/2011/05/14/business/14health.html.

In their response, Regence effectively refused to elaborate on how they arrived at the 12.6% figure, and denied that their filing included a medical trend of 2%. Specifically:

- Regence asserts: "Our rate filing does not say trend is 2%."[11] However, the Regence filing (page 20) clearly states that the historical observed trend is 2.0%.
- Regence refused to explain the difference between the observed 2% figure and the "normalized" 10% figure. Instead, they wrote: "The 2% and 10% figures measure two very different things that cannot be compared," without any type of reconciliation between those very disparate numerical values.
- Regence refused to elaborate on the methodology used to create the 10% normalization figure, simply repeating the language in their filing[12] that prompted our request for more information..
- Regence did not show the calculations they used to ultimately arrive at the 12.6% projected medical trend figure.

This appears to be at odds with actuarial standards of practice. *Actuarial Standard of Practice No. 41: Actuarial Communications* states, **"**3.2 Actuarial Report… In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report."[13]

Regarding the hidden profit issue, Regence confirms that the "fluctuation" factor of 1.4% is indeed to factor in a margin of error[14]. This is in addition to the similar 1.1% "risk and contingency" factor elsewhere in the filing. This merits careful scrutiny by DCBS.

Finally, Regence's answer to the issue of the decreased medical claim trends of recent years[15] raised more questions than answers. Regence asserted that even though utilization has dropped recently, costs for common medical procedures have gone up. To back up this claim, Regence provided two examples where utilization went down and the cost per member per month increased because of increases in unit costs. We find several issues with these examples:

- First, it is nearly impossible to determine if these examples are truly representative of the state of the market.
- Second, the unit cost increases for these two examples were 28% and 24%, which are significant increases. On the face of it, this raises questions as to whether or not Regence's is using its size effectively to negotiate lower per unit costs.

[11] See Regence response to OSPIRG item 8.
[12] "TREND INFORMATION AND PROJECTION", pages 18 – 20

[13] http://www.actuarialstandardsboard.org/pdf/asops/asop041_120.pdf

[14] See Regence response to OSPIRG item 10.

[15] See Regence response to OSPIRG item 3.

- Finally, once utilization is factored in, Regence's own examples show a total cost increase of only 7% and 3%, both of which are significantly lower than the 12.6% annual medical cost trend used by Regence in its rate filing.

4. Conclusion on medical trend

In conclusion, Regence's filing does not appear to justify its choice of medical trend. We urge DCBS to require Regence to more transparently lay out its methodology for developing its medical trend assumptions, and encourage DCBS to clearly set out its own methodology for evaluating insurer's medical trend assumptions as part of the rate review process. We urge DCBS to carefully scrutinize both the fluctuation and risk and contingency figures. We also encourage DCBS to require insurers to provide full information about how they develop medical trend assumptions as part of every rate filing.

Insurer's efforts to reduce medical costs while improving quality

Is the insurer taking sufficient steps within their power to reduce health care costs while improving quality, and if so, are those steps achieving measurable results?

Because DCBS rules require insurers to only include new initiatives launched since their last rate filing, it is sometimes difficult to fully answer this question. We are pleased to see that Regence's filing appears to include both new and ongoing cost and quality efforts, although it is not clear if this represents the entirety of Regence's efforts in this area. We recommend that DCBS require insurers to detail all of their cost control and quality improvement initiatives in rate filings, which will help the public make apples to apples comparisons of what different insurers are doing.

We reviewed the list of initiatives Regence says that it is undertaking to lower costs and improve the quality of care, and compared it with a master list of six important practices, outlined below, that can address the largest factors driving up medical costs. Based on the information provided, Regence is pursuing efforts in all six categories, but provides only cursory references that make it difficult to determine whether these efforts are robust or effective.

Additionally, Regence estimates that its efforts have saved $9.2 million overall, with $1.7 million of these savings allocable to its individual book of business. There are some aspects of this claim that are unclear. Are these savings an estimate of annual or all-time savings? How much has each particular effort saved? How did Regence apply these $9.2 million in savings – did they reinvest them in similar initiatives, or share them with consumers in the form of lower rates?

We encourage DCBS to press Regence to address these questions in more detail. While we understand that there may be some uncertainty in estimating the precise savings from each initiative, this kind of analysis is a critical step towards getting a real handle on medical costs, and learning what initiatives appear to work best across the industry.

Six major initiatives to lower costs and improve quality, compared to Regence's current efforts		
Initiative	**Description**	**Regence's current efforts**
1. Reforming methodology of payment to providers	This includes initiatives such as moving away from a fee-for-service payment model, toward payment methodologies that reward best practices, quality care and outcomes.	The filing contains a short reference to a "pay for value" initiative, and a generic drug pay-for-performance effort. The extent of these programs is unclear.
2. Medical Home initiatives	This includes paying providers differently to best provide coordinated care.	A medical home pilot program is cited, but the extent of the program is unclear.
3. Benefit designs that encourage effective care, such as prevention and chronic disease management.	This includes no co-pays for essential preventative care treatments, low co-pays for treatments proven to be effective, and higher cost sharing for unnecessary procedures.	Regence has, per the federal health reform requirements, added coverage of some preventive services with no cost sharing. It also cites eliminating cost-sharing for the H1N1 vaccine. Since this is the only information provided, we cannot determine if Regence has a comprehensive plan in this area or not.
4. Management of prevalent chronic diseases[16] to reduce unnecessary hospital admissions and expensive escalations of these diseases.	This includes provider reimbursement and incentives for patient behavioral changes and clinical treatments that maintain the health of patients suffering from chronic diseases.	Disease management programs cited for chronic conditions. Regence states that in March of this year, it introduced a new program aimed at providing enrollees with rare and complex conditions with individualized treatment plans and personalized counseling to improve the coordination of the care they receive. It also states that it is focusing its cost and quality efforts on "poly-chronic" patients. Diabetes patients receive glucose monitors at no cost. These could be effective programs, but their extent and impact is unclear.
5. Reduce hospital readmissions	This includes giving preference to providers who make efforts to ensure that a discharged patient has adequate follow up care post-discharge, not reimbursing for preventable readmissions, and other strategies.	A short mention of "Readmissions – enhanced discharge planning," but the substance and extent of the program is unclear.
6. Reduce errors and adverse events in a clinical setting	This includes not reimbursing for "never events," and using payment methodologies and other incentives to encourage provider safety practices.	There is a reference to "never events – reporting and payment" under Utilization Management activities, but it the substance and extent of the program is unclear.

