

Health Insurance in Oregon

March 2013



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

This year's report will be the last before major reforms significantly change how health insurance is regulated and how small businesses and individuals shop for coverage. As a result of these changes, the department is evaluating the content of future Health Insurance in Oregon reports.

The department is preparing for the Patient Protection and Affordable Care Act reforms that start in January 2014, allowing thousands of uninsured Oregonians to access quality health insurance through the private market. Key tasks include the following:

- Assisting Cover Oregon, Oregon's health insurance exchange, with plan management and operational and compliance issues.
- Working with the federal government to help ensure Oregonians continue to enjoy one of the most competitive and protective health insurance markets in the nation.
- Developing rate mitigation strategies for the individual health insurance market in 2014.
- Creating standardized health insurance plans to give consumers the ability to make "apples to apples" comparisons of coverage in the individual and small group markets.
- Proposing legislation to implement changes to the Insurance Code necessitated by the Affordable Care Act.
- Establishing filing standards so carriers have the necessary tools to file rates, forms, and plans in time for 2014.

As always, we continue to closely monitor the financial performance of Oregon's health insurers and to provide outreach and information to consumers about how health insurance works and their rights under the law.

Sincerely,

Patrick Allen
Director, DCBS

Louis Savage
Commissioner, 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 30 percent of Oregonians get coverage in insurance markets regulated by the state but only about 10 percent are covered in plans where the state regulates rates.
- An estimated 15 percent of Oregonians lacked health insurance in 2011, according to an Oregon Health Authority survey.
- 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.
- The state's seven largest health insurers remain financially stable. In 2011, these insurers averaged a 2 percent profit – roughly split between profit from investment income and profit from insuring activities.
- 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 of Consumer and Business Services (DCBS) began holding public hearings on small employer and individual rate requests. With federal grant money, the department continues to fund the Oregon State Public Interest Research Group (OSPIRG) to offer regular input on key rate requests through September 2014.

Health insurance reform

- The Oregon Insurance Division has proposed legislation in 2013 that will conform Oregon law with key provisions of federal reform that take effect in January 2014.
- Companies that plan to sell health plans in Cover Oregon starting in fall 2013 (for a Jan. 1, 2014, effective date) must submit plans and proposed rates to the division by April 30, 2013. The division approves rates for small business and individual health plans before they can be used. Unlike many rate requests that focus on rate changes, these rate reviews will focus on setting rates for new plans that include essential health benefits and meet actuarial value requirements of the federal Affordable Care Act.
- With federal health reform, the Insurance Division maintains its traditional regulatory functions. Cover Oregon, the health insurance exchange, offers new options for shopping for insurance for small employers and individuals. Additionally, the exchange links qualified applicants to federal financial assistance that will help cover the cost of premiums and cost sharing. Section 1 includes information about Cover Oregon and the roles of the division and the exchange.

Section 1: Overview of Health Care Marketplace

Employer-based health insurance is the cornerstone of the American health care system. Understanding the evolution of employer-based coverage and the effect of ongoing premium increases — due in part to the number of 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, the growth in health care spending and premiums, and key elements of the federal Affordable Care Act.

Evolution of Employer-Based Health Coverage

Employer-based health care plans originated as a result of the American war effort during World War II. 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.

For example, in 1941, 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, Kaiser offered prepaid coverage to the general public.

Commercial insurance companies realized that 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. When 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 policy reinforced the trend toward employer-sponsored health insurance. For example, in 1954, the Internal Revenue Code exempted employer contributions from employee taxable income, further encouraging employers to provide and contribute to employee 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, in 2010, an estimated 16 percent of the population remained uninsured, 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.

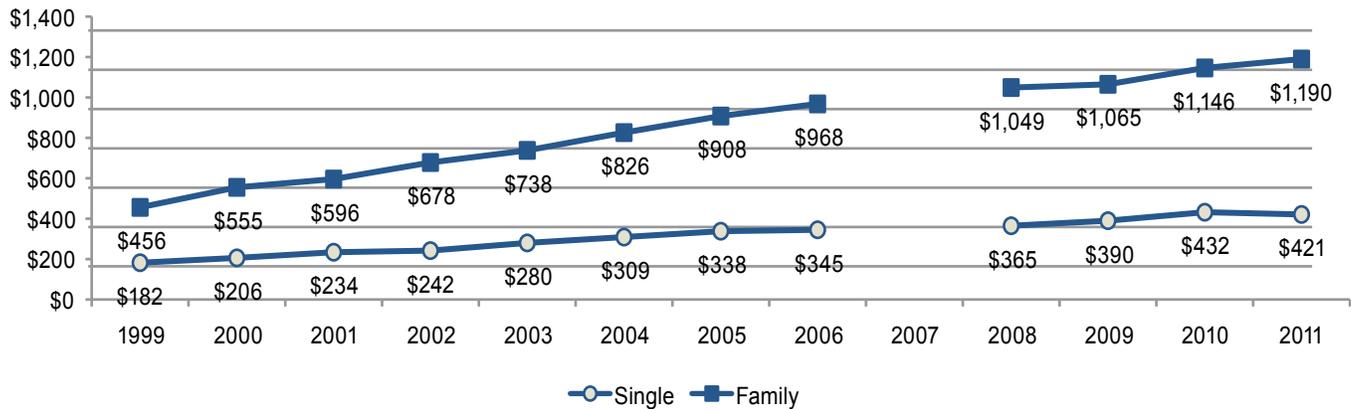
Growth in Health Care Spending

Health insurance premiums reflect the underlying cost of health care. 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 17.9 percent of GDP in 2011. The Centers for Medicare and Medicaid Services project that health spending will account for nearly one-fifth of the economy by 2021, or an average \$14,102 per person. That compares to projected per person spending of \$8,660 in 2011.

Factors that drive increases in health insurance premiums include inflation, greater use of health care, more costly technologies, prescription drug costs, aging, and unhealthy lifestyles.

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 2011 was \$421 for single coverage and \$1,190 for family coverage. These compare to national averages of \$435 monthly for single coverage and \$1,252 monthly for family coverage.

Figure 1-1. Average total monthly Oregon premiums from 1999 to 2011



Source: Medical Expenditure Panel Survey (MEPS), 1999-2006 and 2008-2011. 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

Hospitals and other providers shift costs to the commercial market 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. This results in higher premiums for private insurance and means the commercial health insurance market bears a disproportionate share of the increases in health care spending.

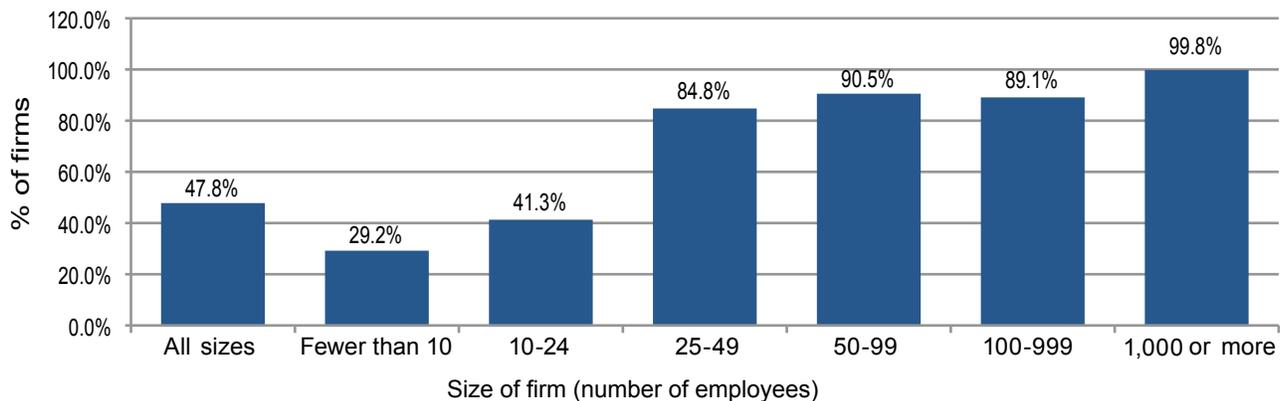
Employers struggling to afford coverage, in turn, shift costs to their employees through higher deductibles and other cost sharing. Some Oregon health insurers have begun to emphasize evidence-based benefits, imposing higher cost-sharing and deductibles for services that are less effective or that cost more than other services that are just as effective. In

doing so, insurers encourage customers to think more about the costs and effectiveness of medical services, and become better purchasers of health care. Although most large employers offer health insurance, many small employers do not.

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.

The number of uninsured and 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.

