ADVANCING ACCOUNTABILITY

Cutting Health Care Waste

OSPIRG Foundation

A progress report on health insurance rate review in Oregon and how to build on its success

ADVANCING ACCOUNTABILITY, CUTTING HEALTH CARE WASTE

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AUTHORS

Jesse Ellis O'Brien
Health Care Advocate, OSPIRG Foundation

David Rosenfeld
Executive Director, OSPIRG Foundation

Laura Etherton
Policy Analyst, Health Care and Public Health, US PIRG Education Fund

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

ABOUT OSPIRG FOUNDATION

With public debate around important issues often dominated by special interests pursuing their own agendas, OSPIRG Foundation offers an independent voice that works on behalf of the public interest. OSPIRG Foundation, a 501(c)3 organization, works to protect consumers and promote good government. We investigate problems, craft solutions, educate the public, and offer Oregonians meaningful opportunities for civic participation.

For more about OSPIRG Foundation or for more copies of this report, please visit: www.ospirgfoundation.org.

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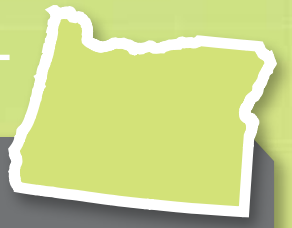

A progress report on health insurance rate review in Oregon and how to build on its success.

> *"Evidence of wasteful spending in our health care system continues to pile up, and studies continue to demonstrate that health insurers are passing along the cost of that spending to consumers instead of doing all they can to cut waste. Health insurance rate review is an important tool to create some accountability for cutting waste in the health care delivery system. OSPIRG Foundation's report and policy recommendations outline a way forward."*
>
> -Sabrina Corlette, Georgetown University

> *"Health insurance rate review is a critical consumer protection, and Oregon's rate review program is a model for the nation. But with costs continuing to skyrocket, stronger action is urgently necessary. OSPIRG Foundation's study is an important contribution to the field and deserves the attention of healthcare policymakers nationwide."*
>
> -Christine Barber, Community Catalyst

REVIEWERS

Sabrina Corlette, J.D.
Research Professor, Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Timothy Jost, J.D.
Robert L. Willett Family Professor of Law
Washington and Lee University

Lori Grubstein, MPH, MSW, MPA
Program Officer
Robert Wood Johnson Foundation

Michael Miller, Director of Strategic Policy
Christine Barber, Senior Policy Analyst
Community Catalyst

Sarah Lueck,
Senior Policy Analyst, Center on Budget and Policy Priorities
NAIC Consumer Representative

William Kramer, MBA
Executive Director, National Health Policy
Pacific Business Group on Health

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EXECUTIVE SUMMARY

The cost of health care for average Oregonians has risen unsustainably for decades. Yet the outline of the solution is already clear.

In this report, we examine the success so far of one tool to rein in runaway costs – Oregon's health insurance rate review program. We also propose changes to the process that will enable Oregon to take its successful rate review program to the next level by tackling the biggest driver of costs: waste in the health care delivery system.

Studies have shown that a third or more of all health care spending is spent in ways that do not improve health—and in too many cases even do harm.[1] In the face of this mounting evidence, it is good news that policymakers and health care leaders are focusing attention on reining in health care costs by cutting waste and focusing on prevention, not by cutting care and passing more costs on to consumers.

The Oregon Insurance Division's (OID) rate review program requires that insurers in the individual and small business markets justify premium rate hikes in writing, showing that they are not excessive and explaining how the insurer is working to reduce costs.

Oregon's rate review program is widely considered a national model, fostering unprecedented transparency, more meaningful public involvement, and closer scrutiny of rate increases. Since new rate review standards were implemented in 2010, Oregon consumers have experienced measurable gains.

In our analysis, we examined 222 rate filings, 110 before and 112 after these standards went into effect.

KEY FINDINGS

- Stronger rate review has cut over $80 million in unjustified costs from consumers' and small businesses' premiums since 2010.

- State officials have cut rate hikes over 17% on average. Prior to 2010, rate review decisions trimmed rate increases by an average of only 6%.[2] This difference cannot be explained by insurers simply requesting higher rate increases, as requested rates have also declined on average since 2010.

- Since 2010, rate review decisions have reduced the portion of premium spent on administrative costs by 5.4% on average, a reversal of the trend seen before 2010.

Many factors affect costs in any market as large as health care, but the trends are clear. Heightened scrutiny of rate increases has been associated with real progress toward a more efficient and cost-effective health insurance market.

We now encourage Oregon to widen the scope of rate review to address the chief

underlying cause of high insurance rates – medical costs. In this report, we make the case for improvements to several traditional components of rate review, and lay out possibilities to make use of rate review to reduce waste in the health care delivery system.

KEY RECOMMENDATIONS

- **Strengthen standards for insurers' cost containment and quality improvement efforts.** By focusing on insurers' payment strategies and quantitative goals and results, rate review can complement other efforts to drive systemic reforms to improve safety, increase care coordination, boost prevention, and bring down costs for consumers and small businesses.

- **Preserve and strengthen the integrity of the process.** Insurers should not be allowed to raise rates without robust review of all data necessary to evaluate the reasonableness of their projections of future cost growth. The Insurance Division should have the authority to take all necessary steps to ensure that this data is available in a timely fashion and accessible for independent review.

- **Make rate review more transparent and user-friendly.** Consumers and small businesses should be notified of pending rate requests that affect them, and informed of opportunities to comment on proposed increases. Rate filings should be made more easily digestible for the public. Consumers should be able to determine the impact of a rate request on their own premium without difficulty.

Health insurance costs are one part of a larger puzzle, and rate review cannot be expected to resolve every driver of out-of-control health care costs. However, it is a key piece of the puzzle, and its proven successes in Oregon suggest that more progress is possible.

Studies continue to demonstrate the waste in our health care system. Taking a few common-sense steps to improve the rate review process now will put our state in a better position to make real progress toward cutting waste, improving quality and making health care work better for Oregon families and small businesses.

INTRODUCTION

Oregonians have reached a breaking point on health care costs. With medical costs well outpacing inflation, the cost of health care for the average Oregon family has nearly doubled in the past ten years.

If current trends continue, the cost for the average family could top $31,000 a year by 2022.[3] By comparison, the median household income in Oregon—$46,816 in 2011[4]—has been largely stagnant over the past decade.

These costs are unsustainable, especially for small businesses and families purchasing coverage on their own, who have often been forced to drop coverage or make painful sacrifices in response. Starting in 2014, the federal Affordable Care Act (ACA) will provide many consumers and small businesses with access to tax credits that will help mitigate some of these costs. Left unchecked, however, these costs will continue to impose a growing burden on budgets for families, businesses and government.

Yet the outline of the solution is already clear. With studies consistently showing that at least a third of all health care spending is wasted on interventions that do not improve patient health,[5] there are clear opportunities to cut costs, not by cutting access to care or raising out-of-pocket expenses, but by cutting the waste out of our health care system.

In Oregon, we have already taken the first steps, as part of a multi-prong approach to rising costs. The Oregon Insurance Division's (OID) health insurance rate review program—widely regarded as one of the strongest rate review programs in the country—represents one such step.

When health insurers in Oregon wish to increase their rates on small businesses or people purchasing coverage on their own, they must submit a detailed proposal to the OID laying out the justification for a rate hike. The OID then determines whether the proposal is reasonable and approves, disapproves or cuts back the proposed rate.

Since small businesses, individuals and families purchasing coverage on their own have little leverage to negotiate with insurance companies on cost and quality, health insurance rate review serves as a critical backstop to create accountability for insurers in the individual and small group market.

In 2011, the OID created a formal process for a consumer organization to analyze and comment on rate filings from a consumer perspective, supported by a grant of federal funds. OSPIRG Foundation has been the contracted organization under that program since November of 2011.[6]

Conducting in-depth consumer analyses of significant rate filings has provided us with an up-close look at the process. It is from that vantage point that we review the historic achievements of Oregon's rate review program and put forward recommendations for building on those successes.

This report concludes that the heightened accountability and transparency put in place in recent years has helped cut waste and unjustified costs out of consumers' premiums, pushed back on insurers' excessive administrative costs and contributed toward promoting a more efficient health insurance market.

Oregon has made and continues to make important progress in containing the cost of health insurance through its rate review program, but, as detailed below, the process has the potential to do even more.

While administrative costs and inefficiencies are an important driver of costs and should continue to receive close scrutiny, they represent a relatively small portion of the average premium paid by consumers and small businesses. Since 2010, administrative costs have represented less than 20% of premium costs on average.[7]

Given that experts estimate that a third or more of medical costs represent wasteful spending,[8] there is reason to believe that as much as 27% or more of the cost of the average consumer's premium during this period could be attributed to waste.

There is a substantial and growing body of evidence demonstrating that insurers, providers and other health care market players have not been successful in moving health care in the direction of containing costs through

cutting waste, and have instead passed along the cost to consumers and businesses.[9] Public policy has a role to play in ensuring that rates are reasonable and consumers are not footing the bill for waste.

Oregon already has made progress toward ensuring that rates are based on reasonable administrative expenses. It seems appropriate to build on this progress by working to ensure that rates are based on reasonable medical expenses.

Cutting a third or more of medical spending would of course be an ambitious test to meet out of the gate. Our policy recommendations take this into account, and propose phasing in reforms over time. To start, we propose that for a premium rate to be considered reasonable, the insurer should be required to show they are taking reasonable steps to pay health providers in ways that reduce waste.

Our recommendations also outline ways that Oregon can build on the traditional functions of the rate review process to make it more transparent, build greater accountability for insurers and bring the public into the process more effectively.

All of our recommendations are motivated by the important contribution we believe an effective and transparent rate review program can contribute to Oregon's broader effort to make health care work better for our state.

In the first section, we review the record of health insurance rate review in Oregon in detail and examine the impact of the policy changes implemented following the passage of HB 2009.

In the second section, we put forward recommendations for strengthening the process moving forward. These include specific recommendations for how the OID can hold insurers accountable for containing health care costs; how the process can be strengthened further to ensure that rate hike requests are held to the highest level of scrutiny; and how the public can be brought into the process more effectively.

In the third section, we outline the role that strengthened rate review can play in Oregon's broader health care transformation efforts, including Governor Kitzhaber's plan to transform the state's Medicaid program as well as the development of the Oregon Health Insurance Exchange (now called Cover Oregon).

While health insurance rate review cannot solve the myriad problems facing our health care system on its own, Oregon's pioneering efforts demonstrate that accountability works. By building on Oregon's successful track record, rate review can make an important contribution to making health care work better for our great state.

OREGON RATE REVIEW: PROGRESS TO DATE

Oregon's rate review program is one of the strongest in the country. Oregon's program has the power of "prior approval," enabling regulators to approve, reject or modify insurer's rate hike proposals, and due to improvements in the law, Oregon has begun to use this power more effectively in recent years.