[16] Such as diabetes, asthma, depression, coronary artery disease, and congestive heart failure

Regence's filing mentions additional cost-containment efforts, including specific programs targeting potential unnecessary use of radiological testing and spinal surgery; renegotiation of provider contracts; and general and targeted utilization review. Depending on the design of these programs, they could provide a further avenue for lowering costs and improving quality, or they could simply serve to throw up barriers between patients and needed care (though Regence's mention of evidence-based treatment protocols in the radiology arena is encouraging).

Regence response to cost-control concerns
OSPIRG requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. In its response, Regence writes: "It is all but impossible to break out specific savings on an item-by-item basis," and reiterated much of what was already outlined in the filing. Given the preponderance of encouraging studies from innovators such as the Cleveland Clinic and the Mayo Clinic, it is unclear why Regence is so pessimistic about their ability to track the effectiveness of their cost control efforts.

Benefits

Is the rate reasonable given the benefits offered?

The benefit changes listed in this filing include changes required by the Affordable Care Act (ACA). In a rate change effective in February of 2011, Regence already increased rates by 3.5% to account for some benefit changes required by the ACA; in this filing, they request further increases for other benefit changes, bringing their cumulative rate increase due to the ACA to 5.5% (p. 29).

Independent analysis of the benefit changes mandated in the ACA has estimated that the premium impact of these new benefits should in most cases be between 1-3%.[17] Regence has already had a 3.5% rate increase approved for ACA-mandated benefit changes, which is higher than this range. Thus, with this new filing Regence is requesting an increase for these benefits that is significantly higher than even the top end of independent estimates for the needed changes.

Regence's response to concerns about benefits
OSPIRG Foundation requested additional information on these issues on May 16, 2011, and received Regence's response on June 1. In their response, Regence said that they believe the 1-3% range did not account for the law's requirement for insurers to cover essential benefits, but did not provide detail on how they developed the 5.5% estimate. Regence said that "These changes have been reviewed by Milliman, an independent actuarial and consulting company." Regence did not provide a copy of the Milliman review as part of the filing or supplemental information.

Variation in Rate Impact

Will the rate increase be uniform over most enrollees, or will some enrollees experience rate changes that are substantially higher or lower than the overall increase?

[17] The Lewin Group, as quoted by Factcheck.org, The Truth About Health Insurance Premiums, Nov. 19, 2010, at http://factcheck.org/2010/11/the-truth-about-health-insurance-premiums/.

The annualized rate impact that enrollees of these plans will see will vary from a low of 16.7% to a high of 34.1% (p. 6). For this specific quarterly filing, the increase ranges from 9.4% to 13.3% (p.6).

Regence did not break down the increases by enrollment in the filing, but based on additional information provided by Regence on June 1, about one-quarter of policyholders will receive a rate increase of 26% to 34%.[18]

Administrative Costs

Do the administrative expenses seem reasonable?

Yes, with some qualifications outlined in greater detail below.

Oregon's rate review program empowers DCBS to reject or modify an insurer's rate filing if the administrative costs are not reasonable.[19] Given that administrative costs are not medical costs, they should not, as a rule, increase according to medical inflation. Instead, they should increase more in line with overall inflation rate. The Producer Price Index (PPI) for Direct Health and Medical Insurance Carriers Industry is a helpful index to compare with an insurance company's proposed increase in administrative costs.[20] In 2010, the PPI was 5.11 percent.

As the charts below indicate, Regence expects its administrative costs for this market segment to decrease by over 6 percent, due in large measure to the efficiency gains of moving to a new eligibility and claims processing system. This is well below the PPI, which shows a 5.11 percent increase.[21]

Increase in Administrative Costs for this Market Segment	
Previous year administrative expenses	$33,849,096.31
Proposed administrative expenses	$31,804,844.66
Percet Change in Administrative Costs	-6.04%

Top 3 Non-Claims Administrative Expense Categories 2010	**Amount spent per member, per month**	**% of total non-claim related admin costs**
Commissions to insurance agents and brokers	$9.84	33.15%
Salaries, Wages, Employment Taxes & Other Benefits	$8.72	27.59%
Other Taxes, Licenses and Fees	$6.68	15.81%

If this projection holds true, we are happy that Regence has made this change and that enrollees will be able to reap the savings. However, this reduction in administrative costs represents a fairly substantial deviation from Regence's recent history of double digit administrative increases, leaving us wondering

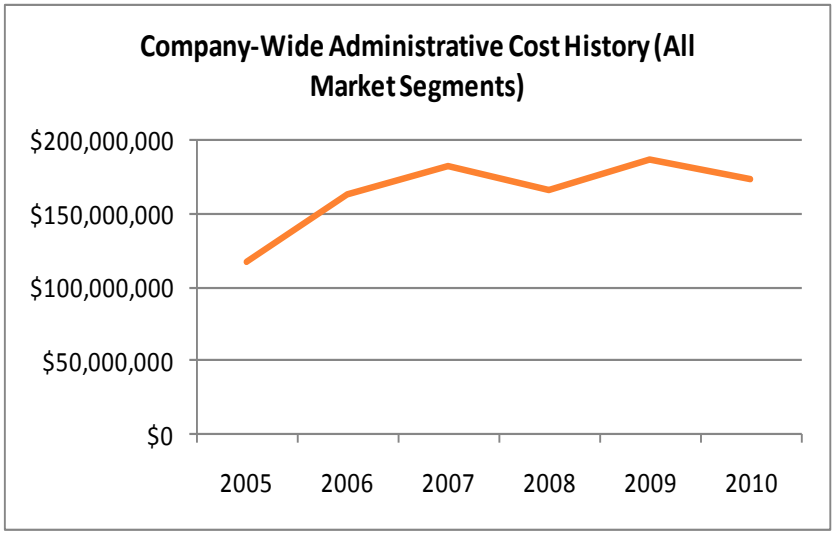
[18] See Regence response to OSPIRG item 5.