Figure 1-2. Oregon private-sector firms that offer health insurance by firm size in 2011



Source: Medical expenditure panel survey (MEPS), Table II.A.1 (2011) 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.

Federal Health Care Reform

Affordable Care Act

Some of the most significant changes under the Affordable Care Act start in January 2014. They are designed to increase the number of insured Americans; reduce cost shifting of uncompensated hospital, doctor, and other provider costs to private insurance payers; and create a healthier country.

Affordable Care Act Reforms, Effective 2014

- People with pre-existing health conditions can no longer be denied coverage.
- To prevent only the sick from buying insurance, most taxpayers must have basic coverage or pay an annual tax penalty.
- Health plans purchased by small employers (50 or fewer employees) and individuals who buy directly from an insurer must contain essential health benefits.
- Federal tax credits will help many lower- and moderate-income families 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 expand. More than 200,000 additional Oregonians could be added to Oregon Health Plan, which already covers more than 650,000 Oregonians.
- Every state will have a state or federal exchange allowing consumers to compare prices, benefits, and health plan performance on easy-to-use websites. Oregonians who want to take advantage of tax credits must purchase insurance through Cover Oregon, our state's exchange.

Beginning in 2014, all non-grandfathered health plans sold to small employers and individuals will include essential health benefits and pay a required share of expected medical costs. Essential health benefits are defined by states although they must cover 10 broad categories outlined in the Affordable

Care Act. These include hospital care, doctor visits, maternity care, prescription drugs, and pediatric vision and dental care. Oregon's essential health benefit package is patterned after a small-employer plan sold by PacificSource Health Plan.

Plans will be labeled to indicate what share of medical costs they are expected to pay. A plan's "actuarial value" is an estimate of what percent of health care costs the plan will cover based on *average* use. It is not a guarantee of how much the plan will pay.

Consumers will see these labels:

- Bronze – covering approximately 60 percent of expected medical costs.
- Silver – covering approximately 70 percent of expected medical costs.
- Gold – covering approximately 80 percent of expected medical costs.
- Platinum – covering approximately 90 percent of expected medical costs.

Even though two bronze plans have the same actuarial value, certain features – such as deductibles and other cost sharing – may differ. In 2013, the Insurance Division was designing standardized "cookie cutter" bronze and silver plans. These additional plans will be the same for all insurers and must be offered wherever insurers sell the coverage (inside or outside the exchange). The standardized plans will let consumers more easily compare plans without having to weigh different deductibles, co-pays, and co-insurance rates.

Pricing: The division used federal grant funds to hire an actuarial firm, the Wakely Consulting Group, to estimate the effects of federal reform on Oregon insurance markets. While there are many unknowns in projecting future premiums, the Wakely estimates provide guidance as Oregon researches ways to mitigate expected cost increases, particularly in the individual health insurance market.

The ACA changes are more significant in the individual market where insurers will no longer be able to deny coverage to people with pre-existing conditions and health plans will be required to cover more benefits at higher levels. Today's individual health plans often do not cover prescription drugs and mental health/substance abuse treatment, for example.

Federal subsidies will help many Oregonians afford coverage. Federal premium tax credits will lower monthly premiums for half of those already insured and nearly 75 percent of the uninsured who are expected to enroll. Some individuals and families with lower incomes will receive help paying out-of-pocket costs (co-payments, co-insurance, and deductibles) when they use medical services.

The ACA also changes how costs are distributed among different ratepayers by prohibiting insurers from charging more than three times as much for a policy sold to an older person than to a younger person. Currently, there is no limit on how much more insurers can charge older people in Oregon's individual market.

This change would increase costs for younger people, and make coverage more affordable for older consumers. Federal reform allows young adults under age 30 to purchase lower-priced "catastrophic plans." These plans must cover essential health benefits but are not required to meet the actuarial value levels. They can only be purchased through the exchange.

To mitigate premium increases in this insurance market, a federal reinsurance program will cover a portion of claims that exceed a certain amount. Oregon officials are exploring additional ways to more evenly spread the risk of particularly high-cost people in the individual market to a broader base of insurers and self-insurers.

Overall, how the ACA affects any one individual varies greatly, depending on factors such as the selected plan, age, and whether the person qualifies for premium assistance, cost-sharing assistance, or both.

Unlike the individual market, a majority of the small group membership is covered by plans that meet the actuarial value requirements of the ACA.

Small employers are more affected by changes in the factors that can be used to set rates. For example, Oregon now allows insurers to consider factors such as claims (within limits) and the percentage of employees who participate in the health plan. These factors are no longer allowed. Factors that will be allowed are geography, average age of the group, tobacco use, and number of family members on the plan.

Tax credits for certain small employers will be available through 2015 to offset the costs of offering health insurance. Federal officials estimate the tax credit would reduce premiums by 8 percent to 11 percent for eligible firms.

Cost shifting: Better access to health insurance coverage under the ACA should reduce the number of people using expensive hospital emergency departments for primary care with reductions in uncompensated care. This should lead to more timely, efficient, and coordinated care for individuals and lower costs to the system.

Additionally, the state will learn from the introduction of Coordinated Care Organizations (CCOs) into public programs such as Oregon Health Plan. The hope is to eventually incorporate this concept of integrated and less wasteful care into the commercial insurance market. Incorporating these concepts into the commercial market will be a key to controlling costs as the state expands access to health care.

A coordinated care organization, or CCO, is a network of all types of health care providers (physical health care, addictions, and mental health care and sometimes dental care providers) who have agreed to work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy. Today, more than 90 percent of Oregon's Medicaid clients are members of a Coordinated Care Organization. Learn more at health.oregon.gov

Making insurance markets work: Federal and state governments in 2014 will operate several programs designed to make sure insurance markets operate smoothly under the ACA. For example, a federal risk adjustment program will reallocate premium income among plans so that no one health plan loses money because it enrolls sicker-than-average members.

Rate filings due in April 2013: Insurance companies that plan to sell coverage in Cover Oregon as well as the outside market in 2014 must submit health plans and proposed rates to the Insurance Division by April 30. Regulators will analyze the rates and the public can weigh in by commenting online or at public hearings. The division must approve any rate before it can be used. Rates for the same plan must be the same inside and outside of the exchange.

2013 Legislation

The Department of Consumer and Business Services is seeking legislation that implements provisions of the Affordable Care Act that take effect in 2014 and eliminates conflicts with existing Oregon insurance law. Here are some of the key provisions:

- Authority to define essential health benefits according to federal law and guidance.
- Repeal portability statutes since insurers can no longer deny coverage and people between jobs can get an individual health plan.
- Authority to regulate multi-state plans, requiring these plans to offer the same protections as other plans.
- Changes to the factors that can be used to set rates in the small group and individual markets. Federal law limits these to age, tobacco use, geographic area, and family size. Individuals who use tobacco can be charged up to 50 percent more than nonusers.
- Define student health plans to be consistent with federal law.

Cover Oregon: A New Marketplace for Individuals and Small Employers

On Oct. 1, 2013, Cover Oregon will launch an online central marketplace where individuals and small employers can shop for and compare health coverage options and access financial assistance.

Cover Oregon is the state's health insurance exchange. Under the ACA, a state can choose to operate its own exchange, allow the federal government to do so, or partner with the federal government. Oregon is one of 18 states that have chosen to operate its own exchange. In Oregon, legislators set up the exchange as a public corporation, funded starting in 2015 by an administrative fee charged to insurance companies selling plans in the exchange.

Cover Oregon's mission is to improve the health of all Oregonians by providing health coverage options, increasing access to information, and fostering quality and value in the health care system. The following are some of the key services it will provide:

For individuals and families

- "Apples-to-apples" comparisons of health plans and costs
- A single application for enrollment in health insurance plans and public programs (such as Medicaid) available through Cover Oregon
- Information and assistance on how to maximize use of health benefits to improve health
- Quality ratings for insurance companies and plans
- Financial assistance to help cover the cost of premiums and co-pays (for qualifying individuals)

For small employers

- Ability to provide employees with more health plan choices
- Easy administration
- Financial assistance to help cover the cost of premiums (for qualifying employers)
- Serving employers with 50 or fewer employees in 2014 and, beginning in 2016, up to 100 employees

Timeline

- October 2013:** Open enrollment starts for individuals and small employers
- January 2014:** Coverage begins for Cover Oregon plans
- October 2015:** School districts can shop in Cover Oregon
- January 2016:** Cover Oregon opens to employer groups with up to 100 employees
- January 2017:** Cover Oregon can expand to larger groups

Insurance Division Role in 2014

The Oregon Insurance Division maintains its traditional role of being the primary regulator of insurance in Oregon. This regulation is described in detail in Section 2. Below is a brief overview of the distinct roles of the division and Cover Oregon.