Oregon's rate review program underwent a major upgrade following the passage of House Bill 2009 in the 2009 Oregon Legislative Session. This landmark health reform legislation, and the rules and policies put in place in the subsequent years to implement it, included significant strengthening of the rate review process, empowering the OID to scrutinize rate increases more thoroughly and to build greater accountability for the health insurance industry.

This heightened scrutiny and strengthened accountability has had a real impact, especially in response to some of the largest proposed premium increases.

When Regence BlueCross BlueShield of Oregon proposed a 22.1% rate hike on 60,000 individual market customers in 2011, the Oregon Insurance Division cut the increase nearly in half, to 12.8%, cutting over $12.5 million in unjustified costs and saving Regence customers an average of nearly $200 a year each.

The OID has been able to achieve gains like these for consumers by scouring rate filings with the goal of ensuring that any premium increase is justified by the medical costs facing insurers, their administrative burden and their financial position, while also ensuring that the numbers used in these calculations are not inflated or obscured to raise rates more than necessary.

The OID's ability to intervene on behalf of consumers was greatly strengthened with the passage of new legislation and the adoption of new administrative rules in 2009 and 2010.[10]

Rate review prior to the introduction of these new policies was far more limited in scope. Rate increase proposals were evaluated for reasonability and adequacy (i.e., whether premiums are sufficiently high to cover costs), and unfair discriminatory pricing was not allowed. However, the OID had limited authority to apply the reasonability standard, and large rate increases remained commonplace. HB 2009 strengthened rate review by clarifying that allowed rate increases should not be excessive, and should be based on reasonable administrative expenses.

HB 2009 clarified the OID's ability to consider a broad range of factors in determining whether a rate is reasonable, including:[11]

- The insurer's financial position, including profitability, surplus, reserves and return on investments;
- Administrative costs and medical and hospital expenses;
- The ratio between the amounts spent on medical services and earned premiums—known as the Medical Loss Ratio (MLR);
- Any anticipated change in the number of enrollees if the increase is approved;
- Changes to covered benefits; and
- The insurer's progress toward health care cost containment and quality improvement.

As the OID has fleshed out its policies to implement these requirements, it has adopted new protections. For example, the OID now prohibits insurers from including a margin or fluctuation factor in medical cost projections, which some insurers previously used to disguise a projected profit margin. The OID has begun to question insurers' justifications for maintaining excessive surpluses while raising rates. Regulators have also begun to consider the effect of increased premiums on overall enrollment in health plans, and the impact of ever-rising costs on the long-term sustainability of health insurers' risk pools, given that it is often the healthiest enrollees that drop coverage.

In response to consumer and policymaker input, Oregon has also become a national leader in increasing transparency in the rate review process. In 2007, the Oregon Legislature passed a transparency law requiring all insurance filings to be publicly posted online. The 2009 law further strengthened the OID's ability to make filing

information public without redaction and to take public comments on pending rate filings.

Since then, through a grant of federal funds, the OID has not only taken steps to bring consumer advocates into the rate review process and incorporate advocate feedback into decisions—it has also developed infrastructure that has made public hearings on rate increases a matter of course. Hundreds of Oregonians have attended such hearings, both in person and via the Internet, since the OID started holding them regularly in 2011.

In addition, Oregon now enables consumers to read the conversation between state officials and insurance companies about pending rate hikes practically in real time. Oregonians can learn more about the rate review process at a user-friendly website maintained by the OID: www.oregonhealthrates.org

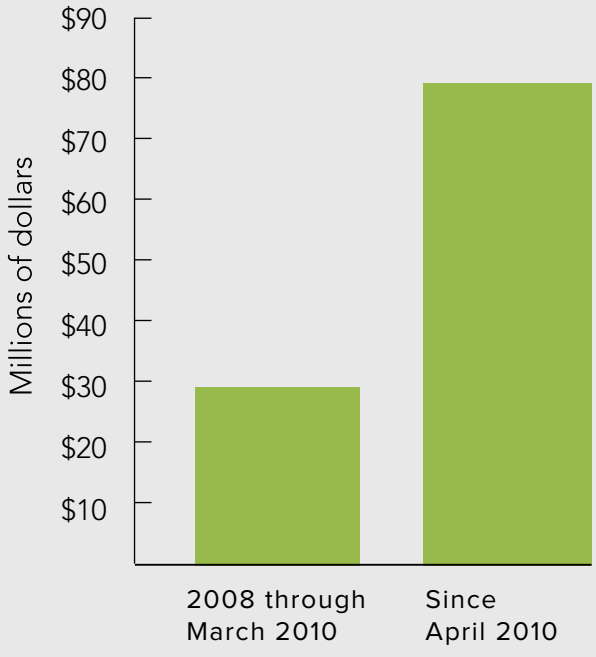
BEFORE AND AFTER: OREGON RATE REVIEW SUCCESS

Oregon's strengthened rate review process has had a real impact on health insurance costs in Oregon. OSPIRG Foundation estimates that the process has eliminated at least $80 million in unjustified costs by trimming back rate hike requests since the new rules took effect in April, 2010. See below for a breakdown of trends since the law was implemented.[12]

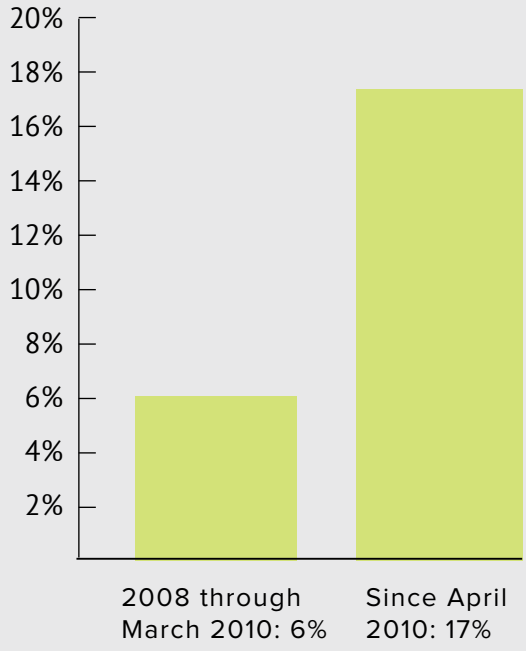
Not only has the total dollar figure of savings gone up,[13] but the average cut the OID applied to approved increases has also significantly increased.[14]

One might be skeptical of these reductions, which could be due to insurers simply "asking high": requesting higher increases with the expectation that those increases will be cut back. However, this is not the case. Another noticeable trend since the implementation of new rate review rules has been a 14.8% decline in the average rate hikes requested by health insurance companies.[15] This decline is likely attributable to many factors, including trends in the broader economy. However, it is clear that stronger rate review has not generally influenced insurers to increase their requested rate hikes, and the higher volume and frequency of cuts since 2010 is not attributable to higher requested rates.

TOTAL UNJUSTIFIED COSTS ELIMINATED FROM PREMIUMS DUE TO RATE REVIEW



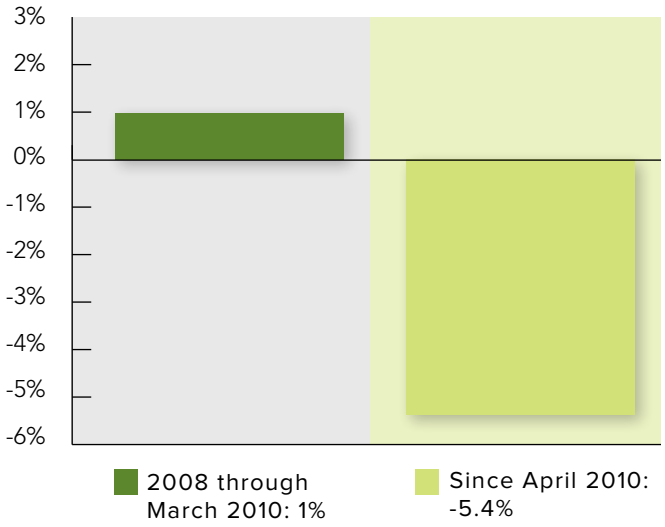
AVERAGE CUT IN RATE HIKE AS A RESULT OF RATE REVIEW DECISION.



Another important trend has been a measurable increase in efficiency in health insurance spending. Before April, 2010, average administrative overhead per member was growing. Since that time, administrative costs have begun to go down substantially in approved rate changes.

This chart compares projected administrative costs in approved rate filings before and after stronger rate review rules went into effect.

AVERAGE ADMINISTRATIVE COST GROWTH



This trend is also reflected in the average medical loss ratios (MLRs) in approved rate increase requests. MLR is an important measure of the efficiency of a health plan's spending, reflecting the percentage of total premium costs that an insurer spends on actual medical care as opposed to administration, marketing or other expenses.

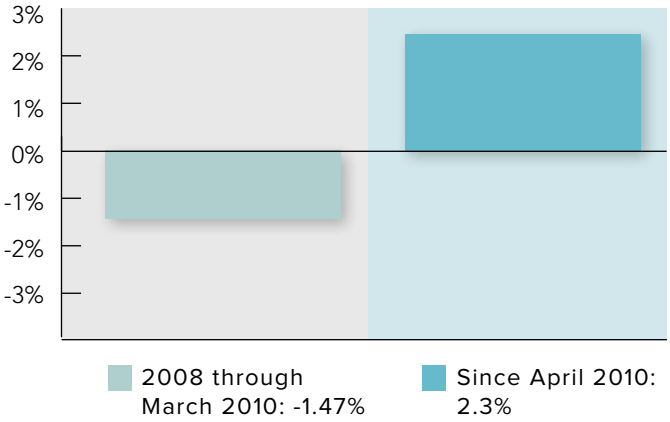
Prior to the implementation of the new rules, projected MLRs declined on average in approved rate hike proposals, meaning that rate increases were being approved despite the fact that consumers were getting less value for their premium dollar. Since the rules were strengthened, with the OID beginning to consider the reasonableness of administrative expenses, projected MLRs have gone up on average.[16]

The primary driver of these MLR increases appears to have been a sizable decrease in the percentage of premium going toward administrative costs during this period, suggesting that insurers have successfully improved efficiency.

The federal Affordable Care Act sets an MLR standard of 80%, requiring most health plans to rebate the difference to consumers if medical spending drops below that threshold. Most plans in Oregon exceeded this threshold prior to the passage of the federal law, with an average MLR of over 83% for individual and small group plans with over 1,000 enrollees during the period from 2008 until the passage of the law in 2010. Now, the Oregon health insurance market has some of the highest average MLRs in the nation.[17] While this is surely the result of multiple factors, Oregon's strong rate review program appears to be playing a role in building on this success.

This chart compares projected MLR in approved rate filings before and after stronger rate review rules went into effect.

AVERAGE MLR CHANGE



Many factors affect premium cost trends aside from rate review, including trends in medical care utilization and in the economy more broadly, so it is difficult to measure the impact of rate review precisely. But the trends are clear: Since the rate review process was strengthened in 2010, the size of rate increases, and the growth in administrative costs, has gone down substantially.