[19] Oregon rule (OAR 836-053-0475).
[20] *Id.*
[21] Note that the top three administrative expenses sum to less than the total administrative expenses per member per month, as Regence lists ten separate categories in total.

whether Regence has truly stabilized their administrative costs. This is important in order to assure consumers that they will not be hit with a price spike in the near future that would negate any savings attributable to this filing.

As the following three charts illustrate, Regence has seen substantial increases in both overall and per-member per-month administrative costs in recent years. It is likely that some of the per-member per-month increase since 2008 is due to the impact of decreased enrollment, as the same fixed costs must be spread over fewer enrollees. However, it is unclear whether that is the entire reason for the increases:

Administrative Expenses Paid Per Member Per Month			
Year	Non-Claim	Claim-Related	Combined
2006	19.79	8.99	28.78
2007	21.79	11.13	32.92
2008	20.56	10.89	31.45
2009	25.45	11.91	37.36
2010	34.3	14.42	48.72



Year	Company-Wide Admin Costs	Admin Cost Increase from Previous Year
2005	$117,922,907	N/A
2006	$162,971,602	38.20%
2007	$182,674,067	12.09%
2008	$165,762,200	-9.26%
2009	$186,642,907	12.60%
2010	$174,187,396	-6.67%

In addition, Regence's filing lists inconsistent numbers for administrative costs in different documents, which makes it hard for us to reach a solid conclusion. The five-year history of administrative expenses (p. 52) and the rate development document (p. 16) use noticeably different values for total administrative costs. They list total administrative costs of $48.89 per member per month and $42.04 per member per month, respectively. Part of this discrepancy may be due to the fact that the former is for calendar 2011, while the latter is for Aug. 2011 through July 2012. However, it appears that there may be deeper discrepancies.

First, the rate development document includes a 1.1% "risk and contingency" increase, which is not an administrative cost but rather an underwriting gain. In fact this 1.1% margin is listed as "profit/loss" in the rate filing summary (p. 2), though the rate development document misleadingly lists a 0% contribution to surplus. Regence should not be counting its profit margin as an administrative cost, as this makes it difficult to assess their true administrative costs. If this is indeed an error, Regence's true administrative costs would be $39.86 per member per month, not $42.04.

Second, the rate change development document also lists projected commissions as $6.84 per member per month over the rating period, while the administrative costs document lists these as $9.94 for calendar 2011. The difference here cannot be explained by the difference in time periods, since this would require a greater than 30% decrease in PMPM commission costs, when in fact they've been growing at an annualized rate of over 5% since 2006.

OSPIRG Foundation requested additional information on this issue on May 16, 2011, and received Regence's response on June 1. Regence claims that "These are not inconsistent estimates, rather they measure two different time periods, calendar year versus rating period".[22] However, Regence did not provide a reconciliation between these differing numerical values. Regence should be required to submit a detailed calculation showing how these different values can be reconciled and shown to be consistent.

In conclusion, we urge DCBS to ask Regence to articulate a clear plan to keep their administrative expenses stable in future years, to clarify whether or not the "risk and contingency" increase is inappropriately being classified as an administrative cost, and to clarify which per member per month figure is accurate.

Does the loss ratio seem reasonable?

The loss ratio is the percentage of premium spent on medical claims, instead of profits or administration. Regence's proposed loss ratio of 79.2% as listed in the filing appears to fall below the federal requirement for a 80% loss ratio. The additional information we received from Regence explained that the calculation to determine whether it meets the federal requirement is different than the one used in the filing, and using the federal calculation they will just exceed the 80% figure.

But, we are concerned that Regence's loss ratio is on the decline. As noted in the previous section, administrative costs should rise more slowly than medical costs. This means that the loss ratio should

[22] See Regence response to OSPIRG item 12.

generally increase over time. In this market segment, Regence has seen a high degree of fluctuation in its medical loss ratio. It was 93% in 2005, then increased to 97% in 2006 and 107% in 2007, lowering somewhat to 105% in 2008 and then 94% in 2009, before coming down to 80.3% in 2010. This shrinking of the medical loss ratio could be due to the significant increase in Regence's per-member per-month administrative costs since 2007, which as discussed above may be tied to shrinking enrollment, or simply the impact of Regence's recent history of significant rate increases, and bears ongoing monitoring.

Does any particular expense seem unreasonable, and why?

We question the reasonableness of Regence's proposal to increase the per-member-per-month expense for agent commissions, especially given the considerable increase in this expense category over the last 5 years (per-member per-month commission costs have increased from $7.69 in 2006 to a projected $9.94 next year).

One possible explanation for Regence's historical rise in commission expenditures is that it might be paying agents and brokers commissions equivalent to a percentage of the overall premium paid. This practice leads to commissions rising at the rate of increase of medical costs, which is much higher than the rise in the actual costs of brokers and agents. If this is the case, moving to a system decoupling commissions from total premiums, as United HealthCare recently did, would help make that particular element of Regence's administrative costs more reasonable.

Development of Rate

Is the insurer's total rate increase proposal reasonable, given the information on expected costs and revenues contained in the rest of the filing?

The rate development document reveals that the impact of predicted benefit buy-downs – consumers shifting to plans with increased cost-sharing, e.g. through higher deductibles or coinsurance – plays a significant role in Regence's projections of both its future claims and its premium income.

In response to our question about the specific calculations to determine the impact of benefit buy-downs, Regence stated that buy-downs do not play a significant role in the rate filing. We disagree.

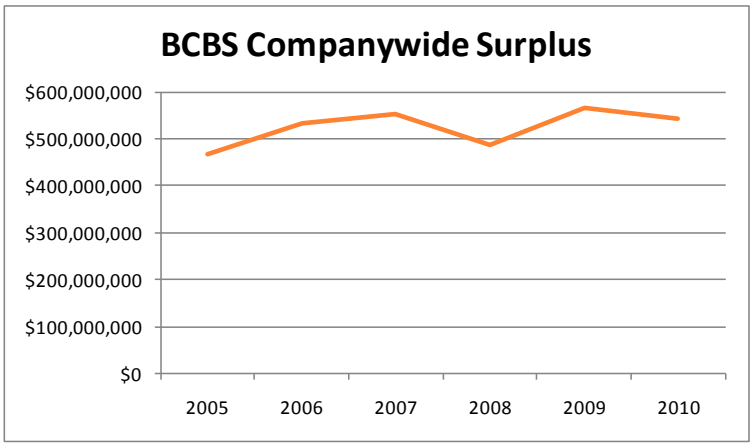
Regence estimates that benefit buy-downs will reduce its claims costs by over $30 million (almost a quarter of its expected claims costs), and lower the premiums it receives by almost $40 million (again, close to a quarter of its projected premium income). That means that if these projections are off by even a small amount, this could have a significant impact on the reasonableness of Regence's rate. Therefore, we urge DCBS to require Regence to fully explain the underlying methodology and calculations behind these numbers, to ensure that they are well-grounded and take adequate measures to prevent consumers from paying an unjustified rate.

