Health Insurance in Oregon

January 2012

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

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We are pleased to present the Department of Consumer and Business Services' sixth-annual "Health Insurance in Oregon" report. The department produces this report to provide Oregonians with an overview of how commercial health insurance is regulated in Oregon and to offer a look at how Oregon's largest insurers are performing financially.

This year's report comes amid changes in health insurance regulation. Now that the initial new consumer protections and benefits under the federal Affordable Care Act have been implemented, the department is working on a variety of other tasks — from drafting future legislation to crafting reinsurance programs — to prepare for reforms that are slated for January 2014. Meanwhile, we continue to use federal grants to increase the depth and transparency of our health insurance rate reviews.

In addition to implementing reforms, we also continue to closely monitor the financial performance of Oregon's health insurers. This report includes company-by-company information as well as overall statistics on the profitability of Oregon insurers in recent years and premium trends in state-regulated markets.

In addition to the report format, this year we are pleased to announce that we have a new, consumer-friendly webpage that highlights key statistics from this document. You can find this information by visiting our health insurance rate page at www.oregonhealthrates.org and clicking on the "financial data" button.

We hope this report continues to be a valuable tool as we work with the Oregon Health Authority, the Oregon Health Insurance Exchange, policymakers, and others on making health care more accessible and affordable to all.

Sincerely,

Patrick Allen
Acting Director, DCBS

Louis Savage
Acting Administrator, Oregon Insurance Division

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Executive Summary: Health Insurance in Oregon

The Department of Consumer and Business Services Insurance Division regulates commercial insurance in Oregon. This report focuses on the state's regulation of commercial insurance and how it is changing as a result of federal and state reforms, including the federal Affordable Care Act of 2010.

The report addresses many important questions about the commercial insurance market in Oregon, including the following: Who is insured in the commercial market? How does the state regulate insurers and protect consumers? Who are the major health insurers and how are they doing financially? What are the latest trends for premiums and other key measures in the individual, small group, and other health insurance markets?

Key points made in this report

- About 33 percent of Oregonians get coverage in insurance markets regulated by the state but only about 11 percent are covered in plans where the state regulates rates.
- An estimated 17 percent of Oregonians lacked health insurance in 2010 despite success in reducing the number of uninsured children, according to the Oregon Health Authority.
- Many insurance companies reported lower-than-expected medical claims costs in 2011 rate requests, slowing growth in health insurance rates in the small employer and individual health insurance markets.
- Despite a slow recovery from the recession, the state's seven largest health insurers remain financially stable. In 2010, the seven largest insurers averaged a 3 percent profit. Most of the profit came from investment income as opposed to profit on health plans.
- Kaiser Foundation Health Plan of the Northwest was the largest health insurer in markets subject to state regulation of rates, policy content, or both. Regence BlueCross BlueShield of Oregon had the single largest share of the small employer and individual markets where the state must review and approve rates.
- In October 2011, the department began holding public hearings on small employer and individual rate requests. With federal grant money, the department will continue to fund the Oregon State Public Interest Research Group (OSPIRG) to offer regular input on key rate requests through September 2014. Consumers, meanwhile, can continue to comment on insurer rate requests online.
- The department created a new website devoted to health insurance rate requests. Consumers can visit **www.oregonhealthrates.org** to find information on how the department reviews rates, company-by-company rate requests, upcoming public hearings on rate requests, financial data on Oregon's largest insurers, premium trends, and other rate-related information.

Health reform

- March 2011 marked the one-year anniversary of the federal Affordable Care Act, which ushered in new consumer protections and benefits in health insurance, starting in 2010. Major changes, including a requirement for most people to have health insurance and government subsidies to help many afford the costs, are slated for 2014.
- The focus of reforms in 2011, meanwhile, shifted to state development of a health insurance exchange where small employers and individuals can more easily shop for insurance, and on ways to control costs while improving health care in public programs.

Section 1: Overview of Health Care Marketplace

Employer-based health insurance is the cornerstone of the American health care system. Understanding the evolution of job-based coverage and the effect of ongoing premium increases — due in part to those who are uninsured or underinsured — helps explain the federal and state reforms that are changing health insurance and health care today.

Section 1 briefly discusses the history of employer-based health insurance coverage and key elements of the Affordable Care Act. It chronicles the growth in health care spending and premiums, cost shifting to the commercial market and employees, and other factors that helped set the stage for the reforms that are under way.

Evolution of Employer-Based Health Coverage

Medical technology before 1920 was extremely limited, and patients were usually treated in their homes. Not surprisingly, most people had very low medical expenses. Weak demand by the public, together with strong opposition by the insurance and medical industries, kept health insurance from being introduced.

In the 1920s, a number of factors contributed to a rise in both health care costs and use: a demographic shift from rural to urban centers, technological advances, stricter professional standards that changed public perceptions about medicine as a science, the increased development of hospitals as centers for treatment, and rising incomes.

Beginning in the 1930s, prepaid hospital service plans grew in popularity with the public seeking a way to pay for higher health care expenses in a time of falling incomes and with hospitals needing the plans as a reliable source of revenue. The American Hospital Association eventually coordinated efforts by some hospitals to cooperate and reduce interhospital competition. The association combined these plans under the name Blue Cross.

In 1939, physicians followed suit, partly out of concern that the hospitals' prepaid plans were threatening physicians' livelihoods. The American Medical Association encouraged state and local medical societies to form their own prepaid plans. In 1946, physician prepaid plans affiliated and became known as Blue Shield.

Initially, both the hospital and physician prepaid plans were exempted from taxation and insurance regulation. Many BlueCross/BlueShield plans, including plans in Oregon, remain nonprofits. Oregon, like the rest of the states, has gradually expanded regulation of nonprofits over the past 40 years.

Employer-based health care plans originated in the American war effort during World War II. In 1942, industrialist Henry Kaiser adopted a prepaid health care system for tens of thousands of workers and their families in his Richmond, Calif., shipyards and his other businesses. In 1945, with the end of the war, Henry Kaiser offered prepaid coverage to the general public.

To halt inflation during the war, the government capped wage increases. Price controls designed to prevent bidding wars by companies desperate for limited labor had an important exception: Benefits above the base wage were not included in the restriction. Companies added health insurance to further compensate workers. By the time the cap on raises was lifted, health insurance was a common benefit.

Commercial insurance companies realized that their earlier concerns about the unpredictability of insuring people's health could be overcome by providing insurance to groups of employed workers, generally composed of younger, relatively healthy people. Once these commercial insurers entered the market, enrollment in health insurance plans increased almost seven-fold from 1940 to 1950.

Another important event that contributed to the growth in employer-sponsored health insurance occurred in 1950 when General Motors and the United Auto Workers (UAW) negotiated the workers' contract. GM Chief Executive Charles Wilson favored a company-by-company approach to worker benefits and offered to pay 50 percent of the health care costs of GM employees. Walter Reuther, national president of the UAW, wanted a universal health care system inclusive of all workers and employers that spread the cost across many companies. UAW eventually agreed to the GM proposal and GM entered the health care business.

Throughout the 1940s and 1950s, federal government policy reinforced the trend toward employer-sponsored health insurance. In 1954, the Internal Revenue Code exempted employer contributions from employee taxable income, further fueling the growth of employer-sponsored health insurance. By 1958, nearly 75 percent of Americans had some form of private health insurance, and reformers focused on expanding coverage to the poor and elderly.

In 1965, with support from labor unions and civil rights organizations and with a large Democratic majority in Congress, President Lyndon Johnson signed the bill creating the government health insurance programs of Medicare and Medicaid.

Still, 16 percent of the population remained uninsured in 2010, according to U.S. Census data. And, in the more than 50 years since employer-based coverage became widespread, health care premiums have increased steadily at rates far exceeding growth in inflation, wages, and other economic indicators.

The number of uninsured, along with the unsustainable rise in health care and health insurance costs, set the stage for passage of the federal Affordable Care Act in 2010. The health care reform bill, signed into law March 23, 2010, retains the employer-based system but significantly alters health insurance regulation.

Growth in Health Care Spending

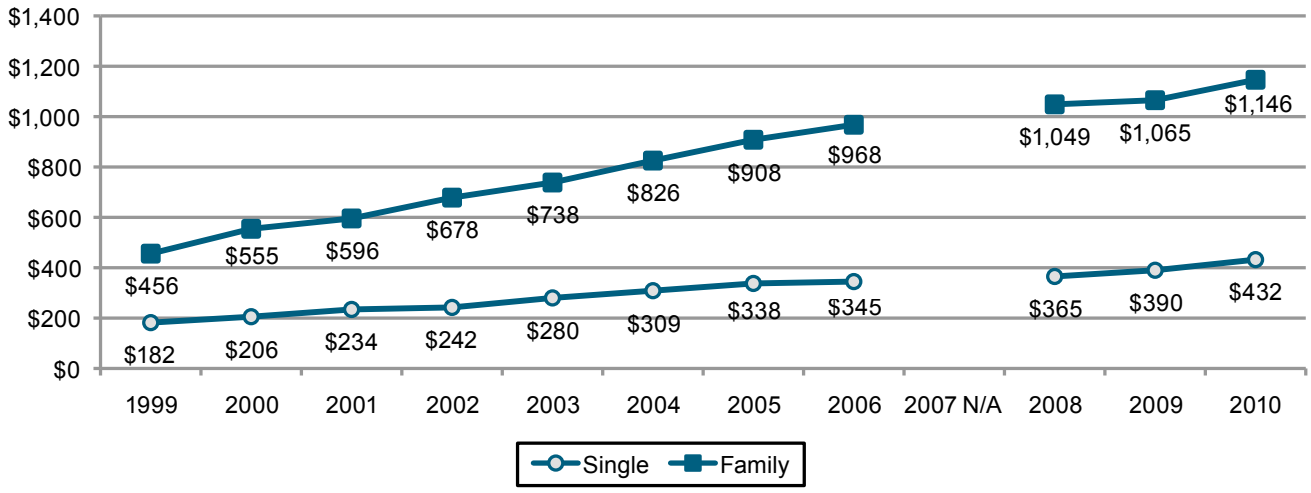
One measure of the steady increase in health insurance premiums is that national health expenditures have more than tripled as a share of the gross domestic product (GDP) in the past five decades — from 5.2 percent of GDP in 1960 to an expected 17.6 percent of GDP in 2010. The Centers for Medicare and Medicaid Services projects that national health expenditures will increase to 19.8 percent of GDP by 2020. At this rate, health care spending will average $13,708 per person in 2020, up from $8,327 in 2010.

Health insurance premiums are a reflection of the underlying cost of health care. Factors that drive increases in health insurance premiums include medical inflation, increases in use of health care services, new technologies that cost more than current medical procedures, prescription drug costs, aging, and unhealthy lifestyles. Just two of the many studies that discuss the underlying cost drivers of health insurance are:

- "Behind the Numbers: Medical Cost Trends for 2012" by PricewaterhouseCoopers at **http://www.pwc.com/us/en/health-industries/publications/behind-the-numbers-medical-cost-trends-2012.jhtml**
- "2011 Milliman Medical Index" at **http://publications.milliman.com/periodicals/mmi/pdfs/milliman-medical-index-2011.pdf**

Figure 1-1 shows the increases in monthly group health insurance premiums in Oregon since 1999. For people with employer-sponsored insurance, the average monthly Oregon premium in 2010 was $432 for single coverage and $1,146 for family coverage. These compare to national averages of $412 monthly for single coverage and $1,156 monthly for family coverage.

Figure 1-1. Average total monthly Oregon premiums from 1999 to 2010



Source: Medical Expenditure Panel Survey (MEPS), 1999-2006 and 2008-2010. Tables II.D.1 (family) and II.C.1 (single). Premiums are for employers of all sizes, including those who self-insure.

Note: The annual Oregon totals are divided by 12 to obtain average total monthly premiums. MEPS data for 2007 is not available.

Cost Shifting to Commercial Market

The commercial health insurance marketplace bears a disproportionate share of the increases in health care spending. When providers believe their reimbursement rates are inadequate in one area, they turn to the commercial market to make up the difference. This fuels increases in commercial health insurance premiums that, in turn, increase the number of people unable to afford coverage.

Families USA, a national nonprofit, nonpartisan group, issued a May 2009 study on the "hidden health tax." It determined that nearly 37 percent of the $116 billion worth of care the uninsured received in 2008 was uncompensated. Unreimbursed health care is estimated to account for 9 percent of the premium cost for commercial health insurance in Oregon, according to a report to the Office for Oregon Health Policy and Research

While the precise amount of the cost shift to the commercial market is unknown, there is little question that the cost shift is real and that it affects the affordability of health insurance. For decades, hospitals have used cost shifting to recover revenue lost as a result of treating the uninsured, underinsured, those on Medicaid and Medicare, and people who do not pay their bills.

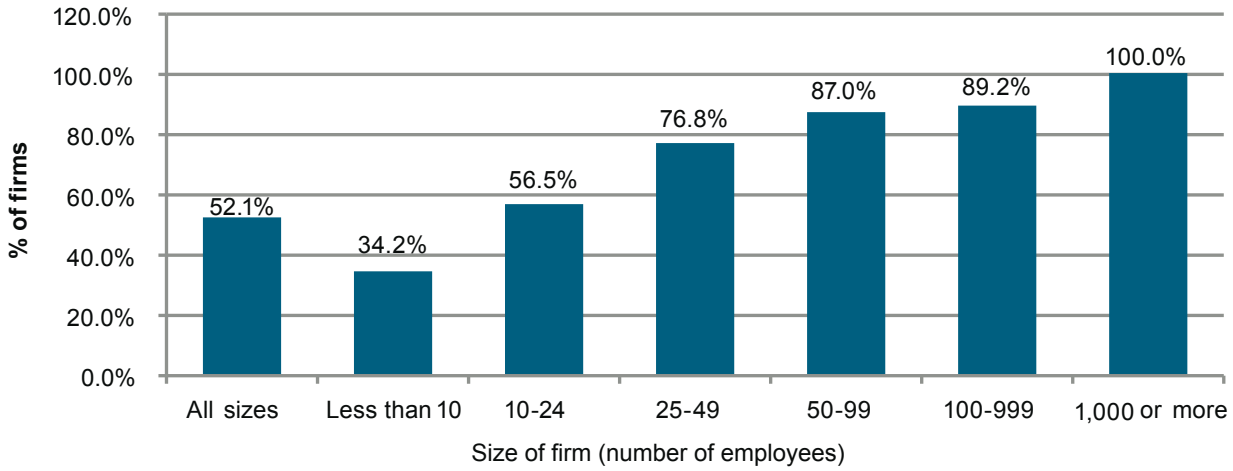
Cost Shifting to Employees

Employers, in turn, shift rising health insurance costs to their employees and, in some cases, stop providing health insurance.

Figure 1-2 shows that in Oregon employers with more than 24 employees are far more likely to offer health insurance than smaller employers. This is generally true throughout the country, as well. A common strategy for employers struggling with affordability is to shift costs to employees through higher deductible and higher cost-share plans. This results in lower monthly premiums for both employers and employees but also results in reduced benefits and increased out-of-pocket expenses for employees. Marketed as "consumer-driven health plans (CDHPs)," some believe these plans encourage consumers to shop for health care, ask about prices, and take control of health care spending.

Similarly, some Oregon health insurers have begun to emphasize evidence-based benefits. In doing so, insurers hope to reduce expenses by encouraging their customers to think more about the costs and effectiveness of medical services. One strategy is to impose higher cost sharing and deductibles on services that are less effective or that cost more without being more effective.

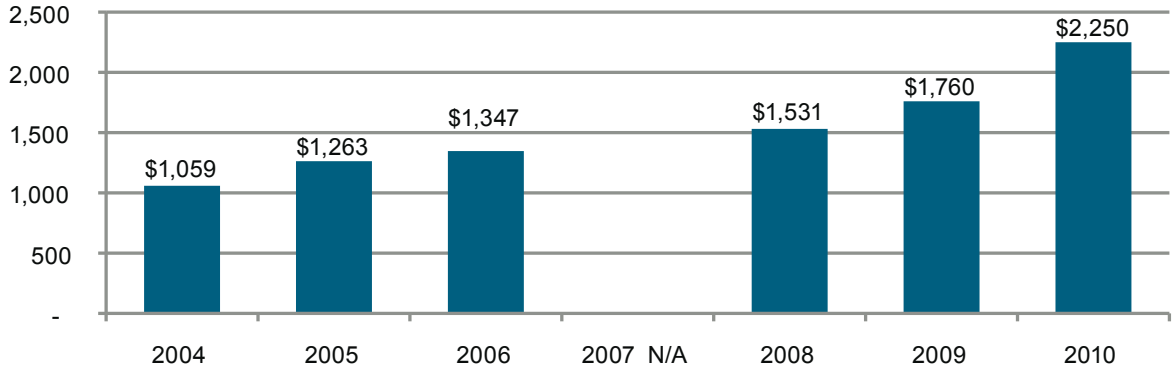
Figure 1-2. Oregon private-sector firms that offer health insurance by firm size in 2010



Source: Medical expenditure panel survey (MEPS), Table II.A.1 (2010) number of private-sector establishments by firm size and state: Table II.A.2 (2010) percent of private-sector establishments that offer health insurance by firm size and state.

Figure 1-3 shows the rise in deductibles paid by Oregon families with employer insurance. Shifting to higher-deductible plans is one way to lower overall premium costs for employers.

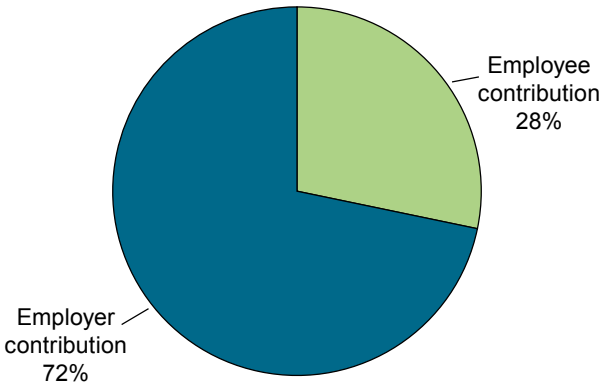
Figure 1-3. Family coverage deductibles, 2004-2010



Source: Medical expenditure panel survey (MEPS) Table II.F.3 (2004-2006 and 2008-2010).
Note: MEPS data for 2007 is not available.

Although employers are increasingly shifting more of these costs to employees, **Figure 1-4** demonstrates that employers still pay the significant majority of the total premium.

Figure 1-4. Family coverage — employee and employer premium contributions, 2010



Source: Medical expenditure panel survey (MEPS) Table II.D.1 and Table II.D.2 (2010).

Federal Health Care Reform —

Affordable Care Act

Unless the new law is overturned as a result of legal challenges or is changed by Congress, most Americans must buy health insurance starting in 2014. That same year, Medicaid will expand to serve more of the lowest-income Americans, and tax credits will reduce the costs of private insurance for millions of lower- and middle-income families, primarily those lacking employer-sponsored insurance. Since most people will be required to buy insurance, starting in 2014, insurance companies will not be allowed to deny coverage to anyone based on health.

The expectation is that by increasing the number of insured people, hospitals and other providers will shift fewer uncompensated costs to the insured population.

Once reforms are fully implemented, federal officials estimate that 93 percent of the U.S. population will be insured by 2019, an increase of 10 percentage points. If accurate, an additional 32 million Americans will be covered.

Affordable Care Act Reforms, Effective 2014

- Most taxpayers must have basic coverage or pay an annual tax penalty.
- Federal tax credits will help many more people afford private coverage.
- Some large employers (more than 50 employees) will pay per-employee penalties under certain circumstances if they do not offer certain basic health benefits.
- Medicaid programs will cover many more people.
- Every state will have a state or federal exchange offering one-stop shopping to consumers who will be able to compare prices, benefits, and health plan performance on easy-to-use websites. People who want to take advantage of tax credits must purchase insurance through an exchange.

Oregon Health Insurance Exchange

The Affordable Care Act requires that all states have exchanges; however, Oregon has been exploring the concept of a health insurance exchange for the past decade. A series of legislative acts, starting in 2007, culminated in the passage of Senate Bill 99, signed into law June 22, 2011.

If states do not have operating exchanges by Jan. 1, 2014, the federal government will operate it for them. By developing its own exchange, Oregon will be able to meet the unique needs of its residents, businesses, and insurance markets.

The Oregon Health Insurance Exchange will be a central marketplace where consumers and small employers can shop for health insurance plans and may access federal tax credits to help them pay for coverage. Through the exchange, Oregonians will be able to easily compare their coverage options and enroll in a plan that best fits their needs.

Beginning in October 2013, exchange services will be available to Oregonians through a Web portal, toll-free phone number, and other formats. Key services will include:

- Central place to shop for insurance plans, with easy-to-compare information on quality and price
- Seamless eligibility and enrollment process for individual and small group plans and Medicaid
- Access to federal tax credits and other assistance available to help make coverage more affordable
- Community-based assistance through navigators and insurance agents
- Innovative plan options and central billing and payment for small employers

Exchange Governance and Funding

The Oregon Legislature established the exchange as a public corporation, overseen by a nine-member board of directors who are appointed by the Governor and confirmed by the Senate. Exchange board meetings are open to the public and allow for public participation. The public can also participate by submitting comments through the exchange website at **http://www.orhix.org**. The board is supported by the Individual and Small Employer Consumer Advisory Committee to provide additional perspectives.

There is no state funding for the Oregon Health Insurance Exchange. Through the end of 2014, federal grant dollars fund the exchange. Beginning Jan. 1, 2015, the exchange will be self-sustaining, funded entirely by an administrative fee charged to insurance companies selling plans in the exchange.

Timeline

February 2012: Exchange presents business plan to Legislature

January 2013: Federal government certifies state exchange readiness

Early spring 2013: Exchange tests technology systems

October 2013: Open enrollment starts

January 2014: Coverage begins for plans in the exchange

January 2015: Exchange must be financially self-sustaining

Exchange Q&A

Will the exchange make health insurance more affordable to Oregonians?

Some Oregonians will be able to go to the exchange and apply for federal tax credits or other assistance to help them pay for health coverage. The exchange is working closely with the Oregon Health Authority on broader efforts to improve the quality of health care in Oregon and reduce costs.

Who will be eligible for tax credits through the exchange?

Premium tax credits will be available for individuals and families buying in the exchange with incomes up to 400 percent of the federal poverty level ($89,400 for a family of four in 2011).

Small employers with low- and moderate-income workers may be eligible for tax credits to help cover the cost of employee coverage. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. For more information, visit the IRS website at **www.irs.gov**.

Are there special standards for insurance companies selling health plans within the exchange?

Yes. The exchange board will establish quality standards for participating insurance companies and the plans they sell in the exchange. This will give people and small employers who buy insurance through the exchange a choice of high-quality health plans.

How is the exchange involving the public in its work?

All meetings of the exchange's board of directors are public and open to public comment and participation. The board's Individual and Small Employer Consumer Advisory Committee also conducts public meetings and provides the board with input on behalf of consumers and small employers. The public can contact the board with questions or ideas through its website at **http://www.orhix.org**.

In addition, the exchange is setting up technical workgroups to help guide its decision making; these groups include industry experts, consultants, businesses, and consumer organizations.

Administrative Simplification

Reducing and simplifying unnecessary administrative work is an important part of building a health care system that yields lower costs and better health outcomes.

Oregon has developed the first standards toward simplifying administrative electronic transactions between doctors, hospitals and other providers, and insurance companies. The first uniform standards involve electronic inquiries to verify eligibility for benefits and standardized transactions (electronic fields) for filing claims information. The benefit eligibility standards began Jan. 1, 2012, and standardized claims transactions take effect Oct. 1, 2012.

While federal standards have not yet been fully implemented, Oregon has been taking state-level action to continue work on electronic transactions until further guidance is issued. The state is also working to standardize prior authorization processes and to centralize provider credentialing, the process used to determine whether a provider can practice at a hospital or participate in a health plan. Oregon's administrative simplification website is here: **http://www.oregon.gov/OHA/OHPB/health-reform/admin/index.shtml**.

Insurance Division: 2012 Legislation

Although the Insurance Division has been able to lower some health insurance rate requests, significant rate relief cannot be achieved without addressing health insurance's primary cost driver: medical costs.

One area of potential cost savings is the reimbursement of preventable medical errors. Also called preventable adverse events or "never events," these are medical errors that should never occur, such as amputation of the wrong limb or bedsores acquired in a hospital.

The Insurance Division will support legislation to the 2012 Legislature that would prohibit insurers from seeking rate increases unless their agreements with health care providers disallow reimbursement for certain preventable medical errors. Although many hospitals and providers already agree not to bill for such events, this legislation would ensure it does not happen — potentially saving costs for the insurer and reducing upward pressure on health insurance premiums.

Section 2: Overview of Health Insurance Regulation

Through its Insurance Division, the Department of Consumer and Business Services (DCBS) is the state's primary regulator of all types of insurance companies, including health insurance companies. Section 2 provides an overview of the health insurance market and describes the department's four major regulatory responsibilities (financial solvency, policy form approval, consumer protection, and rate approval). This section also explains the department's health insurance rate review process, addresses rate increases, and describes the regulations that apply to each of the submarkets within the commercial market, including new protections and benefits resulting from federal health care reform.

Health Insurance Marketplace

The health insurance marketplace comprises a series of distinct markets, each with its own regulatory features.

Figure 2-1 shows that 33 percent of Oregonians get their health insurance in state-regulated markets and provides a breakdown of the submarkets of the commercial market.

Figure 2-1. Oregon health insurance enrollment

	2010	
Oregon population[1]	**3,749,000**	
Commercial/state regulated insurance[2]		
Individual	174,000	4.6%
Portability	19,000	0.5%
Small group 2-50	210,000	5.6%
Oregon Medical Insurance Pool	14,000	0.4%
Large group	634,000	16.9%
Associations and trusts	178,000	4.7%
Total covered under state regulation	**1,229,000**	**32.8%**
Large group self-insured[3]	**576,000**	**15.4%**
Federal health care programs[4]		
Medicare	621,000	16.6%
Medicaid	550,000	14.7%
Total covered under federal regulation	**1,171,000**	**31.2%**
Uninsured[1]	**636,000**	**17.0%**

Figure 2-1 relies on data from the quarterly enrollment reports submitted by insurers. Enrollment figures provided in Sections 4 and 5 of this 2011 report rely on Health Benefit Plan Report (501) data and should not be compared to the data contained in this figure. See Appendix 1 for details on these sources.

These enrollment estimates do not total 100 percent of Oregon's population because the numbers are rounded to the nearest thousand and come from several sources.

[1]Office for Oregon Health Policy & Research (OHPR). Figures for the civilian non-institutionalized population are used.

[2]Oregon Insurance Division quarterly enrollment data. Oregon Medical Insurance Pool (OMIP) data came from OMIP.

[3]Oregon Insurance Division quarterly enrollment data. In prior reports, insurers reported self-insured enrollment. In 2010, insurance companies, special districts, and third-party administrators reported self-insured enrollment.

[4]Centers for Medicare and Medicaid Services.

Commercial/state-regulated insurance. The department regulates approximately 800 health insurers covering more than 1.2 million Oregonians. Seven of these insurers enroll more than 90 percent of the market and dozens of smaller companies insure a small percentage of people.

The department's role in regulating the different health insurance market segments varies. Most regulatory attention focuses on the individual, small employer, and portability insurance markets, which collectively insure 403,000 Oregonians, or roughly 11 percent of Oregonians. The department has authority to review and approve or deny rates for these markets. Health insurance provided to large employers, those with 51 or more employees, is subject to certain Insurance Code requirements, but is not subject to state rate regulation. Instead, insurance companies negotiate prices directly with employers. Competition plays a role in moderating rates in the large group market. Also, larger groups typically do not experience the same rate volatility as individual or small groups, where a single health problem could dramatically affect rates without regulation.

By 2016, federal law will require Oregon to expand its small group market to include groups with up to 100 employees. As a result, groups with 51 to 100 employees that are currently exempt from state rate regulation will be subject to the same rating rules and review of rates as groups with 50 or fewer employees. There are concerns that this expansion may cause some disruption in the markets and push healthier groups with 51 to 100 employees to self-insure.

In addition to the commercial market, the state's Oregon Medical Insurance Pool (OMIP) covers about 14,000 high-risk individuals. OMIP also administers a new federal high-risk pool known as the Federal Medical Insurance Pool for those who have been uninsured for at least six months.

Large group self-insured. Self-insured employers covered approximately 576,000 Oregonians in 2010. That number is up significantly from the prior year, partly because the Public Employees' Benefits Board (PEBB) became self-insured in January 2010.