Insurance Division

- Authorize insurers to sell in Oregon
- Make sure insurance companies are financially sound
- Review policies and rates before they can be used
- Staff consumer hotline
- Help with insurance complaints and appeals
- Enforce federal and state insurance laws
- License insurance agents

Cover Oregon

- Online shopping
- Eligibility and enrollment (individuals, small groups, Medicaid)
- Links to tax credits and other help to make insurance affordable
- Help finding the right coverage through navigators/agents

Section 2: Overview of Health Insurance Regulation

Through its Insurance Division, the Department of Consumer and Business Services 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 division’s four major regulatory responsibilities (financial solvency, policy form approval, consumer protection, and rate approval). This section also explains the division’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 30 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

	2011	
Oregon population¹	3,831,000	
Commercial/state regulated insurance²		
Individual	157,000	4.1%
Portability	14,000	0.4%
Small group 2-50	204,000	5.3%
Oregon and federal high-risk pools	13,000	0.3%
Large group	604,000	15.8%
Associations and trusts	158,000	4.1%
Total covered under state regulation	1,150,000	30.0%
Large group self-insured³	631,000	16.5%
Federal health care programs⁴		
Medicare	640,000	16.7%
Medicaid	653,000	17.0%
Total covered under federal regulation	1,293,000	33.8%
Uninsured¹	560,000	14.6%

Figure 2-1 relies on data from the quarterly enrollment reports submitted by insurers. Enrollment figures provided in Sections 4 and 5 of this 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.

¹Office for Oregon Health Policy & Research (OHPR), 2011 Oregon Health Insurance Survey (OHIS). The survey is based on Oregon’s non-institutionalized population living in households.

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

³Oregon Insurance Division quarterly enrollment data. In prior reports, insurers reported self-insured enrollment. In 2011, insurance companies, special districts, and third-party administrators reported self-insured enrollment.

⁴Centers for Medicare and Medicaid Services.

Health Insurance in Oregon

Commercial/state-regulated insurance. The division regulates health insurers covering nearly 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 division'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 387,000 Oregonians, or roughly 10 percent of all Oregonians. The division 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 not rate regulation. Instead, insurance companies negotiate prices directly with employers and competition plays a role in moderating rates. 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.

In addition to the commercial market, the state's Oregon Medical Insurance Pool (OMIP) covers about 13,000 high-risk individuals. OMIP, a division of the Oregon Health Authority, 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 627,000 Oregonians in 2011. This count includes entities such as the Public Employees' Benefits Board (PEBB), which 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 division's consumer advocates, who help consumers resolve health insurance complaints under state insurance laws. If an insurer violates the law, the division 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 some new benefit requirements and consumer protections to both insured and self-insured plans. For example, federal law provides that enrollees in self-insured plans whose claims are denied have internal and external appeal rights similar to state-regulated plans.

Federally regulated health care. In addition to regulating the self-insured market, the federal government regulates Medicare and Medicaid. These programs cover nearly 1.3 million Oregonians. Medicare covers people 65 and 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 nearly 15 percent of Oregonians, or 560,000 people, were uninsured in 2011. That is based on a survey conducted early in 2011 that asked participants whether they were insured at the time of the survey.

The majority of the uninsured in Oregon are working-age adults ages 19 through 64. Of these Oregonians, one in five lack health insurance. Oregonians 18 years old and younger, along with Oregonians 65 and over, who have more options for health insurance coverage, are uninsured at far lower rates, 5.6 percent and 0.9 percent, respectively.

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

Financial Regulation

The public wants solvent insurers who are financially able to make good on the promises they have made, so financial regulation is a high priority for insurance regulators. All types of insurers operating in Oregon, including all health insurers offering individual or group health insurance, are subject to financial regulation. Certain federal programs, such as Medicare, also rely on state regulators to ensure the solvency of insurers.

Financial regulation begins with the division'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. Capital and surplus is the amount a company's assets exceed its liabilities. The required minimum increases as the company assumes more insurance risk.

The division 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 solvency standards are used 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 health insurer's RBC is calculated by using a formula focusing on the following five major risk categories:

- Asset risk, affiliates — the risk a company's investments in affiliates will incur material 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 maximum or target capital and surplus levels. The division is required to take certain actions, including exercising control of an insurer if its RBC ratio is at or below 200 percent. Under certain circumstances, such as a company losing money, the division has authority to act if the 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.

Health Insurance in Oregon

The ability of a company to meet its obligations to policyholders is ultimately the responsibility of insurance company management. When the division identifies potential solvency issues, 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 division monitors the outcome. If steps taken by management do not improve operating results and adequate surplus cannot be maintained, the division 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 division 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 division 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 division, 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 include:

- 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 in the individual market.
- 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 health benefits. (This applies to all plans.)
- Annual limits on what policies pay for essential health benefits are restricted. (This applies to some plans.)

Federal law identifies 10 categories of essential benefits that must be covered by non-grandfathered health benefit plans issued in individual and small group markets both inside and outside the exchange. The benefit areas are:

- 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
- pediatric services, including oral and vision care

Federal regulations allow states to decide specific essential health benefits by selecting a benchmark plan that reflects services offered by a “typical employer plan.” Oregon selected a small employer plan sold by PacificSource Health Plans as its benchmark, then supplemented that plan with pediatric dental and vision benefits and habilitative services to meet federal requirements.

Starting in 2014, plans in the individual and small group markets will be labeled bronze, silver, gold, or platinum, depending on what percent of health care costs the plan is expected to cover. Bronze plans, for example, are expected to cover 60 percent of medical costs.

Also 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 signed into law after Dec. 31, 2011.

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.”

Claims Mishandling

The division 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.

Appealing a claim denial

More than 44 percent of those who appeal succeed in getting their denials overturned. The Insurance Division’s Consumer Guide to Health Insurance Appeals explains the appeals process and offers tips for those appealing an “adverse decision.” For more information, go to <http://insurance.oregon.gov/consumer/appeals-guide/appeals-guide-toc.html>.

In 2012, the division recovered approximately \$1.1 million on behalf of consumers who were hurt by practices that violated insurance laws. In addition to recovering money on behalf of consumers, the division 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 division's consumer advocates handle approximately 16,000 inquiries and 3,500 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.

In 2012, the Insurance Division used \$128,000 in federal consumer assistance grant funds to help the referral service 211info expand its counseling to people seeking health care. Specifically, the division transferred its online database of government and community programs involved with health insurance or health care (Oregon Health Connect) to 211info. In addition to the extensive online resources directory, Oregon Health Connect had two referral specialists. The program serves as a clearinghouse for consumers who need help navigating the myriad of health insurance assistance programs offered by multiple state agencies.

In addition to the advocates who help consumers with commercial insurance, the division'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.

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 available health insurance options by visiting www.healthcare.gov. Plans 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. Starting in October 2013, small employers and individuals will be able to shop and compare insurance through Cover Oregon, the state's new online marketplace.

Rate Regulation

The division reviews and approves 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. In this market, competition plays a more significant role in keeping rates reasonable.

Federal reforms have generally maintained the role of states in regulating health insurance rates. Insurance companies seeking rate increases of 10 percent or more must 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 Oregon, health insurance 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."

Rate website: 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 Insurance Division reviews rate requests, see dates for public hearings on rate requests, and more.

Division 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 division 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 in Oregon 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 pay rebates to individual and small group policyholders when it fails to spend at least 80 percent of premiums collected 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, 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

Insurers that fail to meet the new standards must rebate money 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. Employers must use the rebates they receive for the benefit of enrollees.

In 2012, the following companies paid rebates in Oregon for 2011 plans:

- 13,528 people who purchased their insurance individually from The MEGA Life and Health Insurance Company and Time Insurance Company saw an average rebate of \$360 per policy.
- 7,359 small-business employees who use LifeWise Health Plan of Oregon, Inc., saw an average rebate of \$282 per policy.
- 2,507 employees of large businesses who use Aetna Life Insurance Company saw an average rebate of \$777 per policy.

In total, about 23,000 Oregonians, less than 2 percent of the population, saw rebates totaling \$4.7 million. Rebates are likely to be rare in Oregon, where a competitive insurance market helps keep the desired balance between spending for medical care versus overhead and profits. Also, the division does not approve rates that would appear to result in rebates because it means the company expects to spend too little on medical care and too much on administration and profit.

However, insurance rates are based on projections – companies estimate how much they expect to pay in claims in the upcoming year, how much they expect to incur in administrative costs, and how much they expect to realize as profit. Because these are projections, it is possible that some companies may end up owing rebates, depending on how actual experience compares to the federal medical loss ratio threshold.

