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

Filing #GH 0075 11

Health Insurance Rate Watch
A Project of OSPIRG Foundation

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

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Executive Summary

Regence Blue Cross Blue Shield (Regence) is proposing a rate increase on small business plans, with an average increase of 10.8%, impacting 54,299 Oregonians, effective July 1, 2011.

While this average rate increase is lower than some of the historical double-digit increases Regence has had approved in the small group market, we are concerned that this rate increase is based on questionable assumptions about medical trend. We are also concerned that due to conflicting numbers provided in the filing, the impact of the rate increase on these 54,299 consumers is unclear.

Further, we are concerned that this rate increase will make it increasingly difficult for Oregonians to afford the premiums for these health insurance plans, and the result will be detrimental to Oregon small businesses, and may pose problems for the long term viability of Regence's small group risk pool.

Key findings:

1. Regence says they expect medical and prescription drug costs to rise at a rate that is higher than their actual claims experience supports, and higher than the medical trend values used by other Oregon insurers. We are particularly concerned that Regence appears to be increasing its medical trend estimation to account for cost variation that could as easily produce lower costs as higher ones.

2. The filing lists many programs Regence is pursuing to lower costs and improve quality, but in many areas, the information provided is extremely cursory, making it difficult to tell whether certain cost-saving measures are living up to their potential, and being pursued in a manner that protects patient health.

3. It is unclear what the true minimum and maximum rate increases consumers will face if this rate increase is approved. The filing lists contradictory numbers in different areas of the filing for range of rate impacts consumers will experience.

4. Regence's projections of administrative costs suggest that Regence may be artificially lowering the administrative portion of premium, while not actually reducing administrative costs. While consumers may benefit in the short run, they could experience price spikes down the road if this practice is not sustainable. We encourage DCBS to inquire further in this area, and work with Regence to achieve a level of administrative expenses that both track with the Producer Price Index (PPI) for Direct Health and Medical Insurance Carriers Industry, and remain sustainable over time.

5. Certain elements of the filing raise questions about the stability of Regence's risk pool in this market segment. Regence has imposed double-digit rate increases every year since 2007, and has recently seen lowered enrollment, which typically reflects healthier enrollees dropping their plans. The filing also notes that Regence is introducing new, higher deductible options for certain products, which can encourage healthier enrollees to "buy-down" to products with greater cost-sharing, reducing revenues from healthy enrollees within the risk pool. We encourage DCBS to work with Regence to assess this potential issue.

Key Features of the Proposal

State tracking # for this filing	GH 0075 11
Name of health insurance company	REGENCE BLUECROSS BLUESHIELD OF OREGON
Type of insurance	Small Grp Hlth Plans (small employers)
Grandfathered under federal health reform?	Both

Average rate increase	10.80%
Minimum rate increase	0.50%
Maximum rate increase	25.10%

Number of Oregonians affected	54,299
Anticipated enrollment if approved	54,299

Insurer's history of rate increases in this market	
2010	15.00%
2009	11.60%
2008	13.20%
2007	12.40%
2006	

Proposed rate	
% premium to be spent on medical costs	83.80%
% premium to be spent on administrative costs	17.10%
% premium to be spent on profits	-0.90%

Increases from previous year	
% increase in medical costs	12.82%
% increase in administrative costs	-10.63%

Basis for proposed increase	
Increase in medical costs	12.00%
Increase in Rx costs	14.00%
Time over which costs increased	since 7/1/2010

Effective Date of rate increase	7/1/2011
Date rate filing posted	3/26/2011
Date comments due	4/27/2011
Link to rate filing:	http://tinyurl.com/3m5ezbj

Note: The above information is drawn from the Filing Summary. As noted later in this analysis, in other areas of the filing, Regence gives contradictory information regarding the minimum and maximum rate increase.

Insurer Information Company-Wide

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

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

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

Discussion of the Rate Filing

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

Medical cost trends

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

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

By applying DCBS's trend evaluation methods described in an earlier rate decision[1] to the information provided by Regence, it appears that the company's annualized medical trend of 12.0% is excessive. DCBS has previously indicated that it evaluates an insurer's projected medical trend by comparing it with (1) the insurer's own two year historical experience, and (2) the average medical trend reported by other insurers. DCBS has described this evaluation practice as actuarially acceptable.