A self-insured employer pays for its employees' health care costs itself rather than paying premiums to a health insurer for coverage. For the largest groups, there is little practical difference between the two since large employers tend to pay their own claims costs either way, whether through an experience-rated insurance plan or through self-insurance. The distinction between insured and self-insured groups is further blurred by the fact that self-insured employers typically pay insurance companies to administer the employer's health benefits as third-party administrators (TPAs). When an insurer acts as a TPA, it is often difficult for employees to determine if their employer is insured or self-insured. For example, assume Jim and Susan are neighbors with employer-sponsored health coverage administered by the same insurance company. Their plans might look the same — their insurance cards may look similar, their procedures for getting bills paid may be similar, and the insurance company processing their claims is the same. In reality, the insurance company may be the actual insurer only for Jim, and merely the third-party administrator for Susan's employer, a self-insured company.

Historically, insurance regulation varied greatly, depending on whether a company was insured or self-insured. Employees with insured plans, for example, enjoy benefits, claims-handling standards, and other protections mandated by state law. They also have access to the department's consumer advocates who help consumers resolve health insurance complaints under state insurance laws. If an insurer violates the law, the department can assess a civil penalty of up to $10,000 per violation. In contrast, the federal government regulates self-insured plans under the 1974 Employee Retirement Income Security Act (ERISA). This act pre-empts most state insurance regulations, including benefit mandates.

The Affordable Care Act, however, is blurring the distinction between regulation of insured and self-insured plans by extending an array of new benefit requirements and consumer protections to all plans, including self-insured plans. For example, the federal law provides that enrollees in self-insured plans whose claims are denied have the same internal and external appeals rights as enrollees in insured plans.

Federally regulated health care. In addition to regulating the self-insured market, the federal government regulates Medicare and Medicaid. These programs cover more than 1 million Oregonians. Medicare covers people 65 or older and those with certain disabilities. Medicaid covers specific categories of people with low incomes. Although Medicare and Medicaid are federal programs, the states are responsible for some aspects of both programs and regulate Medicare supplement insurance.

Uninsured. The Office for Oregon Health Policy and Research estimates that 17 percent of Oregonians, or 636,000 people, were uninsured in 2010. The number might have been even greater if not for expanded coverage of children through the state's Healthy Kids program and federal premium subsidies to help some laid-off workers keep their employer-sponsored coverage through part of the year.

Figure 2-2 shows a significant drop in the percentage of uninsured children in Oregon under age 19 from 2008 to 2010.

Uninsurance rate — all ages			
Age	**2008**	**2009**	**2010**
0-18	12.3%	11.3%	9.2%
19-64	20.9%	23.2%	23.6%
65+	0.6%	0.8%	0.8%

Read more about the uninsured on the Oregon Health Policy and Research website at **http://www.oregon.gov/OHPPR**.

Financial Regulation

Financial regulation is a high priority for insurance regulators to make sure insurers can pay claims. Financial regulation applies to all types of insurers operating in Oregon, including all health insurers offering individual or group health insurance. Certain federal programs, such as Medicare, also rely on state regulators to ensure the solvency of insurers.

The purpose of financial regulation is to ensure that insurers possess and maintain the financial resources necessary to meet their obligations to policyholders. Financial regulation begins with the department's initial decision about whether to license an insurer to do business in Oregon and continues with ongoing financial reviews of licensed companies. The Insurance Code requires a minimum of $2.5 million of capital and surplus before an insurer is authorized to transact insurance. The required minimum increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed its liabilities.

The department uses technical standards established by the National Association of Insurance Commissioners (NAIC) to evaluate insurer solvency and financial stability. The NAIC is made up of insurance regulators from all 50 states, the District of Columbia, and the five U.S. territories. Its standards are used widely throughout the country and are known as risk-based capital (RBC) standards. RBC measures the minimum amount of capital appropriate for a company to support its overall business operations based on its size and risk profile.

A company's RBC is calculated by using a formula focusing on material risks.

The five major risk categories for health insurance are:

- Asset risk, affiliates — the risk a company's investments in affiliates will incur losses
- Asset risk, other — the risk of default of principal or interest payments and market value fluctuations
- Underwriting risk — the risk of underestimating existing policyholder obligations or inadequately pricing business to be written in the coming year
- Credit risk — the risk of recovering receivables
- Business risk — the general risk of operating a business

These factors generate a dollar amount that represents a minimum level of capital and surplus needed to maintain solvency. The adequacy of an insurance company's capital and surplus is evaluated by comparing the company's total adjusted capital and surplus with its RBC requirement. The resulting RBC ratio is used to determine if regulatory intervention is necessary. It is not used to set a maximum capital and surplus level or a target capital and surplus level. The department is required to take certain actions, including exercising control of the insurer, if a company's RBC ratio is at or below 200 percent. Under certain circumstances, such as a company losing money, the department has authority to act if a company's RBC ratio is between 200 percent and 300 percent.

While these RBC levels set a minimum regulatory requirement, a company near these levels is barely above financial hardship. The rating organizations that grade the financial status of insurance companies and help determine the companies' financial viability typically expect higher RBC levels. Financial regulators strongly prefer similar cushions, particularly for nonprofit insurers that do not have the same access to capital markets as for-profit insurers.

The review of a company's financial soundness and compliance with statutes and recordkeeping standards is carried out primarily through the financial

examination and analysis process. A financial examination of an Oregon-domiciled insurer occurs on site and consists of an in-depth financial review. By law, these examinations must be conducted at least once every five years. However, the Insurance Division has the authority to examine a company any time the DCBS director determines an examination is necessary. The financial analysis process involves an in-house desk audit of an insurer's annual and quarterly statements, supplemental filings, and other financial information.

The ability of a company to meet its obligations to policyholders is ultimately the responsibility of insurance company management. When the department identifies a potential problem with meeting policyholder obligations, it contacts company management to explain its concerns and to obtain information regarding the steps management will take to satisfy those concerns. Once company management implements these steps, the department monitors the outcome. If steps taken by management do not improve operating results and adequate surplus cannot be maintained, the department may decide that regulatory action, including supervision, rehabilitation, or even liquidation, is necessary.

Form Regulation

A health policy contract or form refers to the documents that describe the benefits of a health insurance policy (as opposed to the rates that address the charge for those benefits). The department reviews all individual and group health policy forms to ensure they include all the required policy language and provisions necessary to constitute a complete insurance policy. This includes the mandated benefits required by Oregon law and by the Affordable Care Act. The department disapproves forms that do not comply with the law or that contain provisions that are unjust, unfair, or inequitable.

While insurance policies for large groups of 51 or more are not subject to rate regulation by the department, insurers must file policy forms for approval and provide all mandated health benefits for all group insurance plans. An exception to the filing requirement for group health forms exists for policies that are negotiated and unique to a particular group. These forms, however, must still include benefit mandates and comply with insurance regulations.

Consumer Protection

Health insurers are subject to a wide range of consumer protections under the Oregon Insurance Code and the Affordable Care Act. Many of these laws apply to all health insurance, including limited-benefit policies such as those that cover a specific disease or pay a fixed amount for each day of hospitalization. Others, including those required by the Affordable Care Act, target comprehensive health policies, referred to in law as "health benefit plans."

Mandates. State and federal law require health insurers to cover certain services and to include certain types of providers in their plans. Under Oregon law, some mandates, such as maternity coverage, apply to all insurance policies. Others, such as mental health parity, apply only to group and portability policies.

Not all Affordable Care Act reforms apply to all plans. Generally, a plan may be considered grandfathered, and thus exempt from some provisions of the new federal law, if the plan existed before the law took effect (March 23, 2010), and meets other criteria.

Key mandates under the new federal law:

- Adult children may stay on their parents' policies up to age 26 even if they no longer live at home or no longer are students or dependents on a tax return. Both married and unmarried children qualify. (This applies to all plans.)
- Insurers can no longer use pre-existing conditions to deny coverage to children under age 19 in the individual market. (This applies to all plans except grandfathered individual plans.)
- Preventive services must be provided with no co-pays or other cost sharing. (This applies to non-grandfathered plans.)
- Policies may not include any lifetime limits on how much they pay for essential benefits. (This applies to all plans.)
- Annual limits on what policies pay for essential benefits are restricted. (This applies to some plans.)

Federal law identifies categories of essential benefits that must be covered by health benefit plans issued in individual and small group markets both inside and

outside the exchange. They include benefits such as doctor visits and other outpatient care; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative services; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

Federal regulations released in late 2011 give states the authority to decide specific essential benefits by selecting a benchmark plan that reflects services offered by a "typical employer plan." Oregon policymakers have the ability to choose either the state's largest HMO plan, one of the largest three small employer plans, one of the top three state employee benefit plans, or one of the three largest federal employee health benefit plans.

In 2014, federal subsidies will be available to many individuals to buy health insurance through exchanges. However, federal subsidies cannot be used to pay for any state mandates that exceed the state's benchmark plan.

When people obtain coverage through the exchange, the state must pay for the costs of any coverage exceeding the state's benchmark plan that are required by state mandates. Thus, Oregon policymakers will likely weigh the costs of any state mandates not already included in the state's benchmark plan as of March 31, 2012.

Unfair discrimination. ORS 746.015 prohibits "unfair discrimination ... between risks of essentially the same degree of hazard in the availability of insurance, in the application of rates for insurance ... or in any other terms or conditions of insurance policies." For example, insurers must treat people who share characteristics such as age similarly.

Misrepresentation. ORS 746.075 and 746.100 prohibit various types of false or misleading representations, including a broad prohibition against any "practice or course of business which operates as a fraud or deceit upon the purchaser, insured, or person with policy ownership rights."

Appealing a claim denial

More than 44 percent of those who appeal succeed in getting the denial overturned, generally by the company through an internal appeal.

The Insurance Division's Consumer Guide to Health Insurance Appeals explains the appeals process and offers tips for those appealing an "adverse decision." Visit this web page for more information: **http://insurance.oregon.gov/consumer/appeals-guide/appeals-guide-toc.html**.

Claims Mishandling

The department investigates consumer complaints about potential claims mishandling. Investigations involve such issues as whether insurers pay claims timely, conduct reasonable investigations before denying claims, and correctly implement new laws.

From 2009 through 2010, the department recovered more than $3.6 million on behalf of consumers who were hurt by practices that violated insurance laws. In addition to recovering money on behalf of consumers, the department worked with insurance companies to change practices that posed harm to other consumers.

Unfair claims settlement practices. ORS 746.230 prohibits misrepresenting facts or policy provisions in settling claims, failing to act promptly upon claims-related communications, refusing to pay a claim without conducting a reasonable investigation, not attempting in good faith to equitably settle claims in which liability has become reasonably clear, and failing to explain the policy basis for denial of a claim.

Privacy. ORS 746.600 to 746.690 protect the privacy of health information.

Patient protections. ORS 743.801 to 743.913 provide specific protections to consumers and disclosure requirements for insurance companies relating to denial of claims, rights to appeals and independent review of adverse decisions, rights to continuity of coverage, rights of women to choose primary care providers and have access to women's health care providers, and specific claims payment requirements. The Affordable Care Act extends many of these rights to employees of self-insured businesses.

Rescission. For comprehensive coverage, federal law prohibits insurers from rescinding coverage (canceling it retroactively as if it never existed), unless fraud or an intentional misrepresentation of material fact is involved. Oregon law extends this protection to all health insurance coverage.

Consumer advocacy. In a typical year, the department's consumer advocates handle approximately 16,000 inquiries and 4,000 consumer complaints about all lines of insurance. About 40 percent of complaints involve health insurance. In addition to helping individual consumers resolve insurance problems, the advocates also look for violations of the law and broader trends for referral to market analysts. The market analysts conduct investigations designed to stop patterns of consumer abuse. The market surveillance process can result in enforcement actions, with civil penalties of $50,000 or more, for serious patterns of consumer abuse.

The department's advocacy services were expanded in 2011 as a result of a $431,000 federal health care reform consumer assistance grant received in late 2010. The department worked with the Oregon Health Authority to establish the Oregon Health Connect website. This site provides a directory of governmental and community organizations involved with health insurance or health care. The site, along with two referral specialists, is intended to help connect Oregonians with the health care resources, premium assistance, and insurance plans that best fit their needs. From April through October 2011, the website recorded 5,738 visits, and the help line handled more than 1,000 calls from Oregon consumers. Visit this site at **www.oregonhealthconnect.org**.

In addition to the advocates who help consumers with commercial insurance, the department's Senior Health Insurance Benefits Assistance (SHIBA) program helps Oregonians make educated decisions about Medicare. SHIBA is a statewide network of trained volunteers who provide one-on-one help to people with Medicare.

Transparency. As consumers bear more of their health care costs through higher deductibles, co-payments, and co-insurance, it is important for them to know in advance how much their health care will cost so they can make good, cost-effective health care decisions. Health insurers doing business in Oregon must provide reasonable cost estimates for common medical procedures via interactive websites and toll-free telephone numbers. For these procedures, the estimates must include information about how much of the deductible an enrollee has met; the amount of other costs, such as co-insurance, that an enrollee must pay; and the amount of any applicable benefit maximum. The department also gathers information from insurers to provide consumers with the costs of specific inpatient medical procedures at all Oregon hospitals. This information, along with quality data, is available at **http://www.oregon.gov/OHPPR**.

Federal website lists insurance options

Federal reforms require insurers to provide information to the U.S. Department of Health and Human Services (HHS) about the costs and benefits of health plans they offer. Consumers can view options in their area by visiting **www.healthcare.gov**. Options are listed for all consumers, including small employers, individuals who do not get coverage through an employer, people with limited incomes, and people with pre-existing medical conditions.

Rate Regulation

The department must approve health insurance rates in the individual, small group, and portability markets. Health insurance rates are not regulated for large groups with 51 or more employees where competition plays an important role in keeping rates reasonable.

Federal reforms have generally maintained the role of states in regulating health insurance rates. This is particularly true in states such as Oregon that federal officials determined have effective rate review processes. However, insurance companies seeking rate increases of 10 percent or more must also file information justifying the request with the federal government and post it on their own website. The Oregon Insurance Division's website at **www.oregonhealthrates.org** provides a link to information filed with the federal government as well as all documents filed with the division.

In states lacking an effective rate review process, HHS determines whether certain rates are unreasonable and, if so, requires justification for the rate. HHS, however, has no authority to deny an insurer's proposed rate.

New website for rate information: www.oregonhealthrates.org

Consumers can visit this website produced by the Oregon Insurance Division to look up an insurance company's rate request, comment on a rate request, learn how the Oregon Insurance Division reviews rate requests, see dates for public hearings on rate requests, find information on why health insurance costs so much, and more.

In Oregon, rate filings for regulated groups must include actuarial documentation. Oregon law (ORS 742.005) provides that rate filings will be denied if the filings are deemed "prejudicial to the interests of the insured's policyholders," if the filings contain "provisions which are unjust, unfair, or inequitable," or, most significantly, if the "benefits … are not reasonable in relation to the premium charged."

Department actuaries rely on these laws to answer two basic questions about each rate filing: Is the aggregate rate request justified? Is the request fairly allocated among the ratepayers? In some cases, the second question is the more important one since a modest change in aggregate rates can mask a much larger variation among ratepayers. For example, a proposed 3 percent increase in aggregate or average rates could, depending on how the aggregate increase is allocated among ratepayers, mean a 20 percent increase for some individuals or groups and a 10 percent decrease for others. These issues are particularly important as they relate to health insurance, where rate regulation focuses on protecting those with the greatest health needs through pooling of risk and blending of rates.

Below are the key factors the department uses to determine if the overall rate request is actuarially justified:

Historical and projected loss ratio. The loss ratio is the relationship between the claims paid by the insurance company and the premiums received. Companies typically have loss ratios between 80 percent and 90 percent for health insurance. This ratio means that for every dollar in premium, the company pays out 80 cents to 90 cents in medical claims. Loss ratios are typically lower for individual and small group insurance because administrative expenses are higher on a per capita basis in these markets. Insurance companies seek loss ratios below 100 percent because the company will always incur some administrative costs.

Under the Affordable Care Act, an insurance company is required to rebate premiums when it fails to spend at least 80 percent of premiums collected in a state's small group and individual markets on medical care and quality improvement. It must spend at least 85 percent of premiums on these activities in a state's large group market or pay a rebate. Under federal regulations issued in late November 2010, insurance companies that issue individual, small group, or large group coverage will have to report the following for each market in each state in which they do business:

- Total earned premiums
- Total reimbursement for clinical services
- Total spending on quality improvement activities
- Total spending on all other non-claims costs, excluding federal and state taxes and fees

The report is due June 1 of every year, and the information received from the report will be public and posted on the HHS website.

In 2012, insurers that fail to meet the new standards must rebate to enrollees an amount proportional to the amount of premiums paid the previous calendar year. For example, if an insurer had a 75 percent medical loss ratio in the small group market, the insurer would have to rebate 5 percent of the amount of premiums paid by each enrollee in a small group plan. In other words, a $1,000 premium payment would result in a $50 rebate. Rebates in the group market will be paid to the employer. Under federal regulations issued in December 2011, employers must use the rebates they receive for the benefit of enrollees. For example, an employer might reduce employees' future premium contributions. Rebates must be paid by Aug. 1 each year.

It is unlikely that this new regulation will have much of an effect in Oregon. Due in part to this state's detailed and strict rate review requirements and its competitive insurance market, most insurance companies in Oregon already meet or exceed the desired balance between medical care/quality improvement spending and administrative costs and profits.

Historical and projected trend. Trend is the rate of change in the claims portion of an insurance company's loss ratio and consists of two components: medical inflation and use. Medical inflation reflects the increase in the unit cost of covered medical services, including hospital stays, prescription medications, charges by physicians and other medical professionals, and costs for diagnostic services, including tests and imaging. Use reflects the rate at which medical services are used and can be affected by the health and age of the insured population, the level of coverage, the availability of new drugs and new medical technology, and the choice of treatment options by an insured and his or her medical providers. Because medical costs are the primary cost driver of health insurance premiums, trend is an important factor in rate filings.

Figure 2-3 shows projected medical trend for the upcoming year, as approved by the Insurance Division.

Figure 2-3. Projected medical trend for 2012

Individual health plans					Small group health plans (2-50 employees)			
Insurance Company	Effective date of calculation	Medical	Rx	Composite	Effective date of calculation	Medical	Rx	Composite
Health Net	10/1/2011	11.7%	11.7%	11.7%	10/1/2011	9.7%	13.0%	10.1%
Kaiser	2/1/2011	6.5%	6.5%	6.5%	7/1/2011	6.6%	6.6%	6.6%
Lifewise	9/1/2011	11.9%	11.9%	11.9%	7/1/2011	11.5%	10.0%	11.4%
ODS	11/1/2011	10.6%	10.6%	10.6%	7/1/2011	10.0%	10.0%	10.0%
PacificSource	1/1/2011	12.0%	9.5%	11.8%	7/1/2011	10.5%	9.0%	10.3%
Providence	11/1/2011	8.8%	8.8%	8.8%	8/1/2011	7.1%	7.3%	7.1%
Regence	10/1/2011	10.6%	10.6%	10.6%	7/1/2011	11.1%	13.1%	11.4%

Source: Insurance Company rate filings. In some cases, insurers may have projected higher trends than the division approved. These numbers reflect trend projections as approved by the division.

The department carefully considers all adjustments used as the basis for projecting future trends. The department tries to balance the more conservative assumptions and projections of insurance company actuaries with what we regard as more objective assumptions and projections. In 2011, insurers reported that medical claims costs in the Oregon market had begun to slow significantly, with some insurers even reporting decreasing costs. Consequently, the department challenged projections that assumed large increases in medical costs for the next year.

For carriers such as Kaiser Foundation Health Plan of the Northwest that own their buildings as part of integrated systems, the projected trend could be less than for other insurers because these carriers have more control over facility costs.

Developing medical trend. Hospitals, physicians, and other health care providers are often paid for their services by sending health insurers medical claims for specific services. There are other payment models such as contracts that give provider groups a fixed amount of money to pay for all services for members enrolled with the group. All provider compensation methods are considered when carriers establish claims costs.

Recent claims history is important for helping to predict future claims costs. But actuaries must also consider a variety of factors when predicting changes in claims costs.

Estimates for future claims costs are affected by changes in such major factors as unit costs (fees) paid to providers; use by plan members; treatment patterns; medical technology; aging; benefit changes; and increasing demand for services from long-term members, known as underwriting "wear-off."

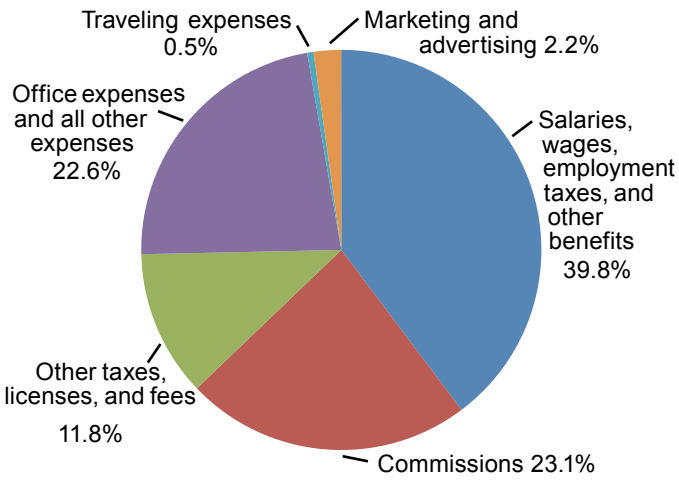
When claims history is not appropriately adjusted for the effects of these other factors, consumers experience greater volatility in rates because short-term increases or decreases in claims costs receive disproportionate weight.

Historical and projected administrative costs. Administrative costs are generally higher for individual and small group health insurance on a per capita basis and typically decline on a percentage basis as a company's business volume grows. Administrative costs are also usually higher for insurers that write fewer policies or that offer coverage with higher deductibles and lower premiums. Short-term administrative costs may increase due to factors such as technology investments designed to improve medical outcomes or reduce long-term costs.

Since April 2010, the department has required insurance companies to separately report and justify changes in administrative expenses by line of business and to provide details about what they spend on salaries, commissions, marketing, advertising, and other administrative expenses.

Figure 2-4 provides a rough breakdown of key administrative expenses in the small group and individual markets combined.

Figure 2-4. Breakdown of total administrative costs in 2010



Source: Oregon Insurance Division rate filings. The chart breaks down average 2010 total administrative costs, including claims-handling costs for individual and small group markets.

Executive pay

One of the issues often raised by consumers in rate filing comments to the department is that of executive compensation. The 2011 rate filings disclosed that executive pay for companies' highest-paid executives amounted to a fraction of 1 percent of premiums paid for coverage.

In the individual market, executive pay ranged from 46 cents of the monthly insurance premium for a large company to $1.96 for a smaller insurer with a significant share of high-deductible plans that produce less premium to offset salary costs. In the small employer market, the effect of executive pay ranged from 46 cents to $1.96 of the monthly health insurance premium.

Agent (producer) commissions

Federal health reforms pressure insurers to reduce administrative costs and this might affect agent compensation.

Historically, many insurance companies paid agents a percentage of the premium they generated in sales. In Oregon, commissions accounted for an average of 4.2 percent of premiums in 2010 in individual and small group markets. If a client uses an agent, a commission is paid as long as the client remains insured.

However, companies are re-evaluating this commission system as escalating claims costs push up premiums and reforms require insurers to spend a certain percentage of premiums on medical care versus administrative costs such as commissions.

In 2011, 62 percent of companies with the bulk of Oregon's health insurance business paid per-member commissions in the small group market. Typical commissions ranged from $8 to $14 per employee per month. In the individual market, however, the majority of companies continue to pay commissions as a percentage of premium, according to an Insurance Division survey. Commissions averaged roughly 7 percent to 8 percent of premium. Only two of the largest insurers paid commission on a per-member basis in this market.

Net income target. Insurance company rate filings include a net income target for the line of insurance that is the projected profit or loss after subtracting projected claims costs and administrative costs from projected revenue.

The department has explicit authority to consider an insurer's investment income, surplus, and cost containment and quality improvement efforts when reviewing a rate filing. It may also consider an insurer's overall profitability rather than just the profitability of a particular line of business, such as small group plans. Because companies generally were more profitable in 2010 and some had healthy

surpluses, the department pushed back on certain insurer rate requests, even though some insurers were losing money in these lines of insurance. However, the department is careful about using surplus and overall company profitability to mitigate rate increases. As medical claims costs continue to rise annually, keeping rates artificially low will only result in even greater increases in the future. In 2011, many insurers experienced lower-than-expected medical claims and some adjusted rates downward during the year for new buyers. The division took this into account as it reviewed rate requests.

Actuarial analysis. For each of these above factors, department actuaries evaluate the reasonableness of insurance company assumptions in light of the company's past experience, the effect on policyholders, and the rates being charged by competitors. Although the department does formally deny rate increase requests when warranted, it more often asks for additional information, questions an insurance company's assumptions, and indicates that the rate increase should be reduced.

The second set of actuarial issues — how rates vary among groups and individuals — typically depends on whether the proposed rates comply with the specific rules applicable to each commercial submarket and whether reasonable adjustments have been made to ensure a rate request that is reasonable in the aggregate is not inequitable to particular groups or individuals.

Consumer input. Consumers have 30 days to comment on insurance company rate requests for individual, small group, and portability health insurance plans. The timeline starts when a rate request filing is deemed complete and details are posted on the Insurance Division website. Consumers who have signed up on the division's website are then notified when a company has filed a rate request. Any comments they submit are posted on the website.

Since October 2011, the division has held public hearings on rate requests involving small employer or individual health plans. Consumers can find hearing information at **www.oregonhealthrates.org**. The Insurance Division uses federal grants to fund a consumer advocacy group to participate in public hearings and provide meaningful comments on rate requests.

Federal grants enhance rate review

The Affordable Care Act set aside $250 million nationwide to help states start or improve their review of health insurance rate requests. The U.S. Department of Health and Human Services grants were awarded in two cycles. Oregon's share for the full period, starting August 2010 and ending Sept. 30, 2014, is $5 million. The division is using its money to:

- **Increase the scrutiny of rate filings:** Additional staff, including two actuaries and a market analyst, enabled the Insurance Division to dig deeper into rate requests and the data that is part of rate filings. This included adding public hearings to the review process in late 2011 and posting ongoing correspondence between division actuaries and company actuaries on the division's website.
- **Bolster public input:** The grant funds a consumer group to provide in-depth comments on rate requests. Requests for proposals were sought; the Oregon State Public Interest Research Group (OSPIRG) was selected for the initial year of the grant and was the only group to seek the grant for the second round of grant funding covering a nearly three-year period. It will receive $314,448 (averaging slightly more than $100,000 a year) from January 2012 through September 2014 to represent consumers at public hearings. OSPIRG offers detailed comments on how rate requests measure up to the legal factors the division considers in evaluating rate requests.
- **Help meet workload demands:** Grants fund eight positions: two actuaries, a market analyst, a rate filing intake coordinator, an administrative assistant, a grant coordinator, a rate liaison to answer consumer questions about rate filings, and a health reform/exchange coordinator. The exchange coordinator will ensure coordination between the Insurance Division and the new Oregon Health Insurance Exchange.
- **Public hearings:** Some grant funds will be used to equip a room to broadcast public hearings on rate requests so that people can watch from their computers.
- **Risk management:** Grant funds will be used to contract for actuarial work that will help determine the effects of federal reform on insurance markets as well as the design of programs to limit companies' financial risk as a result of changes in 2014.

Grant funding ends in 2014. Before then, the division will contract with an outside source to evaluate the effect of our federal grant funds and whether it should seek legislative approval to continue any grant-related positions with other funds.

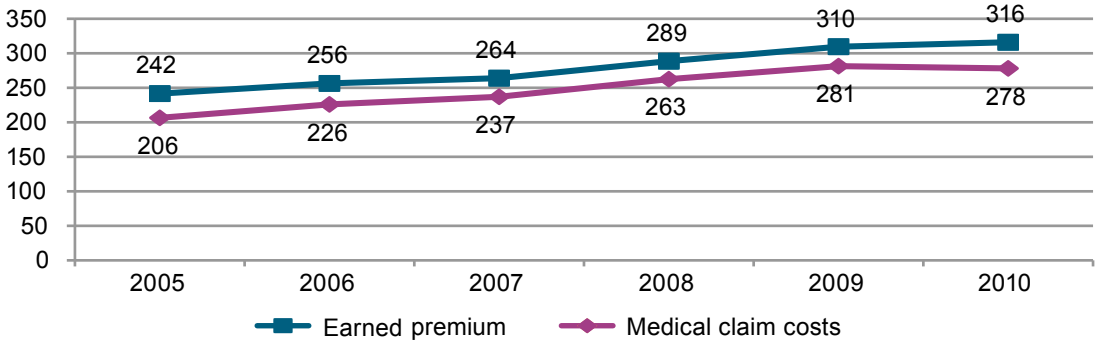
Health Insurance Premiums

Health insurance premiums in Oregon and the rest of the country generally reflect the cost of health care. In 2010, Oregon's seven largest health insurers spent an average of 89 cents of every premium dollar on hospital and medical care, including prescription drug coverage. (An additional 10 cents paid insurance company administrative costs with the remaining penny going to profit.)