However, with increasing health insurance costs still well out-pacing inflation, work remains to be done. OSPIRG Foundation's direct and in-depth experience with rate review has enabled us to identify some concrete steps that can be taken to use this powerful tool to its full potential to help address the rise in the underlying cost of care.

NEXT STEPS AND NEW HORIZONS

Although rate review in Oregon has achieved significant results, the process still holds untapped potential. With a few common-sense changes, Oregon's rate review process could contribute more effectively to the change that Oregon consumers need to see in health care.

The following recommendations represent an aspirational vision for what health insurance rate review in Oregon could accomplish. Few of the policies outlined below could be implemented overnight, and many will require a deliberate phase-in to enable the health care market and Oregon's health care regulators to prepare for market-wide change responsibly. We put forward these recommendations with the hope that presenting a comprehensive vision for the future role of health insurance rate review will contribute to taking the first steps in this direction.

To strengthen the rate review process, and for it to most effectively play its part in aligning the private market with Oregon's health system transformation goals, the Oregon Insurance Division should adopt the following policies:

Strengthen standards for evaluating insurers' cost containment and quality improvement efforts.

Rate review provides an opportunity to build greater accountability for insurance companies—to ensure that rates do not go up for consumers unless carriers are putting in a meaningful effort to keep down costs and improve quality.

The Oregon Insurance Division already requires insurers to report information about cost containment efforts, but this information has not been a major focus of rate decisions. Holding carriers to higher standards of accountability in this area represents the single greatest opportunity to build on Oregon's successful rate review program.

It is clear that insurers are not currently succeeding in in containing costs, in part because their contracts with providers do not sufficiently encourage efficient, effective and coordinated care. There is evidence that more could be done to encourage cost containment through innovation in this area.[18]

It is important to acknowledge that the rate review process alone has limited leverage to drive cost containment innovation, mainly because rate review only regulates 11% of the health insurance market—individual and small group plans.[19] If regulators push this segment of the insurance market to move faster on cost containment without sensitivity to the dynamics at play in other segments of the market, it is possible insurers may begin to drop coverage in those markets, and providers may even begin to stop serving customers who receive their coverage through those markets.

However, there is strong evidence that rate review's leverage is poised to increase, and that the process can become a critical tool for encouraging effective cost containment. First, as individual market coverage begins to expand with full ACA implementation in 2014, the markets subject to rate review will gain many new customers, whose added buying power will provide greater leverage.[20] Second, by aligning standards with cost containment efforts underway in other areas, the rate review process can contribute to containing costs across the spectrum of health care in Oregon, and help ensure that the individual and small group markets do not lose out. (See below, "Rate Review and Health Care Transformation.")

WHAT ARE COST CONTAINMENT AND QUALITY IMPROVEMENT STRATEGIES?

While insurers do not have direct control over the actions of care providers, they do contract with providers and set provider payment structures. There are many strategies to contain cost and improve the quality of care that insurers encourage through incentives and other payment structures with providers. Some of the major categories of such strategies include the following:

a) Coordinated care

Much waste and inefficiency in health care can be attributed to lack of effective coordination between health care providers, and an orientation toward solving health problems through expensive acute interventions instead of catching them early. Insurers can work toward eliminating this waste by paying providers in a way that rewards effective coordination.

Medical home programs are one example of this type of strategy. In a medical home, teams of doctors, nurses and specialists coordinate care for a defined population, and are paid in a way that incentivizes this approach.

Medical homes are an especially useful strategy for providing care to patients with complex chronic conditions. In an example highlighted recently by the Oregon Health Authority,[21] a Grants Pass man with heart disease and diabetes was able to make the transition from regular hospitalizations to effectively managing his own condition at home thanks to his medical home, which not only coordinated his different providers but helped him develop and follow-through on his condition management plan through regular home visits. This kind of follow-through is critical for effective care coordination.

Insurers can incentivize providers to develop effective medical homes and other care coordination models by ensuring that providers are adequately reimbursed for follow-up and supportive care, and for the work of coordination itself—and by providing reimbursement incentives for treating complex chronic conditions in a coordinated way.

b) Preventing hospital readmissions

In-patient hospitalizations are one of the costliest interventions in health care, yet many patients wind up returning to the hospital soon after release. Too often, a patient's return to the hospital could have been prevented,[22] but this often does not occur due to factors including poor discharge procedures and inadequate follow-up care. Studies have suggested that 11% or more of hospital readmissions could be prevented, and that preventable hospital readmissions cost the American health care system at least $25 billion annually.[23]

Insurers can work toward preventing hospital readmissions by creating payment structures that reward effective discharge management and follow-up care by ensuring that these critical activities receive adequate reimbursement. Insurers may also consider taking a step along the lines of what Medicare has recently begun—imposing penalties on hospitals with excessive preventable readmission rates.

c) Improving patient safety and reducing medical errors

The prevalence of medical errors in the American health care system is alarmingly high. Studies have found, for example, that 27% of Medicare patients admitted to the hospital are harmed by medical error in some way during their inpatient stay, and that 44% of these errors were preventable.[24] One study estimated that medical error, ranging from failing to follow established clinical best practices to killing or seriously injuring patients, accounted for $102 billion to $154 billion in wasteful spending in 2011 alone.[25]

Insurers can work toward reducing these alarming figures by paying providers in ways that reward them for taking steps to reduce error, and setting minimal requirements, including requiring hospitals to use pre-surgery checklists and institute best practices to prevent other adverse events such as falls and hospital-acquired infections.

Insurers can also more strongly discourage errors by including provisions in their contracts specifying lower reimbursement rates for costs associated with common, usually preventable complications.[26] Insurers can also clarify that providers may not bill the insurer or the patient for costs associated with the worst kinds of adverse events known as "never events," such as operating on the wrong body part or the wrong person.

d) Evidence-based medicine

One way to contain costs and work toward ensuring high levels of care quality is to institute measures that hold providers to standards of care based on evidence-based best practices. Insurers can help push providers in this direction by providing payment incentives for procedures and practices that have been shown to improve health and cut costs in the long run, and by

reimbursing less or refusing to reimburse for practices that have been shown to be less effective, completely ineffective or harmful.

To ensure that such requirements do not lead to cutting necessary care to the detriment of patients, any such measures should be tied to proven health outcome measures and not just cost savings. However, some simple, low-cost interventions such as diabetic foot exams have been shown to be effective at preventing serious, acute health problems but are often not performed.[27] Financial incentives could help ensure more widespread compliance with such proven measures.

e) Value-based benefit design

The financial incentives insurers provide to patients and consumers can also contribute to improved health and reduced cost. Insurers can design benefits to incentivize consumers to seek proven preventive and health maintenance interventions while discouraging the use of costly and potentially wasteful services through designing out-of-pocket cost systems that recognize value.

Many insurers already use out-of-pocket cost systems to discourage potentially wasteful expenses, such as the purchase of expensive brand-name drugs when generic equivalents are available. By creating a more comprehensive system of value-based benefits, there is the potential for insurers to accomplish much more in this area.

One example of such a system was developed by the Oregon Health Fund Board in 2008 as part of its Essential Benefit Package recommendation, with a four-tiered structure designed to identify services that provide the most value to patients at lowest cost.[28] This structure could serve as one model, but there is room for variation and innovation in this area as well.

It will be important to maintain consumer protections that prevent value-based benefit design from simply being another way to shoulder consumers with unsustainable costs. The Essential Health Benefits provision of the ACA already includes key consumer protections in this area. Although these protections will somewhat limit the range of variation in benefits and cost-sharing, they will also help protect consumers from potentially discriminatory benefits and the possibility of adverse selection.

f) Reducing disparities in health and health care

For many decades, the American health care system has struggled with disparities in health outcomes between different populations. Across a wide spectrum of metrics, minority and other disadvantaged populations experience higher rates of infant mortality, higher rates of disease and shorter life expectancies.

While health disparities are worrisome in themselves, studies have shown that they also have a pernicious influence on health care costs. One study showed that more than 30% of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three year period.[29]

These excess costs have complex causes that are not entirely attributable to the health care system, and health insurers cannot be expected to resolve the problem of health disparities on their own. However, insurers can contribute to reducing disparities by establishing payment structures that reward activities proven to make a difference in this area.

For example, insurers can consider incentivizing providers to take steps to make sure that care is individualized to the unique needs of patients instead of adopting a one-size-fits-all approach. Such steps could include requiring providers to demonstrate that they are using accepted best practices to avoid preventable errors due to language barriers or other sources of potential misunderstanding.

All of these activities a) – f) are associated with reduced cost as well as improved health, and all of them can be implemented or encouraged by insurance company payment structures.

COST CONTAINMENT AND QUALITY IMPROVEMENT IN RATE REVIEW

We propose two steps toward making rate review a stronger tool for cost-containment: more robust and uniform reporting of insurers' cost containment efforts, and standards to hold insurers' accountable for their efforts as part of rate approval.

More robust and uniform reporting of cost containment efforts

As OSPIRG Foundation has observed through Oregon's rate review process, many insurers have already established payment structures or implemented other policies to pursue some of the strategies we recommend.

For example, many insurers have invested in case management programs to better coordinate care, especially for patients with chronic diseases. Many insurers have stopped reimbursing providers for so-called "never events"—an important step toward aligning incentives with the goal of improved patient safety.

However, there is great variation in cost containment activities between insurers, and even greater variation in what information about cost containment programs is made available as part of the rate review process. The information submitted is generally in a narrative format that varies widely between insurers in quality and level of detail and does not enable close scrutiny. This makes it more difficult for the OID to thoroughly evaluate of these programs and determine whether an insurer has a thoughtful plan and is taking all reasonable steps to get results.

By setting stronger, more specific and more uniform standards for reporting cost containment efforts, the OID can streamline this part of the process and make it more effective.

One possibility would be to develop a grid for insurers to populate as part of a standard rate filing that would break down insurers' cost containment efforts. An oversimplified version of such a grid is shown below.

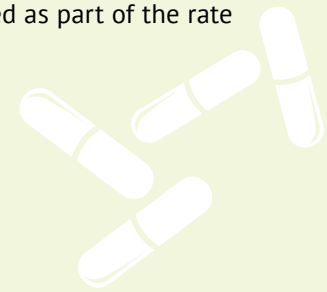
GLOBAL BUDGETING: A COMPREHENSIVE APPROACH TO COST CONTAINMENT

Oregon's new Coordinated Care Organization model of service delivery for Medicaid incorporates several of the approaches to cost containment outlined in this report.[30] This model is meant to align the financial incentives facing health care providers with the health outcomes of patients by restructuring the payment model for medical services altogether.

In a global budgeting system, coordinated health systems are paid a lump sum for tending to the health needs of a population and meeting robust care quality and outcome standards. In this approach, the aim is to reduce overall cost growth, let providers benefit financially from preventing the need for expensive acute interventions, and provide patients with improved care and better health.