Stability of the Plan and the Insurer

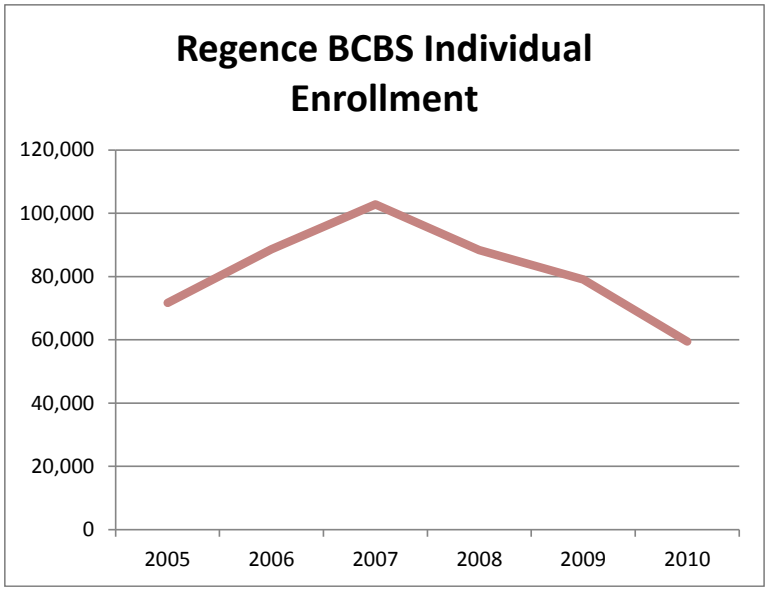
Looking at the historical context of the insurer's rate filing, does it appear the requested rate maintains rate stability and operates in a way to prevent excessive rate increases in the future? Are enrollment numbers stable, increasing, or decreasing?

We are concerned about the impact of this filing on Regence's enrollment stability and its risk pool.

Regence's surplus appears stable, as the chart below illustrates. In fact, Regence's companywide 2010 surplus of $544 million is close to ten times higher than its authorized control level risk-based capital requirement of $56 million.[23]



However, Regence's individual enrollment has shrunk by over 40% since 2007. Regence's filing states that it does not expect material changes in enrollment, but their historical trend suggests otherwise:



Typically, it is the healthiest enrollees who are first to drop coverage, a tendency that is potentially exacerbated where, as here, the insurer has a history of double-digit rate increases stretching back to 2007.

[23] Regence BlueCross BlueShield of Oregon Annual Statement, 2010.

An insurer can adopt several strategies to reverse such a trend. One option is to dip into its surplus in order to mitigate premium increases that would otherwise drive out healthy enrollees. Given that their surplus is at ten times higher than their authorized control level risk-based capital requirement, this would not pose a threat to Regence's solvency. However, Regence is proposing instead to do the opposite – to devote 1.1% of the proposed rate increase to their surplus, or roughly an additional $1.7 million.

The second option to reduce enrollment losses is for the insurers to encourage healthy enrollees to buy down to lower-benefit products with lower premiums and higher out of pocket costs, which appears to be Regence's preferred strategy in this filing. Regence's enrollees are currently clustered in the product with the least cost-sharing, which will see the highest rate increase under this proposal. While this approach can allow an insurer to help keep healthier enrollees in its risk pool, it can also lower the degree of risk-sharing between healthier and sicker enrollees, which can have an adverse impact on premiums over time.

Taking these trends together, we are concerned that Regence is likely to experience a loss of enrollment and/or significant benefit buy-down, which would lead to further increases in administrative costs relative to premiums, and undermine the stability of the risk pool.

Regence's response to enrollment concerns
OSPIRG requested additional information on these issues on May 16, 2011, and received Regence's response on May 31. Their response makes us even more concerned than before.

First, Regence's response misleadingly downplays the magnitude of Regence's enrollment problem.

- Quoting from their response: *"Even with the requested 22.1% increase, our average annual rate increase since 2005 will be 10.8%."* This statement conceals the main point: Over the last five years, from 2007 to 2011, the average annual rate increase was 19.5%, or about twice as high as the value provided by Regence in its response.
- Quoting from their response: *"Regence Individual enrollment in late 2005 and early 2006 was approximately 67,000 and is about 56,500 as of April 2011."* This, too, obscures the key detail: enrollment increased from 2005 to 2007, reaching about 100,000. But since 2007 when the double-digit rate increases began, enrollment has dropped by more than 40% to the 56,500 value from April 2011.

Second, Regence's claim that there is no actuarial basis to project enrollment losses contradicts actuarial standards of practice.

- Quoting Regence: "We have no reasonable actuarial basis to project enrollment losses that may or may not occur with this filing." However, *Actuarial Standard of Practice No. 8 Regulatory Filings for Health Plan Entities* states, "3.2.2 Assumptions—the actuary should consider which assumptions are necessary for the filing. Such assumptions may include the following: … b. enrollment projections …"[24]

[24] http://www.actuarialstandardsboard.org/pdf/asops/asop008_100.pdf

Regence's reluctance to acknowledge the declining enrollment is puzzling, and refusal to build it into their rate filings is alarming. We recommend that DCBS only approve a rate change that ensures that consumers are protected from future rate increases that continued enrollment declines and risk pool segmentation will likely create.

Affordability

Are the rates and out-of-pocket costs affordable for a range of Oregonians?

Oregon has been hard hit by the recession, with exceptionally high unemployment. Oregon median income has been fairly stagnant since 2005. In this economic climate, health insurance rates rising much faster than the rate of inflation has significant impacts on Oregonians' ability to afford coverage.