Rate requests vary greatly among insurance companies depending on their unique financial situation. Similarly, premium increases charged to a particular small business can vary greatly depending on changes in the group's characteristics. For example, rates would more than likely rise because the average employee age went from 35 to 50. Generally, however, cost and use of health care are the key factors that drive rates. Cost is related to such factors as new and more expensive technologies, cost shifting, and reduced competition among providers. Increased use is attributable to such factors as aging of the population and unhealthy lifestyles. Because insurance is a tool to finance the underlying costs of health care, Oregon's planned reforms include efforts to contain health care costs.

Figure 2-5 shows the relationship between medical claims and premiums from 2005 to 2010.

Figure 2-5. Monthly earned premium and medical claim costs per member, of seven largest insurers from 2005 to 2010



Source: Oregon Insurance Division, health benefit plan reports.

In 2011, many insurance companies in Oregon and nationwide saw a drop in consumers' use of medical services. The tables below show the slowing of rate increases in 2011 as a result of the drop in medical claims.

Figure 2-6 shows average rate increases for small group plans for the previous five years. Annual rate increases averaged more than 10 percent from 2007 to 2010. In 2011, the average rate dropped to 6.63 percent. Many think this ebb in rate increases results from a decreased use of health care. It is likely that the combination of higher co-pays, deductibles, and co-insurance, combined with the poor economy, have caused even insured consumers to cut health care spending.

Figure 2-6. Average annual rate increase in the small group market

Year	Increase
2007	11.92%
2008	13.44%
2009	10.47%
2010	11.68%
2011	6.63%

Source: Oregon Insurance Division, approved rate filings.

Small employer premiums in Oregon are relatively low compared to those nationwide. In 2010, Oregon family premiums in the small employer market ranked 42nd among the 50 states and the District of Columbia, meaning only nine states had lower average premiums, according to the federal Medical Expenditure Panel Survey. Oregon's average annual family premium of $11,492 in 2010 was approximately 13 percent lower than the national average of $13,170. See **Appendix 3** for state-by-state annual premium comparisons.

Figure 2-7 shows that Oregon's individual health insurance market has been more volatile than its small group counterpart over the past five years, ranging from an average rate increase of 13.34 percent in 2007 to an average rate increase of 21.34 percent in 2008. One reason for this volatility is that in 2006, following a profitable period, Regence BlueCross BlueShield of Oregon lowered its rates by 16 percent, prompting many other insurers to suppress rate increases. However, insurers could not maintain these artificially low rates in the face of continuing increases in medical costs, forcing them to increase rates significantly in 2008.

Figure 2-7. Average annual rate increase in the individual market

Year	Increase
2007	13.34%
2008	21.34%
2009	14.92%
2010	15.57%
2011	9.05%

Source: Oregon Insurance Division, approved rate filings.

Federal reform and health insurance rates

New consumer benefits mandated by federal health care reform generally accounted for no more than 4 percentage points of rate increases approved in late 2010. The amount varied by insurance company and by plan. For example, policies that already cover preventive benefits with no cost-sharing might have less of a rate increase than a policy that formerly charged members a co-pay for preventive services but can no longer do so under the Affordable Care Act.

Commercial submarkets

Each submarket in commercial health insurance has its own regulations. Below are descriptions of the individual, small group, and large group submarkets.

Individual market

The individual market includes individuals and families who do not have access to employer-sponsored group coverage. Approximately 174,000 Oregonians, or 5 percent of the population, purchase health insurance in the individual market.

Insurers may turn down adult applicants for individual health insurance coverage for various reasons, including health. However, people under age 19 cannot be denied coverage because of pre-existing conditions.

After the Affordable Care Act required insurers providing coverage to children under 19 years of age to do so on a guaranteed-issue basis, some Oregon insurers stopped offering child-only coverage. To encourage insurers to continue to offer such coverage, the department established open enrollment periods for two months out of the year; insurers offering children's coverage were required to enroll children during these months. In 2011, the Legislature passed a law requiring the Oregon Medical Insurance Pool (OMIP) to assess insurers for the cost of a children's reinsurance program. As a result, Oregon's seven largest domestic insurers are now all offering child-only coverage throughout the year.

In general, once coverage is provided, it is guaranteed renewable as long as premiums are paid. Adults age 19 or older who are denied coverage because of health status can obtain coverage through OMIP.

In the individual health insurance market, the department must review and approve both the content of insurance contracts and the rates charged for the coverage provided. The department's review of the insurance contracts ensures that mandated services are included and consumer protection standards are met. Provisions of the Oregon Insurance Code or federal law applicable to the individual market include:

Standard health statement. Companies that sell insurance in the individual market must use information obtained from the standard health statement to decide whether to offer coverage to people age 19 or older. The health statement contains a series of

questions regarding an applicant's medical history for the previous five years. As noted earlier, insurers may decline to offer coverage to adults 19 or older because of health history. If an insurer offers coverage, however, premium rates cannot be based on an individual's health experience. People under age 19 may not be denied coverage because of pre-existing conditions.

High-risk pool eligibility. Individuals denied coverage in the individual market are eligible for coverage through OMIP. This program operates state and federal high-risk pools. Applicants for the federal pool must be uninsured for at least six months, have an existing medical condition, and be a U.S. citizen or legally present in the United States. There is a choice of two comprehensive health plans under the federal pool. The federal government subsidizes premiums, and federal law requires that they be no higher than the market average for comparable benefit plans.

For those who have been uninsured for less than six months or who otherwise do not meet the federal pool eligibility requirements, coverage under the state high-risk pool is available. A board of directors determines the coverage and the rates for the state pool. The law prohibits the state pool from charging rates that are more than 25 percent higher than those in the individual market. The state program may also serve as the health plan option for individuals qualified for the Federal Health Coverage Tax Credit, as well as the portability option for individuals who lose their self-insured, employer-based group coverage. Portability rates are set at the average of current portability market rates. Because premiums in the state pool are not sufficient to cover claims costs, the board imposes an assessment on insurance companies and reinsurance companies to cover the shortfall. Both pools will be available until 2014, when insurers will no longer be able to deny coverage based on pre-existing conditions.

Guaranteed renewability. All individual health insurance policies are guaranteed renewable as long as the individual continues to make the required premium payments. A general exception from the guaranteed renewability requirement exists for a company that chooses to withdraw from a particular geographic area or from the entire state or that discontinues a particular health plan.

Rating rules. Premium rates cannot be based on an individual's health or claims experience, and insurance companies may not consider an individual's health status in setting premium rates. With the exception of age, insurers are prohibited from using individual characteristics when setting premiums and cannot increase rates for an individual more than once per year.

Mandated benefits. All individual health insurance policies must include certain mandated health benefits. Under the Affordable Care Act, insurers must provide preventive benefits, some of which are similar to benefits mandated under Oregon law. Under federal law, however, insurers may not impose cost sharing (co-pays, deductibles, etc.) on preventive benefits. Oregon law does not limit cost sharing on Oregon-mandated coverage. This means that unless an Oregon mandate is also a preventive benefit under federal law, an insurer will be able to continue to impose cost sharing on the coverage. A comparison of coverage required by the preventive benefit requirements of the Affordable Care Act and the Oregon mandates can be found at **http://insurance.oregon.gov/consumer/federal-health-reform/mandate-comparison-chart.pdf**.

Pre-existing conditions. Insurers cannot deny coverage or impose waiting periods for people under age 19 for pre-existing conditions. In the case of adults, an insurer can deny coverage based on health status but can only impose an exclusion from coverage for a pre-existing medical condition if medical advice, diagnosis, care, or treatment was recommended or received during the six months before the effective date of coverage. If an insurer excludes a pre-existing condition from coverage, it may only do so for up to six months. This six-month exclusion period, however, is reduced by the number of months the insured had continuous prior coverage or eliminated altogether. For example, an insurer may exclude coverage for a member's pre-existing heart condition for up to six months; however, if the member had prior continuous coverage without a break of more than 63 days for five months, the six-month exclusion is reduced to one month. If the member had prior continuous coverage for six months, there would be no exclusion of coverage of the heart condition. Insurers can impose waivers of coverage on pre-existing conditions for up to 24

months and can restrict an individual's choice of health plans but must do so based solely on the standard health statement. An insurance company may legally decide not to insure women who are 19 or older and pregnant when they apply for an individual plan. The father of the child may also be denied coverage. However, people who are denied coverage may apply for insurance through the Oregon Medical Insurance Pool and the Federal Medical Insurance Pool.

Small group market (2-50 employees)

Insurers serving the small group market must accept all groups regardless of their health status. The department reviews rates to ensure they meet standards that protect groups with older or less healthy employees. Similar rules apply to "portability" coverage, which is available to Oregonians who leave group coverage and who meet certain eligibility standards. Federal law requires all states to offer portability coverage, and most states offer the coverage either in the individual market or through a state high-risk pool. Oregon has a more successful portability program than most states because Oregon law requires group health insurers to provide portability coverage to individuals leaving an insurer's group business. Portability coverage through the Oregon Medical Insurance Pool is available to individuals leaving group coverage only when a group insurer's portability coverage is not available for very specific reasons. Approximately 6 percent of Oregonians obtain their insurance from the small group (210,000 Oregonians) and portability (19,000 Oregonians) markets.

In the small group health insurance market, as in the individual market, the department must review and approve both the insurance contracts and the rates charged for the coverage provided. Provisions of Oregon law applicable to the small group market include:

Guaranteed issue. Insurers selling health insurance in the small group market must offer all of their small group products to all small groups on a "guaranteed issue" basis, meaning that each small group has access to all products offered to any other small group in the relevant service area. A group cannot be turned down based on the age, health, or claims experience of those covered.

Guaranteed renewability. Small employer plans are guaranteed renewable, meaning the coverage continues at the employer's option as long as the employer continues to make the required premium payments. As with individual insurers, a general exception from guaranteed renewability exists for an insurance company that chooses to withdraw from a particular geographic area or from the entire state.

Rating rules. Insurance companies must pool all of their small group employers when setting rates; thus, the rate charged to a business largely reflects medical claims for the entire small group market and not claims for that particular business.

Rate bands. In the small group market, the most expensive rate charged by an insurer can be no more than three times the lowest rate charged. This is known as a 3-to-1 rate band. For example, if an insurer's lowest offered rate is $50, then the insurer's highest offered rate cannot exceed $150.

Rating factors. The law limits the factors that can be used to set rates. Factors that may be used include age, participation in wellness programs, employer contributions, customer loyalty, tobacco use, and expected claims, which is limited to a 5 percent variation.

Pre-existing condition exclusionary periods. Small group plans can exclude coverage for certain conditions that an employee age 19 and older had before enrollment, but the exclusion period cannot exceed six months (12 months for late enrollees). Insurers cannot impose an exclusion period on coverage for any dependents under age 19 and may not treat pregnancy as a pre-existing condition. Any six-month exclusion period imposed on adults is reduced by the number of months the insured had continuous prior coverage without a break of more than 63 days.

Mandated benefits. All small group health insurance policies must include certain mandated health benefits. See the mandates at **www.cbs.state.or.us/external/ins/sehi/mandated_health_provisions.pdf**.

Nondiscrimination. Both federal and state law prohibit health insurance companies from applying different eligibility rules, offering different health insurance benefits, or charging higher premium rates to individual employees within a small employer group on the basis of health status or other health-related factors, including claims experience, medical history, or genetic information.

Participation requirements. Health insurance companies may require small employers to pay some portion of their employees' health insurance premiums and may also require that a certain percentage of eligible employees participate in the plan. If an insurer requires 100 percent of eligible employees to participate in the plan, the insurer may not require a small employer to contribute more than 50 percent of the premium cost of an employee-only benefit plan.

Associations and trusts

Associations offer group health insurance to their members who may be employers or unions. In 2010, approximately 178,000 Oregonians received health insurance through an association.

Oregon law allows group health insurers flexibility in rating association and trust health benefit plans offered to small employer groups, although association plans offered to individuals and small groups will be subject to federal review of rate increases of 10 percent or more under Affordable Care Act regulations.

Oregon law also establishes protections to keep groups insured under these plans from losing coverage due to high claims. Out-of-state association and trust plans are subject to the same requirements as Oregon-based associations.

Association health plans are exempt from the small group rating laws (previously discussed) if associations meet criteria aimed at preventing "cherry-picking," or providing less expensive coverage to the healthiest groups. Cherry-picking leaves the less-healthy groups to buy coverage in the general market, which leads to increased rates over time.

- Associations and insurers cannot deny membership or coverage to any small employer group based on health.
- There are limits on how much the initial premium rate may vary between groups of small employers so that rates cannot be used to ward off higher-risk groups.
- Associations must maintain high retention rates, apply for an exception to these retention rate requirements, or follow the more stringent regulations of small-group health insurance laws.

Large group market (51 or more employees)

The large group market is made up of employers that have 51 or more employees that choose to purchase insurance for their employees rather than self-insure. There are approximately 634,000 Oregonians, or nearly 17 percent of the population, insured in this market. The insured portion of the market is subject to consumer protection laws, such as mandated benefits and claims-handling rules.

There are no laws regulating rates in this market and no requirement that coverage be offered to all groups. The department reviews and approves the content of large group insurance contracts to ensure that they include coverage mandates and meet consumer protection standards. Legal requirements that apply to both small and large groups are guaranteed renewability, mandated benefits, nondiscrimination, participation requirements, portability, and pre-existing conditions. Oregon laws governing large groups are not applicable to self-insured employers.

Section 3: Financial Status of Largest Health Insurers

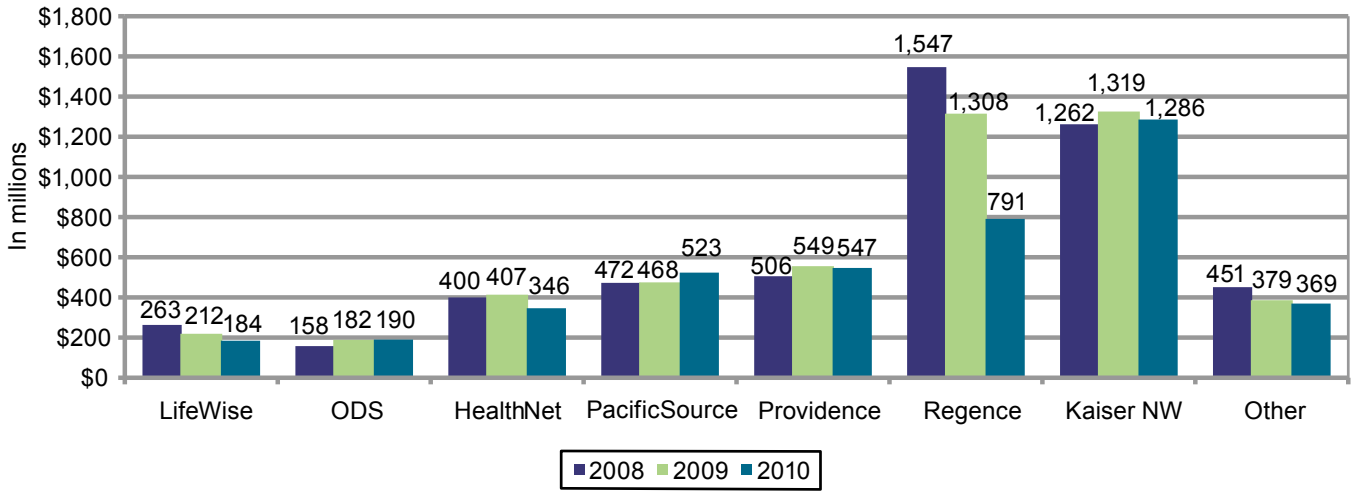
As the health of the economy remains uncertain, the Department of Consumer and Business Services continues to closely monitor the financial condition of Oregon's domestic health insurers. Despite enrollment losses for most insurers, carriers have taken steps to stay financially strong. Nonetheless, these difficult economic times underscore the importance of the department's responsibility to monitor the financial condition of insurers to make sure that each is able to pay policyholder claims.

The department conducts financial examinations of Oregon health insurers every three to five years or more frequently when warranted. Oregon health insurers also submit quarterly and annual financial statements to the department. The department's financial analysts review these statements to evaluate each insurer's financial status and operational health over time.

This section presents an overview of the financial status of the seven largest Oregon-based health insurers using financial statements over five- and 10-year periods.

Figures 3-1 shows Oregon premiums earned by the state's seven largest health insurers and "others" in the individual, small group, large group, and association markets since 2008.

Figure 3-1. Oregon total premiums earned



Source: Oregon Insurance Division, 2008-2010 Health Benefit Plan Reports.

Key Financial Indicators

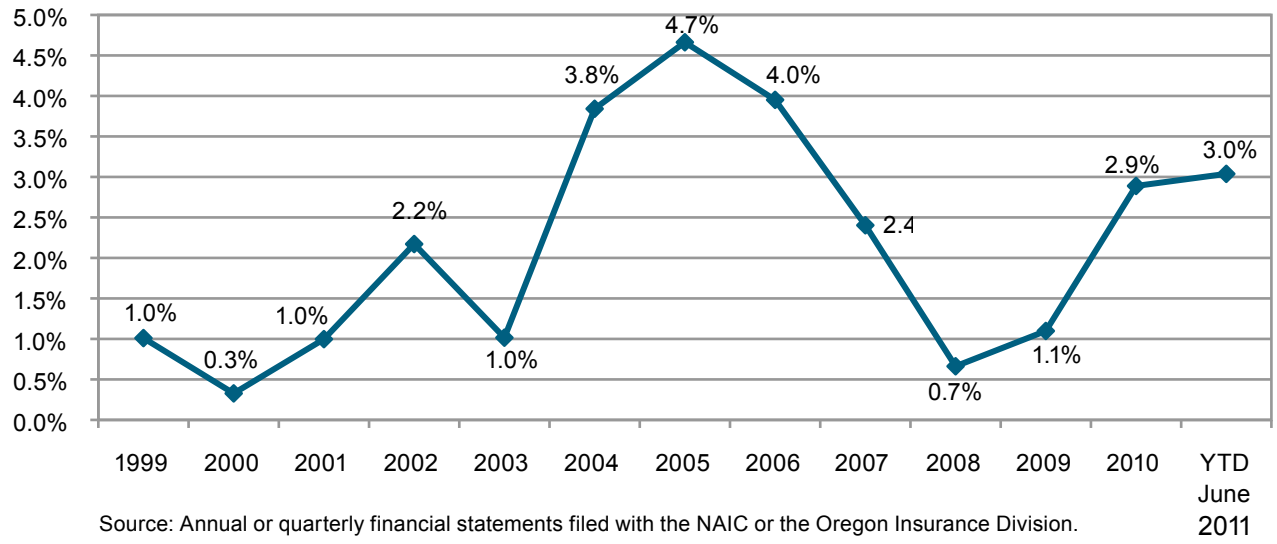
The remainder of this section examines key financial indicators for Oregon's seven largest health insurance companies and is compiled from the insurers' companywide data. This includes financial data from the insurers' operations in other states. The section begins with net income, which is sometimes referred to as profit margin. This is the net result of total revenue minus expenses. This section then considers each insurer's surplus, which is the amount an insurer's assets exceed its liabilities. The remaining indicators — medical loss ratios, administrative expenses, claim adjustment expenses, net underwriting gains or losses, and net investment gains — are key components of an insurer's net income or loss. See the Appendix for a more detailed explanation of these terms.

Profit Margins — Net Income to Premium Earned

One measure of an insurer's profitability is the insurer's net income, which is the net result of all revenue, expenses, and write-offs (total revenues minus expenses). Net income, sometimes referred to as profit margin, includes the insurer's companywide business — not just its Oregon business.

Figure 3-2 summarizes profitability as a percentage of earned premium from 1999 to June 2011. This figure demonstrates that the profitability of Oregon's seven largest insurers is cyclical. Insurers posted earnings between 3.8 percent and 4.7 percent during 2004, 2005, and 2006, at a time when other segments of the economy were also performing better.

Figure 3-2. Cycle of profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 3-3 shows net income to premiums earned by year and by company from 2006 through June 2011. The 10-year average of the largest seven largest insurers is 2 percent. The majority of net income is the result of investment income for 2010.

Figure 3-3. Net income to earned premium from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	10-year average 2001-2010	YTD 6-11
Health Net	3%	3%	1%	-1%	5%	3%	6%
Kaiser	2%	3%	1%	2%	2%	2%	2%
LifeWise	4%	-2%	-4%	0%	-2%	2%	3%
ODS	4%	2%	1%	-5%	2%	1%	4%
PacificSource	6%	2%	-1%	1%	1%	3%	3%
Providence	8%	7%	0%	3%	6%	5%	6%
Regence	4%	1%	1%	1%	4%	2%	3%
Average all seven	**4%**	**2%**	**1%**	**1%**	**3%**	**2%**	**3%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Capital and Surplus

Insurers must maintain capital and surplus. For-profit insurers report capital and surplus amounts; nonprofit insurers report only surplus. Capital reflects the funds received by a for-profit company when it issues shares of its common stock. Surplus includes profits accumulated by for-profit and nonprofit companies.

The combination of capital and surplus is the amount that an insurance company's assets exceed its liabilities. It is the amount over and above what a company expects to pay out for medical claims, expenses, taxes, and other obligations.

Insurers are legally required to maintain minimum levels of capital and surplus to ensure that they will be able to meet their financial obligations to policyholders. Capital and surplus requirements vary by insurer because they depend on the size and risk profile of a company. While the law specifies the minimum amounts of surplus a company must have, there is no limit on how much surplus a company can maintain.

Companies use surplus in a variety of ways. Capital and surplus provide an insurance company with assets to protect against adverse conditions, allow the company to take on additional enrollment, and allow it to invest in new technology and infrastructure. Adverse conditions may include unusually high and unexpected medical expenses, lower-than-expected investment income, or investment losses. When an insurer experiences an adverse condition, it cannot immediately raise premium rates because health insurance rates are guaranteed for 12-month cycles. As a result, insurers must rely on surplus or other nonpremium sources.

Figure 3-4. Oregon's for-profit and nonprofit insurers

For-profit:	Nonprofit:
Health Net Health Plan of Oregon	Regence BlueCross BlueShield of Oregon
LifeWise Health Plan of Oregon	Kaiser Foundation Health Plan of the Northwest
ODS Health Plan, Inc.	PacificSource Health Plans
	Providence Health Plan

For a variety of reasons, Oregon's largest for-profit insurers have maintained consistent levels of surplus over the past 10 years, despite varying operational and investment gains and losses.

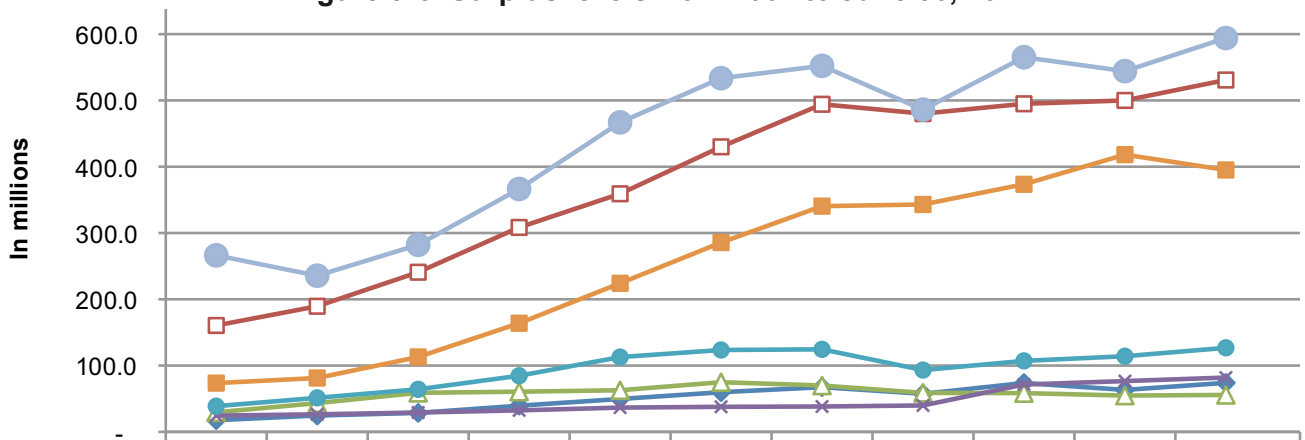
Oregon's largest nonprofit insurers maintain larger surpluses than the for-profit insurers because they tend to rely on surpluses to cover operation and investment losses. For-profit insurance companies, on the other hand, have access to additional surplus contributions from a parent company or additional capital through the issuance of common stock.

Surplus and Rate Review

The Insurance Division has authority to consider surplus in reviewing insurer rate requests and has used this authority to approve rates that are lower than initially requested, even when a company is losing money in a particular line of business. However, using surplus to keep rates artificially low does not address ongoing increases in health care costs and will likely create problems for consumers in future years when rates need to be raised to cover medical claims. Additionally, the division believes Oregon consumers benefit from a competitive insurance market. Companies that continually lose money in a particular line of insurance may ultimately leave that market, leaving consumers with fewer choices.

Figure 3-5 shows 10 years worth of surplus levels, along with the mid-year trend for 2011.

Figure 3-5. Surplus levels from 2001 to June 30, 2011



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	YTD 6-2011
Health Net	17.6	24.7	28.6	39.5	49.6	59.8	67.4	57.4	73.7	63.3	73.9
Kaiser	160.5	189.5	240.8	308.4	359.2	430.0	494.2	480.1	494.9	500.0	530.8
Lifewise	29.5	43.4	58.9	60.6	62.8	74.9	69.9	58.8	58.5	54.8	55.7
ODS	24.5	26.5	29.2	32.4	36.6	37.8	38.3	39.8	71.4	76.6	82.0
PacificSource	38.8	51.3	64.3	84.6	112.8	123.5	124.5	93.2	107.1	114.1	126.8
Providence	73.5	81.3	113.0	163.9	224.2	285.6	340.5	343.0	373.5	418.2	395.1
Regence	266.3	235.6	282.2	366.4	466.9	533.5	552.2	486.1	565.2	544.2	594.1

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Medical Loss Ratios

Medical loss ratio is the percentage of health insurance premiums that an insurer pays in health care claims, including amounts reserved for expected future payments for services already provided and for claims the insurer expects to be reported. For example, an insurer with a 90 percent medical loss ratio pays 90 cents in claims costs for every dollar collected in premiums.

Starting in 2012, the Affordable Care Act requires an insurance company to rebate premiums when it fails to meet specific medical loss ratio benchmarks (80 percent in the small group and individual markets and 85 percent in the large group market). The calculation under federal law for rebating purposes is different than the medical loss ratio calculation referenced in this report. The federal calculation, which allows insurers to count amounts spent on quality improvement activities toward health care claims expenditures and deduct amounts paid for state taxes and fees from administrative expenses, is more generous to insurers than the calculation used in this report. **Figure 3-6** demonstrates it is unlikely the largest seven Oregon insurers will be required to rebate premiums to enrollees.

Figure 3-6 illustrates the medical loss ratios for Oregon's seven largest insurers from 2006 through June 2011 in all markets. Kaiser, with its integrated delivery system, typically has a higher medical loss ratio than other insurers. Expenses that other insurers record as administrative are included in Kaiser's claim costs.

Figure 3-6. Medical loss ratios — averages from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	5-year average	YTD 6-11
Health Net	82%	82%	87%	89%	81%	85%	79%
Kaiser	96%	95%	96%	96%	96%	96%	95%
LifeWise	78%	88%	88%	83%	83%	84%	78%
ODS	84%	84%	88%	101%	93%	91%	88%
PacificSource	86%	89%	87%	84%	85%	86%	83%
Providence	85%	88%	89%	90%	90%	88%	89%
Regence	87%	89%	90%	87%	82%	87%	85%
Average all seven	**89%**	**90%**	**91%**	**91%**	**89%**	**90%**	**89%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

General Administrative Expenses

General administrative expenses are expenses an insurer incurs to run its business that are not directly related to paying claims. Included in this category are variable expenses such as salaries and benefits; commissions, marketing, and advertising expenses; office supplies and travel; and fixed expenses such as rent, taxes, utilities, and facilities maintenance and depreciation. Generally, variable expenses directly relate to the volume of business and will fluctuate with premium volume. Fixed expenses are those that are incurred regardless of the volume of premium and can be difficult to reduce, especially if the insurer owns its facilities.

Figure 3-7 shows overall that the level of general administrative expenses in 2010 has remained consistent with prior years. Administrative costs vary by insurer for a variety of reasons. For example, plans with higher deductibles have lower premiums and higher administrative costs as a percent of premium. The top five administrative expenses for all Oregon companies are included in the Health Benefit Plan Reports on the department's website at **http://www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html**.