While Oregon's CCOs represent the biggest test to date of the global budgeting model, evidence to date suggests that the model can be effective at both containing costs and improving health outcomes. In Massachusetts, one study showed a 2.8% cost savings associated with implementing a global budget.[31]

Global budgeting approaches and other comprehensive methods of tying provider reimbursement to patient outcomes, such as bundled payment systems, can serve as models for insurers in the commercial market, and insurers' efforts in this area should be considered as part of the rate review process.



	Strategy	Cost Containment Goal	Health Outcomes Goal	Results achieved since previous filing
Care coordination				
Preventing hospital readmissions				
Evidence-based medicine				
Value-based benefit design				
Reducing disparities				
Improving safety and preventing medical errors				

There are likely other ways to execute this concept. The principle is to require insurers to report cost containment initiatives in a streamlined, standardized format along these lines; to report all cost containment efforts and not just new initiatives; and to push insurers in the direction of providing concrete, quantitative data and projections about savings and health outcomes that can be independently evaluated.

OSPIRG Foundation observes that many insurers do not currently have processes to track cost savings and cost containment projections quantitatively. Therefore, these requirements should be phased in along a deliberate timeline that will allow insurers to put systems in place to track relevant data about costs and outcomes.

Standards to hold insurers accountable for cost containment efforts as part of rate approval

Once uniform and substantive tracking is in place, the OID should establish uniform standards for how evaluation of cost containment and quality improvement will be incorporated into accepting, rejecting or cutting back a proposed increase.

Given the variation between insurers' current cost containment efforts and insurers' ability to track their own success or failure in containing costs—and the possibility of disrupting coverage or access by pushing harder than the market can bear—these standards may also require a deliberate phase-in over time. It is important to make the timeline for strengthening standards as clear as possible to create strong expectations that insurers can prepare for in advance.

To be effective, cost containment and quality improvement standards should contain three elements:

a) Require proven, common sense measures

Some cost containment strategies are so well-established that there is no excuse not to implement them fully. Examples include using checklists to prevent error and banning providers from billing for "never events." Implementing these strategies should be required as a condition of any rate increase.

During the initial implementation phase of such requirements, insurers without cost containment strategies in place that meet the standards developed by the OID could be allowed to raise rates if they submit a credible, concrete proposal to develop such strategies going forward. Insurers could then be held accountable for doing so in next year's rate filing.

Moving forward, as insurers and providers innovate and learn more about what works best to contain costs, the OID could expand the list of specific requirements to ensure widespread adherence to best practices.

b) Require efforts in each major cost-containment area

In addition to requiring specific interventions such as the use of checklists, insurers could be required to pursue at least one type of cost-containment strategy in the six areas a) through f) above. Since many initiatives in these areas remain largely untested, such as programs to reduce health disparities, or have shown varying results, such as Medical Home programs,[32] there is an important role for innovation in this area.

The OID should review such plans and only approve rate increases where they are judged to be feasible, comprehensive, and sufficient to have an impact on cost. Plans without strategies, or with inadequate strategies, should not be allowed to raise rates, or should be allowed smaller rates than requested — perhaps rates tied to an established measure of health care cost trends, such as the Medical Consumer Price Index.

As the rate review process moves forward under this model, standards for such strategies could evolve and learn. The OID can begin to evaluate insurers' strategies in light of the proven results experienced by other carriers, and can push back when it becomes clear that rates could be lower if an insurer implements a specific strategy that has been proven to succeed.

c.) Require cost-containment goals

To create greater incentive for insurers to innovate to find new ways of containing cost, rate filings should be required to lay out an insurer's overall cost containment goals in specific, measurable terms. Some health insurers in Oregon already set such goals, e.g. by setting a specific medical trend target.[33] The OID should require all insurers to do so, and should incorporate an evaluation of such goals into the rate review process.

Given the differences between insurers' networks, geographic reach and risk pools, holding all insurers to the same standard with regard to cost containment overall may be unrealistic, but rate decisions could nonetheless incorporate an evaluation of whether an insurer's goals were realistic and whether its strategies were sufficient to realize cost containment. Plans could then be held accountable for reaching those goals in future years.

Insurers that do not reach established cost containment goals should be required to provide a frank assessment of the causes of failure and lay out a feasible strategy to improve cost-containment performance going forward before being allowed a rate increase.

There may also be merit to exploring options for creating positive incentives for insurers to implement effective cost containment strategies. For example, one idea is to enable insurers to offer multi-year rate guarantees if they demonstrate success in cutting cost and improving care.

To engage in the kind of thorough evaluation outlined above, including the impact of insurers' strategies on cost, quality of care and health outcomes, it is likely that the rate review process will require different expertise than the Oregon Insurance Division currently has at its disposal—including greater clinical and public health expertise. The OID would benefit from building on its existing relationship with the Oregon Health Authority to create a partnership in this effort, especially given the potential for synergy with ongoing work in developing Oregon's CCOs.

Preserve and strengthen the integrity of the rate review process.

A central component of the rate review process is the evaluation of an insurance company's projections for future medical and prescription drug cost trends. This helps ensure that rate increases are necessary and reasonable. For rate review to contribute toward the changes Oregon consumers need to see in health care, preserving and strengthening the integrity of the process of reviewing these trend projections is critical.

Requiring insurers to show the math behind their cost projections

No health insurance rate hikes should be approved without a thorough review of all the data necessary to determine the justification for an increase. Despite the important steps the OID has taken to increase transparency and make rate filing information public, health insurers have often failed to make public sufficient data to determine the validity of their trend projections.

The rules that govern Oregon's rate review process require that medical and prescription drug trends must be clearly stated in terms of projections that take into account past cost growth patterns and reasonable assumptions about future changes in costs.[34]

Unfortunately, insurers' presentation of these elements is often lacking in sufficient detail to enable thorough

OVERSTATING MEDICAL TREND, UNCLEAR RATIONALE

OSPIRG Foundation's experience with Oregon's rate review process has revealed a number of occasions where insurers' projections and assumptions have overstated medical trend—and the insufficient transparency of medical trend calculations in rate filings makes it nearly impossible to understand why.

All rate filings include historical average costs to allow regulators and the public to consider the reasonableness of a requested rate in light of past cost increase trends. However, the rate increases requested by insurers are frequently much higher than trends in historical claims would suggest and at times are not based on historical trend at all.[35]

Past trends can only form part of any analysis of a rate increase. Medical costs can significantly rise or fall from year to year due to trends in utilization of health care services, changes to the health care industry or broader economic trends. Costs facing insurers can also be influenced by deductible leveraging and other technical factors.[36] However, it is frequently unclear how historical trend data is incorporated into projections, if at all. Moreover, other components of trend calculations—such as projections of future trends in utilization—are often unsupported by any data that can be independently evaluated.

A comparison of projected medical trends for the year 2011-2012 from some major carriers in Oregon's small group market suggests that many participants in this market erred on the side of overstating medical trend over this time period.

	Medical trend projection from 2011 Small Group Rate Filing	Actual medical trend reported in 2012 rate filing	Overstatement of medical cost trend
Health Net[37]	10.9%	8.9%	22%
Regence[38]	12%	10.8%	11%
PacificSource[39]	10.5%	7.1%	47%
ODS[40]	10%	8.1%	24%

Without an in-depth analysis of the assumptions and calculations driving these projections, it is difficult to diagnose the origin of the problem and put measures in place to prevent consumers from being overcharged in the future.

evaluation. Insurers often present numbers for each category of cost trend without displaying the calculations behind them, and the presentation of the mathematical development of pricing trend is frequently narrative and abstract instead of enabling quantitative evaluation. This makes it more difficult to evaluate the reasonableness of a requested rate increase, which in turn makes it more difficult to ensure that rate review is protecting consumers and small businesses from paying too much.

For health insurance rate review to act as an independent check on health insurance costs, insurers should be required to show the calculations used to develop their trend claims, supporting any numerical assumptions used in that development with data. Data should be

sufficiently detailed to allow outside actuaries to determine the legitimacy of statements about increasing claims costs.

In some cases, when trend projections have been questioned, insurers have failed to provide any clear basis for their projections. For example, in a 2011 filing, Health Net projected an 11.2% medical cost trend.[41] When OSPIRG Foundation raised questions about this projection, pointing to a Health Net filing with the Securities and Exchange Commission suggesting a cost trend of 7.5%,[42] the insurer responded it based its projections on an internal assessment that was not supplied in the rate filing.

In response to such concerns, the OID has stated—in this case, in response to concerns about the Health Net filing—that "the department typically compares trend assumptions in rate requests to industry-wide assumptions to test for reasonableness. This method of verifying trend assumptions is an acceptable actuarial practice."[43] However, such verification methods do not account for the possibility that industry-wide assumptions could be skewed.

The difficulty of independently evaluating insurers' claims is worrisome when requested rates are higher than historical trends would suggest, as this leaves consumers facing potentially excessive rate increases.

Enabling transparency and independent evaluation

Creating a requirement that insurers show all the calculations necessary to evaluate a rate increase may involve strengthening standards to ensure that sufficient data included in all filings. But it will also likely require clearer guidelines for how to handle potentially sensitive information so that market competition is not harmed.

When questions are raised about insurers' assumptions and projections of cost drivers such as utilization, leveraging or provider contracts, insurers must be able to provide sufficient information to enable independent verification. This information could include quantitative modeling, de-identified claims data, or in some cases contractual information.

Our experience with the rate review process is that the majority of the information required to develop a full picture of the basis for an insurer's projections would not cause competitive harm, and the burden of proof should fall on insurers to demonstrate how releasing particular documents would harm the interests of consumers.

In two recent rate filings from Regence BlueCross BlueShield and Health Net, insurers have moved forward with a rate increase after submitting information relevant to the justification for the increase that was withheld from the public. [44]

There may be some instances where essential but sensitive information should be disclosed only to limited parties with standing to view the data, as outlined below. In any event, there should be a clear process for evaluating what information should not be made public, and none exists to date.

Creating such a process is important not only for the sake of ensuring that policyholders have access to sufficient information to understand and evaluate rate proposals that affect them. If insurers' trade secret claims are not subject to scrutiny and to a clearly defined process, consumers may lose out on the potential benefits of greater transparency in contracting. While providers and insurers may argue that such transparency would undermine their ability to negotiate, secrecy may also lead to unjustified variation in prices, which can inflate costs. Oregon's insurance regulators should take steps to make sure that any information withheld from the public is kept secret in the interests of consumers.

The Insurance Commissioner has the authority to determine a process to handle potentially trade secret information by rule.[45] The OID has already established that no aspect of a standard filing under the current rate review rules should be withheld from the public. However, no rules have yet been put in place to establish a clear process for information that may be necessary for thorough review that goes beyond the bounds of a standard filing.