Health Insurance in Oregon

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 main 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. The division carefully considers all adjustments used as the basis for projecting future trends. The division tries to balance the more conservative assumptions and projections of insurance company actuaries with what we regard as more objective assumptions and projections.

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 billing health insurers for specific services. There are other payment models that give provider groups a fixed amount of money to pay for all services for members enrolled in the group. All provider compensation methods are considered when carriers establish claims costs.

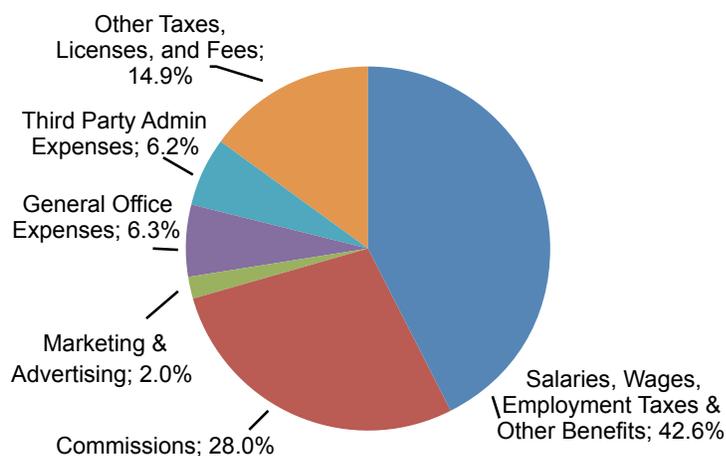
Recent claims history is important for helping to predict future claims costs. But actuaries must also consider a variety of factors when predicting changes in claims costs. Estimates for future claims costs are affected by changes in such major factors as unit costs (fees) paid to providers; use by 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 division 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 2-2 provides a rough breakdown of key administrative expenses in the small group and individual markets combined.

Figure 2-2. Breakdown of total administrative costs in 2011



Source: Oregon Insurance Division rate filings. The chart breaks down average 2011 total administrative costs, including claims-handling costs for individual and small group markets.

Net income target. Insurance company rate filings include a net income target for each line of insurance. Net income target is the projected profit or loss after subtracting projected claims costs and administrative costs from projected revenue. The division 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. In a few instances when companies were more profitable with healthy surpluses, the division pushed back on certain rate requests, even though some insurers were losing money in these lines of insurance.

However, the division 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.

Actuarial analysis. For each of these above factors, division 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 division 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. The Insurance Division uses federal grants to fund a consumer advocacy group to participate in public hearings and provide meaningful comments on rate requests. Consumers can find hearing information at www.oregonhealthrates.org.

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 do the following:

- **Increase the scrutiny of rate filings:** Additional staff members, including two actuaries and a market analyst, enabled the Insurance Division to dig deeper into rate requests and the data that are 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. The Oregon State Public Interest Research Group (OSPIRG) was selected to represent consumers at public hearings through September 2014. OSPIRG offers detailed comments on how rate requests measure up to the legal factors the division considers in evaluating rate requests.
- **Public hearings:** Some grant funds were used to equip a room to broadcast public hearings on rate requests so that people can watch from their computers.
- **Risk management:** Grant funds were used to contract for actuarial work to help determine the effects of federal reform on Oregon insurance markets as well as the design of programs to limit companies' financial risk as a result of changes in 2014.

Health Insurance in Oregon

Grant funding ends in 2014. The division has contracted with Georgetown University to evaluate the effectiveness of grant-funded programs and whether it should seek legislative approval to continue any grant-related positions with other funds.

Health Insurance Premiums

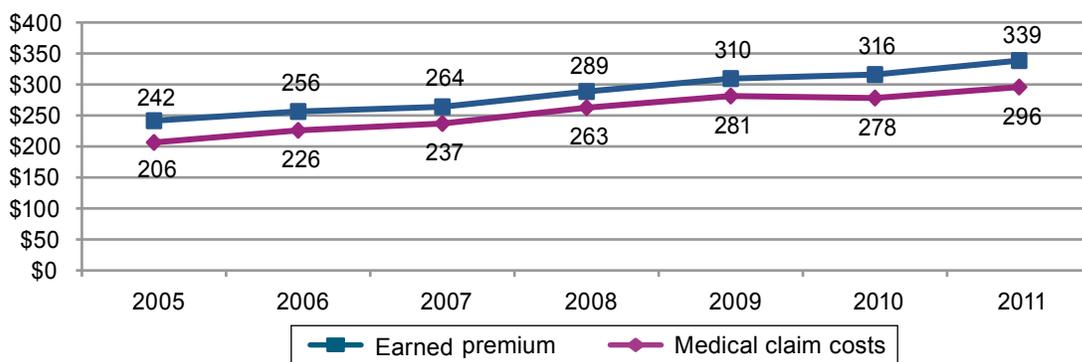
Health insurance premiums in Oregon and the rest of the country generally reflect the cost of health care. In 2011, Oregon's seven largest health insurers spent an average of 89 cents of every premium dollar on hospital and medical care, including prescription drug coverage. Approximately 10 cents paid 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 factors such as new and more expensive technologies, cost shifting, and reduced competition among providers.

Increased use is attributable to factors such 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 2-3 shows the relationship between medical claims and premiums from 2005 to 2011.

Figure 2-3. Monthly earned premium and medical claim costs per member, of seven largest insurers from 2005 to 2011



Source: Oregon Insurance Division, health benefit plan reports.

Figure 2-4 shows average rate increases for small group plans for the previous five years. Annual rate increases dropped significantly in 2011 and 2012 compared to the three prior years. 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, caused even insured consumers to cut health care spending.

Figure 2-4. Average annual rate increase in the small group market

Year	Increase
2008	13.44%
2009	10.47%
2010	11.68%
2011	6.63%
2012	4.13%

Source: Oregon Insurance Division, approved rate filings.

Small employer premiums in Oregon are below the nationwide average. In 2011, Oregon family premiums in the small employer market were the 20th lowest in the country, meaning 31 states and the District of Columbia had higher average rates, according to the federal Medical Expenditure Panel Survey. Oregon's average annual family premium

was \$13,058 in 2011, compared to the national average of \$14,086. See Appendix 3 for state-by-state annual premium comparisons.

Figure 2-5 shows that Oregon’s individual health insurance market has been more volatile than its small group counterpart over the past five years. 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. Insurers could not maintain these artificially low rates in the face of continuing increases in medical costs and were forced to increase rates significantly in 2008.

Figure 2-5. Average annual rate increase in the individual market

Year	Increase
2008	21.34%
2009	14.92%
2010	15.57%
2011	9.05%
2012	7.00%

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 four percentage points of rate increases approved in late 2010 and 2011. 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.

However, as addressed more fully in Section 1, in January 2014, the ACA will fuel more significant premium increases, particularly in the individual health insurance market. This is because individual health plans will provide additional benefits, including prescription drug coverage, mental health and substance abuse coverage, and pediatric dental and vision coverage. Also, many Oregonians who are currently uninsured and less healthy than their insured counterparts, will be able to afford coverage with federal subsidies that lower both monthly premiums and their share of costs for medical care (out-of-pocket costs).

Commercial submarkets

Each commercial health insurance submarket 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 167,000 Oregonians, or 4 percent of the population, currently purchase health insurance in the individual market. Insurers can 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.

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 still offer child-only coverage throughout the year. The reinsurance program spreads the cost of insuring high-risk children among all companies licensed to sell health insurance in Oregon. In general, once coverage is provided, it is guaranteed renewable as long as premiums are paid. Adults age 19 and older who are denied coverage because of health status can obtain coverage through the state’s high-risk pool.

In the individual health insurance market, the division must review both the content of insurance contracts and the rates charged for the coverage provided. The division’s review of insurance contracts ensures that mandated benefits are covered 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 and 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 and 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.

Health Insurance in Oregon

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. To be eligible for the federal pool, a person 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 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 premium payments are made. 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 pre-existing conditions for people under age 19. 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 or eliminated based on the number of months the insured had continuous prior coverage.

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 and 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 obtain insurance through the Oregon Medical Insurance Pool or, if eligible, 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 division reviews rates to ensure they meet standards that protect groups with older or less healthy employees. Similar rules apply to “portability” 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. Less than 6 percent of Oregonians obtain their insurance from the small group (204,000 Oregonians) and portability (16,000 Oregonians) markets.