Figure 3-7. General administrative expenses to earned premium from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	5-year average	YTD 6-11
Health Net	12%	12%	9%	9%	10%	10%	11%
Kaiser	4%	4%	4%	5%	5%	4%	4%
LifeWise	11%	10%	11%	13%	15%	12%	13%
ODS	7%	8%	6%	4%	4%	6%	5%
PacificSource	9%	10%	10%	12%	12%	11%	11%
Providence	4%	4%	4%	5%	4%	4%	4%
Regence	8%	8%	6%	8%	9%	8%	8%
Average all seven	**7%**	**7%**	**6%**	**7%**	**7%**	**7%**	**6%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Claims Adjustment Expenses

Claims adjustment expenses are expenses incurred to record, adjust, and settle claims. Claims adjustment expenses are a separate category from general administrative expenses.

Figure 3-8 shows claims adjustment expenses for Oregon's seven largest health insurers consistently average 3 percent.

Figure 3-8. Claims adjustment expenses to earned premium from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	5-year average	YTD 6-11
Health Net	2%	2%	2%	3%	3%	3%	3%
Kaiser	1%	1%	1%	1%	1%	1%	1%
LifeWise	7%	6%	7%	7%	8%	7%	8%
ODS	8%	8%	6%	4%	3%	5%	4%
PacificSource	2%	2%	3%	3%	3%	3%	3%
Providence	4%	4%	3%	4%	4%	4%	4%
Regence	4%	6%	5%	5%	6%	5%	6%
Average all seven	**3%**	**4%**	**3%**	**3%**	**3%**	**3%**	**3%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Net Underwriting Gain/Loss

Net underwriting gain or loss is not a separate revenue or expense category. Rather, it represents an insurer's gain or loss from its insuring activities. When an insurer earns more premiums than it incurs in medical claims, claims adjustment expenses, and administrative expenses, the insurer has an underwriting gain. If the medical claims, claims adjustment expenses, and administrative expenses exceed the premiums earned, the insurer has an underwriting loss. An insurer with a net underwriting loss may still be profitable if it earns enough investment income to offset its underwriting losses.

Figure 3-9 shows that, collectively, underwriting gains for the seven largest insurers improved for the first time since 2006. In 2007, 2008, and 2009, three insurers out of the seven reported underwriting losses. Year-to-date data through June 2011 show an overall average net underwriting gain of 2 percent.

Figure 3-9. Net underwriting gain/loss to earned premium from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	5-year average	YTD 6-11
Health Net	4%	3%	1%	-2%	6%	2%	7%
Kaiser	1%	1%	1%	1%	1%	1%	1%
LifeWise	4%	-4%	-6%	-2%	-6%	-3%	1%
ODS	1%	0%	-1%	-9%	0%	-2%	3%
PacificSource	4%	-2%	0%	1%	1%	1%	3%
Providence	7%	4%	3%	2%	3%	4%	3%
Regence	1%	-2%	-1%	0%	2%	0%	1%
Average all seven	**2%**	**0%**	**0%**	**0%**	**1%**	**1%**	**2%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Net Investment Gain

An insurer's net investment gain includes all income earned from invested assets minus expenses related to investments (service fees, management expenses, etc.) plus the profit (or loss) realized on the sale of investments.

For some types of insurance, investment income can play a decisive role in overall profitability. For example, property and casualty insurers routinely have underwriting losses but remain profitable because they earn investment income based on long lag periods between when premiums are earned and when claims are incurred. Health insurers earn investment income, too, but the investment income is a smaller factor in the company's overall profitability because most claims incurred are settled within one year of earning the premium.

Figure 3-10 illustrates that from 2006 to 2010, the seven largest health insurers averaged 2 percent in investment gains. Data for the first six months of 2011 showed investment gains averaging 2 percent.

Figure 3-10. Net investment gain to earned premium from 2006 to June 30, 2011

Insurer	2006	2007	2008	2009	2010	5-year average	YTD 6-11
Health Net	1%	1%	0%	0%	1%	1%	1%
Kaiser	1%	1%	1%	1%	1%	1%	1%
LifeWise	2%	2%	1%	2%	3%	2%	3%
ODS	3%	3%	-1%	2%	2%	2%	3%
PacificSource	4%	3%	-2%	0%	1%	1%	1%
Providence	1%	3%	-3%	1%	3%	1%	3%
Regence	2%	4%	2%	1%	3%	2%	3%
Average all seven	**2%**	**3%**	**0%**	**1%**	**2%**	**2%**	**2%**

Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Section 4: Comparisons of Seven Largest Insurers by Market Segment

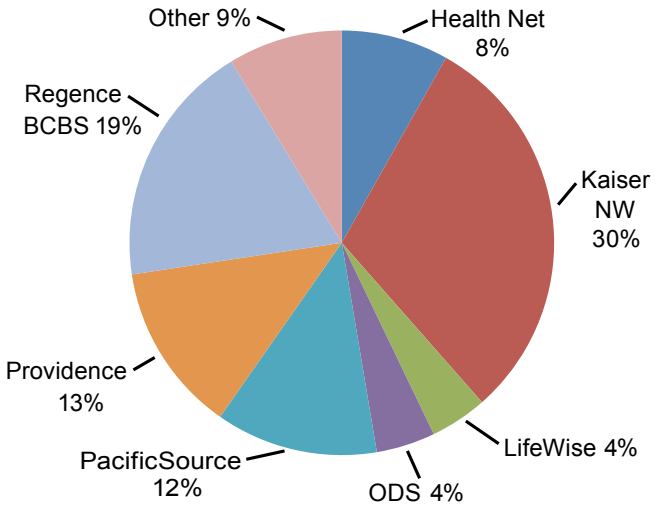
The analysis in this section shifts to different health insurance markets, including what share each of the largest health insurers holds of the individual, small group, large group, and association markets.

The analysis is based on Health Benefit Plan Reports data submitted to the department. These reports, required by Senate Bill 501 (passed in 2005), allow policymakers to spot trends in the different health insurance markets. (The enrollment data collected from the Health Benefit Plan Reports used in this section differs from that of the quarterly enrollment reports used in Figure 2-1 of this report. See Appendix 1 for details.)

All markets

Figure 4-1 shows that in 2010, the two largest health insurers, Kaiser and Regence, earned 49 percent of all Oregon health premiums.

Figure 4-1. Oregon health insurance market share, premium earned in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 4-2 summarizes data by market segment and compares Oregon's seven largest health insurers with all health insurers that reported data. These seven insurers combined have dominant market shares in premiums earned and members enrolled in every market segment.

Figure 4-2. Health Benefit Plan Report in 2010

Totals for seven largest Oregon insurers

Market segment	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Individual	161,174	$414	88%	$208
Small group	193,345	$828	82%	$336
Large group	550,408	$2,268	90%	$345
Associations and trusts	82,154	$358	89%	$297
Total	**987,081**	**$3,867**	**88%**	**$316**

Totals for all insurers reporting (including the seven largest Oregon insurers)

Market segment	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Individual	177,825	$462	85%	$209
Small group	214,447	$881	82%	$326
Large group	590,628	$2,428	89%	$342
Associations and trusts	109,779	$466	88%	$284
Total	**1,092,679**	**$4,237**	**87%**	**$311**

*Rounded in millions

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

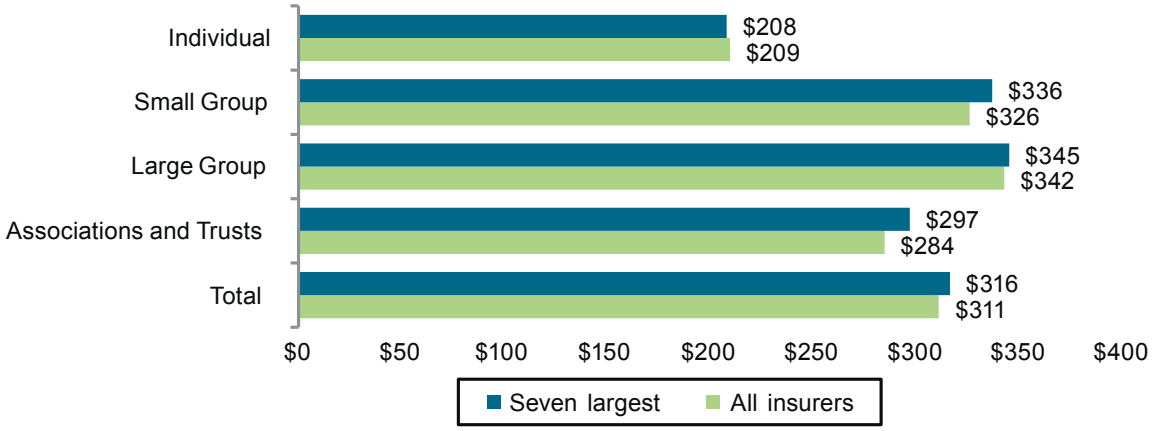
These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Figure 4-3 reflects that average premiums for Oregon's seven largest health insurers were similar to the average premiums of all insurers combined.

Average premium per member per month is calculated by dividing the total premiums paid by all members by the total number of members. It is not representative of what a person might pay for an individual health plan. Actual premium rates may differ for individuals and groups based on a number of factors, including the type and level of benefits, family members covered, the amount of co-insurance, geographical location within the state, the age of members, and, for large groups, the claims experience of the group. These variations are important to consider when comparing premiums of insurers or market segments.

Average premium per member is only one way to discuss average premiums. In the group market, another common method is average monthly premium for single employee coverage or family coverage. Family coverage will have the highest average since it combines employees and dependents in single-family units, but even single coverage will have a higher average than a "per member" calculation. That's because the former counts only individual employees as units and the latter counts both employees and dependents as separate units. For example, consider an employer that spends $400 per month to cover an employee and an additional $400 a month to cover the employee's three dependents. The cost of family coverage is $800, the cost of single coverage is $400, and the cost per member is $200 ($800 divided by the four members).

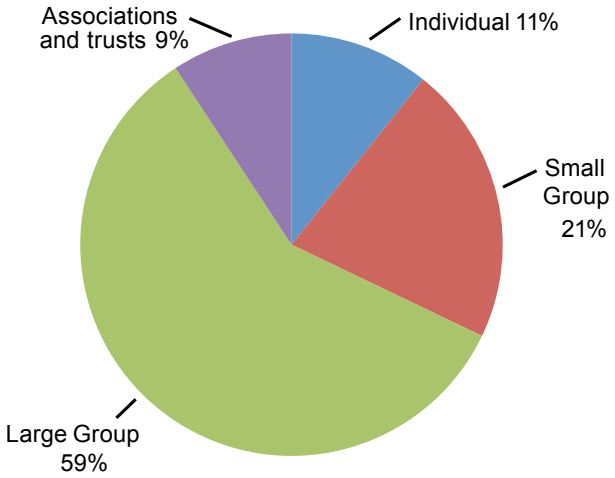
Figure 4-3. Average premium per member per month, market segments in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 4-4 shows that in 2010, the large group market accounted for 59 percent of the total health insurance premiums earned by the seven largest insurers in Oregon.

Figure 4-4. Market share by premium, seven largest insurers in 2010



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Individual Market

The individual market is composed of individuals who either lack access to employer-sponsored health insurance or decline group coverage.

Figure 4-5 summarizes individual market data for 2010. The average monthly premium for Oregon's seven largest health insurers was $208, nearly the same as for all insurers at $209.

Figure 4-5. Seven largest insurers, individual plans in 2010

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	5,513	$20.5	80%	$285
Kaiser	15,160	$52.5	124%	$298
LifeWise	26,607	$71.5	81%	$210
ODS Health Plans	25,492	$36.7	82%	$136
PacificSource	12,243	$24.6	69%	$163
Providence	10,676	$24.6	69%	$203
Regence BCBS	65,483	$183.8	87%	$213
Total – above seven insurers	**161,174**	**$414.1**	**88%**	**$208**
Total – all insurers	**177,825**	**$462.4**	**85%**	**$209**

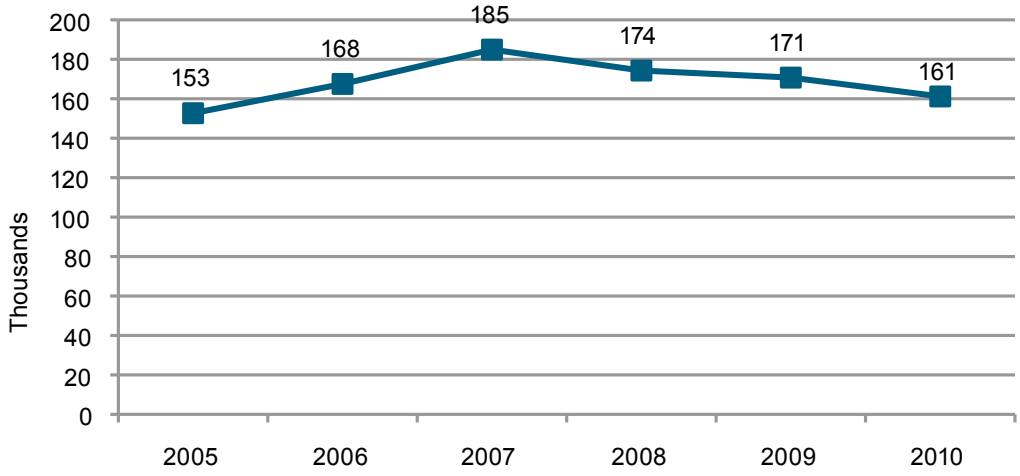
*Rounded in millions.

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Figure 4-6 shows a 13 percent decline in individual enrollment for Oregon's seven largest insurers since the recession began in 2007.

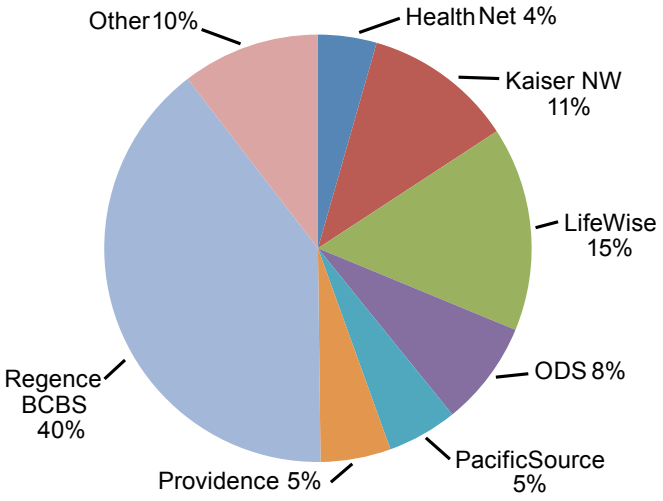
Figure 4-6. Individual plans seven largest insurers, number of members 2005 to 2010



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-7 shows that in 2010, Oregon's seven largest health insurers earned 90 percent of the premiums in the individual health insurance market. Smaller Oregon insurers and national insurers earned the remaining 10 percent of total premiums.

Figure 4-7. Market share by premium, individual market in 2010

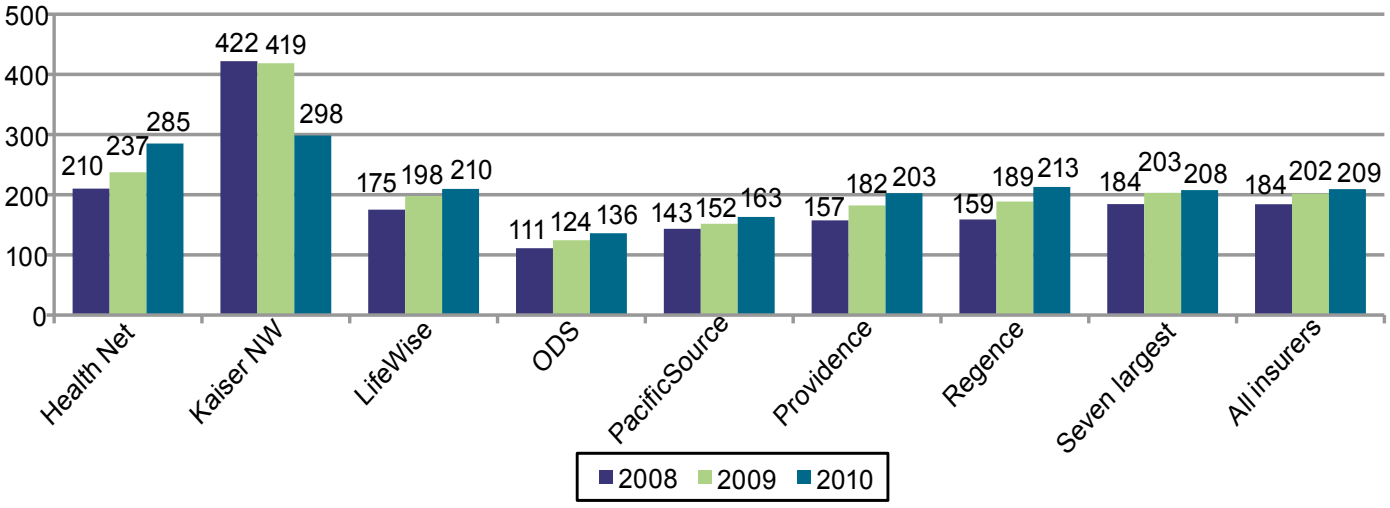


Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Note: Percents do not add to 100 percent due to rounding.

Figure 4-8 compares Oregon's seven largest insurers' average premiums in the individual market to those of all insurers. There were significant variations in premium among insurers. These variations reflect the array of plans available in the individual market.

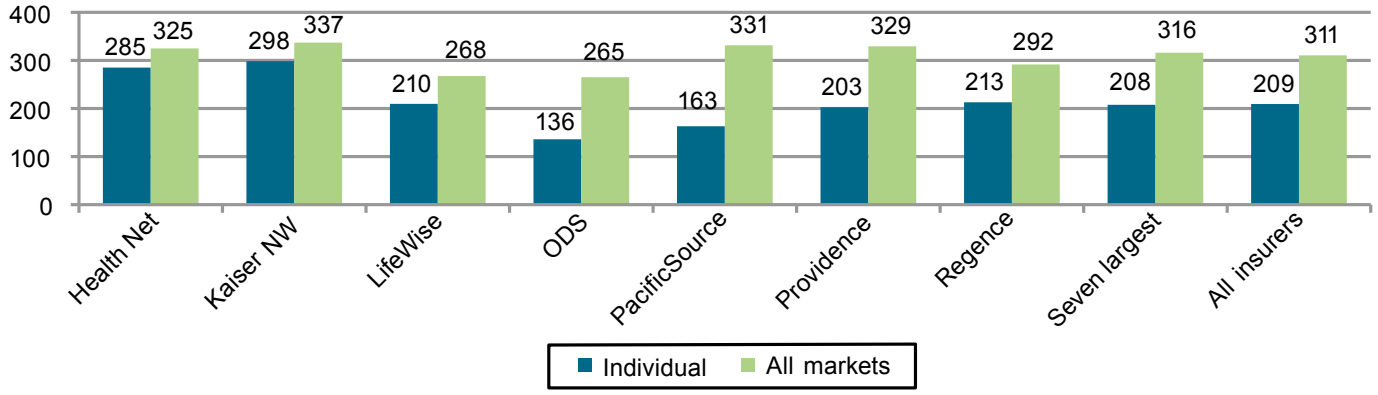
Figure 4-8. Average premium per member per month in individual plans from 2008 to 2010



Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

Figure 4-9 compares the seven largest insurers' average premium per member per month of $208 for the individual market with $316 for all markets, a difference of 34 percent. Individual premiums tend to be lower because benefits are not as rich and because insurers can limit their risk by denying coverage to people age 19 and older with health problems. They cannot do this in the group market.

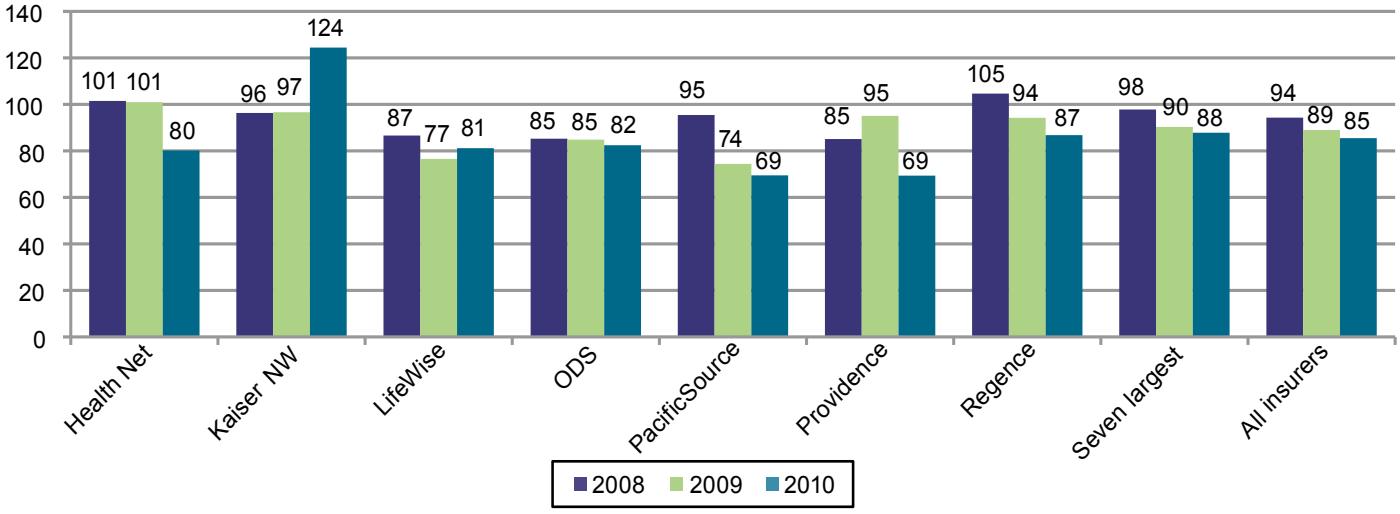
Figure 4-9. Average premium per member per month, individual plans vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 4-10 shows the 2008 to 2010 medical loss ratios for Oregon's seven largest companies in the individual health market compared to all insurers. Medical loss ratios reveal what portion of premiums goes to pay medical claims. Companies typically have loss ratios between 80 percent and 90 percent. This ratio means that for every dollar in premium, the company pays out 80 cents to 90 cents in medical claims. Loss ratios are typically lower for individual and small group insurance because administrative expenses are higher on a per-capita basis in these markets. Insurance companies seek loss ratios below 100 percent because a company will always incur some administrative costs. In 2010, medical loss ratios for the seven largest insurers ranged from 69 percent to 124 percent. Medical loss ratios averaged 88 percent in 2010, which is down from 90 percent in 2009. This compares with a 2010 average loss ratio of 85 percent for all insurers.

Figure 4-10. Medical loss ratios, individual plans from 2008 to 2010

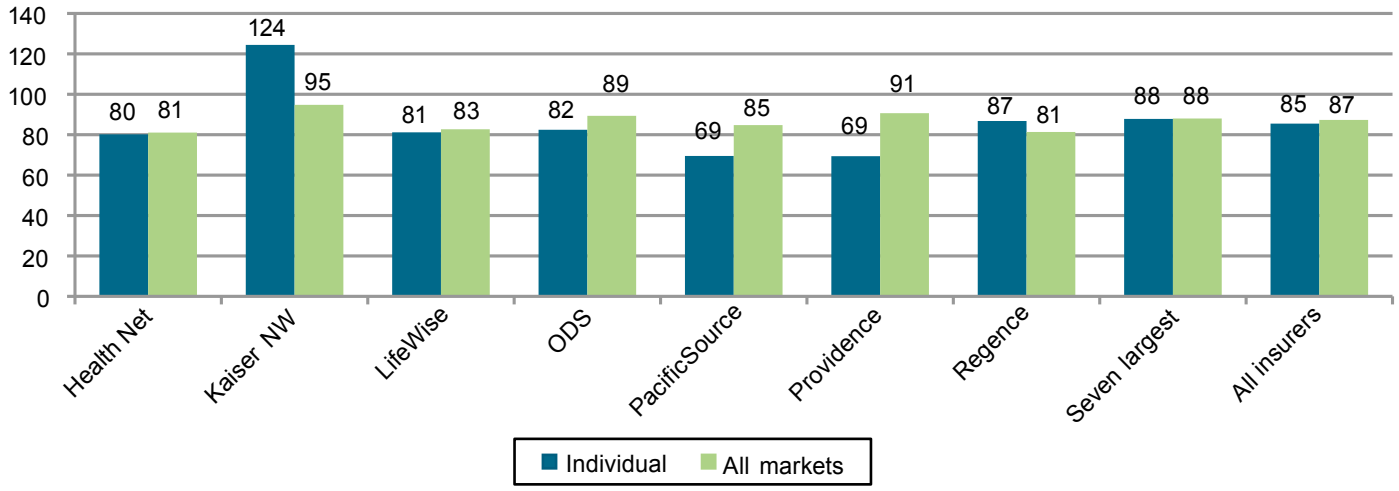


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Figure 4-11 shows the 2010 medical loss ratios for individual plans compared to all markets. On average, the seven largest insurers spent 88 cents of every premium dollar on medical services in the individual market, the same as in all markets.

Figure 4-11. Medical loss ratio, individual plans vs. all markets in 2010



Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Small Group Market

(Employer groups with 2-50 employees)

Small employers account for 61 percent of all employers in Oregon, according to the Oregon Employment Department. Any one of these 77,170 small employers may apply for health insurance in the small group market. An insurer's small group rates are based on the combined (pooled) claims of all the small groups it insures. Rates for a specific small employer's plan may be increased based on its own expected claims experience, but not by more than 5 percent in any year.

Figure 4-12 summarizes the small group market data for 2010. Average premium costs per member per month were $336 for the seven largest insurers, compared to $326 for all insurers.

Figure 4-12. Seven largest insurers, small group plans in 2010

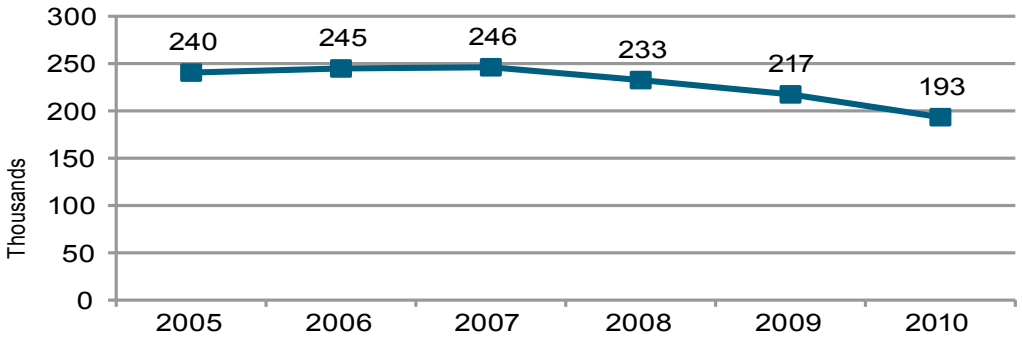
Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	29,882	$149.0	78%	$330
Kaiser	32,285	$123.9	96%	$325
LifeWise	8,064	$32.1	75%	$285
ODS Health Plans	10,717	$34.1	97%	$239
PacificSource	32,919	$155.0	76%	$378
Providence	26,258	$105.1	81%	$354
Regence BCBS	53,220	$228.6	80%	$344
Total – above seven insurers	**193,345**	**$827.8**	**82%**	**$336**
Total – all insurers	**214,447**	**$881.1**	**82%**	**$326**

*Rounded in millions.

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports. These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Figure 4-13 shows a nearly 22 percent drop in small group enrollment for Oregon's seven-largest insurers since 2007.

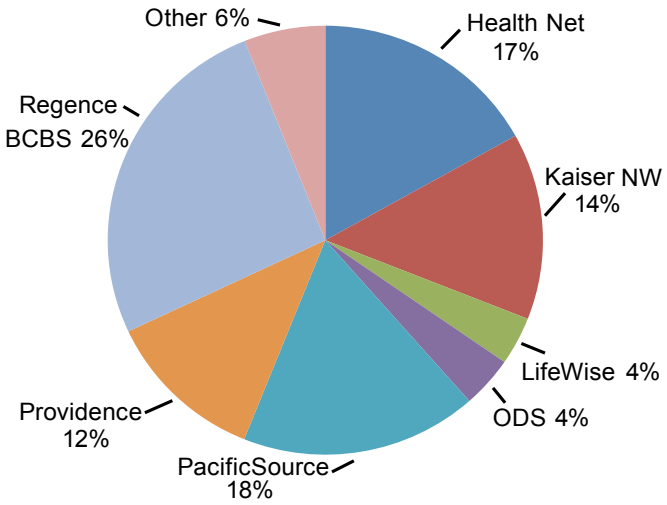
Figure 4-13. Small group plans seven largest insurers, number of members 2005 to 2010



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-14 shows each insurer's share of Oregon's small group health insurance market. The seven largest insurers earn 94 percent of small group premium. Regence is Oregon's largest insurer in this market with 26 percent of the total.