We urge the Commissioner to exercise this rulemaking authority and develop a process that:

- *Preserves the presumption of transparency and does not allow insurers to withhold information that is currently made publicly available.*

- *Holds all carriers to uniform standards regarding what kinds of information can be considered trade secrets and how this will be evaluated.*

- *Ensures that no information is withheld unless it can be shown that release would cause concrete, specific and measurable harm to consumers.*

- *Enables a process for independent review of such information under embargo to ensure accountability.*

Regarding the final recommendation above, standards will have to be established regarding what individuals and organizations have standing to request access to potentially sensitive information under embargo. No individuals or organizations with clear conflicts of interest—such as insurance company representatives, health care providers, or organizations representing the health care industry—should be allowed to access this information. Whether further restrictions should be set will be a critical question to determine via future rulemaking.

Ensuring timely access to all data necessary to review a rate hike proposal

For rate review to serve as the independent check on health insurance rates that it is meant to be, hard data must be made available to back up claims about increased costs, and this data must be made available for independent review in a timely fashion.

Despite rules and product standards issued by the OID outlining the information required in a health insurance rate request, insurers often omit key information from initial filings.

When this happens, the OID and OSPIRG Foundation will often attempt to fill in the gaps in the record by engaging in a question-and-answer process with insurers. However, the due date for insurers to provide information in response to questions is often late in the process—often the day of or the day before the public hearing on the filing, and just days before the close of the 30-day public comment period. This lack of timely access to key filing information can create an insurmountable obstacle to the public's ability to assess and provide meaningful comment on rate increases.

There are three potential solutions that could help build a better rate review process:

• *Give the OID the authority to "stop the clock" when questions arise that need to be answered to evaluate a rate increase.*

Under this model, the public comment period would begin as usual when a rate increase proposal is filed but the OID would have the authority to put the process on hold whenever it became clear that more information was required.

• *Strengthen rate review product standards to ensure that no necessary information is left out when rate increase proposals are filed.*

Per the current Oregon Administrative Rules governing the rate review process, the Insurance Commissioner has the authority to determine whether a rate filing is complete, and the 30-day clock does not start counting down until this determination is made.[46] By tightening these requirements, the OID can make it much less likely that pressing questions will come up during the public comment period. However, without enabling the OID to stop the clock, this step by itself may not be enough, as it is difficult to anticipate every question that may need to be answered.

• *Refuse to approve any rate increase when insufficient information has been made available.*

The OID already has the authority to disapprove rate increases in such situations, but this authority is rarely exercised. To ensure that sufficient information is made available to thoroughly evaluate rate proposals, however, it may be worth pursuing this avenue more frequently. Insurers can re-file for a rate increase after a request has been denied, so disapproval need not be final if sufficient information is made available.

Make rate review more transparent and user-friendly.

In recent years, The Oregon Insurance Division has greatly improved the transparency of the rate review process, and has taken a number of important steps to involve the public. The OID now routinely holds public hearings on rate filings, giving consumers a new way of engaging with the rate review process. Rate filing documents and correspondence between the OID and the insurer are now posted on the OID's website, facilitating transparency and independent review.

However, some important opportunities remain for the OID to expand the ability of the public to engage with the process in a meaningful way:

Ensuring that affected consumers and small employers are notified when insurers file for a rate change and informed of their opportunity to participate in the process.

Consumers and small employers should have a say in rate decisions that affect them, and the rate review process was designed to enable public involvement. But without prior notice, most affected consumers are unlikely to hear about a pending rate hike until well after it is approved.

At present, affected consumers are not generally made aware of the review process unless they seek out information on the OID's website or hear about it through OSPIRG Foundation's outreach efforts. Policyholders often do not learn about an impending rate increase until well after it has been approved, at which point they have no ability to participate in the review process.

A simple solution is to require insurers to send a short letter, postcard or email notification including a summary of the rate increase and laying out the avenues for consumer participation, including information about the public hearing and a link to the OID's rate review website, www.oregonhealthrates.org. Ideally, such a notification could specify the impact of the rate increase on each customer's own premium. Insurers should be required to send out this notification promptly when the Insurance Commissioner determines that a rate filing is complete and the public comment period begins.

Finding ways to enable individuals, small business owners and their employees to quickly and easily determine the impact of a proposed rate increase on their own premium.

It is presently next to impossible for most Oregonians to determine the exact impact of a rate hike on their own insurance premium without expert help — and since the range of rate changes in a single rate filing can vary greatly, this makes it difficult for most Oregonians to engage with the rate review process in an informed way. One solution is to develop a web tool to enable consumers to determine rate impacts by entering a few pieces of demographic data.

Such a tool could piggyback on IT work currently being done by Cover Oregon, where they intend to make it easy for consumers to determine the costs and benefits of different available plans by filling out short, simple online forms.

Requiring more "plain language" in rate filing documentation and public hearings on rate increases.

Individuals and small businesspeople in Oregon are savvy about health care and can be trusted to be experts in their own experience with and need for insurance, but few have the time or specialized expertise required to sift through the dozens if not hundreds of pages of actuarial tables and form documentation that accompany each rate filing.

While the technical aspect of rate review is unavoidable, the public will always struggle to participate when the actuarial details overwhelm discussion of the tangible impacts of rate decisions and insurers' policies on real people. Continuing to find ways to use language that is more accessible and to communicate rate decisions in a way that will be meaningful to non-specialists will enable a stronger public process.

The OID has already taken important steps in this direction, including the development of the very user-friendly www.oregonhealthrates.org website and developing a plain language summary that is required in every rate filing.

Critical rate review concepts such as medical trend and utilization can be made more accessible to non-specialists by ensuring that they are described in terms of their on-the-ground origins and effects. For example,

clarifying in plain language the relationship between medical trend and the contracts between insurers and health care providers can not only help build informed participation in rate review, it can help consumers better understand the health care system and the sources of increased costs.

Holding public hearings on evenings and weekends, and in different parts of the state, to enable greater participation.

Making public hearings on rate hike requests routine is a uniquely Oregon innovation, and has been an important step in the direction of building a stronger public process. While rate hearings are not always heavily attended, the OID has taken a number of steps to encourage participation, including enabling participation via phone and Internet.

However, the average Oregonian will have a difficult time attending a public function scheduled during regular business hours on a weekday. Moreover, holding hearings at the OID's office in Salem is also likely to significantly limit attendance from other areas of the state. The OID should vary location and timing for its public hearings to give more Oregonians a chance to participate in the process in person.

RATE REVIEW AND HEALTH CARE TRANSFORMATION

Health insurance rate review has an important role to play in the ongoing transformation of Oregon's health care delivery system. If rate review can successfully push insurers to pursue innovative cost containment strategies, those efforts can complement Oregon's other health reform efforts and make them more effective in cutting waste and improving the quality of care.

An overarching challenge to the transformation of Oregon's health care system is the fragmented nature of the health insurance market itself. Each of the major health insurance markets—Medicare, Medicaid, public employees, self-insured employers, large group, small group and individual—are subject to different dynamics and regulations. This makes it virtually impossible for a market segment to unilaterally spur reforms to the health care delivery system. Rate review, which only covers the small group and individual markets, is no exception.

Oregon policymakers generally agree that the best way for Oregon to overcome this limitation is to encourage the different health care markets to align their reforms with each other. This already has been a major focus of Governor Kitzhaber's administration.

The benchmark for this effort has been Oregon's efforts to reform the Medicaid service delivery system to cut costs through better coordination and reorienting care toward prevention. Governor Kitzhaber's trailblazing plan, based on the development of regional Coordinated Care Organizations (CCOs), aims at nothing less than fundamental transformation of health care for Oregon's Medicaid recipients. Through global budgeting and holding providers accountable for health outcomes, the plan aspires to align incentive structures to lower costs, improve care and improve health.

Meanwhile, public employee and large employer plans have been experimenting for years to improve quality of care while lowering costs.

Yet too few of these innovations—ranging from better coordination of care for patients with chronic conditions to efforts to reduce health disparities—are widely available in the private market. Oregonians purchasing health insurance through the private market, and especially small employers and families purchasing coverage on their own, are in danger of being left behind.

Oregon's nascent Health Insurance Exchange, now known as Cover Oregon, has taken some initial steps towards encouraging these reforms in the individual and small group markets. Yet there is much more that can be done.

As the primary check on costs for private, non-subsidized coverage, the OID's rate review program is an important tool in Oregon's toolkit. Rate review has the potential not only to keep premium increases in check but to hold insurers accountable for providing good value for our premium dollars. As such, it can play an important role as health reform moves forward in Oregon.

One reason that the individual and small group markets have lagged behind as Medicaid, Medicare, other public payers, and large self-insured employers innovate to contain costs and improve quality of care is that private market health insurers do not always experience the same direct pressure to contain costs as these other entities, and do not always have sufficient leverage over provider networks to drive changes in provider behavior.

In a state like Oregon that has many insurance carriers competing against each other, provider networks often have more leverage in contract negotiations. Carriers may lose access to provider networks to their competitors if they push too hard, and lose customers as a result. This limits the ability of individual insurance companies to drive a hard bargain on cost and quality. This is particularly true in locations where one hospital system dominates, or has a virtual monopoly, on providing care in a region. As the hospital sector consolidates and absorbs private practices into their networks, this dynamic will become more intense and widespread.

By setting standards for cost containment and quality improvement strategies in order to pass rate review, as outlined above, Oregon can change this dynamic. If no health insurer in Oregon is able to raise rates without taking all reasonable steps to contain costs by cutting waste and improving care, no providers or provider networks in the state can continue to expect increased payments in reward for resistance to transforming the way they do business.

Setting rate review cost containment standards that require insurers to push providers beyond what the market can presently bear could in some situations cause providers to stop serving customers who receive coverage through the individual and small group markets. State regulators should take care to avoid this outcome, and the best way to do so is to ensure that rate review standards contribute to a coordinated effort to encourage cost containment across Oregon's entire health insurance marketplace.

By aligning the rate review process with other reform efforts, the state can make sure that all the major players work in tandem to encourage evidence-based strategies to lower costs and improve quality across the spectrum of health care in Oregon. A coordinated effort can strengthen the rate review process by giving the OID more tools to hold insurers accountable and more information about what works and what does not. The OID can use this information to put pressure on insurers to invest more in strategies that have been proven to work.

Oregonians cannot afford another year of punishing double-digit health insurance rate increases. Strengthening the rate review process can not only help prevent some of those increases—it has the potential to contribute to broader systemic reforms that can improve care and contain cost going forward. Oregon deserves nothing less.

NOTES

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7 For individual and small group plans with over 1,000 enrollees. See Appendix D for supporting calculations.

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11 See HB 2009 (2009), Section 31 (5)

12 OSPIRG Foundation calculations based on data made publicly available by the OID at www.oregonhealthrates.org. See Notes on Methodology and Appendices A-D for more detail.

13 See Appendix A for supporting calculations.

14 See Appendix B for supporting calculations. Cuts are displayed as a percent of requested premium increase—e.g., a 20% cut applied to a 20% requested increase would result in a 16.6% increase.