On the first criterion, Regence's proposed medical trend is nearly twice as high as their previous two years of claims experience data,[2], which shows per-member per-month claims increasing only at an annualized rate of 6.1%.

As to the second criterion – comparing the trend to that used by other insurers – Regence's proposed 12.0% medical trend is significantly higher than the past year's average small group trend in Oregon, which was 10.4%. Regence's prescription drug trend increase of 14.0% is also higher the average trend of 12.5%.[3]

Regence argues – in contrast with DCBS's approach – that this historical data has "little predictive value," because the final trend also must incorporate factors such as changes in enrollee demographics and enrollees shifting to lower-benefit products (p. 42.) According to Regence, three factors drive their medical trend: the change in the per-unit cost of services; the change in services used, including both overall utilization increases and shifts in what treatments are used; and the leveraging impact of deductibles and other fixed cost-sharing elements. However, the filing does not include a detailed breakdown of these factors, or information about how much each of these three factors contribute to the overall trend.

After the rate filing was submitted, DCBS obtained more detailed information from Regence on its trend calculations, and shared that information with us two days before the due date for these public comments. We are grateful to have been able to obtain this critical breakdown so that we were able to better evaluate Regence's medical trend numbers. We urge DCBS to require this more detailed information to be included as part of rate filings so that they can be made publically available, and available to DCBS, as early in the rate review process as possible.

In this subsequent information, Regence did not use the same three-factor method it discussed in its filing. Instead, it used five separate factors, allocated as follows: "reimbursement 5.7%, utilization 1.7%, mix/intensity 4.6%, leverage 1.8%, and fluctuation 1.8%." Mix/intensity and utilization are reflected in the "change in services used" factor Regence listed in its filing, but the "fluctuation" factor was not

[1] DCBS evaluation methods as described in the February 16 DCBS rate decision on a United Health Plan small business rate increase.
[2] Claims experience data is the amount the insurer has historically spent on medical claims in the market segment (see p. 43 of Regence's filing for month by month claims experience).
[3] Industry-wide annualized trend information is derived from data provided by DCBS to OSPIRG in March 2011.

discussed in the insurer's filing. Per Regence's communication to DCBS, this value is "based on the standard deviation of the rolling 12-month claim costs."

While we have had insufficient time to complete a full analysis of this methodology, we do want to raise concerns about the "fluctuation" factor. The standard deviation of monthly claim costs will reflect the extent to which claims are either higher than or lower than average over the course of the year. That is, any months in which claims were higher than average are balanced by those with lower claims costs. Thus, we are not persuaded that it is reasonable to increasing medical trend by a nearly 2 percentage point "fudge factor" to account for fluctuations that will as often lead to lower costs as higher ones.

We urge DCBS to further scrutinize Regence's methodology for developing its medical trend assumptions, and encourage DCBS to clearly set out its own methodology for evaluating insurer's medical trend assumptions as part of the rate review process. We also encourage DCBS to require insurers to provide full information about how they develop medical trend assumptions as part of the rate filing.

Insurer's efforts to reduce medical costs while improving quality

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

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

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

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

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

Six major initiatives to lower costs and improve quality, compared to Regence's current efforts		
Initiative	**Description**	**Regence's current efforts**
1. Reforming methodology of	This includes initiatives such as	The filing contains a short reference

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

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

Benefits

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

Is the rate reasonable given the benefits offered?

The rate filing does not provide, and we were unable to obtain from DCBS, complete information about all the benefit plans included in the filings in time to analyze whether the rates are reasonable for the benefits offered.

Benefit changes listed in this filing include changes required by the ACA. Benefit changes required by the ACA are listed in the filing as having an average premium impact of 3.0%. Independent analysis of the benefit changes mandated in the ACA has estimated that the premium impact of these new benefits should in most cases be between 1-3%.[5] Regence's assessment of the premium increase attributable to the new benefits mandated by the ACA is thus at the high end of this range. It is our understanding that this increase has already been approved by DCBS in a prior rate filing submitted in August 2010.