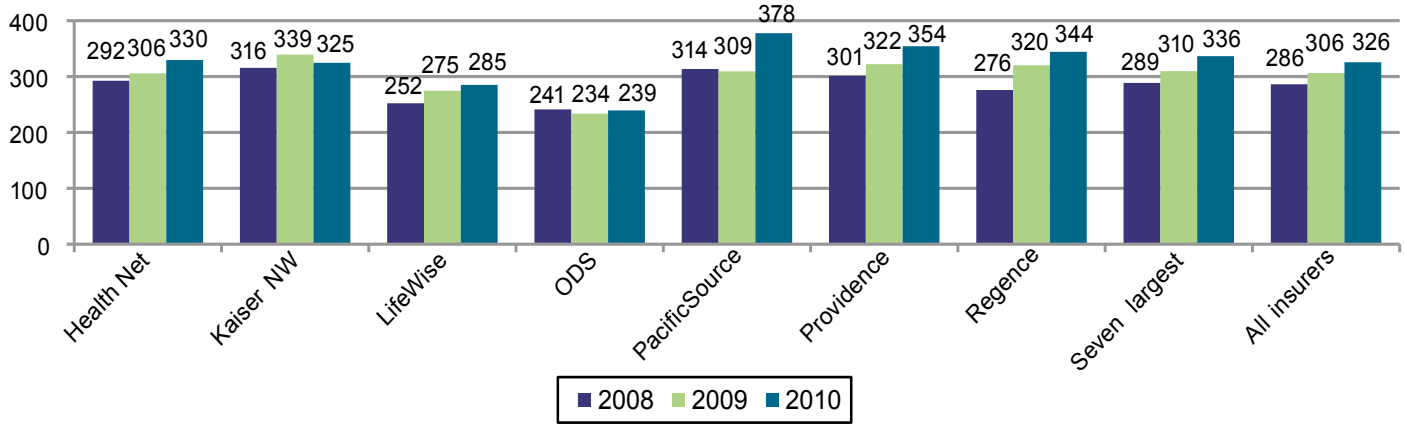
Figure 4-14. Market share by premium, small group market in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 4-15 compares the seven largest insurers' average premiums in the small group market from 2008 to 2010 to those of all insurers.

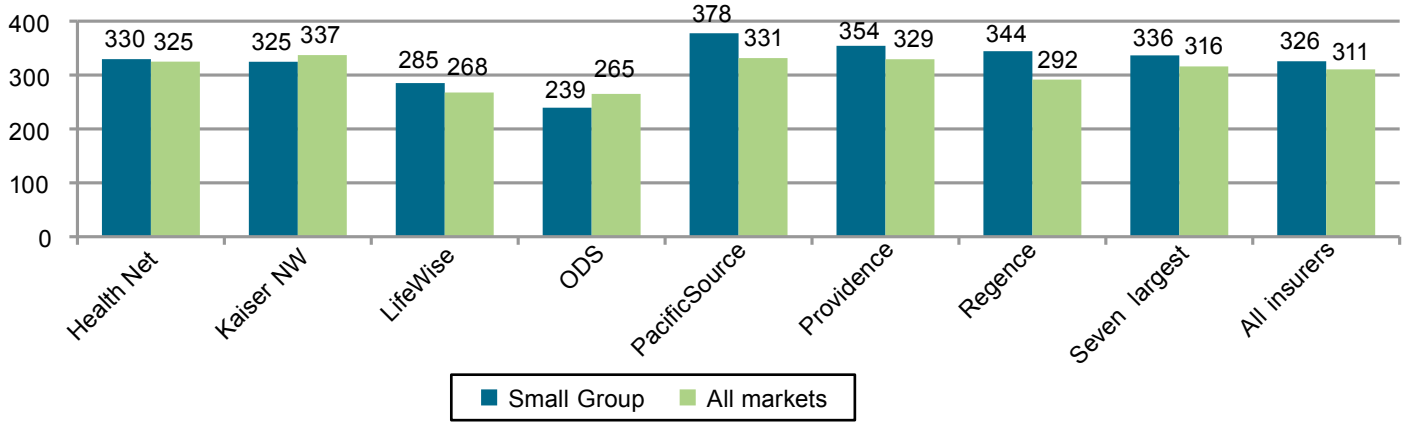
Figure 4-15. Average premium per member per month in small group plans from 2008 to 2010



Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

Figure 4-16 shows that in 2010 the average premium per member per month of $336 for Oregon's seven largest insurers was higher for the small group market than for all markets.

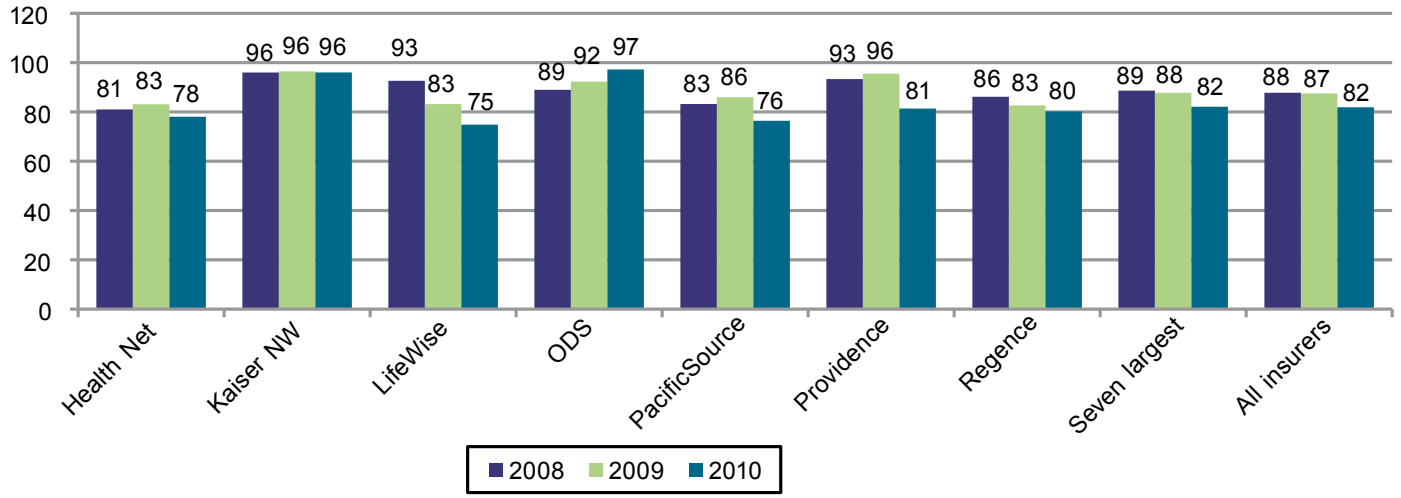
Figure 4-16. Average premium per member per month, small group vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 4-17 compares the 2008 to 2010 average medical loss ratios for Oregon's seven largest insurers in the small group market to those of all insurers. In 2010, the average medical loss ratio for the seven largest insurers as well as for all insurers was 82 percent.

Figure 4-17. Medical loss ratios, small group plans from 2008 to 2010

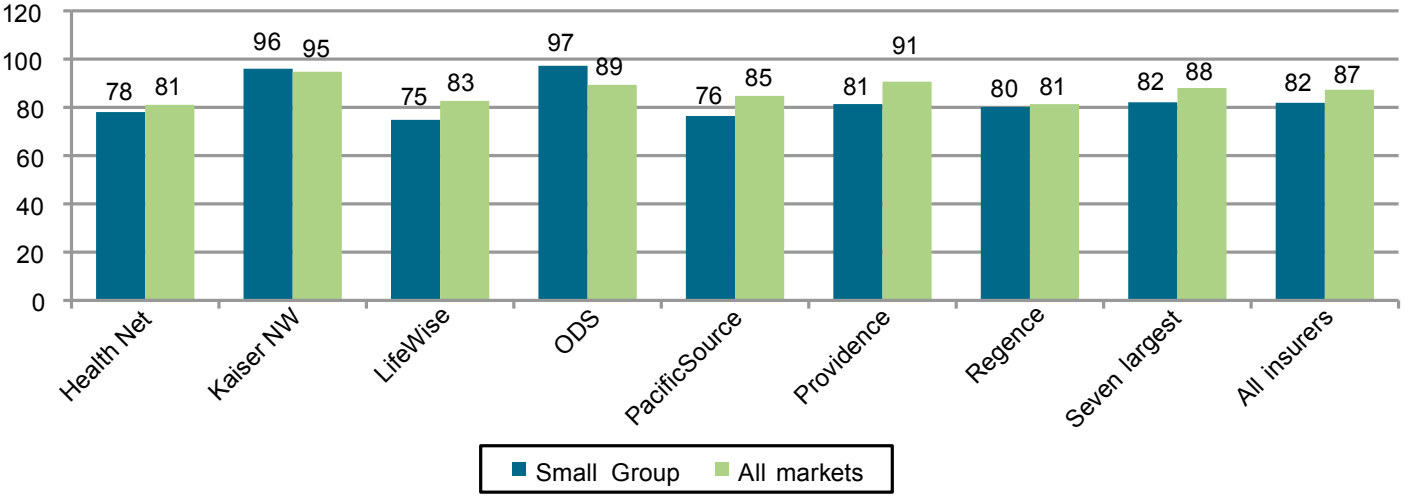


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Figure 4-18 compares the medical loss ratios for Oregon's seven largest insurers in the small group market to all markets and all insurers. These seven largest insurers' overall average medical loss ratio for the small group market was lower than the average for all markets, consistent with that of all insurers.

Figure 4-18. Medical loss ratio, small group plans vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Large Group Market

(Employer groups with 51 or more employees)

There are 5,275 large employers in Oregon, representing 4 percent of the state's 125,855 total employers.

Figure 4-19 summarizes the 2010 Health Benefit Plan Report data for the large group market. The average monthly large group premium per member for the seven largest health insurers was $345, compared to $342 for all insurers.

Figure 4-19. Seven largest insurers, large group plans in 2010

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	36,395	$122.5	83%	$335
Kaiser	237,639	$1,024.5	93%	$360
LifeWise	15,191	$67.0	89%	$361
ODS Health Plans	22,868	$116.8	89%	$396
PacificSource	73,492	$288.5	93%	$332
Providence	80,959	$350.5	96%	$336
Regence BCBS	83,864	$297.9	73%	$306
Total – above seven insurers	**550,408**	**$2,267.8**	**90%**	**$345**
Total – all insurers	**590,628**	**$2,427.7**	**89%**	**$342**

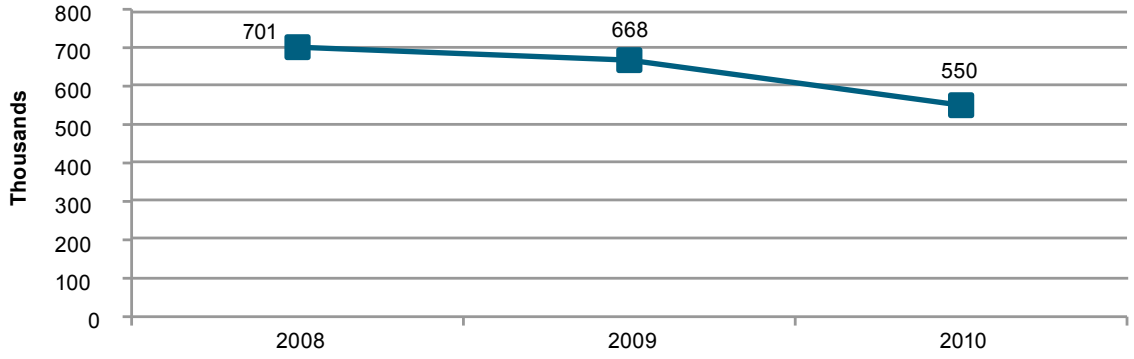
*Rounded in millions.

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Figure 4-20 shows a decline in large group enrollment for Oregon's seven largest insurers in 2010. Part of the reason for the decline is the Oregon Public Employees Benefits Board (PEBB), which formerly was counted as a large group plan, became self-insured effective Jan. 1, 2010. PEBB's more than 100,000 members no longer show up in this enrollment count even though they remain insured.

Figure 4-20. Large group plans seven largest insurers, number of members 2008 to 2010

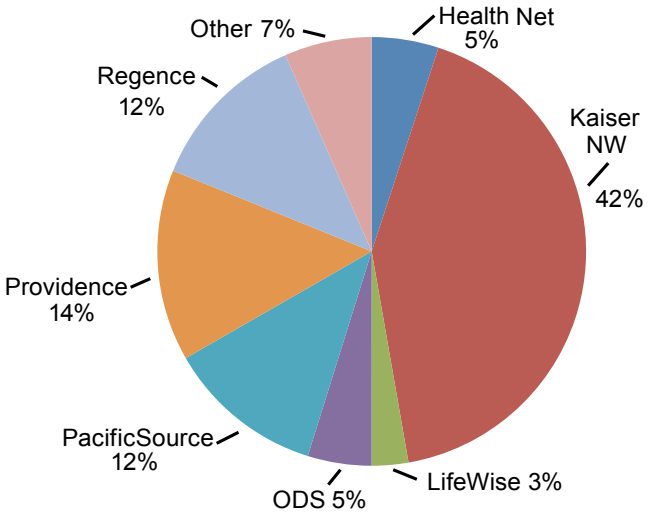


Source: Oregon Insurance Division, Health Benefit Plan Reports.

Note: Enrollment for large groups is shown for only three years because large groups and associations were counted together before 2008.

Figure 4-21 shows the seven largest Oregon insurers earned 93 percent of all premiums in the large group market. Oregon's largest insurer, Kaiser, earned 42 percent of premiums in this market with Providence having the next-largest share with 14 percent of premiums.

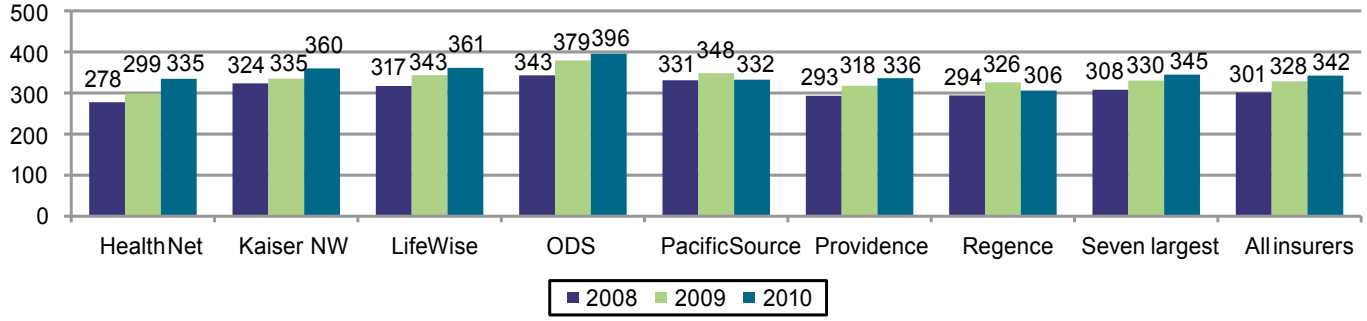
Figure 4-21. Market share by premium, large group market in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 4-22 shows that average premiums for the seven largest insurers in the large group market increased in 2010.

Figure 4-22. Average premium per member per month in large group plans from 2008 to 2010

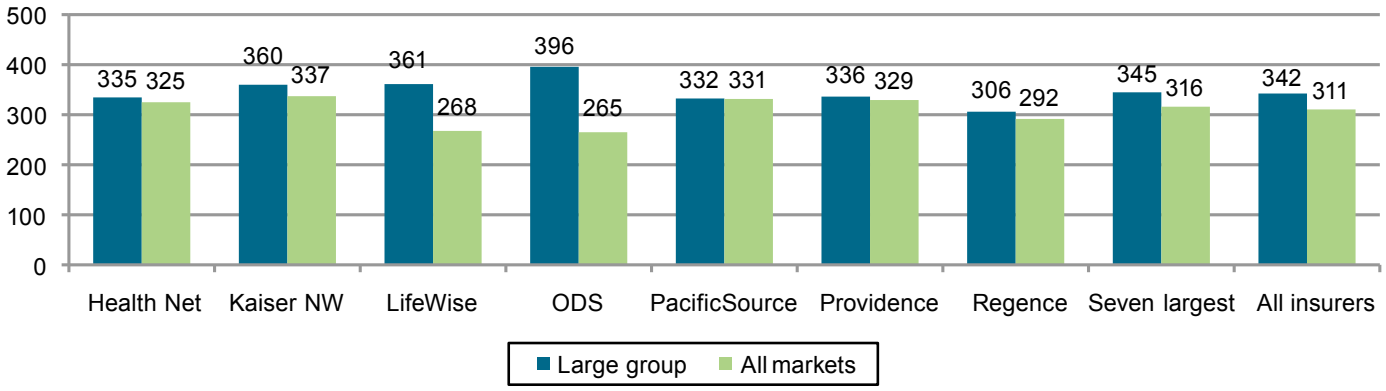


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

Note: In reporting year 2010, Regence BCBS corrected its 2009 reported figures. Therefore, the 2009 figures differ from what was reported last year.

Figure 4-23 shows that the seven largest insurers' large group market average premium per member per month of $342 is 8 percent higher than the average for all markets. This might be because large employers tend to offer health benefit plans with more and richer benefits than those purchased in the individual and small group markets. Large employers typically negotiate both benefit levels and premium rates directly with insurers.

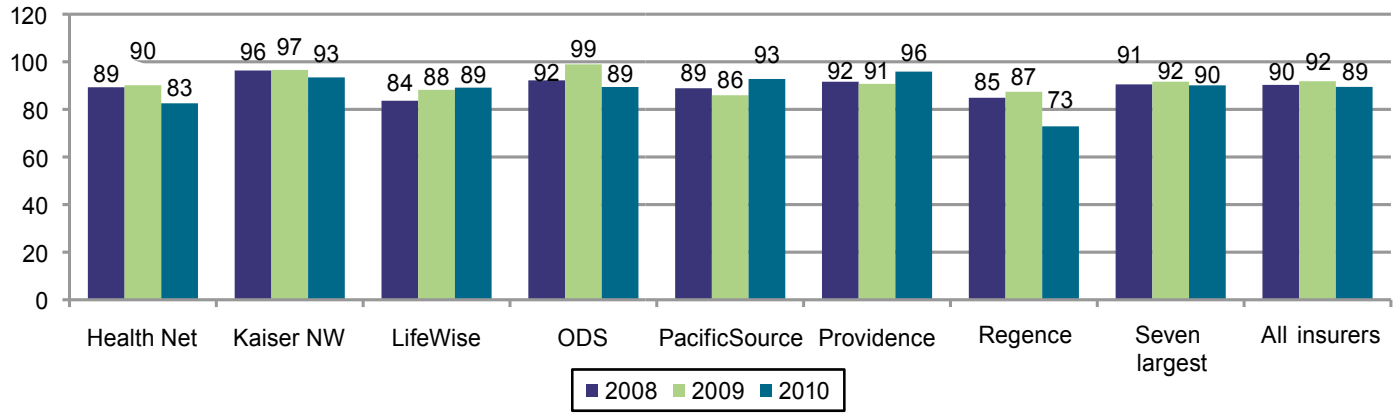
Figure 4-23. Average premium per member per month, large group vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 4-24 shows that the seven largest insurers spent an average of 90 cents of every premium dollar on medical claims in 2010.

Figure 4-24. Medical loss ratios, large group plans from 2008 to 2010

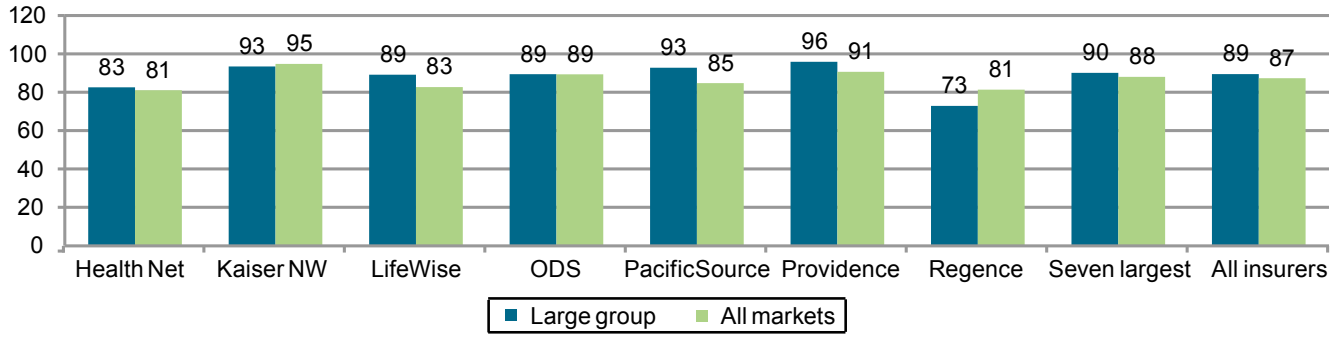


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Figure 4-25 shows that the medical loss ratio for large groups was higher than that of all markets.

Figure 4-25. Medical loss ratio, large group vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Associations

Some employers and individuals purchase health insurance through associations. Associations may take many forms, including trade organizations made up of businesses that represent a particular industry or individuals who work in common fields or have common experiences or interests. To qualify, an association must be active for at least one year and must be organized and maintained in good faith primarily for purposes other than serving as a vehicle for its members to obtain insurance.

The department does not review or approve association health plan rates unless an insurer chooses to rate an association group according to small employer group premium rating laws or is required to do so because the plan does not meet certain exemptions.

Figure 4-26 summarizes the association and trust plan data for 2010. The average premium per member per month was $297 for the seven largest insurers compared to $284 for all insurers.

Figure 4-26. Seven largest insurers, associations in 2010

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	12,839	$54.1	86%	$309
Kaiser	32,801	$84.9	91%	$207
LifeWise	4,028	$13.9	77%	$276
ODS Health Plans	828	$2.3	79%	$254
PacificSource	12,259	$55.4	73%	$369
Providence	16,688	$66.5	86%	$334
Regence BCBS	2,711	$80.7	104%	$381
Total – above seven insurers	**82,154**	**$357.7**	**89%**	**$297**
Total – all insurers	**109,779**	**$465.6**	**88%**	**$284**

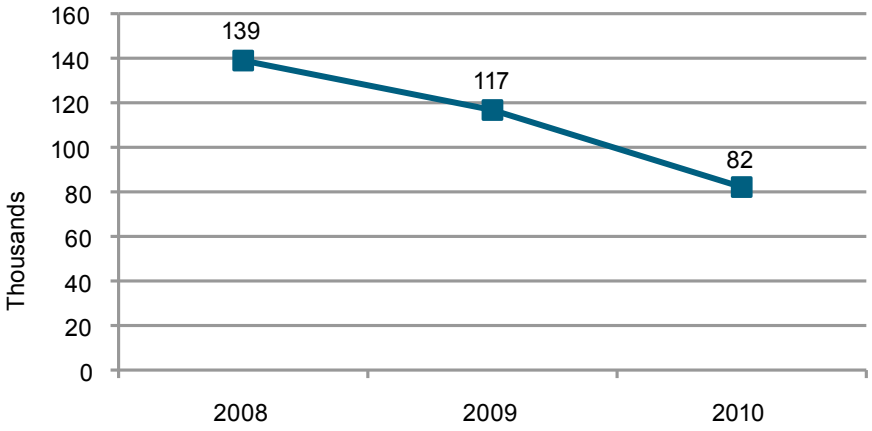
*Rounded in millions.

Source: Oregon Insurance Division, 2008 Health Benefit Plan Reports

These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Figure 4-27 shows a decline in association membership for Oregon's seven-largest insurers.

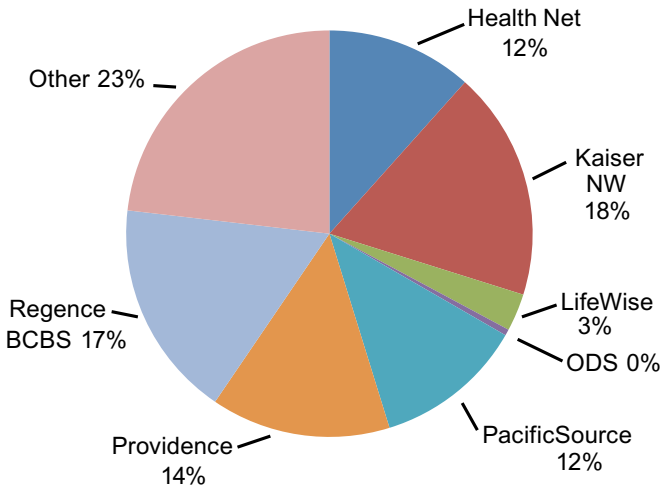
Figure 4-27. Associations and trusts, seven largest insurers, number of members, 2008 to 2010



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-28 shows that in 2010, the seven largest insurers earned 77 percent of all premiums in Oregon's association market.

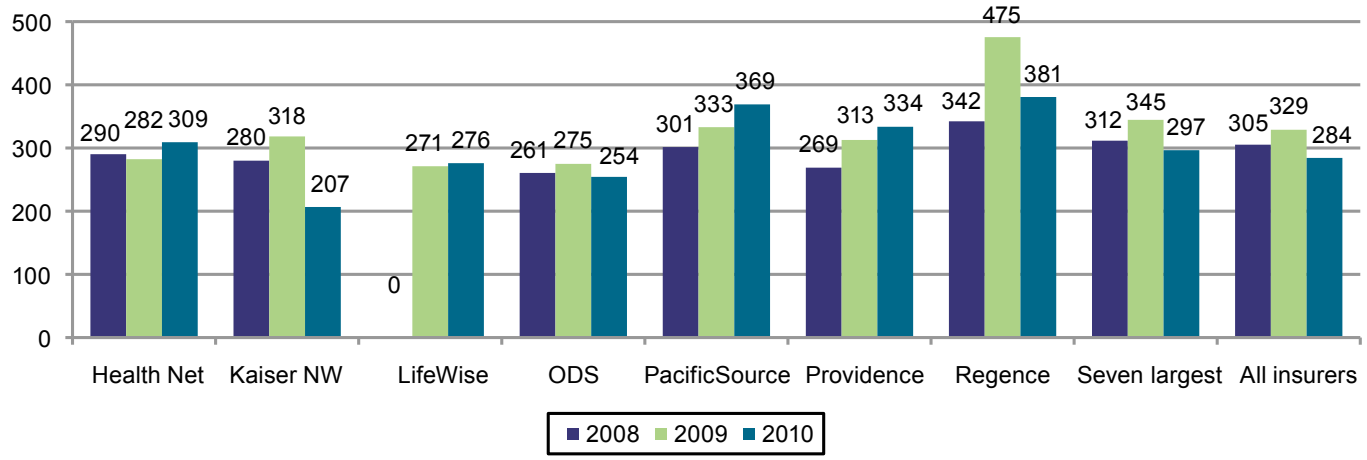
Figure 4-28. Market share by premium, associations and trusts market in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 4-29 shows that in 2010, average association plan premiums for Oregon's seven largest insurers were higher than those of all insurers

Figure 4-29. Average premium per member per month, association and trust plans from 2008 to 2010

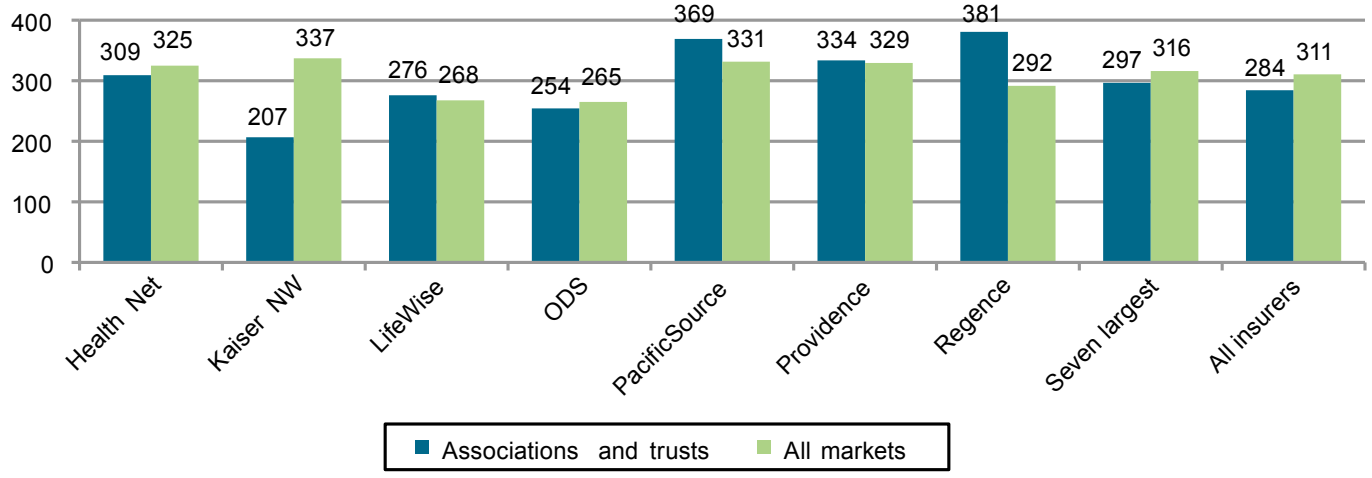


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

Note: In reporting year 2010, Regence corrected its 2009 reported figures. Therefore, the 2009 figures differ from what was reported last year.