Economic Trends

	Annual CPI increase (Portland-Salem OR-WA)	Unemployment Rate - OR	Median Household Income - OR	Median Income - individual*	Median Income - two person household*	Median Income - family of 3+*
2005	2.56%	6.20%	44,159	22,963	34,886	60,498
2006	2.60%	5.30%	47,091	24,487	37,202	64,515
2007	3.71%	5.10%	50,236	26,123	39,686	68,823
2008	3.28%	6.50%	51,727	26,898	40,864	70,866
2009	0.12%	11.10%	49,098	25,531	38,787	67,264

*Note: Estimates of income for individuals, 2-person households, and 3+ person households derive from U.S. Census data, Table H-11AR, which provides median income data by size of household. Taking a five-year average, individual income is estimated at 52% of total median household income; income for a two-person household is estimated at 79% of the overall number; and for families of 3+, income is estimated at 137% of overall median household income. This data is available at http://www.census.gov/hhes/www/income/data/historical/household/index.html.

To examine the real-world impact this rate increase could have if approved, we calculated the premium rate the following hypothetical individuals and families would experience, if they were enrolled in one of three different products included in the filing.

The highest-benefit product we examined was the Evolve Plus 1000, which is the product with the highest enrollment. It features a $1,000 deductible, and a $4,000 coinsurance maximum, for an individual plan – for families enrolling in this product, these limits are three times higher. There is a copay of $25 for office visits. Coverage for prescription drugs includes a $10 copay for generics, 50% coinsurance for name-brand drugs, and a $500 drug-only deductible.[25] Most coinsurance is 20% for preferred providers, 50% for others. Thus, even though this is comparatively richer than the other products Regence offers, consumers will still pay significant out of pocket costs – in particular, patients on name-brand drugs are likely to reach the $500 drug-only deductible, adding to the costs enrollees

[25] All of the Evolve Core and Plus products currently include an annual benefit limit on their prescription drug coverage. Regence is removing these benefit limits in this filing, to comply with the ACA.

can expect to pay. A very sick consumer could face $5,500 in out of pocket costs in addition to the premium and co-pays.

The lowest-benefit product we examined has even more significant cost-sharing. The Evolve Core 10000 has a $10,000 deductible and a $7,500 coinsurance maximum (and again, for families, their deductibles and coinsurance maximum are tripled). Office visits have a $35 co-pay, while drug coverage is similar to the Evolve Plus product, with a $10 generic co-pay, 50% brand-name coinsurance, and a $500 drug-only deductible. Coinsurance for most procedures is 30% for preferred providers, and 50% for others. Consumers with this product will see lower premiums, but if they need to visit the doctor or have one or more prescriptions, they could easily spend significantly out of pocket – a very sick individual could find themselves paying $18,000 a year in addition to the premium and co-pays.

Finally, we looked at a mid-range product, the Evolve Core 2500. This product has benefits identical to those of the Evolve Core 10000, except with a $2,500 deductible. A very sick individual with this product would pay up to $10,500 out of pocket.

Plan details

Plan Name	**Evolve Core 2500**	**Evolve Plus 1000**	**Evolve Core 10000**
Deductible (individual / family)	$2,500 / $7,500	$1,000 / $3,000	$10,000 / $30,000
Coinsurance Max (individual / family)	$7,500 / $22,500	$4,000 / $12,000	$7,500 / $22,500
Drug Coverage (generic copay / brand coinsurance / deductible)	$10 / 50% / $500	$10 / 50% / $500	$10 / 50% / $500
Hospitalization Coinsurance (preferred / nonpreferred providers)	30% / 50%	20% / 50%	30% / 50%

After calculating the premium rate for three hypothetical Oregon families, we compared the resulting premiums to the median income in Oregon for individuals, two-person households, and families, evaluating whether premium would exceed 8% of the median monthly income. Note that Regence does not employ geographic rating for these products, so these premiums are Oregon-wide.

Individual Consumer Profiles

	Sally Age: 28 Plan type: Individual			Gladys and Eddy Ages: 54 and 53 Plan type: Individual + Spouse			The Hendersons Ages: 43, 44, 20, 15 Plan type: Family		
	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost
Evolve Core 2500	**$154**	**$10,500**	**$1,029**	**$697**	**$21,000**	**$2,447**	**$701**	**$30,500**	**$3,243**
Evolve Plus 1000	**$292**	**$5,500**	**$750**	**$1,323**	**$11,000**	**$2,240**	**$1,331**	**$15,500**	**$2,623**
Evolve Core 10000	**$64**	**$18,000**	**$1,564**	**$288**	**$36,000**	**$3,288**	**$289**	**$53,000**	**$4,706**
8% monthly median income	**$170.21**			**$258.58**			**$448.43**		

As can be seen from the above table, there is a significant variation in the premiums Regence's enrollees can expect to pay depending on the specific product they choose. The lowest-benefit plans have premiums that are either lower than or comparable to 8% of a typical Oregon family's income, though the highest-benefit products quickly become unaffordable. This suggests that enrollees with higher-

benefit products might face significant pressure to buy a plan with increased cost-sharing to reduce their monthly premiums.

Note too that all of these products have high out-of-pocket costs. Thus, while the lower-benefit plans may appear more affordable on the premium end, many enrollees could see a significant hit to their savings if they did become sick and have to pay the full deductible and co-insurance costs.

Conclusion

Is the rate reasonable considering the proposed profit or contribution to surplus and other factors?

We have significant concerns that Regence's rate request is not reasonable.

1. The medical trend in this filing relies in large measure on Regence's normalization of its claims experience trend to account for the impact of past benefit buy-downs and demographics, while the rate development also depends in large measure on Regence's projected revenue loss and claims savings from future buy-downs. The filing, however, contains no methodological details or supporting data for these critical calculations, which makes it impossible to assess their reliability.

2. While most insurers have had to increase rates to slightly include the new benefits required by the ACA, Regence's request for a cumulative 5.5% rate hike to account for these changes is almost two times larger than even the high end of independent estimates of likely cost impacts. We urge that DCBS carefully scrutinize the basis for this request, to ensure that the benefit changes are being fairly priced.