In the small group health insurance market, as in the individual market, the division 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. This requirement does not apply to coverage offered through a bona fide association. 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 highest 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, geography, 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 enrollee 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. Although association regulation will change in 2014, approximately 158,000 Oregonians received health insurance through an association at the time of this report.

Association health plans are currently 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 retain a high number of their enrolled member groups, 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 604,000 Oregonians, or nearly 16 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 division 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

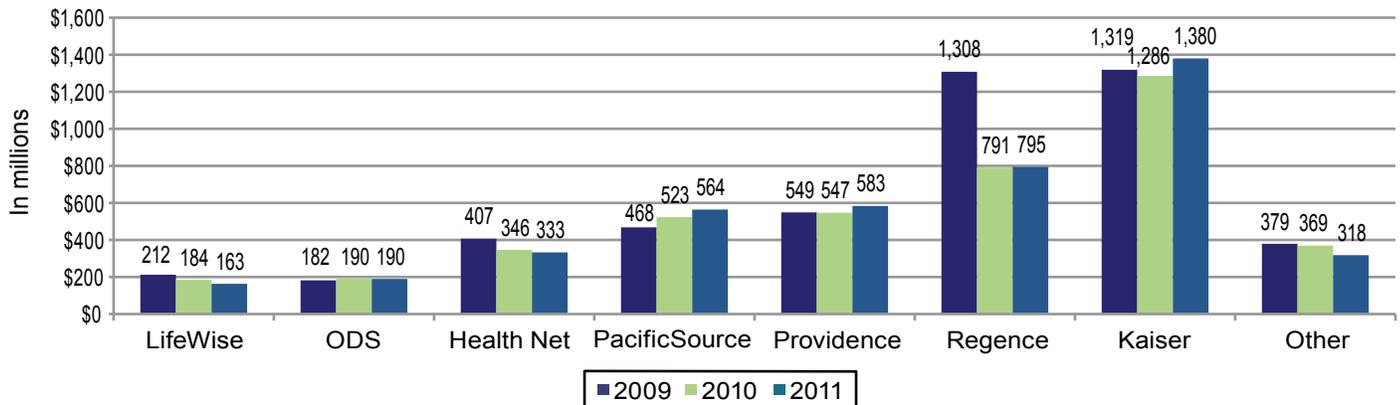
The Oregon Insurance Division closely monitors the financial condition of health insurers to make sure that each is able to pay policyholder claims.

The division conducts financial examinations of Oregon’s domestic health insurers every three to five years or more frequently when warranted. Oregon health insurers also submit quarterly and annual financial statements to the division. The division’s financial analysts review these statements to evaluate each insurer’s financial status and operational health over time. Other states’ insurance regulators similarly monitor and analyze the financial health of their health insurers using nationally accepted technical standards described in Section 2.

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 2009.

Figure 3-1. Oregon total premiums earned



Source: Oregon Insurance Division, 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. 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 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 2012. 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 2012

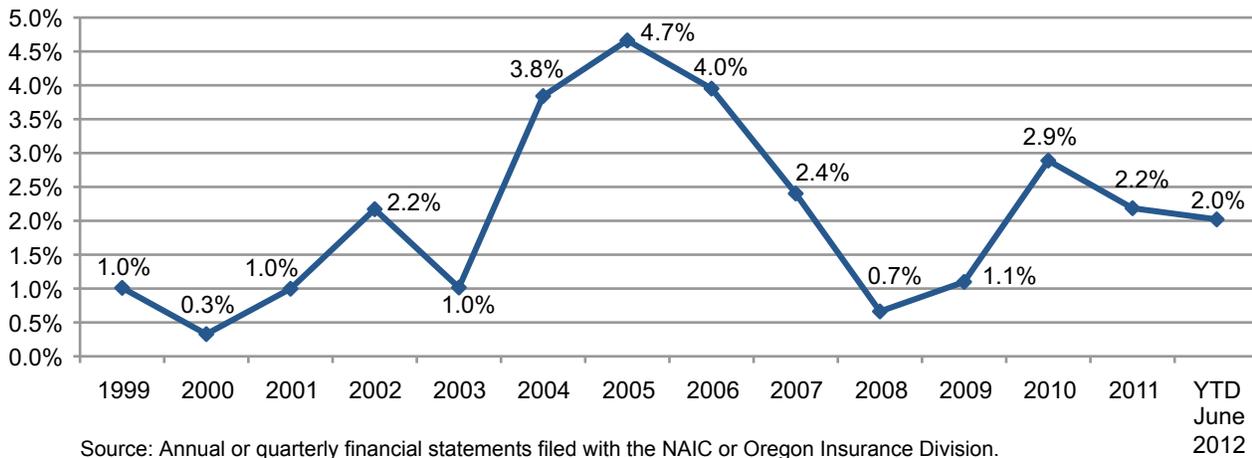


Figure 3-3 shows net income to premiums earned by year and by company from 2007 through June 2012. During the most recent 10-year period, the seven largest insurers averaged a 2 percent profit, about half as much as in the 2004-2006 period.

Figure 3-3. Net income to earned premium from 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	10-year average (2002-2011)	YTD 6-12
Health Net	3%	1%	-1%	5%	6%	3%	3%
Kaiser	3%	1%	2%	2%	1%	2%	1%
LifeWise	-2%	-4%	0%	-2%	2%	2%	-1%
ODS	2%	1%	-5%	2%	3%	2%	1%
PacificSource	2%	-1%	1%	1%	2%	3%	-1%
Providence	7%	0%	3%	6%	7%	6%	5%
Regence	1%	1%	1%	4%	0%	2%	3%
Average all seven	2%	1%	1%	3%	2%	2%	2%

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 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

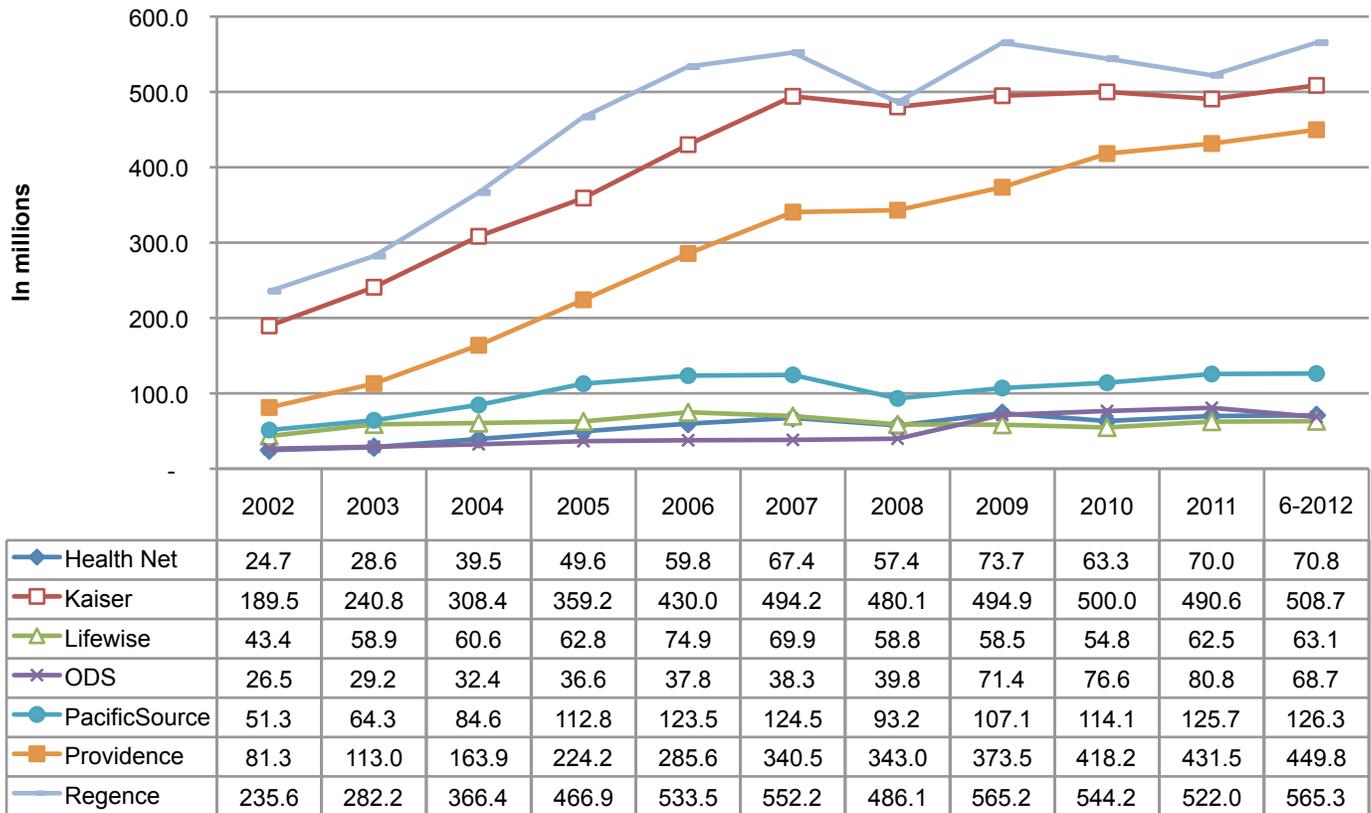
For a variety of reasons, Oregon's largest for-profit insurers have maintained consistent levels of surplus over the past 10 years, despite varying operational and investment gains and losses. Oregon's largest nonprofit insurers maintain larger surpluses than the for-profit insurers because they tend to rely on surpluses to cover operation and investment losses. For-profit insurance companies, on the other hand, have access to additional 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 and maintain insurer solvency. 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, giving consumers fewer choices.