Figure 4-30 shows that in 2010, average premiums for associations and trusts were lower than premiums for all markets.

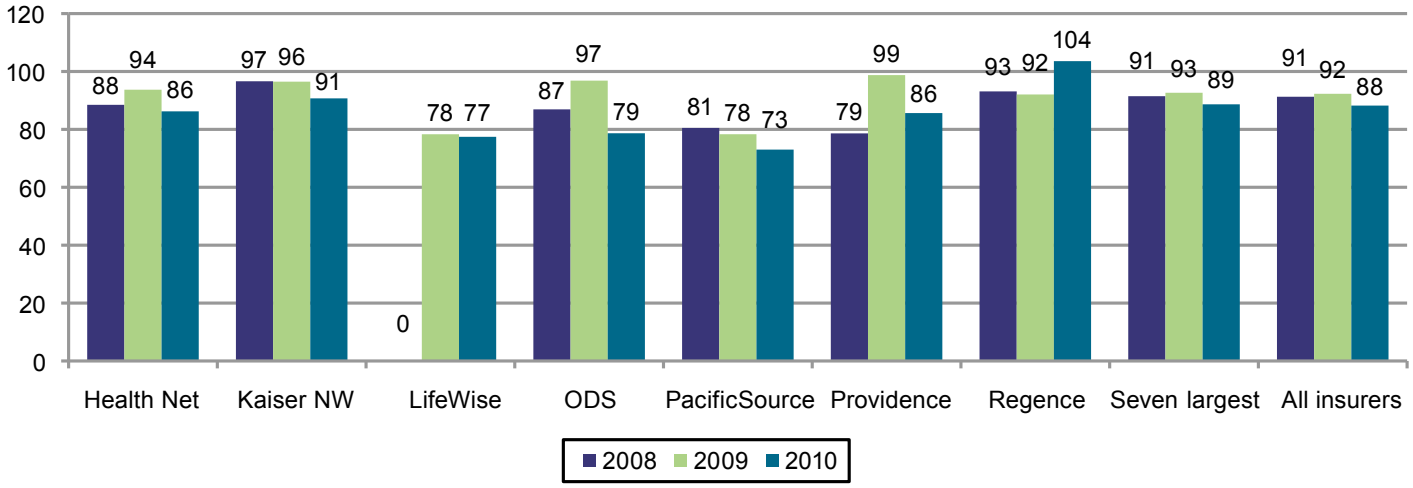
Figure 4-30. Average premium per member per month, associations and trusts vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 4-31 shows Oregon's seven largest insurers spent 89 cents of every association and trust premium dollar on medical claims, similar to that of all insurers.

Figure 4-31. Medical loss ratios, associations and trusts from 2008 to 2010

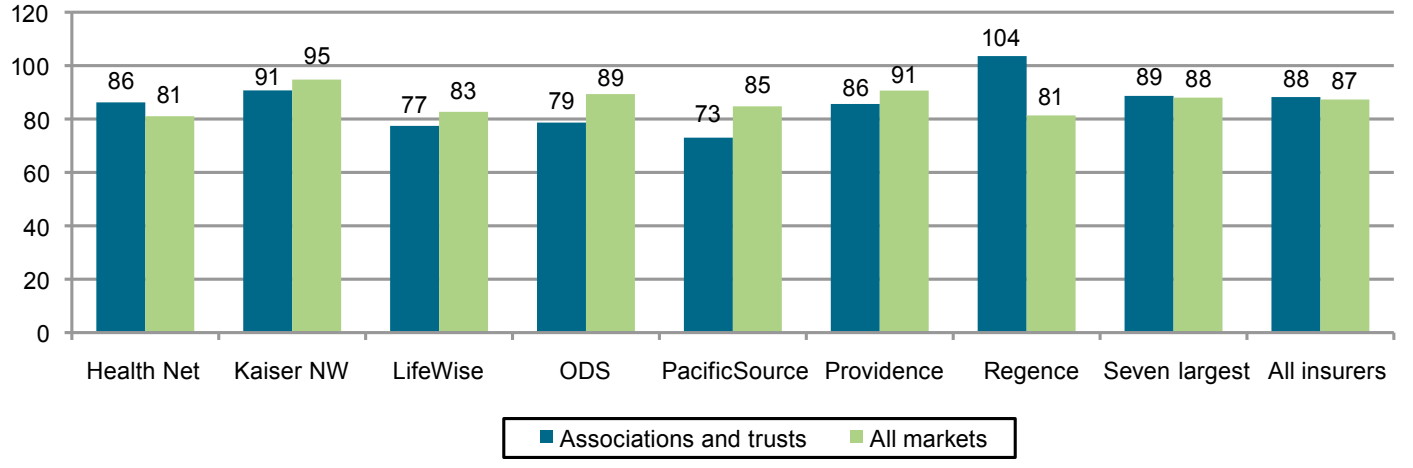


Source: Oregon Insurance Division, 2008 to 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Figure 4-32 shows insurers spent about the same amount of the premium dollar to pay medical claims for associations and trusts versus other insurance markets.

Figure 4-32. Medical loss ratio, associations and trusts vs. all markets in 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

These calculations for medical loss ratio are different than those required by the federal government and cannot by used to determine if an insurance company owes a rebate.

Section 5: Insurer Profiles

This section profiles Oregon's seven largest health insurers using data from the Health Benefit Plan Reports. The information contained in these annual reports allows the Department of Consumer and Business Services to analyze trends in enrollment, premiums, and medical loss ratios for each insurer in each market segment.

Some numbers discussed in this section relate exclusively to a company's individual, small group, large group, and association business in Oregon. Other statistics — specifically graphs showing profitability and surplus — are based on the companywide business and take into account all the company's business, including Medicare and Medicaid, dental insurance, and third-party administrative services for self-insured employers.

The data for Oregon's seven largest insurers show that in 2010:

- Six insurers saw enrollment declines ranging from 2 percent to 41 percent. Only PacificSource Health Plan picked up enrollment, with membership increasing by 3 percent.
- Regence BlueCross BlueShield of Oregon's loss of a contract to provide health insurance to state employees through the Public Employees Benefits Board (PEBB) resulted in that company's significant drop in enrollment in 2010, primarily in the large group market. However, because PEBB is now self-insured, Regence's lost PEBB members do not show up as other companies' gains in the enrollment data presented in this section.
- Five insurers earned less in premiums in 2010 than in 2009. The decreases in premiums ranged from less than 1 percent to 40 percent. Only PacificSource and ODS Health Plans earned more in premium.
- Despite the loss in enrollment and premium, six of the companies reported a net gain in income after taxes with only LifeWise Health Plan of Oregon showing a net loss. Also, only LifeWise showed a net underwriting loss, meaning it earned less in premiums than it incurred in medical claims and total administrative expenses.
- Starting in 2010 and continuing in 2011, insurers generally saw lower-than-expected use of medical services, resulting in lower average rate increases in the small employer and individual markets in 2011 than in recent years.

Kaiser Foundation Health Plan of the Northwest

Kaiser Foundation Health Plan of the Northwest was granted a certificate of authority in 1948. Kaiser Permanente is part of a national network of health plans headquartered in Oakland, Calif., with members in nine states and Washington, D.C. Based in Portland, the Northwest region of Kaiser Permanente encompasses Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Hospitals; Northwest Permanente, P.C., Physicians and Surgeons; and Permanente Dental Associates.

Kaiser is one of the largest nonprofit managed health care companies in the country. It has an integrated care model, meaning its members have access to hospital and physician care through a network of hospitals and physician practices operating under the Kaiser Permanente name. Plans offered include traditional co-payment plans, deductible plans, and Medicare plans with care provided at participating facilities. Point-of-service plans are also offered that provide additional locations where enrollees can receive care.

Figure 5-1 shows that Kaiser Foundation Health Plan of the Northwest insured nearly 318,000 Oregonians in 2010, about 8,000 fewer than in 2009. Kaiser's approximately $1.3 billion in Oregon premiums in 2010 was down nearly 3 percent from 2009.

Figure 5-1. Kaiser Foundation Health Plan of the Northwest, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	15,160	$52,465,617	124%	$298
Small group	32,285	$123,903,715	96%	$325
Large group	237,639	$1,024,499,467	93%	$360
Associations and trusts	32,801	$84,868,188	91%	$207
Total for all markets above	**317,885**	**$1,285,736,987**	**95%**	**$337**

Nationwide for 2010*

Total surplus maintained	$499,991,024
Total unpaid claims reserves maintained	$31,886,704
Net underwriting gain or loss	$16,223,591
Net income after taxes	$39,486,783
Oregon Medical Insurance Pool	$14,208,718
Total general administrative expense	$115,569,671

Nationwide for 2010

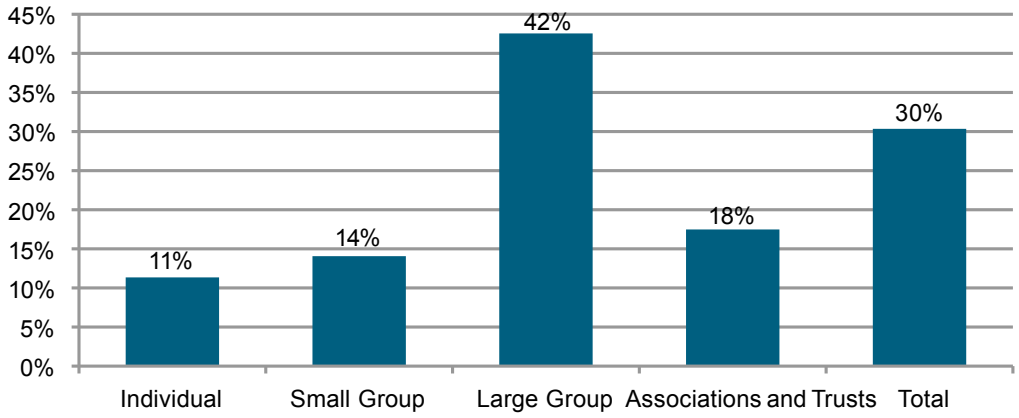
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$68,872,886
Commissions	$17,157,585
Rent (occupancy)	$3,431,367
Marketing and advertising	$2,418,721
Legal fees, expenses, and other professional or consulting fees	$2,104,915

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-2 shows Kaiser's overall market share and its market share in each market segment. Kaiser earned 30 percent of all premiums in 2010 in all Oregon health insurance markets. Kaiser had 11 percent of the individual market, 14 percent of the small group market, 42 percent of the large group market, and 18 percent of the associations and trusts market.

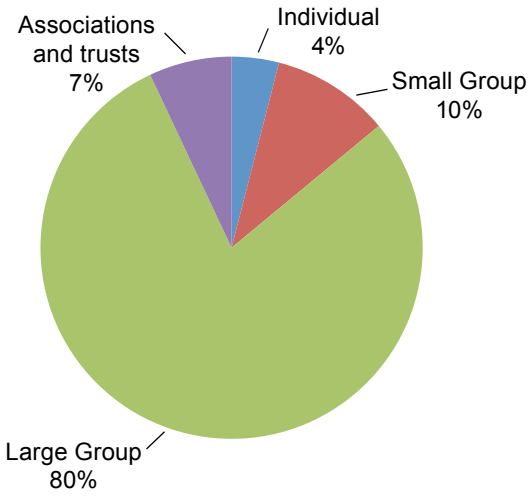
Figure 5-2. Kaiser, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-3 provides a breakdown by market segment of Kaiser premiums. Kaiser earned 80 percent of its premiums from the large group market.

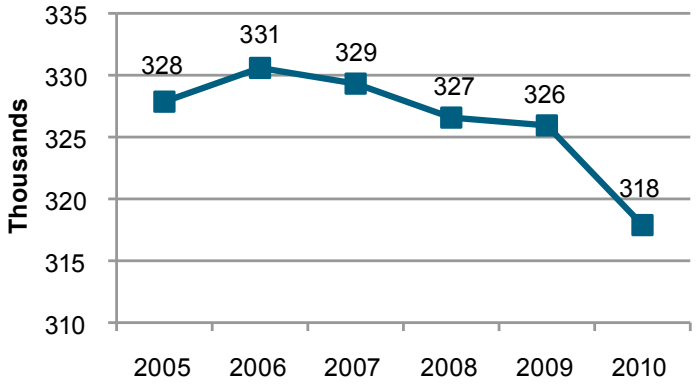
Figure 5-3. Kaiser, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 5-4 shows four years of enrollment losses for Kaiser.

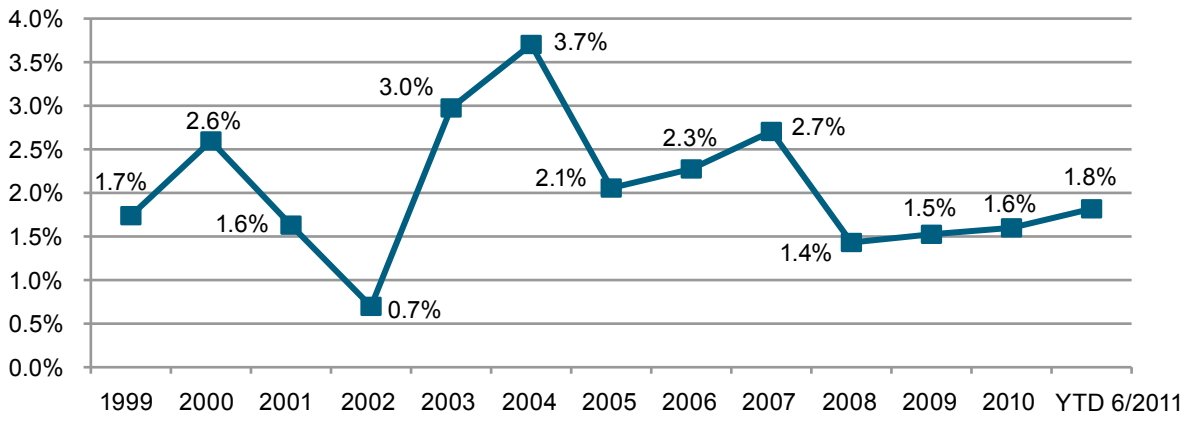
Figure 5-4. Kaiser, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-5 shows Kaiser's net income improving since a sharp drop during the recession.

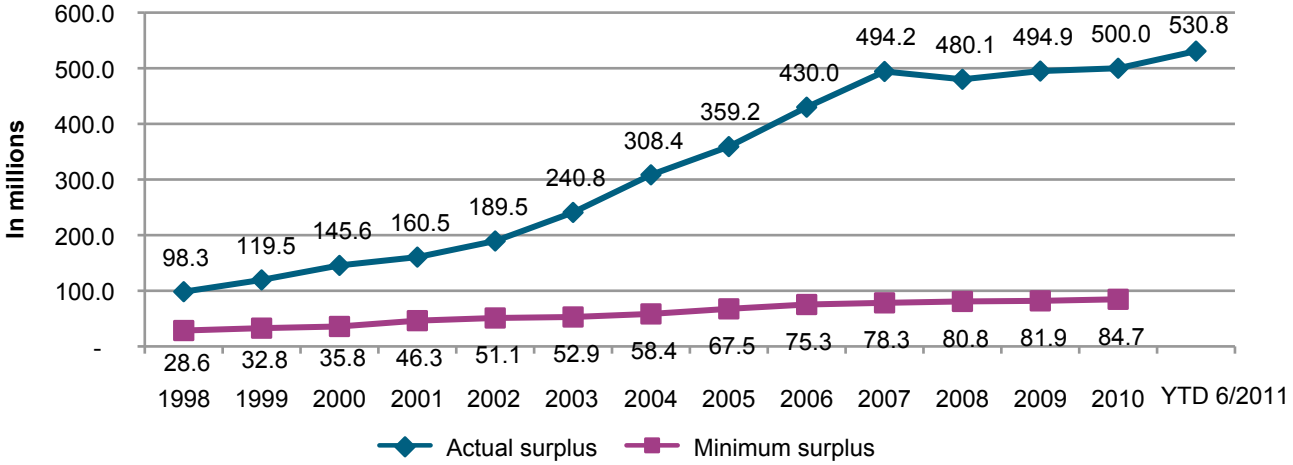
Figure 5-5. Kaiser profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-6 shows that Kaiser's surplus increased 1 percent in 2010 despite a distribution of $40 million in late 2010 to its nonprofit parent company. Kaiser's surplus remains above the minimum required surplus.

Figure 5-6. Kaiser surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-7 shows Kaiser's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-7. Kaiser five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	7.30%	14.30%	17.30%
2008	6.50%	8.00%	4.90%
2009	9.60%	7.70%	6.10%
2010	0.00%	10.78%	6.70%
2011	7.60%	8.59%	7.20%
2007-2011	**34.76%**	**59.93%**	**49.33%**

Source: Data were obtained from rate filings.

Regence BlueCross BlueShield of Oregon

Cambia Health Solutions, Inc., formerly The Regence Group, is the Pacific Northwest's largest affiliation of health care plans. Cambia Health Solutions includes Regence BlueCross BlueShield of Oregon, Regence BlueShield (Washington), Regence BlueShield of Idaho, and Regence BlueCross BlueShield of Utah.

Regence BlueCross BlueShield of Oregon is an independent licensee of the BlueCross and BlueShield Association, a national association of community-based and locally operated Blue Cross and Blue Shield companies. Although each "Blue" is an independent company, each must adhere to specific requirements and guidelines established by the national association in order to use the name.

Regence operates under a certificate of authority issued by the State of Oregon in 1942 and is headquartered in Portland. Before 1983, Regence was incorporated and operated as Oregon Physician's Service (Blue Shield). Regence is a nonprofit company.

Figure 5-8 shows that Regence enrolled more than 205,000 Oregonians in its health plans in 2010. This is down approximately 41 percent from 2009, due in large part to the loss of a contract with the Public Employees Benefit Board, effective Jan. 1, 2010. Regence generated nearly $791 million in Oregon premium in 2010, a decrease of nearly 40 percent from 2009. Net income, however, was up.

Figure 5-8. Regence BlueCross BlueShied, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	65,483	$183,834,157	87%	$213
Small group	53,220	$228,556,632	80%	$344
Large group	83,864	$297,877,593	73%	$306
Associations and trusts	2,711	$80,665,272	104%	$381
Total for all markets above	**205,278**	**$790,933,654**	**81%**	**$292**

Nationwide for 2010*

Total surplus maintained	$544,163,691
Total unpaid claims reserves maintained	$157,212,401
Net underwriting gain or loss	$36,115,266
Net income after taxes	$75,158,557
Oregon Medical Insurance Pool	$14,234,643
Total general administrative expense	$174,187,396

Nationwide for 2010

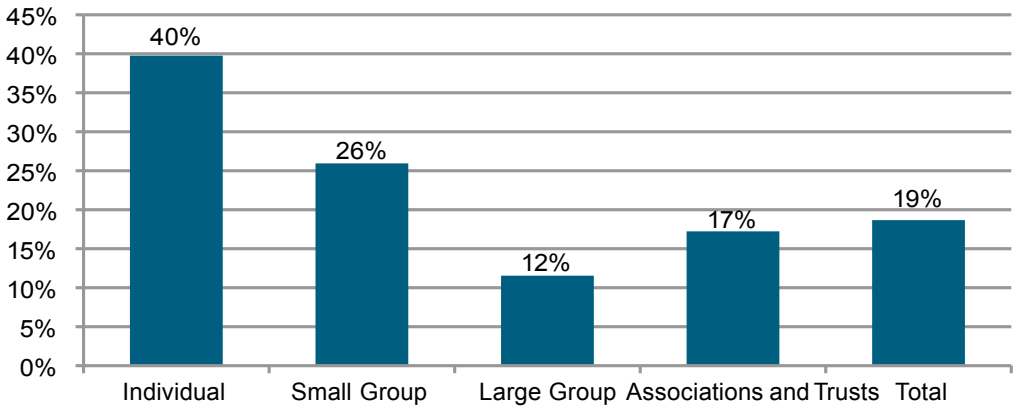
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$76,069,452
Other taxes, licenses, and fees	$37,667,063
Commissions	$33,189,292
Cost depreciation: equipment, software, furniture, etc.	$21,885,138
General office expenses: sundries, supplies, phones, printing, postage, etc.	$9,263,022

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-9 shows Regence's overall market share and its market share in each market segment. Regence earned 19 percent of all premiums in 2010 in all Oregon health insurance markets. Regence had 40 percent of the individual market, 26 percent of the small group market, 12 percent of the large group market, and 17 percent of the associations and trusts market.

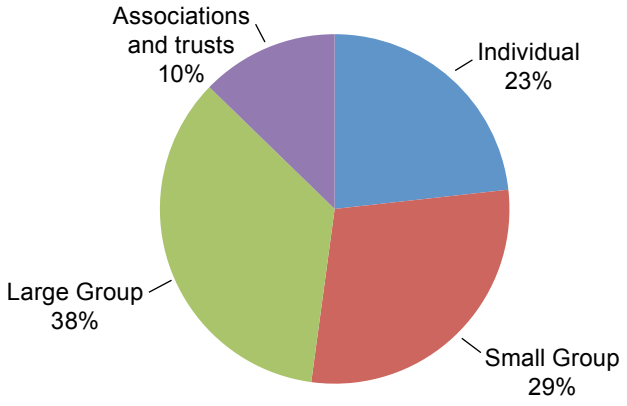
Figure 5-9. Regence BlueCross BlueShield, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-10 provides a breakdown by market segment of Regence premiums. Regence earned more than half of its premiums from the individual and small group markets.

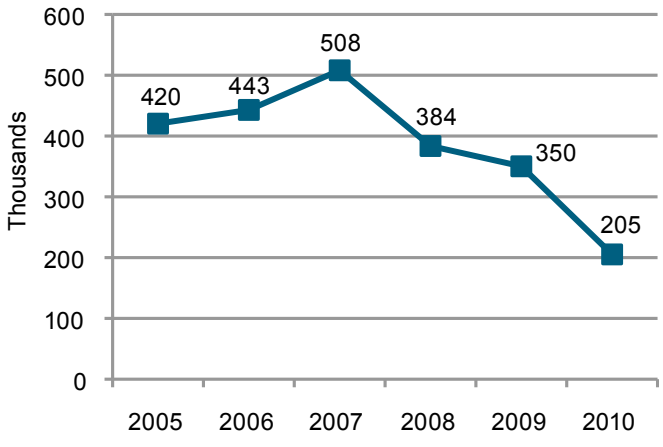
Figure 5-10. Regence, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-11 shows a significant decline in Regence enrollment since 2007. The drop from 2009 to 2010 is due in large part to loss of a contract to insure state workers through the Public Employee Benefit Board (PEBB).

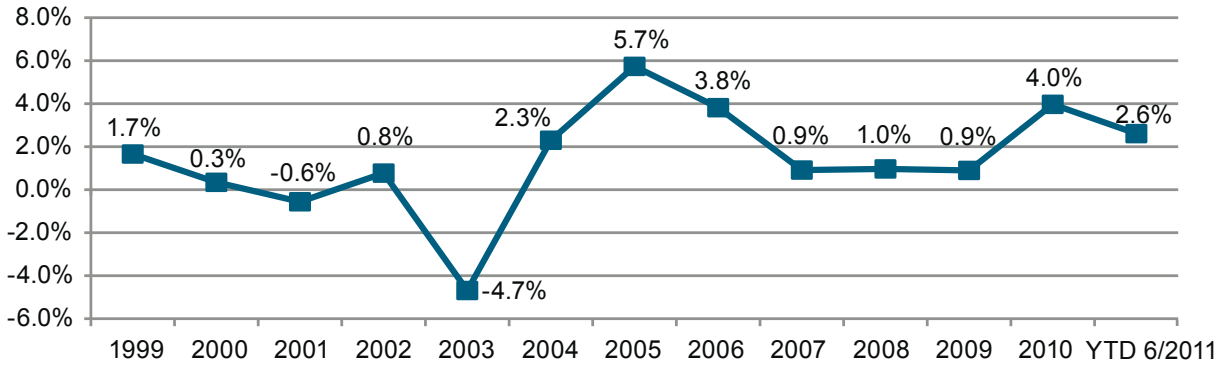
Figure 5-11. Regence, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-12 shows that Regence's profitability increased in 2010, due largely to investment income. Regence reported net underwriting losses from 2007 to 2009, contributing to lower net income during that period.

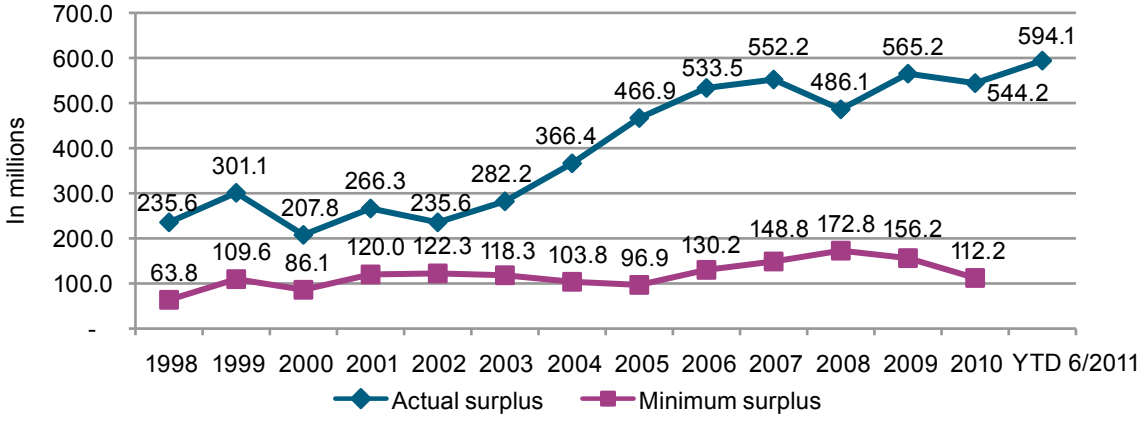
Figure 5-12. Regence profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-13 shows that Regence's surplus decreased by about 4 percent in 2010. This reduction in surplus was due in part to a $56 million distribution to its nonprofit parent company. Through June 2011, however, surplus was up 9 percent from 2010. Regence's surplus remains above the minimum required surplus.

Figure 5-13. Regence, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-14 shows Regence's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-14: Regence five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	17.60%	12.37%	25.80%
2008	24.10%	13.20%	28.10%
2009	17.10%	11.62%	20.80%
2010	16.36%	15.00%	0.00%
2011	13.61%	9.10%	9.60%
2007-2011	**125.92%**	**78.14%**	**113.36%**

Source: Data were obtained from rate filings.

Providence Health Plan of Oregon, Inc.

Providence is an Oregon-based, nonprofit plan sponsored by Providence Health System. Providence is authorized to do business in both Oregon and Washington and operates in Oregon under a certificate of authority granted by the state in 1984. As Providence only began offering health insurance to individuals in 2005, it is a relatively recent entrant into the Oregon individual health insurance market.

Figure 5-15 shows that Providence enrolled more than 134,000 Oregonians in its health plans in 2010. That is down approximately 4 percent from 2009. Providence generated close to $547 million in Oregon premiums in 2010, down less than a percentage point from 2009. Net income was up, however.