Variation in Rate Impact

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

There is a substantial potential variation in rate impact enrollees will see as a result of this proposed increase, but due to an inconsistency in Regence's filing, we cannot say to what degree.

The primary filing description states that enrollees will experience increases ranging from 1.0% to 18.2% (p. 36). However, the SERFF filing attached to the main filing states the range as 0.5% to 25.1% (p. 7). And in a chart on page 39, the filing lists 0% of members as experiencing an increase of more than 15%. These are sizable differences, and we ask DCBS to request additional information from Regence to clarify which range is correct.

In addition to this ambiguity over the degree of variation, it is also unclear how many enrollees will experience higher increases. According to the chart mentioned above, 43% of enrollees will see an impact of 10% to 15%, but the high proportion of enrollees in this comparatively broad category makes it very difficult to assess how many enrollees will see the most significant increases. This consideration is important, because enrollees who find their plans suddenly much more difficult to afford accordingly might drop coverage or move to products with greater cost sharing and lower premiums, affecting the stability of Regence's risk pool.

Other Changes

If the filing includes changes to other rating factors, are these changes justified and will they have a substantial impact on enrollees?

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

In this filing, Regence also proposes changing its Contribution and Participation rating factors (p. 36). Regence states that these adjustments are meant to be revenue-neutral (p. 39). However, since it does not list the previous values used for these factors, it is impossible for us to analyze these changes. We recommend DCBS obtain the previous values before evaluating this change.

In addition, Regence has added a new $4,000 deductible option to its Innova range of products; since this is a new option it will not impact the rates of current enrollees unless they choose to purchase such products.

Administrative Costs

Do the administrative expenses seem reasonable?

Yes, with some qualifications outlined in greater detail below.

Oregon's rate review program empowers DCBS to reject or modify an insurer's rate filing if the administrative costs are not reasonable.[6] Given that administrative costs are not medical costs, they should not, as a rule, increase according to medical inflation. Instead, they should increase more in line with overall inflation rate. The Producer Price Index (PPI) for Direct Health and Medical Insurance Carriers Industry is a helpful index to compare with an insurance company's proposed increase in administrative costs.[7] In 2009, the most recent year for which data was available, the PPI was 4.90 percent.

Below is the change in administrative expenses proposed in this rate filing:[8]

Increase in Administrative Costs for this Market Segment	
Previous year administrative expenses	$47,871,525.17
Proposed administrative expenses	$42,783,595.00
Percent increase in administrative costs	-10.63%

Top 3 Administrative Expense Categories 2010	**Amount spent per member, per month**	**% of total non-claim related admin costs**
Salaries, Wages, Employment Taxes & Other Benefits	$22.48	33.15%
Commissions to insurance agents and brokers	$18.71	27.59%
Legal Fees and Expenses & Other Professional or Consulting Fees	$10.72	15.81%

In one section of the filing, Regence contemplates a net reduction of 10.63% in administrative costs.[9] However, in the section of the filing[10] that breaks down the per-member per-month administrative costs, Regence projects administrative costs to remain almost flat[11] with no expected change in enrollment.

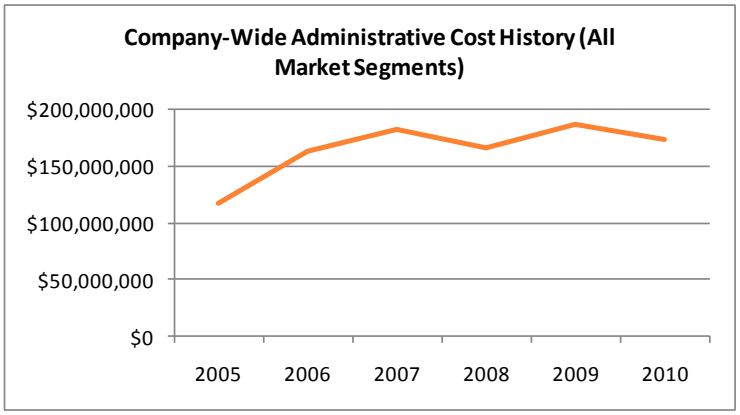
[6] Oregon rule (OAR 836-053-0475).
[7] *Id.*
[8] Note that the top three administrative expenses sum to less than the total administrative expenses per member per month, as Regence lists ten separate categories in total.
[9] This number is derived from Regence's projections of total premium, and the shares going to claims, administrative costs, and contribution to surplus, if the rate is approved. See p. 1.