3. Regence appears to be pursuing a wide variety of efforts to lower costs while maintaining or improving the quality of care. However, the filing includes only cursory detail on many of these initiatives, making it difficult to assess the sale and success of the programs.

4. We are concerned that Regence's projection that it will not see any change in enrollment will not be borne out in reality. The filing gives no reason to suspect that this double-digit rate hike will bring an end to the recent trend of shrinking enrollment. If Regence's individual market plans do continue to lose members, this could undermine the stability its risk pool. Further, Regence's projections suggest that it expects a significant degree of benefit buy-down, which can serve to segregate risk. Combined, these trends could pose a significant risk that Regence's remaining enrollees would see an even larger premium hike next year. We urge DCBS to ascertain the likelihood of such risks, and push Regence to take appropriate action.

5. Regence proposes to contribute 1.1% or more of premium to its surplus, even though its surplus is already ten times higher than its authorized control level risk-based capital. Especially given the concerns outlined above, this component of the rate increase proposal appears unnecessary. Before deciding to approve or deny this rate request, we urge the Insurance Division to scrutinize the details of this filing very carefully, and require Regence to outline a concrete plan to rein in costs and stabilize enrollment.

Appendix A – Regence responses to OSPIRG questions about the rate filing

Regence

Regence BlueCross BlueShield of Oregon is an independent licensee of the Blue Cross and Blue Shield Association

May 31, 2011

TO: Teresa Miller, Oregon Insurance Division Administrator
FROM: Jared Short, President, Regence BlueCross BlueShield of Oregon
SUBJ: Regence BlueCross BlueShield of Oregon's Individual Rate Filing/OSPIRG Questions

Our members are justifiably concerned about rising health care costs and their impact on premiums. As a nonprofit health insurer, we are too. We strongly support information transparency so consumers can better understand the factors that contribute to higher premiums.

The public appetite for financial information about health insurance premiums has grown in the wave of rising health care costs and federal reform. The heightened interest is not surprising – and frankly, Regence welcomes it as an opportunity for us to talk about why health care costs so much.

Under the auspices of the Oregon Insurance Division's $100,000 grant to the Oregon State Public Interest Research Group (OSPIRG) to review our Individual rate filing, OSPIRG has relayed concerns about whether or not our proposed rate increase is justified. Their questions and our responses are included below.

Our filing is available to the public through your agency's website. In it are extensive technical details as to why these increases are necessary. Here is a high-level summary of our rate filing to provide context for our responses to OSPIRG's questions.

Overview of Regence's rate request

- **Proposed rate increase** (average) for Regence's individual members in Oregon: 22.1% The actual rate will vary based on plan benefits and the member's family status.
- **Effective date** (if approved): 8/1/11
- **Oregonians impacted**: 56,500 as of April 2011
- **Basis for increase**: The increase requested in this filing is due in large part to rising medical and prescription costs. Additionally, costs for benefit changes related to federal health care reform are included.
- **Link to filing**: http://www.oregonhealthrates.org/
- **Independent review**: To confirm that our filing met the highest quality actuarial standards, we retained Milliman, an independent actuarial and consulting company, to evaluate our assumptions and findings prior to submitting the rate filing.

OSPIRG's key concerns

While we address each of OSPIRG's questions separately, we noticed three major areas of concern:

- **Medical cost trends**: Health insurers use medical cost trends to estimate what the same health plan will cost in the future. OSPIRG questions the medical cost trends used in our filing, citing a particular concern with how those trends compared with the actual claims experience of our individual members. It's important to note that recent claims experience is not a total predictor of what will happen in the future. Our actuaries forecast costs based on both prior trends and anticipated changes to medical costs in the future. Additionally, they must factor in changes to demographics and plan benefits.

- **Benefit adjustments**: Benefit changes related to The Patient Protection and Affordable Care Act (federal health care reform) are a key factor impacting this rate request. Provisions of the new law that went into effect on Sept. 23, 2010, required changes to health insurance coverage, including an expansion of benefits. While premium increases are due primarily to rising medical and prescription costs, the additional benefits and protections afforded by the new law do have some associated costs. OSPIRG is concerned these costs are higher than independent assessments of 1 to 3 percent. However, we believe that range does not include new federal restrictions on annual dollar limits for essential benefits. Our filing includes previously approved costs associated with the early provisions that went into effect on Sept. 23, 2010 AND costs associated with the removal of annual benefits on essential benefits.

- **Enrollment**: OSPIRG has raised questions about our enrollment projections for this line of business. Despite a steady decline in membership across the entire market for all insurers, Regence continues to make changes to its products to better meet the financial and health needs of its members. Our goal continues to be retaining membership and an appropriate balance of healthy members to help pay the costs of those who are sick. The Oregon individual marketplace remains highly competitive and consumers have a wide variety of plans and price points available to them. For purposes of this filing, we have followed common actuarial practice and not projected future enrollment changes in our calculations.

Regence's response to questions posed by OSPIRG

1) **Last year, Regence made significant changes to benefit design, claiming that doing so would prevent big rate increases in the future. What is Regence's analysis of how that strategy worked or didn't work?**

   The cost-cutting impact of our new product, Evolve, was significantly diminished by the near-simultaneous passage of federal health care reform in March, 2010. Evolve was designed to cover several upfront doctor visits with minimal out-of-pocket costs to encourage preventive care, while limiting coverage for certain services that may be subject to over-utilization, which would have the effect of curbing future cost growth.

However, the Patient Protection and Affordable Care Act (PPACA) required us to remove many of these cost-saving features.

Our Individual members saw an average rate increase of only 6.2% in July 2010 with Evolve, before any changes in age or family status were considered, but without these cost-saving features, and with persistent cost increases in medical and prescription drug trends, we do not project the savings we originally anticipated.

2) **Enrollment trends are an important way of gauging an insurer's stability, because shrinking enrollment generally means higher costs, because fixed costs need to spread over fewer enrollees, and because healthier enrollees tend to be the first to drop coverage. Regence has seen its individual-market enrollment shrink every year since 2007 when it has imposed double-digit rate increases. This filing does not forecast any change in enrollment, however, despite this history and despite projections in the filing that suggest that a significant number of enrollees will shift to products with lower premiums and more limited benefits. Given these factors, why is Regence confident that its overall enrollment will not decrease as a result of this rate increase?**

Even with the requested 22.1% increase, our average annual rate increase since 2005 will be 10.8%. This is consistent with historical annual cost trends in our market for the period. Regence Individual enrollment in late 2005 and early 2006 was approximately 67,000 and is about 56,500 as of April 2011. The Oregon market for Individual coverage is extremely competitive with several consumer choices. Regence will remain competitive in this market. We have no reasonable actuarial basis to project enrollment losses that may or may not occur with this filing.