Figure 5-15. Providence Health Plan, Oregon 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	10,676	$24,573,353	69%	$203
Small group	26,258	$105,131,649	81%	$354
Large group	80,959	$350,505,484	96%	$336
Associations and trusts	16,688	$66,524,796	86%	$334
Total for all markets above	**134,581**	**$546,735,882**	**91%**	**$329**

Nationwide for 2010*

Total surplus maintained	$418,180,948
Total unpaid claims reserves maintained	$73,932,744
Net underwriting gain or loss	$29,084,090
Net income after taxes	$54,658,758
Oregon Medical Insurance Pool	$6,927,715
Total general administrative expense	$37,439,654

Nationwide for 2010

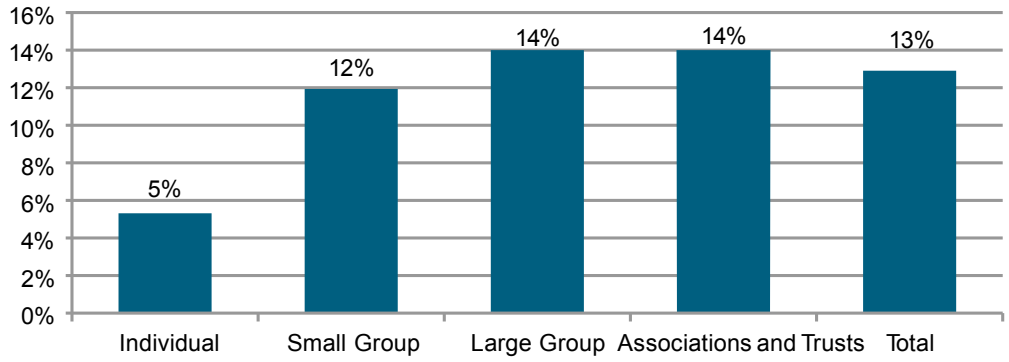
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$15,505,916
Commissions	$11,782,145
Third-party administration expenses or fees or other group service expenses or fees	$8,241,197
Other taxes, licenses, and fees	$7,494,947
Marketing and advertising	$5,012,363

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-16 shows Providence's overall market share and its market share in each of the market segments. Providence earned 13 percent of all premiums in all Oregon health insurance markets. Providence had 5 percent of the individual market, 12 percent of the small group market, 14 percent of the large group market, and 14 percent of the associations and trusts market.

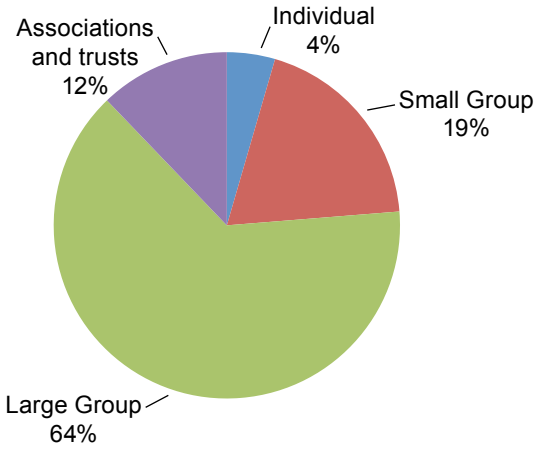
Figure 5-16. Providence, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-17 provides a breakdown by market segment of Providence premiums. In 2010, Providence earned 64 percent of its premiums from the large group market.

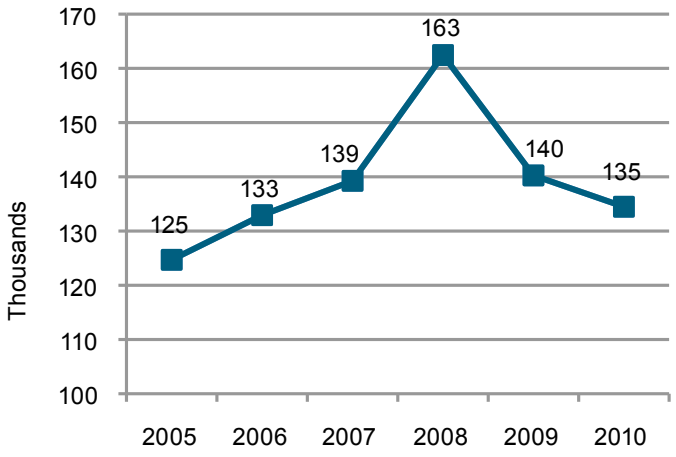
Figure 5-17. Providence, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 5-18 shows two years of declining enrollment for Providence.

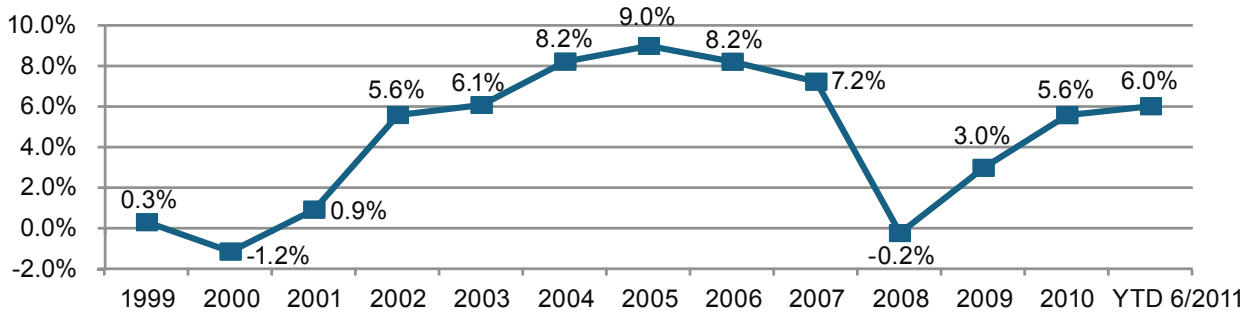
Figure 5-18. Providence, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-19 shows that after losing money in 2008, Providence's profitability has steadily improved. Providence experienced a net investment loss in 2008, leading to a net loss that year.

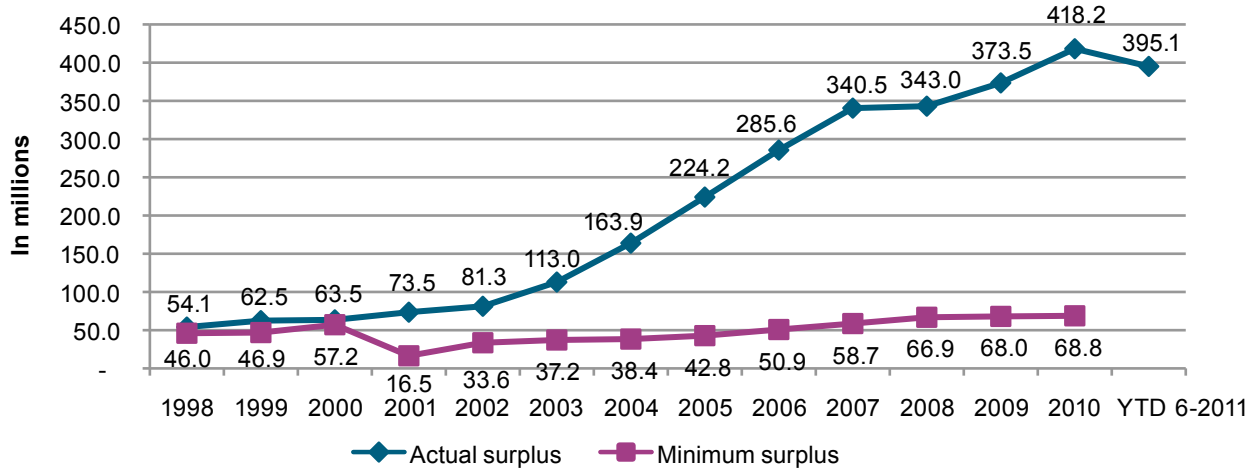
Figure 5-19. Providence profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-20 shows that Providence's surplus increased by about 12 percent in 2010. Through June 2011, Providence's surplus was down 6 percent from 2010. In May 2011, Providence distributed $53 million to its nonprofit parent company. Providence's surplus remains above required surplus levels.

Figure 5-20. Providence, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-21 shows Providence's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-21: Providence five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans Large Group | Small Group	
2007	12.00%	13.34%	-1.10%	4.10%
2008	25.00%	0.86%	6.60%	10.00%
2009	15.50%	16.99%	7.50%	3.00%
2010	12.90%	1.16%	8.50%	17.10%
2011	-4.00%	2.43%	0.40%	0.50%
2007-2011	**75.26%**	**38.58%**	**23.46%**	**38.80%**

Source: Data were obtained from rate filings.

PacificSource Health Plan

PacificSource is a Eugene-based independent, nonprofit health care service contractor that operates under a certificate of authority granted by the State of Oregon in 1940. Founded in 1933, PacificSource is licensed in Oregon, Idaho, and Washington. In late 2011, PacificSource signed a letter of intent to buy a significant block of commercial health insurance business from a Montana health insurer, New West Health Services.

Figure 5-22 shows that PacificSource enrolled nearly 131,000 Oregonians in health plans in 2010, up 3 percent from 2009. PacificSource generated more than $523 million in Oregon premiums, up nearly 12 percent from 2009.

Figure 5-22. PacificSource Health Plans, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	12,243	$24,565,469	69%	$163
Small group	32,919	$154,992,111	76%	$378
Large group	73,492	$288,497,244	93%	$332
Associations and trusts	12,259	$55,380,332	73%	$369
Total for all markets above	**130,913**	**$523,435,156**	**85%**	**$331**

Nationwide for 2010*

Total surplus maintained	$114,107,602
Total unpaid claims reserves maintained	$42,960,491
Net underwriting gain or loss	$4,888,134
Net income after taxes	$8,134,728
Oregon Medical Insurance Pool	$6,005,959
Total general administrative expense	$68,549,200

Nationwide for 2010

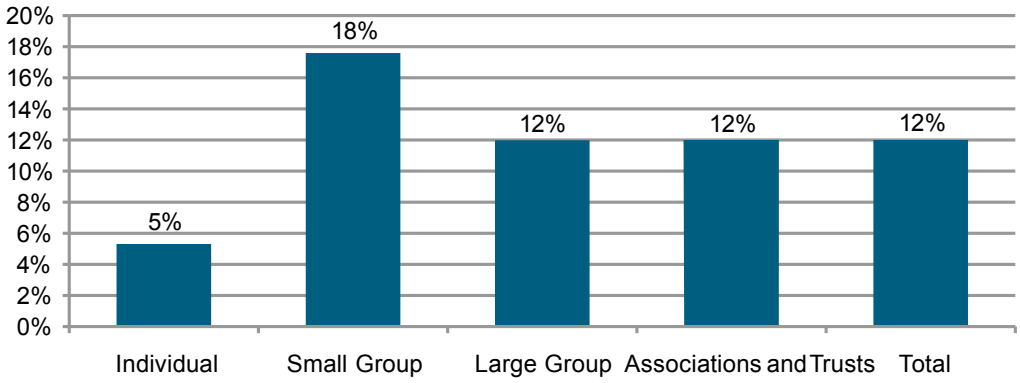
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$19,094,068
Commissions	$17,856,155
Cost depreciation: equipment, software, furniture, etc.	$6,941,380
Other taxes, licenses, and fees	$5,586,843
Legal fees, expenses, and other professional or consulting fees	$5,207,521

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-23 shows PacificSource's overall market share and its market share in each market segment. PacificSource earned 12 percent of all premiums in 2010 in all Oregon health insurance markets. PacificSource had 5 percent of the individual market, 18 percent of the small group market, 12 percent of the large group market, and 12 percent of the associations and trusts market.

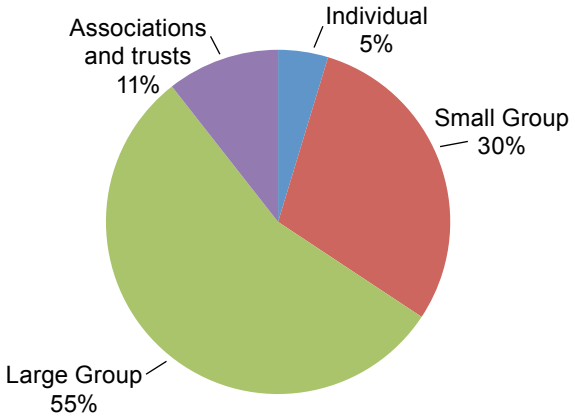
Figure 5-23. PacificSource, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-24 provides a breakdown by market segment of PacificSource premiums. In 2010, PacificSource earned more than half of its premiums from the large group market.

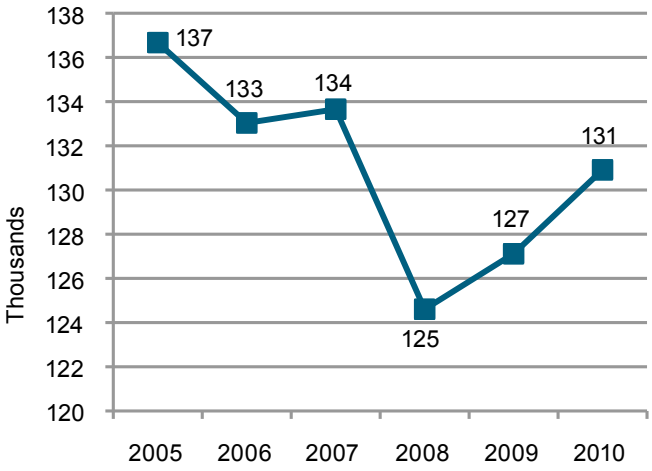
Figure 5-24. PacificSource, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 5-25 shows that PacificSource enrollment has climbed two years straight, nearing its pre-recession levels.

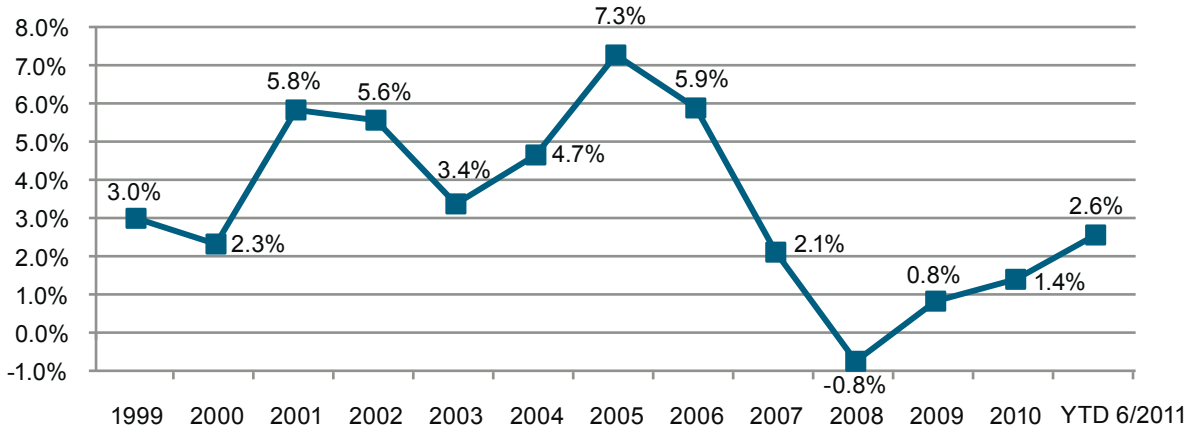
Figure 5-25. PacificSource, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-26 shows PacificSource's profitability improving since 2008. The company experienced a net investment loss in 2008, leading to a net loss that year.

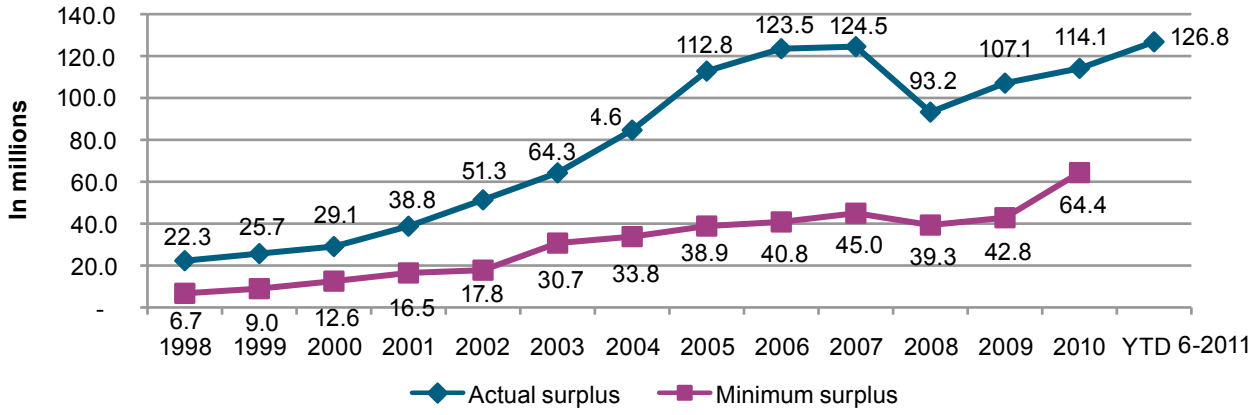
Figure 5-26. PacificSource profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-27 shows that PacificSource's surplus increased by about 7 percent in 2010 compared to the prior year. Through June 2011, surplus was up nearly 11 percent from 2010. PacificSource's surplus exceeds the minimum required surplus.

Figure 5-27. PacificSource, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-28 shows PacificSource's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-28: PacificSource five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	3.20%	10.34%	9.70%
2008	18.10%	20.27%	13.40%
2009	25.00%	9.23%	13.80%
2010	15.40%	13.60%	14.50%
2011	6.75%	4.28%	15.10%
2007-2011	**87.68%**	**71.71%**	**86.57%**

Source: Data were obtained from rate filings.

Health Net Health Plan of Oregon, Inc.

Health Net is a subsidiary of Health Net, Inc., a national, for-profit publicly traded managed health care company providing health benefits to about 6.1 million people nationwide. Health Net operates under a certificate of authority issued by the State of Oregon in 1989.

Figure 5-29 shows that Health Net insured nearly 85,000 Oregonians in its health plans in 2010, down nearly 20 percent from 2009. Health Net's approximately $346 million in Oregon premium was down about 15 percent from the prior year, although net income improved.

Figure 5-29. Health Net Health Plan of Oregon, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	5,513	$20,490,732	80%	$285
Small group	29,882	$149,008,405	78%	$330
Large group	36,395	$122,534,212	83%	$335
Associations and trusts	12,839	$54,109,013	86%	$309
Total for all markets above	**84,629**	**$346,142,362**	**81%**	**$325**

Nationwide for 2010*

Total surplus maintained	$63,307,359
Total unpaid claims reserves maintained	$27,769,421
Net underwriting gain or loss	$21,764,127
Net income after taxes	$16,606,808
Oregon Medical Insurance Pool	$4,313,049
Total general administrative expense	$35,930,716

Nationwide for 2010

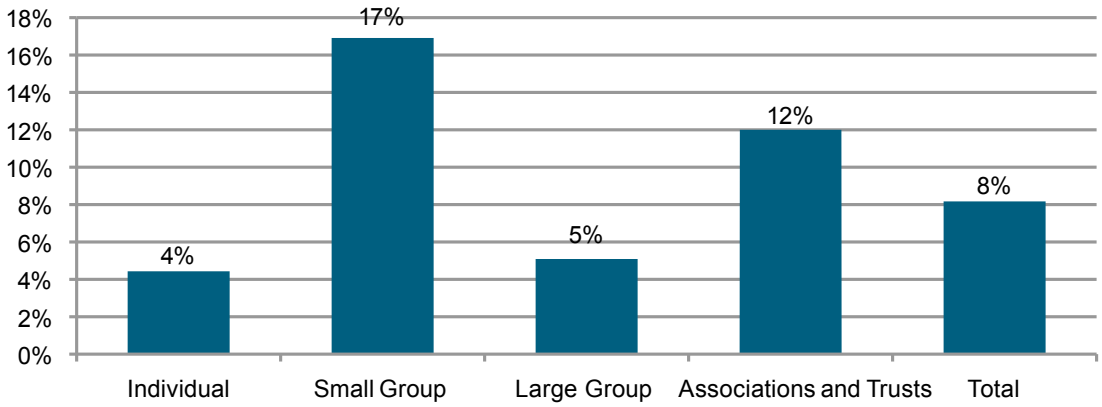
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$13,187,773
Commissions	$10,274,453
Other taxes, licenses, and fees	$6,230,632
Cost depreciation: equipment, software, furniture, etc.	$1,752,252
Legal fees, expenses, and other professional or consulting fees	$1,274,348

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-30 shows Health Net's overall market share in Oregon and its market share in each market segment. Health Net earned 8 percent of all premiums in 2010 in all Oregon insurance markets. Health Net had 4 percent of the individual market, 17 percent of all small group premiums, 5 percent of the large group market, and 12 percent of the associations and trusts market.

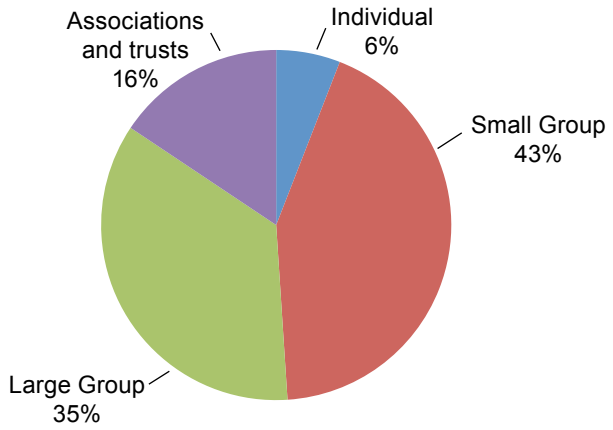
Figure 5-30. Health Net, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-31 provides a breakdown by market segment of Health Net premiums. Health Net earned 43 percent of its premiums from the small group market.

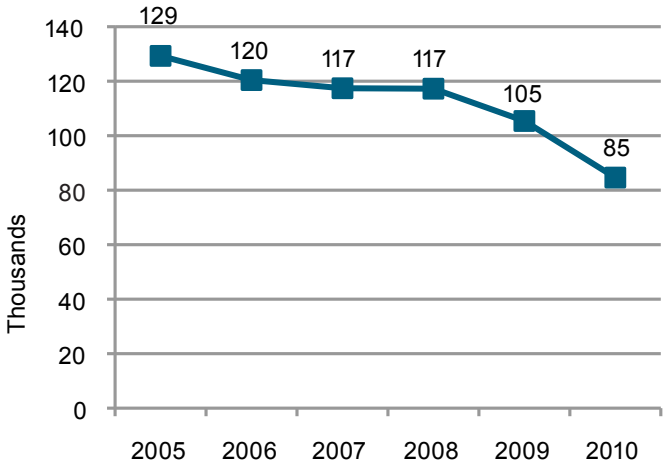
Figure 5-31. Health Net, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-32 shows Health Net enrollment has been flat or declined since 2005.

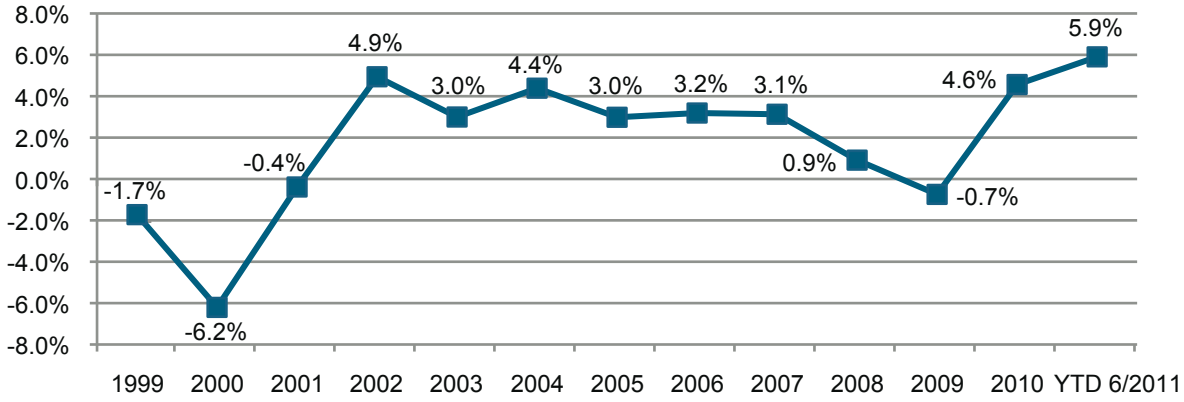
Figure 5-32. Health Net, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-33 shows Health Net's profitability increased in 2010, and was the best since 2002.

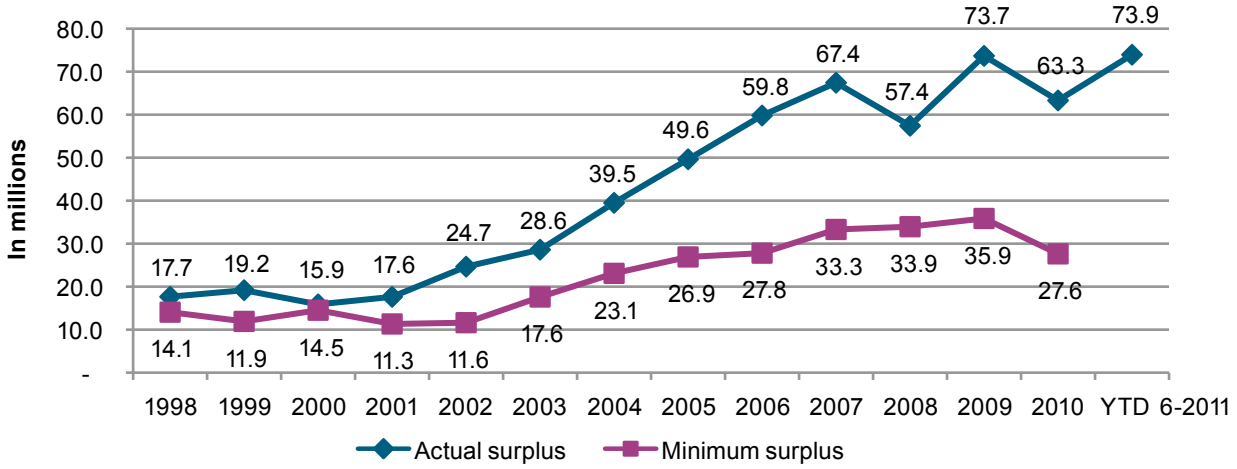
Figure 5-33. Health Net profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-34 shows that Health Net's surplus decreased by approximately 14 percent in 2010. In late 2010, the company paid stockholders $7.3 million in dividends. Through June 2011, surplus was up 17 percent. Health Net's surplus remains above the minimum required amounts.

Figure 5-34. Health Net, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-35 shows Health Net's five-year history of rate changes in the health insurance markets the state regulates.

Figure 5-35: Health Net five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	9.30%	8.50%	10.00%
2008	13.50%	7.50%	11.40%
2009	22.80%	10.32%	13.40%
2010	8.00%	12.20%	20.60%
2011	4.75%	5.17%	7.52%
2007-2011	**72.34%**	**51.84%**	**80.19%**

Source: Data were obtained from rate filings.

ODS Health Plan, Inc.

ODS, a for-profit company, first received a certificate of authority in Oregon in 1988. The company is a subsidiary of the nonprofit Oregon Dental Service that has offered dental insurance and administered dental benefits in Oregon since 1955. ODS provides medical insurance in Oregon, Washington, and Alaska and also is licensed in Idaho. The nonprofit Oregon Dental Association appoints the ODS board of directors. The ODS Companies are headquartered in Portland.

Figure 5-36 shows that ODS insured nearly 60,000 Oregonians in 2010, down nearly 2 percent from 2009. ODS generated nearly $190 million in Oregon premiums in 2010, up 4 percent from 2009. ODS's net income of $3.5 million in 2010 compares to a net loss of nearly $10 million in 2009.

Figure 5-36. ODS Health Plan, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	25,492	$36,723,845	82%	$136
Small group	10,717	$34,138,004	97%	$239
Large group	22,868	$116,838,012	89%	$396
Associations and trusts	828	$2,292,291	79%	$254
Total for all markets above	**59,905**	**$189,992,152**	**89%**	**$265**

Nationwide for 2010*

Total surplus maintained	$76,604,830
Total unpaid claims reserves maintained	$20,580,000
Net underwriting gain or loss	$65,398
Net income after taxes	$3,580,211
Oregon Medical Insurance Pool	$3,148,312
Total general administrative expense	$7,874,068

Nationwide for 2010

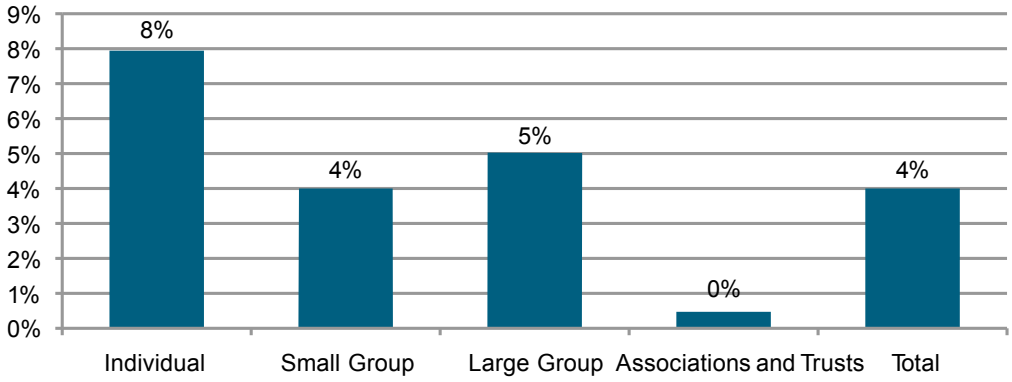
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$14,395,548
Other taxes, licenses, fees, and state premium taxes	$7,542,626
Commissions	$6,173,599
Cost depreciation: equipment, software, furniture, etc.	$6,130,673
Third-party admininstration expenses or fees and other group service expenses or fees	$1,262,216

Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-37 shows ODS's overall market share in Oregon and its market share in each market segment. ODS earned 4 percent of all premiums in 2010 in all Oregon health insurance markets. ODS had 8 percent of the individual market, 4 percent of the small group market, 5 percent of the large group market, and less than 1 percent of the associations and trust market.