Assuming the latter calculation is a more accurate reflection of Regence's actual administrative costs, it appears that Regence is artificially subsidizing its administrative costs for this filing by lowering the share of their rate that goes to such costs, rather than simply reducing their actual administrative costs.

If that is the case, then consumers might benefit in the short run, but likely be hit with a price spike in the not too distant future. Regence's recent history of administrative cost increases, illustrated in the table below – suggests this probability.

Administrative Expenses Per Member Per Month			
Year	Claims	Non-Claim	Combined
2006	9.87	27.99	37.86
2007	14.87	33.12	47.99
2008	13.82	29.38	43.2
2009	16.05	39.05	55.1
2010	16.89	50.92	67.81

Looking at this trajectory, it seems unlikely that combined per-member per-month administrative costs will be only $67.68 in 2011, as Regence claims – non-claims related costs, in particular, have seen roughly 30% annualized increases each year since 2008. And as the tables directly below further illustrate, the company overall has seen double-digit growth in administrative costs every year since 2005, except for 2008 when it experienced a nearly 10% drop and last year when it experienced a drop of 6.67%.



[10] These per-member per-month breakdowns are provided on p. 67 of the filing.
[11] Changing from $67.81 in 2010 to $67.68 in 2011

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

Regence's filing addresses these trends by stating that the substantial increase between 2009 and 2010 was driven by a 4% drop in small-group enrollment (p. 68) – with fewer members to spread fixed costs across, per-member costs will increase.

However, Regence saw its per-member per-month administrative costs in this segment also grow substantially in previous years, when its enrollment in this market segment was growing, and a 4% enrollment drop is not large enough to explain the double-digit increases listed in the chart above.

Overall, we are glad that Regence appears to be pushing to limit the growth in its administrative costs. However, we are unclear if Regence is actually keeping its administrative costs down, or "buying down" its administrative rates through other means. The former would be desirable, the latter potentially unsustainable. We encourage DCBS to further inquire on this matter.

Does the loss ratio seem reasonable?

Regence's proposed loss ratio of 83.80% appears reasonable, falling in the normal range for the small group market.

The loss ratio is the percentage of premium spent on medical claims, as opposed to administrative costs or profits. As noted in the previous section, administrative costs should rise more slowly than medical costs. This means that the loss ratio should ideally increase over time.

As discussed above, the filing contemplates a significant reduction in the share of premium going to administrative costs, with the bulk of these savings going to contribution to surplus, but with some going to increase the medical loss ratio for the segment.

Historical data reveals that Regence saw a substantial spike in its medical loss ratio in 2009 (the MLR in this market segment went from 85.5% in 2007 to 86.15% in 2008, 94.00% in 2009, and 82.3% in 2010), but its experience in 2010 and the small improvement this year suggests that this fluctuation has not lead to a longer-term shift in the medical loss ratio, which is now again beginning to slowly increase.

Does any particular expense seem unreasonable, and why?

We question the reasonableness of Regence's proposal to increase the per-member-per-month expense for agent commissions, especially given the considerable increase in this expense category over the last

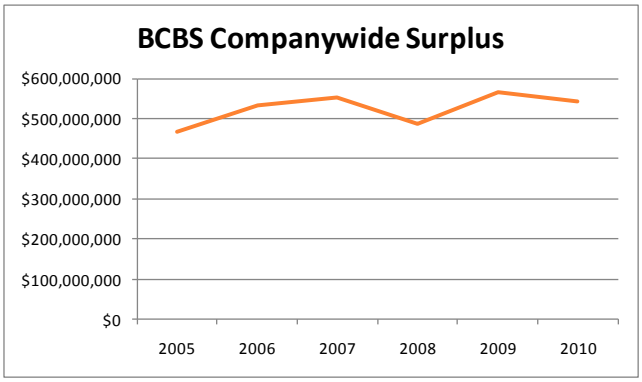
5 years (per-member per-month commission costs have increased from $11.88 in 2006 to a projected $18.90 next year).