3) **Many other insurers have recently reported that they have seen medical costs rising more slowly than they had projected, due in part to patients using less medical care because of the recession. Is Regence experiencing this trend, and has Regence taken into account this experience of other insurers in making its latest projections of expected health care costs?**

Even though many of our members shifted to higher-deductible plans and generally used less care, mirroring national trends, costs for many common medical procedures still continue to rise. In addition, many national experts expect trends to return to more typical levels by 2012.

Here are just two examples of common medical procedures in which member utilization went down but costs still went up:

2009 - Oregon Individual	2010 - Oregon Individual
Prof. Fees Outpat MRIs & CTs: $158 Cases: 6,076 Total Cost: $960,008	Prof. Fees Outpat MRIs & CTs: $203 Cases: 5,073 Total Cost: $1,029,819 Difference in cost: + $69,811 Total Cases Dropped 17% Unit Costs Increased 28% Total Costs Increased 7%
Therapeutic Injections: $124 Cases: 17,243 Total Cost: $2,138,132	Therapeutic Injections: $154 Cases: 14,316 Total Cost: $2,204,554 Difference in cost: + $66,532 Total Cases Dropped 17% Unit Costs Increased 24% Total Costs Increased 3%

4) **The federal Affordable Care Act requires insurers to include new benefits in the products they offer, including not denying coverage to children with pre-existing conditions, and access to preventive care without out-of-pocket costs. Independent assessments have predicted that these new benefits should increase premiums by only 1-3%, but Regence is proposing to raise premiums by 5.5% as a result of these benefit changes. What is Regence's explanation for its significantly higher projection?**

Early estimates of the effect of PPACA on costs did not account for coverage of essential benefits, which goes into effect this year. We don't know where the "independent assessments" of 1-3% come from, but we can validate the cost to our individual members of benefit changes. Federal health reform benefits enacted in 2010 plus coverage of "essential benefits" account for an additional 5.6 percent for members renewing starting August 1, 2011. (Note: this 5.6% figure is after calculating for cost of care and administrative increases; where we cite a 6.5% benefit cost, that was added before calculating the cost of care and administrative increases. It's important to realize that both calculations arrive at the same figure: $11 average benefit increase per member.)

This *includes* a previously approved 3.5 percent rate adjustment to cover expanded benefits and consumer protections that went into effect September 23, 2010 under the Patient Protection and Affordable Care Act. Information regarding the coverage and benefit changes that Regence made to comply with the early provisions of the federal health reform law is detailed in a previous filing posted on the Oregon Insurance Division's web site (state tracking number HL-0470-10).

Since then, the federal reform law now restricts annual dollar limits on essential benefits. Since the U.S. Department of Health and Human Services (HHS) is not expected to define "essential benefits" until late in 2011, Regence has decided to treat all benefits as "essential." This change was not included in our previous filing.

These changes have been reviewed by Milliman, an independent actuarial and consulting company.

5) **While Regence's filing notes that the average annual rate increase its enrollees will experience is 22.1%, it is unclear how many enrollees will see increases significantly different from this average. How exactly will premium increases be distributed across the enrollee population?**

It's important to remember that the proposed rate increase is an average and it is also possible to have a rate increase LOWER than 22.1 percent.

Actual rates will vary based on plan benefits and the member's family status.

Annual Increase	Percentage of Policies
<20%	27.2%
20-25%	48.2%
26-34%	24.6%

6) **Federal law now requires insurers to spend at least 80 percent of premium dollars on medical benefits, rather than overhead or profit. Regence's filing projects that it will spend less than 80% of premium income on medical care, however. Does Regence expect that it will provide rebates to consumers for not reaching the new standard? And does Regence have a plan in place to provide those rebates if they are ultimately required?**

The federal calculation of medical benefits differs from that used by states. According to the federal calculation defined in PPACA, our target loss ratio is 83.3%, above the federal minimum loss ratio requirement of 80%.

Actual experience can fluctuate from our projections in any given year. We do have an administrative plan in place for rebates. Given that our target MLR exceeds the federal minimum standards, we do not expect rebates to be necessary.

7) **One of the most important ways to reduce claims and thereby reduce the need for premium increases is to improve the health of the insured population by focusing on prevention, chronic disease management and other best practices. In the filing,**

Regence lists a number of strategies in this vein, but it is not clear what the whole picture is, and what exact savings Regence is seeing because of each of these changes. Can Regence please outline more specifically what Regence is doing to reduce costs through delivery system reform, and what cost reductions Regence has seen so far due to each strategy, and how those reductions of cost specifically relate to the rate filing?

Regence actively is engaged in both highly targeted cost-savings and quality improvement strategies, as well as broader delivery system reform. Because savings from such initiatives are continuously incorporated into claims costs, it is all but impossible to break out specific savings on an item-by-item basis. We can measure medical claims, but it is very difficult to measure claims and other costs that do not occur as a result of such initiatives. An example of a relatively new specific cost-saving initiative is Enhanced Concurrent Review for select network hospitals. This program focuses on selecting admissions with the greatest potential impact, and initiating clinical review soon after admission. The new approach allows for earlier involvement with discharge planning and more timely referral to other care management programs that support the member's health and wellness, such as case and disease management. As of January 2011, Regence has engaged nine facilities in Oregon to participate in this program and expects to add more facilities over the coming year as the program is further refined. The new model promotes a more collaborative approach to conducting concurrent review with our providers.

More broadly, Regence is collaborating with major providers, such as hospitals and large medical groups, to develop new methods of payment that reward individual providers for positive medical outcomes rather than for numbers of items of service (i.e. fee-for-service). This is a collaborative, evolving process, working with providers to strive to improve quality and outcomes, from which we expect to reduce long-term cost trends.