15 See Appendix B for supporting calculations.

16 See Appendix D for supporting calculations. Changes in MLR are displayed as a percentage of previous MLR.

17 As reflected, e.g., in a relatively low volume and dollar value of MLR rebates. See http://cciio.cms.gov/resources/files/mlr-issuer-rebates-20120710.pdf

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35 Historical trends can also sometimes overstate future cost trends, especially when expiring patent protections lead to significantly reduced costs for prescription drugs. Rate review also has a role to play in ensuring that consumers reap the benefits of such reduced costs.

36 Deductible leveraging represents the additional costs borne by an insurer due to the fact that deductibles generally remain fixed despite the rapid pace of medical inflation. An insurer offering a $1,000 deductible plan for the past decade, for example, would have seen that deductible drop to cover only about half of the total cost that it covered by the end of that period.

37 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzN3E for 2011 and http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MjM3IgM%3D%3D for 2012

38 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzN0g for 2011 and http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MTOwE for 2012

39 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzNwQ for 2011 and http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MTMxcgM%3D%3D for 2012

40 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzNwc for 2011 and http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MjMzIAO%3D%3D for 2012

41 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzN3E

42 See OSPIRG Foundation's analysis: http://ospirgfoundation.org/sites/pirg/files/reports/Health%20Net%20%23GH%200664%2010%20OSPIRG%20Rate%20Review%20Comment.pdf

43 See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UnRkBiZwZGZ9YzN4E

44 In both cases the information withheld related to differences in contracted rates between provider networks. See http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MjMxkAN%3D%3D for detail of the Regence correspondence and http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MzMzUgM%3D%3D for a copy of the document submitted by Health Net with redactions for public release.

45 See Section 31, (3)

46 See OAR 836-053-0471 (4)(a)(A)

APPENDICES

NOTES ON METHODOLOGY

The research supporting this report reviewed 248 total rate filings with proposed effective dates ranging from April, 2008 to January, 2013. Of these, we decided to focus on the 222 requests that were approved or cut back.

Rate requests that were denied entirely were not included in any of the calculations supporting this report because the reasons for denial can vary widely and insurers have the opportunity to re-file after a denial, meaning that the relationship between the rejection of a rate and specific cost savings can be equivocal.

Of the 222 approved requests, most of the calculations included in the report focus on the 127 filings in the individual and small group markets that affected more than 1,000 Oregonians, excluding the portability market and filings affecting smaller risk pools.

Since portability plans usually operate at a loss and have extraordinarily high loss ratios, comparing them directly to individual and small group plans can distort important trends in the data. Since medical trends and utilization in very small risk pools can be highly sensitive to small changes in enrollment or health status, including them in these calculations could also distort important trends.

Health insurance rate review is an especially critical consumer protection for people who receive their coverage through portability plans or in very small risk pools, as they are uniquely vulnerable to paying high rates due to the sensitivity of their rates to small changes. However, in reviewing the historic successes of rate review in Oregon, we feel that it is more important to highlight the impact of the rate review decisions that affect the largest number of Oregonians—and here, the trends are clear.

In the charts below, "Code" refers to the state identification number associated with each filing. For more recent rate requests, this is a unique number assigned to each filing by the federal electronic filing system established by the National Association of Insurance Commissioners (NAIC), and can be used to track filings as they move through the rate review process or to identify old filings in the System for Electronic Rate and Form Filing (SERFF) database. For some of the older filings considered below, the "Code" referenced is instead a State of Oregon reference number used to identify the filing in OID's system.

APPENDIX A:

Premium Cost Cut through Rate Review

Only rate filings that ended in a decision to cut back the requested rate are included in the chart below. Out of 222 approved rate filings considered in the research supporting this report, the 57 below most clearly highlight the potential for rate review to cut costs for consumers and small businesses.

All dollar amounts are either provided by the Oregon Insurance Division in their rate decision documents or are OSPIRG Foundation estimates based on rate filing documentation made available by OID at www.oregonhealthrates.org

Insurer	Code	Effective Date	$ Cut, in Millions
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128338093	1/1/2013	0.03
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595855	1/1/2013	0.01
ODS HEALTH PLAN, INC.	ODSV-128687663	1/1/2013	0.04
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128337978	1/1/2013	0.03
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128564839	1/1/2013	0.02
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595881	1/1/2013	0.02
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128527422	12/1/2012	9.3
PROVIDENCE HEALTH PLAN	PROV-128501040	11/1/2012	3.4
ODS HEALTH PLAN, INC.	ODSV-128563740	11/1/2012	2
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128236481	10/1/2012	1.1
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128563646	10/1/2012	0.4
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232390	9/1/2012	0.05
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232375	9/1/2012	0.14
PROVIDENCE HEALTH PLAN	PROV-128000799	8/1/2012	3.1
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128151919	8/1/2012	0.08
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178849	7/1/2012	0.32
PACIFICSOURCE HEALTH PLANS	PCSR-128083567	7/1/2012	2.1
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178766	7/1/2012	0.32
ODS HEALTH PLAN, INC.	ODSV-128209518	7/1/2012	0.48
ODS HEALTH PLAN, INC.	ODSV-128094609	6/1/2012	0.13
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-127852825	4/1/2012	1.33
PACIFICSOURCE HEALTH PLANS	PCSR-127913003	4/1/2012	0.1
PACIFICSOURCE HEALTH PLANS	PCSR-127378926	1/1/2012	0.24
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	1/1/2012	0.14
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-127385403	1/1/2012	2.01
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	1/1/2012	0.42
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	12/1/2011	3.4
ODS HEALTH PLAN, INC.	HL 0408 10	11/1/2011	0.43
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2011	0.96
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL 0470 10	10/1/2011	12.5

HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0596-10	10/1/2011	0.02
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0664-10	10/1/2011	0.64
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2011	0.19
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2011	0.83
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0268-11	8/1/2011	1.08
PROVIDENCE HEALTH PLAN	GH-0141-11	8/1/2011	2
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0236-11	8/1/2011	0.27
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH 0075 11	7/1/2011	4.1
ODS HEALTH PLAN, INC.	GH-0108-11	7/1/2011	0.48
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH 0395 10	7/1/2011	1.9
PROVIDENCE HEALTH PLAN	GH-0663-10	5/1/2011	1.75
PACIFICSOURCE HEALTH PLANS	HL-0674-10	4/1/2011	0.62
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH 0664 10	4/1/2011	1.2
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	4/1/2011	4
UNITEDHEALTHCARE INSURANCE COMPANY	GH 0393 10	2/1/2011	4
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0470-10	2/1/2011	9.57
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0422-10	12/1/2010	3.36
AMERICAN FAMILY MUTUAL INSURANCE COMPANY	HL-0044-05	11/15/2010	0.13
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2010	0.36
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	8/1/2010	0.63
TOTAL SINCE MARCH 2010			81.73

TIME INSURANCE COMPANY	HL-0169-04	5/1/2010	1.79
JOHN ALDEN LIFE INSURANCE COMPANY	HL-0287-05	5/1/2010	0.08
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	4/1/2010	12.44
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/1/2010	14
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/21/2009	0.52
TIME INSURANCE COMPANY	HL-0169-04	1/3/2009	1.1
PROVIDENCE HEALTH PLAN	HL-0206-05	11/1/2008	0.32
TOTAL 2008-MARCH 2010			30.25

APPENDIX B:

Trends in Approved Rate Increases

Insurer	Code	Effective Date	Requested	Approved
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128338093	1/1/2013	2.00%	1.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128668764	1/1/2013	5.30%	5.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595855	1/1/2013	2.60%	2.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128337978	1/1/2013	2.80%	2.60%
PACIFICSOURCE HEALTH PLANS	PCSR-128672739	1/1/2013	7.70%	7.70%
PACIFICSOURCE HEALTH PLANS	PCSR-128627276	1/1/2013	8.62%	8.60%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595881	1/1/2013	3.20%	3.10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128527422	12/1/2012	9.60%	8.90%
PROVIDENCE HEALTH PLAN	PROV-128501040	11/1/2012	15.70%	12.20%
ODS HEALTH PLAN, INC.	ODSV-128563740	11/1/2012	7.50%	3.80%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128236481	10/1/2012	5.00%	4.30%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128563646	10/1/2012	8.00%	6.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232390	9/1/2012	3.10%	2.80%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232375	9/1/2012	2.40%	2.10%
PROVIDENCE HEALTH PLAN	PROV-128000799	8/1/2012	5.00%	2.20%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128218998	8/1/2012	8.80%	8.80%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178849	7/1/2012	8.80%	8.20%
PACIFICSOURCE HEALTH PLANS	PCSR-128083567	7/1/2012	5.56%	4.20%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178766	7/1/2012	8.80%	8.20%
ODS HEALTH PLAN, INC.	ODSV-128209518	7/1/2012	2.10%	-0.20%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-127852825	4/1/2012	8.00%	7.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-127723319	2/1/2012	-0.30%	-0.30%
PACIFICSOURCE HEALTH PLANS	PCSR-127378926	1/1/2012	5.00%	3.90%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-127723573	1/1/2012	1.40%	1.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2012	8.68%	8.68%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	1/1/2012	6.90%	4.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	1/1/2012	8.80%	6.90%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	12/1/2011	6.60%	1.20%
ODS HEALTH PLAN, INC.	HL 0408 10	11/1/2011	9.94%	8.94%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2011	-0.50%	-4%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL 0470 10	10/1/2011	22.10%	12.80%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0664-10	10/1/2011	3.10%	2.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2011	6.30%	5.10%

LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2011	6.80%	5.30%
PROVIDENCE HEALTH PLAN	GH-0141-11	8/1/2011	7.70%	5.90%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0236-11	8/1/2011	9.00%	7.20%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH 0075 11	7/1/2011	10.80%	9.10%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	7/1/2011	2.40%	2.40%
PACIFICSOURCE HEALTH PLANS	GH-0064-11	7/1/2011	4.28%	4.28%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	7/1/2011	1.90%	1.90%
ODS HEALTH PLAN, INC.	GH-0108-11	7/1/2011	12.45%	11.30%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH 0395 10	7/1/2011	9.50%	8%
PROVIDENCE HEALTH PLAN	GH-0663-10	5/1/2011	0.16%	-1.31%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH 0664 10	4/1/2011	8.27%	7.52%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	4/1/2011	16.80%	10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	2/1/2011	7.50%	7.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	2/1/2011	8.00%	8%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL 0599 10	2/1/2011	4.21%	4%
UNITEDHEALTHCARE INSURANCE COMPANY	GH 0393 10	2/1/2011	16.80%	10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0470-10	2/1/2011	22.70%	14.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	1/1/2011	13.40%	13.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2011	9.20%	9.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	1/1/2011	15.60%	15.60%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0422-10	12/1/2010	17.10%	15.50%
ODS HEALTH PLAN, INC.	HL-0408-10	12/1/2010	20.73%	17.54%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2010	17.70%	12.90%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2010	15.40%	15.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	10/1/2010	1.04%	1.04%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2010	10.60%	8%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2010	15.00%	15%
PROVIDENCE HEALTH PLAN	GH-0112-09	8/1/2010	1.16%	1.16%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	7/1/2010	0.00%	0%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	7/1/2010	9.90%	9.90%
ODS HEALTH PLAN, INC.	GH-0121-09	7/1/2010	16.50%	16.50%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	7/1/2010	0.00%	0%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	7/1/2010	12.90%	12.90%
AVERAGE SINCE MARCH 2010			8.09%	6.70%