Figure 3-5 shows 10 years worth of surplus levels, along with the mid-year trend for 2012.

Figure 3-5. Surplus levels from 2002 to June 30, 2012



Source: National Association of Insurance Commissioners (NAIC) annual and quarterly financial statement filings.

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. 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 division uses the traditional actuarial definition of medical loss ratio, claims divided by premiums, in its rate review process. For example, an 80 percent medical loss ratio means 80 cents of every dollar of premium collected is spent on claims.

The federal definition is more lenient, allowing adjustments to both claims (counting quality improvement initiatives and anti-fraud efforts as part of claims costs) and premiums (allowing insurers to subtract taxes, fees and assessment from premium revenue). To meet the federal medical loss ratio standard for small group and individual plans, the adjusted claims divided by the adjusted premium must not be lower than 80 percent. Insurers that do not meet the federal standard will be required to issue rebates to policy holders. The division does not approve rates that appear likely, based on Oregon data and the traditional definition of medical loss ratio, to result in rebates.

Figure 3-6 shows that Oregon's largest insurers in 2011 spent an average of 89 percent of all premiums in all markets on medical claims. 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 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	5-year average	YTD 6-12
Health Net	82%	87%	89%	81%	79%	84%	83%
Kaiser	95%	96%	96%	96%	95%	96%	95%
LifeWise	88%	88%	83%	83%	79%	85%	82%
ODS	84%	88%	101%	93%	90%	92%	88%
PacificSource	89%	87%	84%	85%	85%	86%	87%
Providence	88%	89%	90%	90%	88%	89%	89%
Regence	89%	90%	87%	82%	86%	87%	85%
Overall average	90%	91%	91%	89%	89%	90%	90%

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, including 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 incurred regardless of the volume of premium and can be difficult to reduce, especially if the insurer owns its facilities.

Health Insurance in Oregon

Figure 3-7 shows overall that the level of general administrative expenses in 2011 was consistent with prior years. Administrative costs vary by insurer for a variety of reasons. For example, plans with higher deductibles generally have lower premiums and higher administrative costs as a percent of premium. The top five administrative expenses for all Oregon companies are shown in Section 5 of this report.

Figure 3-7. General administrative expenses to earned premium from 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	5-year average	YTD 6-12
Health Net	12%	9%	9%	10%	10%	10%	11%
Kaiser	4%	4%	5%	5%	6%	5%	5%
LifeWise	10%	11%	13%	15%	13%	12%	13%
ODS	8%	6%	4%	4%	5%	5%	6%
PacificSource	10%	10%	12%	12%	11%	11%	12%
Providence	4%	4%	5%	4%	5%	4%	5%
Regence	8%	6%	8%	9%	8%	8%	7%
Overall average	7%	6%	7%	7%	7%	7%	7%

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 typically averages 3 percent to 4 percent of premium.

Figure 3-8. Claims adjustment expenses to earned premium from 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	5-year average	YTD 6-12
Health Net	2%	2%	3%	3%	3%	3%	3%
Kaiser	1%	1%	1%	1%	1%	1%	1%
LifeWise	6%	7%	7%	8%	8%	7%	7%
ODS	8%	6%	4%	3%	4%	5%	5%
PacificSource	2%	3%	3%	3%	3%	3%	3%
Providence	4%	3%	4%	4%	3%	4%	3%
Regence	6%	5%	5%	6%	7%	6%	6%
Overall average	4%	3%	3%	3%	4%	3%	3%

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

Note: 5-year average includes 2007-2011.

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 insurance 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 one of the seven largest insurers, Regence BlueCross BlueShield of Oregon, had an underwriting loss in 2011. Year-to-date data through June 2012 show an overall average net underwriting gain of 1 percent for the largest insurers.

Figure 3-9. Net underwriting gain/loss to earned premium from 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	5-year average	YTD 6-12
Health Net	3%	1%	-2%	6%	8%	3%	3%
Kaiser	1%	1%	1%	1%	0%	1%	1%
LifeWise	-4%	-6%	-2%	-6%	1%	-4%	-2%
ODS	0%	-1%	-9%	0%	1%	-2%	1%
PacificSource	-2%	0%	1%	1%	1%	0%	-2%
Providence	4%	3%	2%	3%	4%	3%	2%
Regence	-2%	-1%	0%	2%	-1%	-1%	2%
Overall average	0%	0%	0%	1%	1%	1%	1%

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

Note: 5-year average includes 2007-2011.

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 2007 to 2011, the seven largest health insurers averaged 1 percent in investment gains. Data for the first six months of 2012 shows investment gains averaged 1 percent.

Figure 3-10. Net investment gain to earned premium from 2007 to June 30, 2012

Insurer	2007	2008	2009	2010	2011	5-year average	YTD 6-12
Health Net	1%	0%	0%	1%	1%	1%	2%
Kaiser	1%	1%	1%	1%	1%	1%	1%
LifeWise	2%	1%	2%	3%	3%	2%	2%
ODS	3%	-1%	2%	2%	3%	2%	0%
PacificSource	3%	-2%	0%	1%	1%	1%	1%
Providence	3%	-3%	1%	3%	3%	1%	2%
Regence	4%	2%	1%	3%	2%	2%	2%
Overall average	3%	0%	1%	2%	1%	1%	1%

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

Note: 5-year average includes 2007-2011.

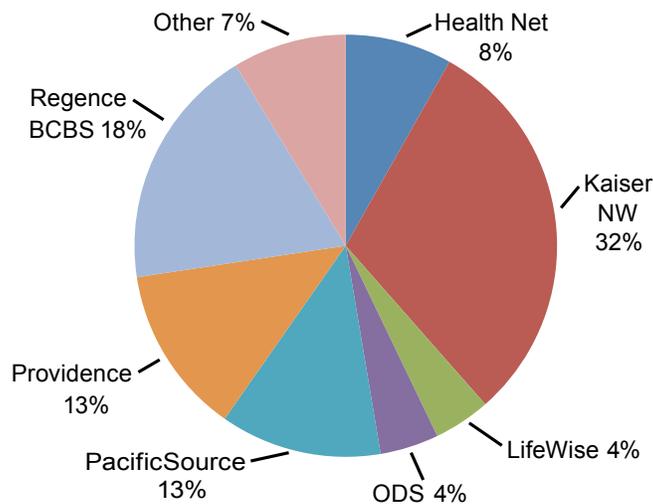
Section 4: Comparisons of Seven Largest Insurers by Market Segment

The analysis in this section concerns the different health insurance markets in Oregon, including the 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 division. 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 2011, the two largest health insurers, Kaiser and Regence, earned 50 percent of all Oregon health premiums.

Figure 4-1. Oregon health insurance market share, premium earned in 2011



Source: Oregon Insurance Division, 2011 Health Benefit Plan Reports.
 Note: Percents do not add to 100 percent due to rounding.

Health Insurance in Oregon

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 2011
Totals for seven largest Oregon insurers

Market segment	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Individual	157,071	\$427	90%	\$223
Small group	192,124	\$837	82%	\$358
Large group	537,883	\$2,387	89%	\$371
Associations and trusts	95,914	\$357	86%	\$313
Total	982,992	\$4,008	87%	\$339

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	170,405	\$466	89%	\$223
Small group	211,436	\$890	81%	\$346
Large group	620,250	\$2,546	88%	\$342
Associations and trusts	110,218	\$425	87%	\$306
Total	1,112,309	\$4,326	87%	\$321

*Rounded in millions

Source: Oregon Insurance Division, 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.