8) **One of the most important elements of Regence's rate increase request is its estimate of the rate at which medical costs are increasing. The filing states that Regence's claims costs have been going up at an annualized rate of 2%. However, the filing reports that after accounting for the impact of changes in enrollee benefits and demographics, the "underlying" trend of increase is over 10%. Will Regence provide the full methodology and data used to arrive at this increased value?**

Our rate filing does not say trend is 2%. The 2% and 10% figures measure two very different things that cannot be compared. The annualized claims cost trend of 2.0% does not consider changes in plan benefits or pool demographics, both of which changed substantially during the experience period. For a more realistic assessment, we look at the change in the average benefit plan and the change in demographics over time, and adjust the paid claims to determine the normalized (underlying) trend, assuming no further benefit or population changes. This is consistent with commonly accepted actuarial rating approaches. We have included a summary in our rate filing.

9) **Similarly, another significant component of Regence's rate request is its estimate of the impact that enrollees switching to lower-premium products with higher cost sharing will have on the insurer's premium income and claims costs. Will Regence provide the full methodology and data used to make these projections, including their estimates of how many members will change plans, and what benefits they will wind up with?**

We do not agree that a significant component of our rate request has to do with how enrollees choose the benefit level that meets their needs. What is important is that all of our products are priced on a sound actuarial basis. It is difficult to predict what products will be selected by any given consumer. What we can be sure of, however, is that members will receive enhanced benefits consistent with what is called for under PPACA.

10) **Regence's filing states that its medical costs are increasing due to a combination of factors, including the increased use of medical care, the increasing price of individual medical services, and so on. Will Regence provide the full details and methodology behind this calculation, including a breakdown of how much each of these factors contributes to the overall projected rise?**

The following components were used to develop the 12.6% projected claims trend used in our rate calculation:

Pricing Trend (used in filing)	**12.6% (annual)**
Components of trend:	Total
1. Reimbursement	5.7%
2. Utilization	1.2%
3. Mix/Intensity	2.2%
4. Leverage	2.1%
5. Fluctuation	1.4%

Reimbursement trend includes changes in negotiated hospital, physician, pharmacy, or any other medical provider reimbursement levels, assuming no change in the mix of services. 5.7% is our best estimate of annual provider reimbursement increases.

Utilization reflects the number of services provided. We expect an annual increase of 1.2%. Forces that influence the utilization of medical services include:

- Epidemics (such as the flu), which can result in increased physician visits and increased inpatient hospital admissions;
- Aging of the population - according to the Department of Health & Human Services' Administration on Aging, the percent of the population over age 65 in 2008 was 12.4%. By 2030, the percent of the US population over age 65 is projected to grow to 19%;

- Changes in benefit design (e.g., removing dollar limits for physical therapy may result in higher visits per 1,000 members); and
- New technology and medical advances to treat medical conditions in a new or additional way.

The mix/intensity trend of 2.2% annually reflects consideration of the following:

- Changes in the mix of services within a category (e.g., more MRIs rather than x-rays will result in increased outpatient cost per service trends);
- Changes in the mix of providers (e.g., a shift from primary care physicians to specialists for office visits will produce higher cost per service trends); and
- Introduction of new and more expensive drugs (for example, Simponi [golimumab], a new covered drug marketed for rheumatoid arthritis beginning in 2009, costs approximately $1,700 per month).
- Changes in mix of benefits (e.g., a shift to leaner plan designs will usually result in lower utilization trends, even though the services provided will be at a higher unit cost).

Leveraging is the market dynamic that magnifies paid claims trend when the benefit design includes fixed dollar cost-sharing amounts (primarily deductibles and copays). For example, in year 1 a member has total allowed charges of $2,000 and a deductible of $1,000, so the insurer pays $1,000 in claims. In year 2, the member maintains the $1,000 deductible and uses the same services with allowed charges of $2,100, so the insurer pays $1,100 in claims. In this example, the allowed charge trend is 5% ($2,100 / $2,000 -1), yet the paid claims trend is 10% ($1,100 / $1,000 -1). It should be noted that this simple example presents a hypothetical case and that overall annual leveraging is smaller overall.

The use of fluctuation is to account for statistical variability in the underlying data, to ensure consistent pricing over time. The use of a fluctuation estimate is a reasonable and appropriate actuarial methodology commonly used for estimating uncertain future outcomes.

11) One document in the rate filing lists Regence's proposed annualized rate increase as 19.7% (see p. 16 of the filing). However, the rate filing summary appears to request a 22.1% increase from one year earlier. What is the reason for this discrepancy?

There is no discrepancy, as detailed in the Actuarial Memorandum. The 19.7% annual rate change reflects the proposed increase due to pool experience, including all previously approved benefit changes. We also are filing for additional rate increases reflecting federal health care reform requirements to remove annual limits on all essential benefits, for which we have not previously filed. The benefit changes and corresponding rate adjustments vary by plan. The 22.1% annual rate change reflects the annual pool increase (19.7%) and the average benefit adjustment for removal of annual limits (2.0%), i.e., 1.197 x 1.02 = 1.221 (cumulative). The calculation of the 22.1% is detailed in the Actuarial Memorandum.

12) Similarly, the filing contains inconsistent estimates for Regence's projected administrative costs (contrast page 16, lines K through P, with page 52 of the filing). Will Regence explain which set of estimates are correct, and which set it is using as a basis for its proposal to increase rates?

These are not inconsistent estimates, rather they measure two different time periods, calendar year versus rating period. Both are correct. The 2011 expense forecast labeled "Administrative Expenses Five Year History" provides a forecast of expenses on a **calendar** basis for 2011 as required for our statutory filing. The administrative costs provided in the "Development of Rate Change" are forecast for the **rating period**, August 1, 2011 through July 31, 2012, as required for purposes of the rate filing. In addition, these numbers reflect our most current pricing assumptions and reflect anticipated savings due to improved eligibility and claims processing systems as documented in the "Cost Containment and Quality Improvement Efforts" exhibit.

Conclusion

Regence welcomes the opportunity for transparency and public engagement on the crucial matter of health costs. As with our rate filing and plain-language summary, we have offered rigorously developed data in response to OSPIRG. We also reiterate our offer to OSPIRG to discuss these issues further to foster a broader public understanding of the forces that affect affordability of coverage.