A cut from 8.09% to 6.7% represents a 17% cut:
8.09% - 6.7% = 1.39%
1.39% / 8.09 = 17%

UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	6/1/2010	15.40%	15.40%
TIME INSURANCE COMPANY	HL-0169-04	5/1/2010	21.00%	15%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	4/1/2010	12.20%	12.20%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	4/1/2010	14.60%	14.60%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	4/1/2010	11.70%	11.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	4/1/2010	25.30%	16%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/1/2010	26.40%	17.30%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	1/1/2010	11.52%	11.52%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	1/1/2010	11.60%	11.60%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2010	-5.40%	-5.40%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2010	15.40%	15.40%
ODS HEALTH PLAN, INC.	HL-0050-07	12/1/2009	17.67%	17.67%
PROVIDENCE HEALTH PLAN	HL-0157-09	11/1/2009	15.50%	15.50%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	10.57%	10.57%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0140-09	10/1/2009	9.60%	9.60%
PROVIDENCE HEALTH PLAN	GH-0112-09	10/1/2009	12.78%	12.78%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	10/1/2009	10.70%	10.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0270-09	10/1/2009	22.80%	22.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	10/1/2009	12.60%	11.20%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	10/1/2009	7.70%	7.70%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	10.57%	10.57%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2009	16.00%	16%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	8/1/2009	10.32%	10.32%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2009	4.00%	4%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	7/1/2009	2.00%	2%
ODS HEALTH PLAN, INC.	GH-0121-09	1/31/2009	3.29%	3.29%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/30/2009	14.70%	14.70%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	1/27/2009	8.30%	8.30%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/21/2009	5.00%	4%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0134-08	1/20/2009	5.00%	5%
ODS HEALTH PLAN, INC.	GH-0328-07	1/17/2009	6.49%	6.49%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/16/2009	5.00%	5%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	1/15/2009	-0.10%	-0.10%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/14/2009	5.00%	5%
PACIFICSOURCE HEALTH PLANS	GH-0334-07	1/12/2009	11.90%	11.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0242-04	1/10/2009	6.80%	6.80%
PACIFICSOURCE HEALTH PLANS	GH-0336-07	1/8/2009	2.90%	2.90%

ODS HEALTH PLAN, INC.	GH-0328-07	1/4/2009	-1.50%	-1.50%
TIME INSURANCE COMPANY	HL-0169-04	1/3/2009	18.00%	15%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/1/2009	1.60%	1.60%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0352-08	1/1/2009	8.00%	8%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2009	25.00%	25%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/1/2009	1.60%	1.60%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2009	0.00%	0
ODS HEALTH PLAN, INC.	HL-0050-07	11/1/2008	8.90%	8.90%
PROVIDENCE HEALTH PLAN	HL-0206-05	11/1/2008	29.70%	25%
PACIFICSOURCE HEALTH PLANS	GH-0336-07	11/1/2008	3.20%	3.20%
PREFERRED HEALTH PLAN, INC.	GH-0337-07	10/14/2008	-1.80%	-1.80%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0063-04	10/1/2008	6.50%	6.50%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0160-04	10/1/2008	13.50%	13.50%
PROVIDENCE HEALTH PLAN	GH-0324-07	10/1/2008	-0.58%	0.58%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0021-04	10/1/2008	5.00%	3.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2008	28.00%	28%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2008	4.54%	4.54%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	7/1/2008	-5.00%	-5%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	7/1/2008	-5.00%	-5%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	7/1/2008	10.30%	10.30%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0071-08	7/1/2008	5.90%	5.90%
WESTERN GROCERS EMPLOYEE BENEFITS TRUST	GH-0033-08	6/17/2008	12.60%	12.60%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	4/1/2008	5.00%	5%
AVERAGE 2008 – MARCH 2010			9.50%	8.92%

A cut from 9.5% to 8.92% represents a 6% decrease:
9.5% - 8.92% = 0.58%
0.58% / 9.5% = 6%

The decline in requested rate increases between the period 2008 – March 2010 and the later period, a decline from 9.5% to 8.09%, represents a 14.8% decline:

9.5% - 8.09% = 1.41%
1.41% / 9.5% = 14.8%

APPENDIX C:

Administrative Cost Trends

Insurer	Code	Effective Date	Previous Admin Cost	New Admin Cost
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128338093	1/1/2013	14.50%	14.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128668764	1/1/2013	16.40%	15.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595855	1/1/2013	27.60%	23.60%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128337978	1/1/2013	14.50%	14.70%
PACIFICSOURCE HEALTH PLANS	PCSR-128672739	1/1/2013	24.30%	22.60%
PACIFICSOURCE HEALTH PLANS	PCSR-128627276	1/1/2013	15.10%	14.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595881	1/1/2013	27.60%	23.60%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128527422	12/1/2012	20.70%	24.90%
PROVIDENCE HEALTH PLAN	PROV-128501040	11/1/2012	19.83%	16.57%
ODS HEALTH PLAN, INC.	ODSV-128563740	11/1/2012	24.50%	24.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128236481	10/1/2012	12.60%	14.20%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128563646	10/1/2012	18.30%	18.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232390	9/1/2012	22.30%	22.80%
PROVIDENCE HEALTH PLAN	PROV-128000799	8/1/2012	13.73%	15.43%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128218998	8/1/2012	15.70%	14.30%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178849	7/1/2012	14.70%	13.90%
PACIFICSOURCE HEALTH PLANS	PCSR-128083567	7/1/2012	15.40%	14.90%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178766	7/1/2012	14.70%	13.90%
ODS HEALTH PLAN, INC.	ODSV-128209518	7/1/2012	24.10%	19.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-127852825	4/1/2012	17.10%	16.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-127723319	2/1/2012	28.20%	24.00%
PACIFICSOURCE HEALTH PLANS	PCSR-127378926	1/1/2012	27.60%	23.20%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-127723573	1/1/2012	16.00%	14.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2012	14.70%	14.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	1/1/2012	16.30%	15.60%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	1/1/2012	16.30%	15.60%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	12/1/2011	15.10%	13.70%
ODS HEALTH PLAN, INC.	HL 0408 10	11/1/2011	24.10%	23.10%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2011	20.70%	18.00%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL 0470 10	10/1/2011	21.80%	19.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0664-10	10/1/2011	16.00%	14.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2011	22.00%	17.60%

LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2011	27.10%	22.10%
PROVIDENCE HEALTH PLAN	GH-0141-11	8/1/2011	16.91%	17.79%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0236-11	8/1/2011	27.10%	22.10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH 0075 11	7/1/2011	21.20%	17.10%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	7/1/2011	25.70%	20.30%
PACIFICSOURCE HEALTH PLANS	GH-0064-11	7/1/2011	16.90%	15.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	7/1/2011	25.70%	20.30%
ODS HEALTH PLAN, INC.	GH-0108-11	7/1/2011	19.20%	19.20%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH 0395 10	7/1/2011	15.50%	15.10%
PROVIDENCE HEALTH PLAN	GH-0663-10	5/1/2011	17.60%	17.46%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH 0664 10	4/1/2011	13.30%	13.60%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	4/1/2011	15.70%	14.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	2/1/2011	16.50%	15.00%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	2/1/2011	16.50%	15.00%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL 0599 10	2/1/2011	24.00%	24.50%
UNITEDHEALTHCARE INSURANCE COMPANY	GH 0393 10	2/1/2011	17.50%	17.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0470-10	2/1/2011	20.90%	19.60%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	1/1/2011	20.70%	21.30%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2011	15.50%	17.80%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	1/1/2011	20.70%	21.30%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0422-10	12/1/2010	17.40%	18.30%
ODS HEALTH PLAN, INC.	HL-0408-10	12/1/2010	25.80%	24.10%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2010	25.00%	19.00%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2010	15.50%	15.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	10/1/2010	19.80%	21.10%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2010	20.34%	19.50%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2010	20.80%	24.10%
PROVIDENCE HEALTH PLAN	GH-0112-09	8/1/2010	16.44%	17.16%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	7/1/2010	22.00%	22.00%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	7/1/2010	15.70%	16.50%
ODS HEALTH PLAN, INC.	GH-0121-09	7/1/2010	18.20%	19.20%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	7/1/2010	17.80%	18.40%
AVERAGE SINCE MARCH 2010			19.40%	18.34%

An average reduction in administrative costs from 19.4% to 18.34% represents a 5.4% reduction:
19.4% - 18.34% = 1.06%
1.06% / 19.4% = 5.4%

UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	6/1/2010	17.50%	18.00%
TIME INSURANCE COMPANY	HL-0169-04	5/1/2010	29.00%	29.00%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	4/1/2010	13.70%	14.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	4/1/2010	19.70%	18.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	4/1/2010	15.70%	16.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	4/1/2010	22.00%	20.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/1/2010	19.80%	19.50%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	1/1/2010	14.70%	15.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	1/1/2010	16.70%	17.50%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2010	19.10%	19.30%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2010	21.70%	23.30%
ODS HEALTH PLAN, INC.	HL-0050-07	12/1/2009	31.10%	26.70%
PROVIDENCE HEALTH PLAN	HL-0157-09	11/1/2009	23.00%	21.00%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	12.90%	14.70%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0140-09	10/1/2009	10.70%	10.10%
PROVIDENCE HEALTH PLAN	GH-0112-09	10/1/2009	16.10%	16.10%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	10/1/2009	17.50%	18.10%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0270-09	10/1/2009	20.40%	19.90%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	10/1/2009	15.90%	16.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	10/1/2009	16.40%	16.20%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	12.90%	14.70%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2009	22.10%	22.50%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	8/1/2009	13.00%	13.00%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2009	17.70%	19.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	7/1/2009	16.90%	16.80%
ODS HEALTH PLAN, INC.	GH-0121-09	1/31/2009	17.70%	18.20%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/30/2009	20.70%	19.70%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	1/27/2009	16.00%	16.00%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/21/2009	13.80%	20.60%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0134-08	1/20/2009	17.50%	17.50%
ODS HEALTH PLAN, INC.	GH-0328-07	1/17/2009	17.50%	17.70%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/16/2009	17.50%	17.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	1/15/2009	15.70%	15.80%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/14/2009	17.50%	17.50%
PACIFICSOURCE HEALTH PLANS	GH-0334-07	1/12/2009	14.80%	17.30%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0242-04	1/10/2009	14.10%	14.00%
PACIFICSOURCE HEALTH PLANS	GH-0336-07	1/8/2009	13.40%	13.90%