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

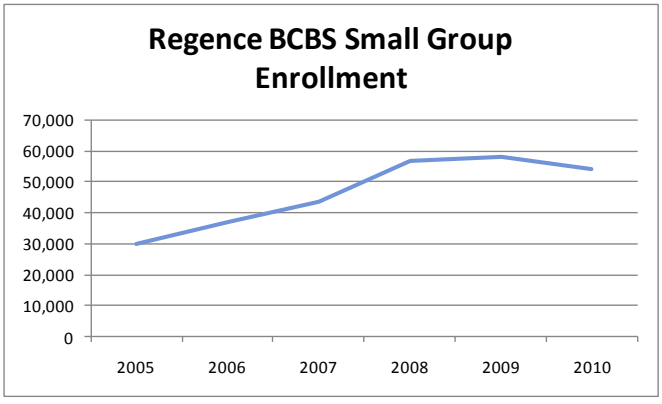
Stability of the Plan and the Insurer

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

Surplus appears stable, and Regence states that while the rate increase will not increase their surplus, the insurer "remains financially secure with an A- rating from A.M. Best." (p. 3). The insurer expects their surplus to decline by .9% as a result of this rate increase proposal (p. 38).



Likewise, Regence's filing states that it does not expect material changes in enrollment, though last year it saw the number of its small group enrollees shrink:



While these overall indicators do not raise significant warning flags, there may be reason to be concerned about the stability of Regence's risk pool in this market segment. The filing notes that Regence has recently experienced a loss of enrollment in these products, and typically it is the healthiest enrollees who are first to drop coverage.

This tendency is potentially exacerbated where, as here, the insurer has a history of double-digit rate increases stretching back to 2007. An insurer can adopt several strategies to reverse such a trend: in particular, it can dip into its surplus in order to mitigate premium increases that would otherwise drive out healthy enrollees, or it can increase cost-sharing options to encourage healthy enrollees to "buy-down" to lower-benefit products with lower premiums, rather than dropping their coverage.

The products covered in this filing already display a substantial range of cost-sharing, with some specific plans including deductibles of up to $7,500. The introduction of a new, higher deductible option of $4,000 will attract primarily healthy enrollees and, as discussed above, encourage buy-down.

While this approach can allow an insurer to help keep healthier enrollees in its risk pool, it can also have downsides, inasmuch as it lowers the degree of cross-subsidization between healthier and sicker enrollees. Therefore, we recommend that DCBS request per-product enrollment data to allow it to assess to what degree enrollees are concentrated in high-cost-sharing products, and that it further ask Regence whether the insurer is concerned about the stability of its risk pool.

Affordability

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

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

Economic Trends

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

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

To examine the real-world impact this rate increase could have if approved, we calculated the premium rate the following hypothetical businesses would experience, based in the information in the filing. After performing these calculations, we compared the resulting premiums to the median income in Oregon for individuals, two-person households, and families, evaluating whether premium would exceed 8% of the median monthly income.[12]

Business Profiles

	Eastside Bikes Average Age: 27 # employees = 4 Employee Rate			Al's Garage Average Age: 36 # employees = 8 Employee & Spouse Rate			ABC Accounting Average Age: 50 # employees = 40 Family Rate		
Geographic area:	Union, Wallawa, Wasco, Wheeler	Marion, Polk	Deschutes, Klamath, Lake	Union, Wallawa, Wasco, Wheeler	Marion, Polk	Deschutes, Klamath, Lake	Union, Wallawa, Wasco, Wheeler	Marion, Polk	Deschutes, Klamath, Lake
Premium rate - average benefit plan	**$291.28**	**$260.77**	**$285.18**	**$683.78**	**$612.14**	**$669.45**	**$1,398.76**	**$1,252.22**	**$1,369.45**
Premium rate - highest benefit plan	**$334.89**	**$299.81**	**$327.87**	**$786.14**	**$703.78**	**$769.67**	**$1,608.15**	**$1,439.68**	**$1,574.46**
Premium rate - lowest benefit plan	**$134.62**	**$120.52**	**$131.80**	**$316.02**	**$282.91**	**$309.40**	**$646.44**	**$578.72**	**$632.90**
8% monthly median income	**$170.21**	**$170.21**	**$170.21**	**$258.58**	**$258.58**	**$258.58**	**$448.43**	**$448.43**	**$448.43**