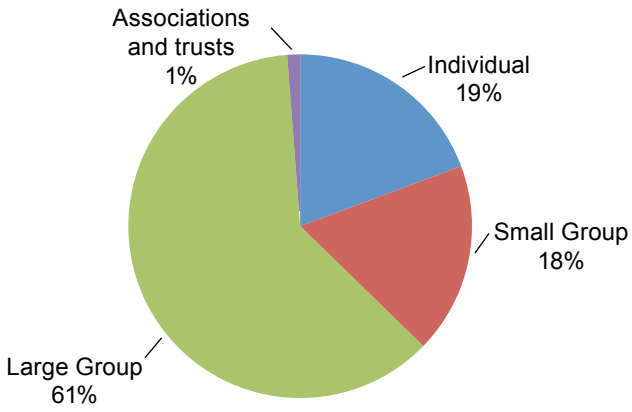
Figure 5-37. ODS, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-38 provides a breakdown by market segment of ODS premiums. ODS earned 61 percent of its premiums from the large group market.

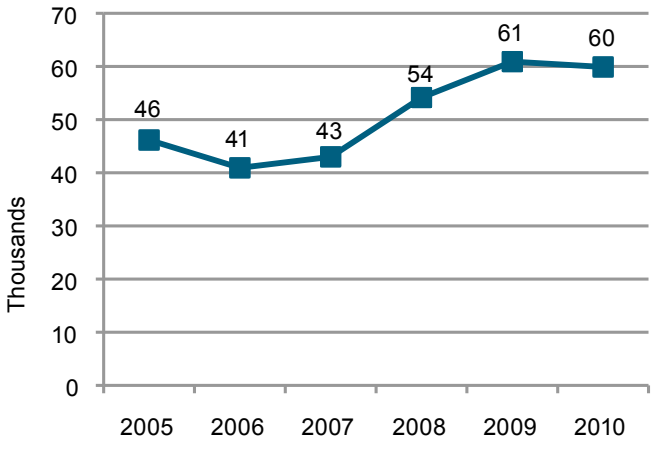
Figure 5-38. ODS, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.
Note: Percents do not add to 100 percent due to rounding.

Figure 5-39 shows ODS enrollment generally increasing despite the recession.

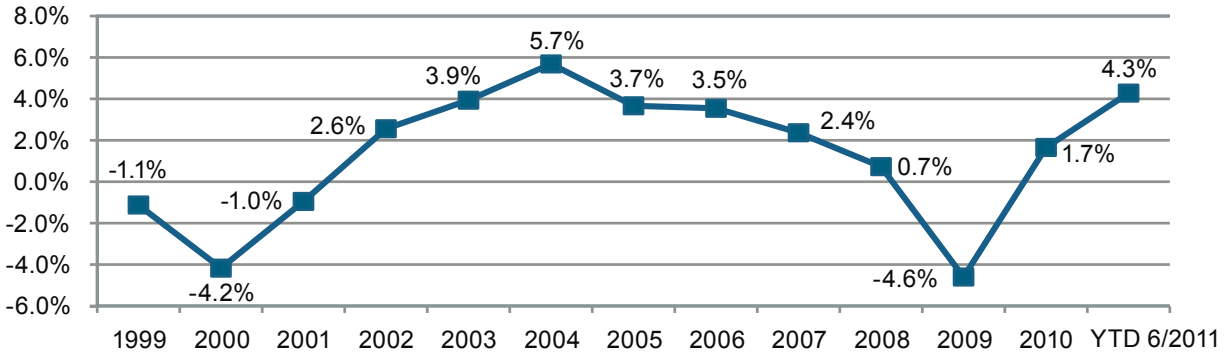
Figure 5-39. ODS, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-40 shows ODS pulling out of a five-year decline in profitability.

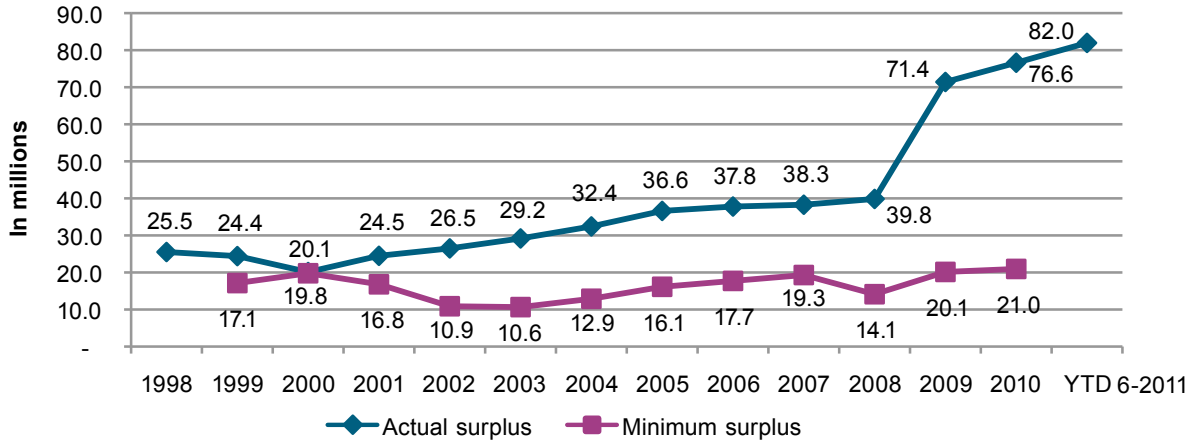
Figure 5-40. ODS profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-41 shows that from 2009, ODS increased surplus by approximately 7 percent. (The sharp increase in 2009 was primarily the result of issuing surplus notes, a type of indebtedness, totaling $23 million.) Through June 2011, surplus was up 7 percent from 2010. The company's surplus exceeds the minimum required surplus.

Figure 5-41. ODS, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-42 shows ODS's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-42: ODS five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	-4.50%	6.31%	0.03%
2008	8.90%	13.02%	11.40%
2009	17.67%	14.27%	8.06%
2010	17.54%	16.50%	0.00%
2011	8.94%	11.30%	13.73%
2007-2011	56.70%	78.03%	36.95%

Source: Data were obtained from rate filings.

LifeWise Health Plan of Oregon, Inc.

LifeWise operates as a health insurer under a certificate of authority granted by the State of Oregon in 1986. LifeWise is a privately held, for-profit company. It is part of the group of Premera companies whose ultimate parent is Premera, a Washington nonprofit. LifeWise is headquartered in Portland. The company and its affiliates provide health care coverage to members throughout Oregon, Washington, and Alaska.

Figure 5-43 shows that LifeWise insured nearly 54,000 Oregon members in 2010. That's down about 14 percent from 2009. LifeWise generated $184 million in Oregon premiums in 2010, a decrease of 13 percent from 2009. LifeWise's net loss of more than $4 million in 2010 compares to a nearly $800,000 gain in 2009.

Figure 5-43. LifeWise Health Plans of Oregon, 2010 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	26,607	$71,476,937	81%	$210
Small group	8,064	$32,057,389	75%	$285
Large group	15,191	$67,016,395	89%	$361
Associations and trusts	4,028	$13,891,293	77%	$276
Total for all markets above	**53,890**	**$184,442,014**	**83%**	**$268**

Nationwide for 2010*

Total surplus maintained	$54,758,998
Total unpaid claims reserves maintained	$20,398,728
Net underwriting gain or loss	-$11,290,364
Net income after taxes	-$4,185,255
Oregon Medical Insurance Pool	$3,405,426
Total general administrative expense	$28,402,232

Nationwide for 2010

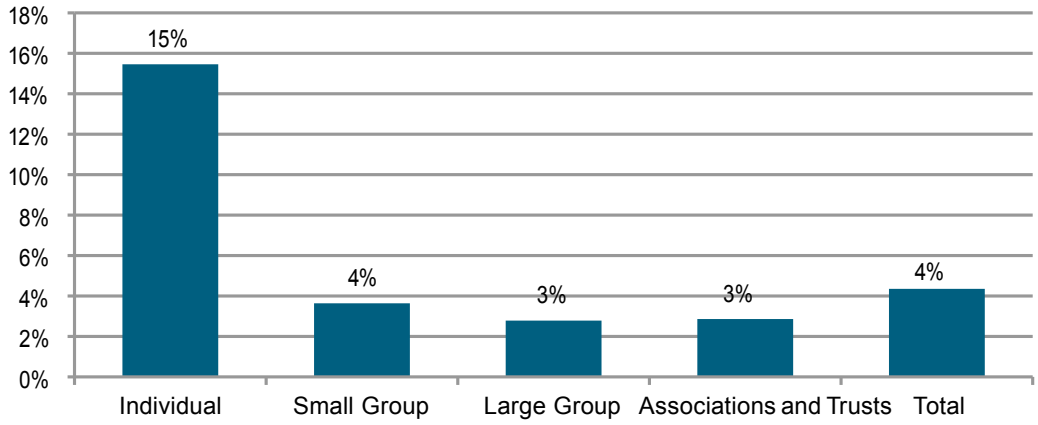
Largest nonmedical administrative expenses	**Total year-end**
Salaries, wages, and other benefits	$10,557,365
Commissions	$8,335,105
Other taxes, licenses, and fees	$2,240,453
Marketing and advertising	$2,181,725
Cost depreciation: equipment, software, furniture, etc.	$1,685,038

Source: Oregon Insurance Division, 2009 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from markets not regulated by the state, such as Medicare, is included.

Figure 5-44 shows LifeWise's overall market share in Oregon and its share in each market segment. LifeWise earned 4 percent of all Oregon premiums in 2010 in all Oregon health insurance markets. LifeWise had 15 percent of the individual market, 4 percent of the small group market, 3 percent of the large group market, and 3 percent of the associations and trusts market.

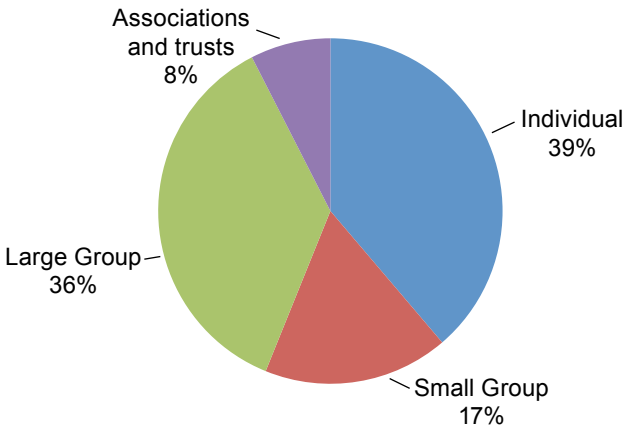
Figure 5-44. LifeWise, premium as percent of 2010 Oregon market



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-45 provides a breakdown by market segment of LifeWise premiums. LifeWise earned 75 percent of its premiums from the large group and individual markets.

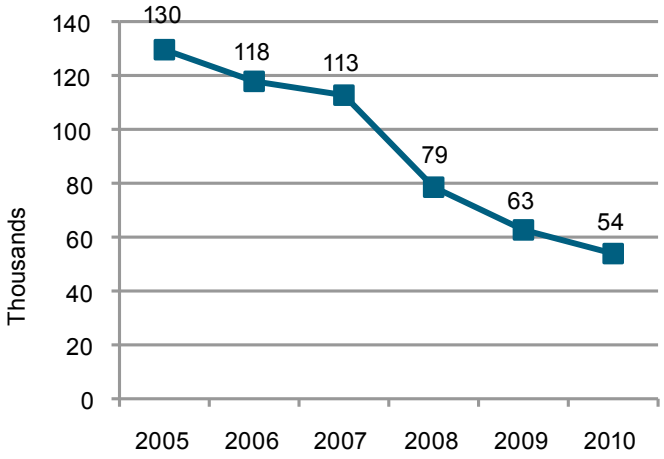
Figure 5-45. LifeWise, premium as percent of its Oregon 2010 business



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-46 shows a steady decline of LifeWise's enrollment since 2005.

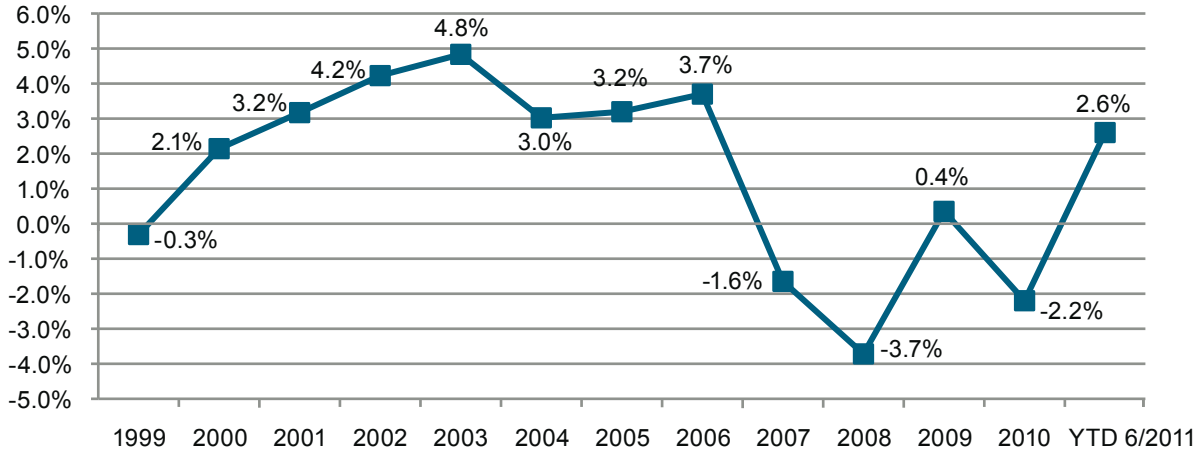
Figure 5-46. LifeWise, number of members, 2005 to 2010



Source: Oregon Insurance Division, 2010 Health Benefit Plan Reports.

Figure 5-47 shows that LifeWise's profitability has been particularly variable the past several years. LifeWise reported underwriting losses from 2007 to 2010, contributing to the net losses seen in 2007, 2008, and 2010.

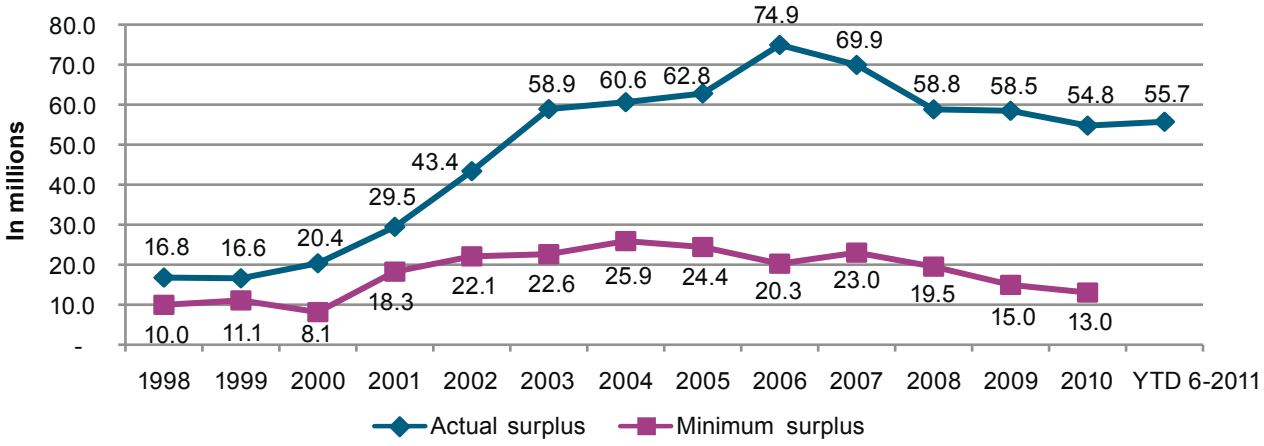
Figure 5-47. Lifewise profitability, net income to earned premium 1999 to June 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.

Figure 5-48 shows that LifeWise's surplus in 2010 decreased by 6 percent. However, through June 2011, LifeWise's surplus was up nearly 2 percent from its 2010 levels and remains above minimum requirements.

Figure 5-48. LifeWise, surplus trend, actual and minimum required from 1998 to June 30, 2011



Source: Annual or quarterly financial statements filed with the NAIC or the Oregon Insurance Division.
Note: The minimum surplus required is not available for YTD June 2011.

Figure 5-49 shows LifeWise's five-year history of rate changes in health insurance markets the state regulates.

Figure 5-49: LifeWise five-year history of rate changes

Year	Individual plans	Small employer plans	Portability plans
2007	9.00%	13.17%	8.60%
2008	28.00%	28.82%	20.10%
2009	16.00%	3.42%	24.00%
2010	15.00%	-4.26%	11.90%
2011	5.68%	8.40%	11.86%
2007-2011	**96.69%**	**56.47%**	**102.44%**

Source: Data were obtained from rate filings.

Appendix 1: Key Data Sources

The analyses in this report rely on data from several key sources and numbers sometimes cannot be compared. Figure 2-1, for example, contains enrollment numbers from "quarterly enrollment reports" that vary from "Health Benefit Plan Report" enrollment data reported elsewhere. Differences in the data are explained below. Also, Section 3 generally deals with companywide data, while Section 4 deals with specific Oregon insurance markets. Thus, the 89 percent medical loss ratio reported in Figure 3.6 differs slightly from the 88 percent figure reported in Figure 4-2.

Health Benefit Plan Report (501) data

- Numbers cover: Only data specific to health benefit plans issued in Oregon, including out-of-state residents who are covered by a plan issued in Oregon.
- Who submits them: Any insurance carrier licensed in Oregon that has issued or offered a health benefit plan in this state. "Health benefit plans" refer to comprehensive health policies as opposed to limited benefit policies that might cover a specific disease or pay a fixed amount for each day of hospitalization.
- How they are used: The department uses this information to prepare reports on the regulated health insurance market segments (individual, small employer group, associations/trusts, and large group). The department also posts the full filings for each insurer on its website: **www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html**.

Quarterly enrollment reports

- Numbers cover: All Oregon residents, regardless of where the policy was issued and whether the insurance plan is regulated by the State of Oregon. For example, these reports collect enrollment data on coverage such as Medicare and TRICARE (military health plan) in addition to commercial markets.
- Who submits them: Licensed carriers, third-party administrators, and special districts.
- How they are used: In addition to looking at enrollment, these reports collect geographical average rate data for small group policies, small employer group and individual health benefit plan age bands, and individual health plan rejection rates. The Oregon Medical Insurance Pool uses this information when developing assessment amounts. You can review these reports online at **http://insurance.oregon.gov/sehi/health-insurance_member-enrollment.html**.

Rate filing documents

Information presented in Sections 2 and 5 on average annual rate changes in the small employer, individual, and portability markets comes from rate filings.

Medical expenditure panel survey

Section 1 of this report also draws on survey data collected by the federal Agency for Healthcare Research and Quality. Its Medical Expenditure Panel Survey (MEPS), which began in 1996, includes surveys of employers across the United States. MEPS collects data on the number and types of private insurance plans offered, premiums, contributions by employers and employees, eligibility requirements, plan benefits, and employer characteristics. Learn more at **http://meps.ahrq.gov/mepsweb**.

Insurance Company Financial Information

Premium and expense reports — The financial data used in this report was taken from the annual statements filed by each insurer.

Financial statements — Each insurer files detailed, audited financial statements covering its financial status and income and expense activity for each calendar quarter and each calendar year. The annual statement (prepared as of Dec. 31 of each year) must be filed with the department by March 1 of each year. The quarterly statements are prepared as of March 31 and due to be filed May 15; as of June 30 and due to be filed Aug. 15; and as of Sept. 30 and due to be filed Nov. 15.

The detailed financial statements for Oregon domestic insurers are available at the Insurance Division's office in Salem. Call 503-947-7982 to schedule an appointment to review filed statements. A copier is available for public use. Copy charges apply.

Data from the NAIC — Insurers electronically file their financial statements with the National Association of Insurance Commissioners (NAIC), and state insurance departments file summarized information with the NAIC about consumer complaints against insurers. The NAIC makes basic financial and complaint information available on its website, **www.naic.org**. The following information is available without registration or charge: summarized closed complaint reports, licensing by state, and basic financial information (premium, assets, liabilities, financial profile). Consumers who set up an account with the NAIC Consumer Information Source can access financial information on five insurers free of charge. After the fifth, there is a charge. To access the NAIC's insurer information, go to the NAIC website, select "Consumer Information Source," and follow the directions.

Appendix 2: Glossary

Claims adjustment expense — Expenses to record, adjust, and settle claims. This includes cost-containment expenses that reduce the number of health services provided or the cost of services. Included in this category are salaries of claims personnel.

General administrative expense — Expenses an insurer incurs to run its business. This includes all expenses that are not directly attributed to settling and paying claims of members. Examples are commissions, marketing and advertising expenses, and salaries of non-claims personnel.

Lines of business (all) — Comprehensive, Medicare supplement, dental only, vision only, Federal Employees Health Benefit Plan, Medicare, Medicaid, stop loss, disability income, other health, and other non-health.

Lines of business (comprehensive) — Individual, group, and portability plans.

Medicare — A federal health insurance program for people 65 years of age and older, and for people of all ages with certain disabilities. Eligibility is not income based.

Medicaid — A federal program that provides health coverage for certain categories of people with low incomes.

Medical loss ratio — The percent of health insurance premiums spent on medical claims. A 0.96 loss ratio means that 96 percent of the insurer's health insurance premiums purchased medical services. The more technical definition of medical loss ratio is claims incurred divided by net premium earned. Under the federal Affordable Care Act, medical loss ratio is defined somewhat differently to determine whether an insurer is required to rebate premium. The federal definition calculates medical loss ratio by dividing incurred claims plus health care quality improvement costs by earned premiums less federal and state taxes and licensing or regulatory fees.

Net claims incurred — Cost for hospital and medical benefits, emergency room, and prescription drugs minus recoveries from the reinsurer plus the change in the unpaid claim liability. The unpaid claim liability is the insurer's estimate of the cost for claims already reported but not yet paid and an estimate of claims incurred by a member but not yet submitted for payment.

Net income — The net result of all revenue, claims incurred, expenses, investment results, taxes, and write-offs. Net income is sometimes referred to as profit margin.

Net investment income (or gain) — Includes all income earned from invested assets minus expenses associated with investments plus the profit (or loss) realized from the sale of assets.

Net premium earned — The amount charged by the insurer to the policyholder for the effective period of the contract, reinsurance premiums, plus the change in the unearned premium liability. The unearned premium liability is the portion of the premium that has been received by the insurer for insurance that has not yet been provided. It is the amount that would have to be returned to the policyholder if the policy was canceled before the end of the policy period.

Net underwriting gain/loss — Gain or loss after an insurer pays claims, adjustment expenses, and general administrative expenses. In other words, it is the amount an insurer earns from its insuring activities. When insurers collect more premiums than they pay in medical claims, claims expenses, and administrative expenses, the insurer has an underwriting gain. If the medical claims, claims expenses, and administrative expenses exceed the premiums collected, the insurer has an underwriting loss.

Premium-to-surplus ratio — This ratio measures an insurer's ability to support its existing business, as well as any growth. Since surplus provides a cushion for claims and expenses that exceed what the insurer expected, this ratio measures the adequacy of the surplus cushion available for unexpected claims and expenses.

Risk-based capital (RBC) — A method for evaluating an insurer's surplus in relation to its overall business operations in consideration of its size and lines of business written. An insurer's RBC is calculated by applying factors to various assets, premium, and reserve items. The calculation produces the "authorized control level." The RBC ratio is the insurer's surplus divided by the authorized control level. The department is required

to take certain actions, including exercising control of the insurer, if a company's RBC ratio is at or below 200 percent. Under certain circumstances, such as a company losing money, the department has authority to act if a company's RBC ratio is between 200 percent and 300 percent.

Reserves — Funds created to pay anticipated claims.

Surplus — The amount an insurance company's assets exceed its liabilities. Additional funds are surplus over and above what the insurer expects to pay out for medical claims, expenses, taxes, and other obligations. All insurers must, by law, maintain minimum levels of surplus to ensure they will be able to meet their financial obligations to policyholders. Surplus includes common and preferred stock issued to its shareholders, any funds that are contributed to the insurer, and the accumulation of the insurer's net income or losses since its inception.

Surplus notes — Surplus notes are a form of indebtedness that insurers are allowed to include as surplus because they are subject to strict control by the director of the department. Surplus note obligations are subordinated to all other obligations of an insurer, and the payment of interest and repayment of principal requires prior approval of the director.

Taxes and other adjustments — Includes federal and foreign income taxes, and income and expenses that are not included in the underwriting results or investment results. Generally, these include net gain/(loss) from write-off of agent/premium balances, restructuring costs, pension adjustments, and other extraordinary expenses not related to underwriting or investments.

Total revenue — Net premium earned plus other revenue.

Appendix 3: Annual Premiums by State, Small Group Market

Individual (single employee) coverage

Alaska	1	$7,090
Delaware	2	$5,916
Connecticut	3	$5,899
District of Columbia	4	$5,850
Massachusetts	5	$5,673
New Jersey	6	$5,650
Wyoming	7	$5,644
Rhode Island	8	$5,607
Illinois	9	$5,553
New Hampshire	10	$5,524
West Virginia	11	$5,306
New Mexico	12	$5,303
New York	13	$5,272
Vermont	14	$5,257
Wisconsin	15	$5,209
Oklahoma	16	$5,182
Pennsylvania	17	$5,140
Michigan	18	$5,098
Florida	19	$5,090
Maryland	20	$5,004
North Carolina	21	$4,984
South Carolina	22	$4,959
Indiana	23	$4,936
Louisiana	24	$4,905
Virginia	25	$4,878
Texas	26	$4,829
Oregon	27	$4,826
Nebraska	28	$4,822
Maine	29	$4,814
Montana	30	$4,809
Colorado	31	$4,807
Georgia	32	$4,785
Minnesota	33	$4,751
Mississippi	34	$4,744
Missouri	35	$4,743
Washington	36	$4,711
Alabama	37	$4,711
Tennessee	38	$4,705
South Dakota	39	$4,684
Ohio	40	$4,678
Arizona	41	$4,656
California	42	$4,608
Hawaii	43	$4,544
North Dakota	44	$4,492
Nevada	45	$4,475
Kansas	46	$4,352
Utah	47	$4,336
Arkansas	48	$4,273
Kentucky	49	$4,271
Iowa	50	$4,134
Idaho	51	$3,976

Source: Medical Expenditure Panel Survey (MEPS), 2010. Table II.C.1 (2010) Average annual total individual premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 2010.

Family coverage

New Hampshire	1	$15,976
Alaska	2	$15,623
Connecticut	3	$15,306
Massachusetts	4	$15,132
Illinois	5	$15,130
District of Columbia	6	$15,052
Wisconsin	7	$14,864
Rhode Island	8	$14,668
New Jersey	9	$14,659
Delaware	10	$14,467
New York	11	$14,388
Florida	12	$13,775
Vermont	13	$13,763
Texas	14	$13,755
New Mexico	15	$13,697
Wyoming	16	$13,695
Maryland	17	$13,500
Minnesota	18	$13,396
West Virginia	19	$13,351
Colorado	20	$13,033
Missouri	21	$12,997
Kansas	22	$12,890
North Carolina	23	$12,884
Michigan	24	$12,852
Kentucky	25	$12,724
California	26	$12,700
Virginia	27	$12,684
Indiana	28	$12,652
Pennsylvania	29	$12,581
Hawaii	30	$12,505
Louisiana	31	$12,338
Ohio	32	$12,244
Maine	33	$12,172
Iowa	34	$12,158
Oklahoma	35	$12,052
Nevada	36	$12,034
Tennessee	37	$11,987
Washington	38	$11,828
Mississippi	39	$11,796
Alabama	40	$11,615
Nebraska	41	$11,546
Oregon	42	$11,492
North Dakota	43	$11,464
Georgia	44	$11,454
Arizona	45	$11,392
Montana	46	$11,361
South Dakota	47	$11,245
Utah	48	$10,994
South Carolina	49	$10,873
Idaho	50	$9,891
Arkansas	51	$9,574

Source: Medical Expenditure Panel Survey (MEPS), 2010. Table II.D.1 (2010) average annual total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 2010.

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