ODS HEALTH PLAN, INC.	GH-0328-07	1/4/2009	17.51%	17.51%
TIME INSURANCE COMPANY	HL-0169-04	1/3/2009	29.00%	29.00%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/1/2009	17.50%	17.50%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0352-08	1/1/2009	13.00%	13.00%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2009	14.90%	21.70%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/1/2009	17.50%	17.50%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2009	18.40%	17.70%
ODS HEALTH PLAN, INC.	HL-0050-07	11/1/2008	28.30%	27.40%
PROVIDENCE HEALTH PLAN	HL-0206-05	11/1/2008	23.00%	23.00%
PACIFICSOURCE HEALTH PLANS	GH-0336-07	11/1/2008	13.90%	13.40%
PREFERRED HEALTH PLAN, INC.	GH-0337-07	10/14/2008	14.50%	14.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0063-04	10/1/2008	9.60%	9.60%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0160-04	10/1/2008	22.00%	21.00%
PROVIDENCE HEALTH PLAN	GH-0324-07	10/1/2008	16.10%	16.10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0021-04	10/1/2008	14.50%	11.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2008	20.00%	22.10%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2008	18.40%	17.70%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	7/1/2008	17.50%	17.50%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	7/1/2008	17.50%	17.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	7/1/2008	16.10%	14.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0071-08	7/1/2008	16.60%	16.90%
WESTERN GROCERS EMPLOYEE BENEFITS TRUST	GH-0033-08	6/17/2008	7.40%	7.40%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	4/1/2008	16.10%	15.60%
AVERAGE 2008 – MARCH 2010			17.53%	17.70%

An increase from 17.53% to 17.7% represents an increase of approximately 1%:
17.53% - 17.70% = -0.17%
0.17% / 17.53% = 0.97%

APPENDIX D:

Medical Loss Ratio (MLR) Trends[1]

Insurer	Code	Effective Date	Previous MLR	New MLR
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128338093	1/1/2013	85.10%	83.30%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128668764	1/1/2013	82.60%	84.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595855	1/1/2013	69.00%	76.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128337978	1/1/2013	85.10%	83.30%
PACIFICSOURCE HEALTH PLANS	PCSR-128672739	1/1/2013	72.10%	75.40%
PACIFICSOURCE HEALTH PLANS	PCSR-128627276	1/1/2013	81.30%	83.70%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128595881	1/1/2013	69.00%	76.40%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-128527422	12/1/2012	79.40%	78.70%
PROVIDENCE HEALTH PLAN	PROV-128501040	11/1/2012	78.20%	80.20%
ODS HEALTH PLAN, INC.	ODSV-128563740	11/1/2012	72.90%	74.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	KFNW-128236481	10/1/2012	88.70%	88.20%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128563646	10/1/2012	76.70%	78.70%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232390	9/1/2012	69.50%	75.50%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-128232375	9/1/2012	*	82.00%
PROVIDENCE HEALTH PLAN	PROV-128000799	8/1/2012	84.98%	83.07%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-128218998	8/1/2012	78.10%	83.60%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178849	7/1/2012	83.40%	86.00%
PACIFICSOURCE HEALTH PLANS	PCSR-128083567	7/1/2012	77.90%	83.80%
UNITEDHEALTHCARE INSURANCE COMPANY	UHLC-128178766	7/1/2012	83.40%	86.00%
ODS HEALTH PLAN, INC.	ODSV-128209518	7/1/2012	77.90%	78.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	RGAC-127852825	4/1/2012	80.30%	74.80%
LIFEWISE HEALTH PLAN OF OREGON INC.	PBCC-127723319	2/1/2012	70.90%	77.50%
PACIFICSOURCE HEALTH PLANS	PCSR-127378926	1/1/2012	69.42%	129.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HNOR-127723573	1/1/2012	80.80%	76.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2012	88.60%	85.00%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	1/1/2012	86.00%	82.70%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	1/1/2012	86.00%	82.70%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	12/1/2011	80.80%	87.80%
ODS HEALTH PLAN, INC.	HL 0408 10	11/1/2011	74.70%	79.20%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2011	70.70%	81.00%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL 0470 10	10/1/2011	80.30%	83.40%

[1] * = Information not included in filing

HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0664-10	10/1/2011	80.80%	85.60%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2011	73.10%	80.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2011	74.30%	77.90%
PROVIDENCE HEALTH PLAN	GH-0141-11	8/1/2011	81.25%	83.42%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0236-11	8/1/2011	74.30%	77.90%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH 0075 11	7/1/2011	82.30%	84.70%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	7/1/2011	76.30%	80.20%
PACIFICSOURCE HEALTH PLANS	GH-0064-11	7/1/2011	81.90%	83.20%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	7/1/2011	76.30%	80.20%
ODS HEALTH PLAN, INC.	GH-0108-11	7/1/2011	83.60%	81.60%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH 0395 10	7/1/2011	85.30%	83.80%
PROVIDENCE HEALTH PLAN	GH-0663-10	5/1/2011	82.34%	83.26%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH 0664 10	4/1/2011	83.90%	*
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0617-10	4/1/2011	79.40%	84.40%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0627-10	2/1/2011	79.80%	80.10%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0628-10	2/1/2011	79.80%	80.10%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL 0599 10	2/1/2011	76.10%	78.10%
UNITEDHEALTHCARE INSURANCE COMPANY	GH 0393 10	2/1/2011	85.40%	*
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0470-10	2/1/2011	86.30%	90.30%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	1/1/2011	81.80%	80.70%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0395-10	1/1/2011	85.30%	81.10%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0515-10	1/1/2011	81.80%	80.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0422-10	12/1/2010	85.60%	82.50%
ODS HEALTH PLAN, INC.	HL-0408-10	12/1/2010	78.10%	75.90%
PROVIDENCE HEALTH PLAN	HL-0380-10	11/1/2010	81.50%	83.00%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2010	88.80%	84.90%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0378-10	10/1/2010	89.30%	80.70%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0378-10	10/1/2010	75.30%	78.60%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2010	78.20%	74.90%
PROVIDENCE HEALTH PLAN	GH-0112-09	8/1/2010	82.70%	82.34%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	7/1/2010	86.80%	83.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	7/1/2010	87.20%	82.80%
ODS HEALTH PLAN, INC.	GH-0121-09	7/1/2010	80.50%	80.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	7/1/2010	86.20%	82.00%
AVERAGE SINCE MARCH 2010			80.24%	82.10%

An increase from 80.24% to 82.1% represents a 2.3% increase:
82.1% - 80.24% = 1.86%
1.86% / 80.24% = 2.3%

UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	6/1/2010	87.70%	88.70%
TIME INSURANCE COMPANY	HL-0169-04	5/1/2010	65.00%	65.00%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	4/1/2010	82.50%	84.30%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	4/1/2010	85.00%	82.60%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	4/1/2010	87.20%	82.80%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	4/1/2010	86.80%	77.70%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/1/2010	81.60%	79.10%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	1/1/2010	82.30%	82.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0301-09	1/1/2010	85.90%	81.80%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2010	80.90%	80.70%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2010	85.70%	76.70%
ODS HEALTH PLAN, INC.	HL-0050-07	12/1/2009	74.30%	72.30%
PROVIDENCE HEALTH PLAN	HL-0157-09	11/1/2009	75.00%	77.00%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	84.70%	82.30%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0140-09	10/1/2009	89.10%	89.70%
PROVIDENCE HEALTH PLAN	GH-0112-09	10/1/2009	81.90%	83.10%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	10/1/2009	78.10%	81.10%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0270-09	10/1/2009	84.80%	80.10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	10/1/2009	82.10%	80.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	10/1/2009	86.30%	84.90%
PACIFICSOURCE HEALTH PLANS	GH-0177-09	10/1/2009	84.70%	83.00%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2009	77.90%	75.50%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0115-09	8/1/2009	79.80%	84.70%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2009	77.30%	80.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	7/1/2009	89.90%	88.70%
ODS HEALTH PLAN, INC.	GH-0121-09	1/31/2009	81.00%	80.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/30/2009	80.20%	81.90%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0536-08	1/27/2009	87.80%	85.60%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0260-08	1/21/2009	82.50%	79.40%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0134-08	1/20/2009	136.50%	130.00%
ODS HEALTH PLAN, INC.	GH-0328-07	1/17/2009	82.50%	81.00%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/16/2009	82.00%	78.10%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0529-08	1/15/2009	79.20%	81.40%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/14/2009	92.90%	82.50%
PACIFICSOURCE HEALTH PLANS	GH-0334-07	1/12/2009	81.20%	78.20%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	GH-0242-04	1/10/2009	87.90%	87.20%

PACIFICSOURCE HEALTH PLANS	GH-0336-07	1/8/2009	84.20%	84.70%
ODS HEALTH PLAN, INC.	GH-0328-07	1/4/2009	82.49%	82.49%
TIME INSURANCE COMPANY	HL-0169-04	1/3/2009	65.00%	65.00%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	1/1/2009	91.70%	90.30%
HEALTH NET HEALTH PLAN OF OREGON, INC.	GH-0352-08	1/1/2009	78.90%	81.00%
PACIFICSOURCE HEALTH PLANS	HL-0274-07	1/1/2009	82.10%	85.70%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	1/1/2009	81.10%	79.80%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	1/1/2009	78.60%	77.30%
ODS HEALTH PLAN, INC.	HL-0050-07	11/1/2008	68.70%	69.60%
PROVIDENCE HEALTH PLAN	HL-0206-05	11/1/2008	75.00%	75.00%
PACIFICSOURCE HEALTH PLANS	GH-0336-07	11/1/2008	83.10%	84.20%
PREFERRED HEALTH PLAN, INC.	GH-0337-07	10/14/2008	83.50%	83.50%
KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST	HL-0063-04	10/1/2008	90.70%	91.40%
HEALTH NET HEALTH PLAN OF OREGON, INC.	HL-0160-04	10/1/2008	78.70%	85.30%
PROVIDENCE HEALTH PLAN	GH-0324-07	10/1/2008	81.90%	81.90%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0021-04	10/1/2008	86.50%	84.40%
LIFEWISE HEALTH PLAN OF OREGON INC.	HL-0180-00	9/1/2008	74.00%	77.90%
LIFEWISE HEALTH PLAN OF OREGON INC.	GH-0335-07	8/1/2008	78.60%	77.30%
PACIFICARE LIFE ASSURANCE COMPANY	GH-0136-08	7/1/2008	83.00%	80.00%
UNITEDHEALTHCARE INSURANCE COMPANY	GH-0137-08	7/1/2008	83.00%	80.00%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	7/1/2008	96.10%	86.50%
REGENCE BLUECROSS BLUESHIELD OF OREGON	GH-0071-08	7/1/2008	91.90%	82.90%
REGENCE BLUECROSS BLUESHIELD OF OREGON	HL-0146-04	4/1/2008	96.10%	94.40%
AVERAGE 2008 – MARCH 2010			83.48%	82.25%

A decrease from 83.48% to 82.25% represents a 1.4% decrease:
83.48% - 82.25% = 1.23%
1.23% / 83.48% = 1.47%

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