Across the board, premium rates facing our hypothetical businesses and their employees significantly exceed 8% of the median income, except for the low-benefit plan we modeled. This low-benefit plan, however, features extensive cost-sharing, including a $7,500 deductible. Our analysis suggests that Oregon small businesses and their employees would have difficulty affording these health insurance premiums and out-of-pocket costs.

Conclusion

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

Our central concern about the reasonableness of Regence's rate filing is that its requested medical and prescription drug trends lack adequate justification. As discussed above, claims experience over the last two years shows Regence's medical claims costs growing at just over 6%. Regence's cursory invocation of demographic and other factors is an inadequate basis upon which to justify inflating that 6.1% claims experience into a 12.0% predicted medical trend. Our concern is exacerbated by the fact that even by reference to medical trends chosen by other insurers, Regence's values are very high, and that it appears to be adding a substantial "fudge factor" to inflate its medical trend.

Because medical and prescription drug trends are the central factors in calculating a rate increase, if these trends are unreasonable or unjustified, this rate filing would force consumers to pay an

[12] Assumptions: 80% participation for all, median experience factor (1.000). Rates calculated as of Q2 2011. Average employer contributions taken from Kaiser State Health Facts for Oregon, at http://www.statehealthfacts.org/profileind.jsp?cat=5&sub=67&rgn=39. Assume Eastside Bikes in first year of coverage, Al's Garage has three years of coverage duration, ABC Accounting has six years. For family and employee + spouse plans, we assume spouse the same age as employee, and families contain children ages 10 and 15. Specific plans used: Average: Innova unlimited visits, 40/55 copay, 500 deductible, 80/60/60 coinsurance, 6000 coinsurance max. High benefit: Innova 4 visits, 20/35 copay, 250 deductible, 90/70/70 coinsurance, 2000 coinsurance max. Low benefit: Engage, 7,500 deductible, 50/50/50 coinsurance, 6000 coinsurance max.

unreasonable rate. As discussed in the section on affordability directly above, many Oregon consumers will have a difficult time affording coverage; for the premiums they pay, they should get a fair value.

On a more positive note, Regence's effort to limit the growth in their administrative costs is laudable. As stated above, we are concerned that their projection might be overly optimistic and understate the administrative costs they will in fact need to incur, but if Regence does reach these goals, it will be providing good value to consumers on this front.

Are there areas in the rate filing where DCBS should seek additional information from the insurer?

As discussed above, trends noted by Regence within this market segment raise concerns that the stability of the insurer's risk pool may be weakening, specifically in the shunting of healthier enrollees into products with significantly higher cost-sharing, which reduces the power of cross-subsidization. We encourage DCBS to gather additional information from the insurer to determine whether this is occurring.

Regence's rate filing lists two separate ranges of values for the distribution of rate increases its enrollees could potentially see as a result of this filing; DCBS should request that Regence clarify which is correct.

In closing, we do not find that in this rate filing, or in the additional information supplied by Regence to DCBS, Regence has adequately justified its proposed average rate increase of 10.8% on small business plans impacting 54,299 Oregonians.

This increase is lower than some of the historical increases Regence has had approved in this market segment. However, we are concerned that there are features of this filing that rely on questionable assumptions, and there are areas where the filing does not provide sufficient information to allow for a full evaluation of the justification and impact of the rate increase. Further, many Oregon small businesses and their employees will likely find it difficult to afford premiums and out-of-pocket costs for these products.