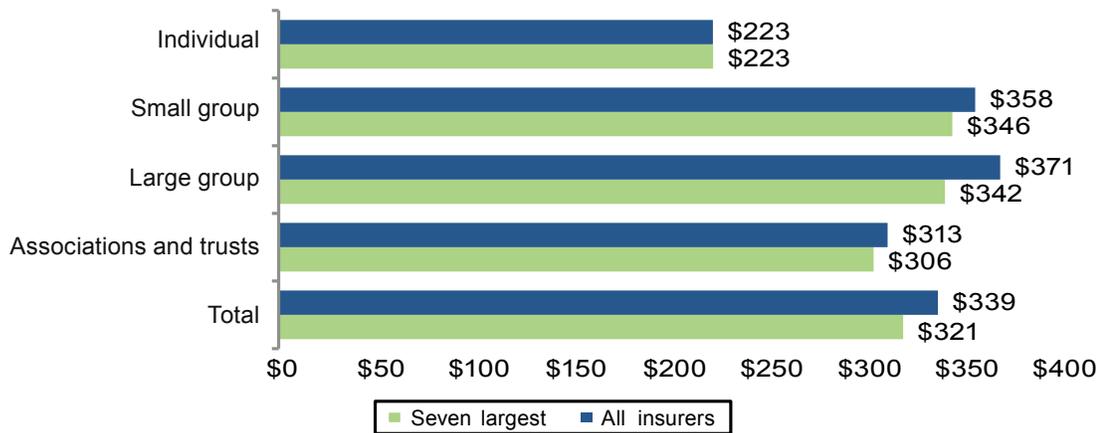
Figure 4-3 reflects that average premiums for Oregon’s seven largest health insurers were nearly 6 percent greater than average premiums of all insurers combined. Average premium per member per month is calculated by dividing the total premiums all members paid by the total number of members. It is not 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 single coverage counts only individual employees as units, and family coverage 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).

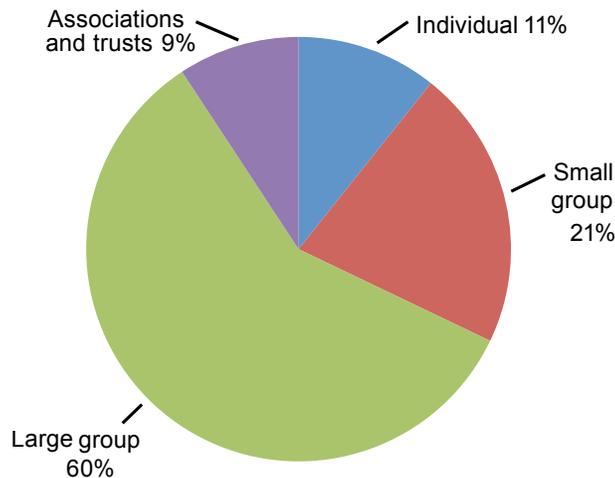
Figure 4-3. Average premium per member per month, market segments in 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-4 shows that in 2011, the large group market accounted for 60 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 2011



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

Health Insurance in Oregon

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 2011. The average monthly premium for Oregon's seven largest health insurers was \$223, the same for all insurers.

Figure 4-5. Seven largest insurers, individual plans in 2011

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	4,190	\$18.0	82%	\$305
Kaiser	15,469	\$56.4	122%	\$314
LifeWise	22,766	\$66.3	74%	\$228
ODS Health Plans	28,392	\$52.2	78%	\$158
PacificSource	13,926	\$27.9	73%	\$170
Providence	13,047	\$36.8	94%	\$245
Regence BCBS	59,281	\$169.5	92%	\$229
Total – above seven insurers	157,071	\$427.1	90%	\$223
Total – all insurers	170,405	\$465.5	89%	\$223

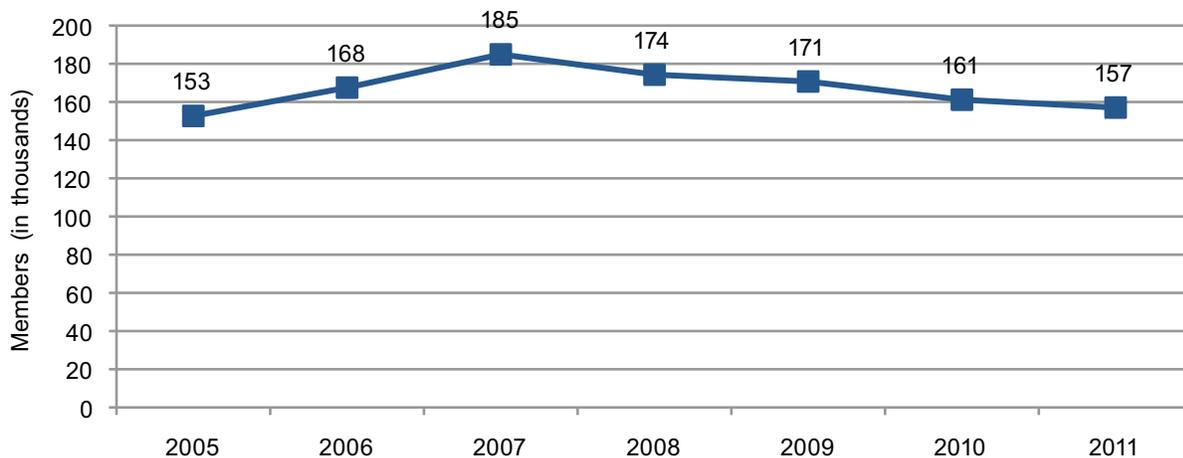
*Rounded in millions.

Source: Oregon Insurance Division, 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 nearly 15 percent decline in individual enrollment for Oregon's seven largest insurers since the recession began in 2007.

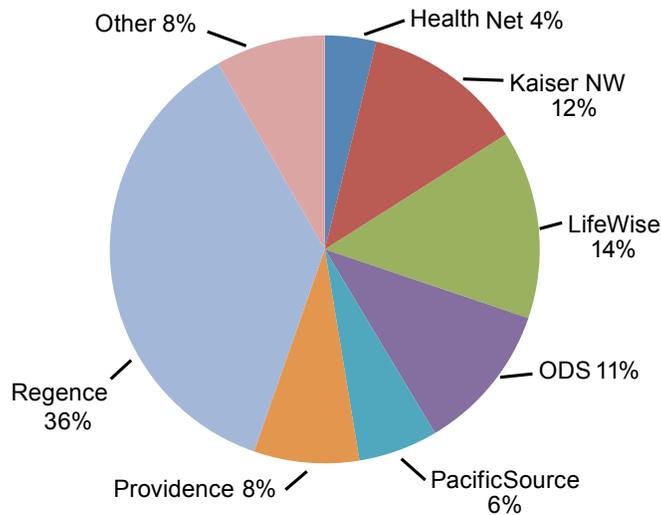
Figure 4-6. Individual plans seven largest insurers, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-7 shows that in 2011, Oregon’s seven largest health insurers earned about 91 percent of the premiums in the individual health insurance market. Smaller Oregon insurers and national insurers earned the remainder of total premiums.

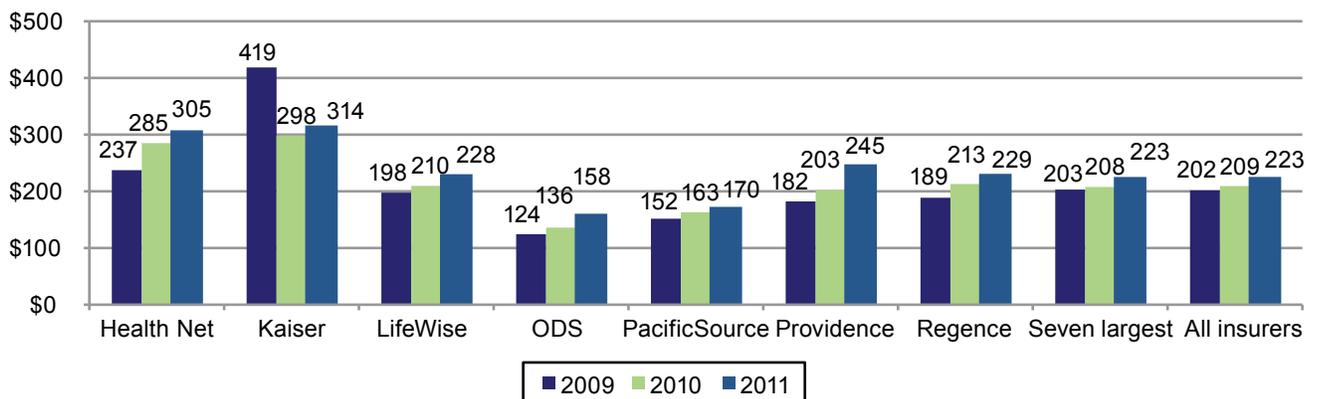
Figure 4-7. Market share by premium, individual market in 2011



Source: Oregon Insurance Division, 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 2009 to 2011

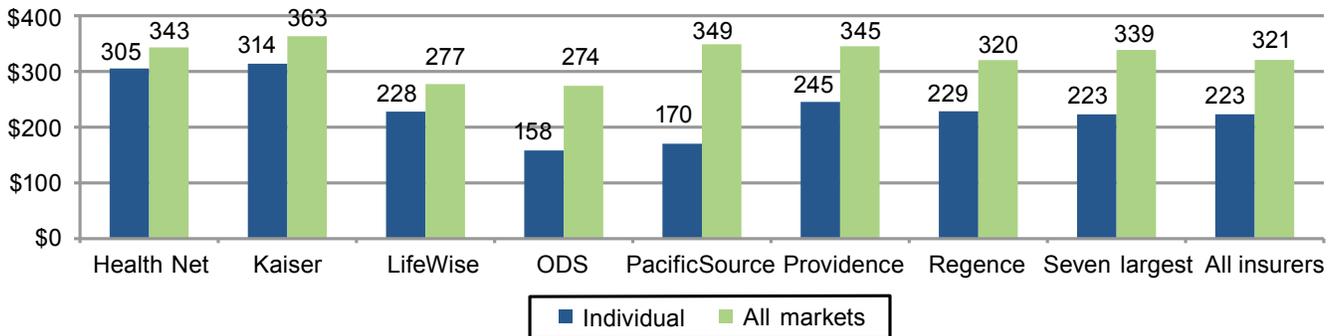


Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 4-9 compares the seven largest insurers' average premium per member per month of \$223 for the individual market with \$339 for all markets. Individual premiums tend to be lower because benefits are typically not as rich and because insurers can limit their risk by denying coverage to people age 19 and older with health problems. Starting in January 2014, individual health plans must contain essential benefits and insurers can no longer reject people for coverage based on health. Insurers are already prohibited from denying coverage based on health in the group market.

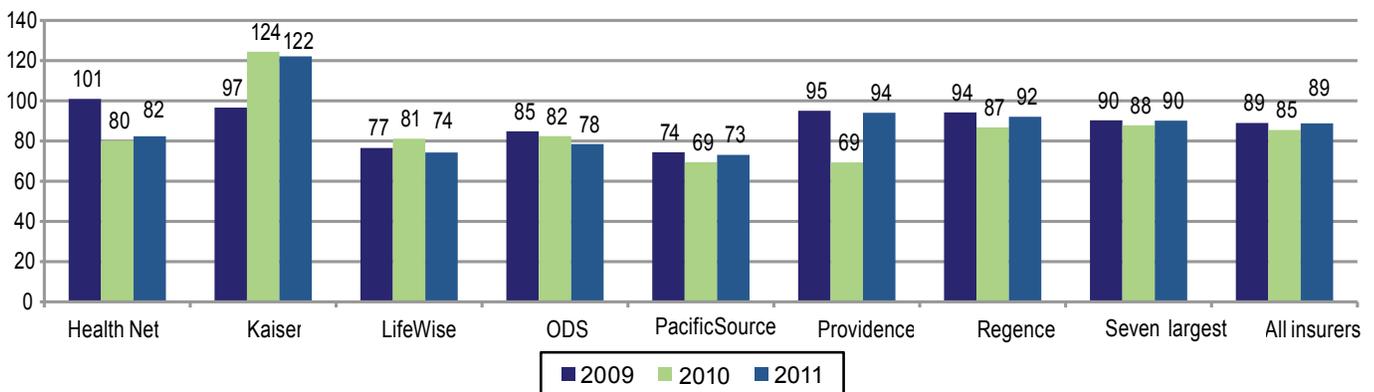
Figure 4-9. Average premium per member per month, individual plans vs. all markets in 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-10 shows the 2009 to 2011 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 2011, medical loss ratios for the seven largest insurers ranged from 73 percent to 122 percent. Medical loss ratios averaged 90 percent in 2011.

Figure 4-10. Medical loss ratios, individual plans from 2009 to 2011

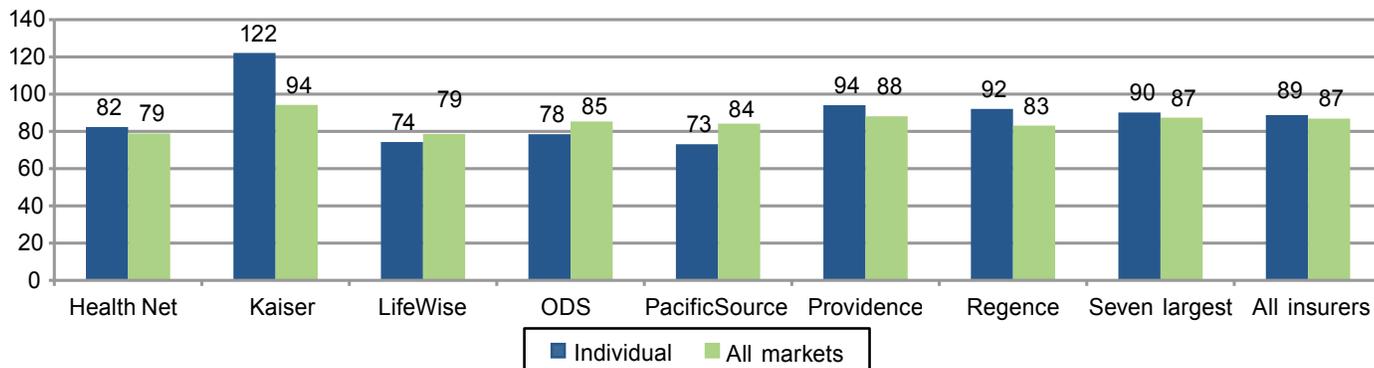


Source: Oregon Insurance Division, Health Benefit Plan Reports.

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 4-11 shows the 2011 medical loss ratios for individual plans, compared to all markets. On average, the seven largest insurers spent 90 cents of every premium dollar on medical services in the individual market compared to 87 cents in all markets.

Figure 4-11. Medical loss ratio, individual plans vs. all markets in 2011



Source: Oregon Insurance Division, 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.

Small Group Market

(Employer groups with 2-50 employees)

Small employers account for approximately 63 percent of all employers in Oregon, according to the Oregon Employment Department. Any small employer 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 2011. Average premium costs per member per month were \$358 for the seven largest insurers, compared to \$346 for all insurers.

Figure 4-12. Seven largest insurers, small group plans in 2011

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	36,751	\$150.2	76%	\$344
Kaiser	32,694	\$134.7	92%	\$343
LifeWise	7,396	\$25.0	69%	\$283
ODS Health Plans	8,011	\$28.1	83%	\$265
PacificSource	31,657	\$153.4	75%	\$415
Providence	30,422	\$129.8	85%	\$360
Regence BCBS	45,193	\$216.0	84%	\$369
Total – above seven insurers	192,124	\$837.2	82%	\$358
Total – all insurers	211,436	\$889.7	81%	\$346

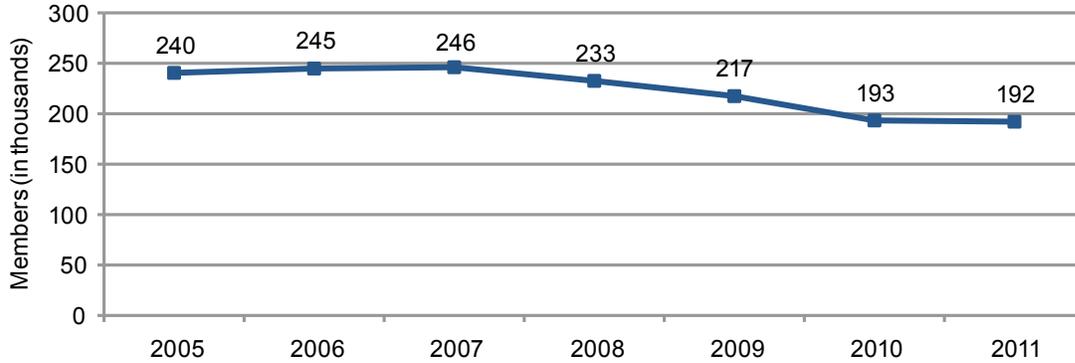
*Rounded in millions.

Source: Oregon Insurance Division, 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.

Health Insurance in Oregon

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

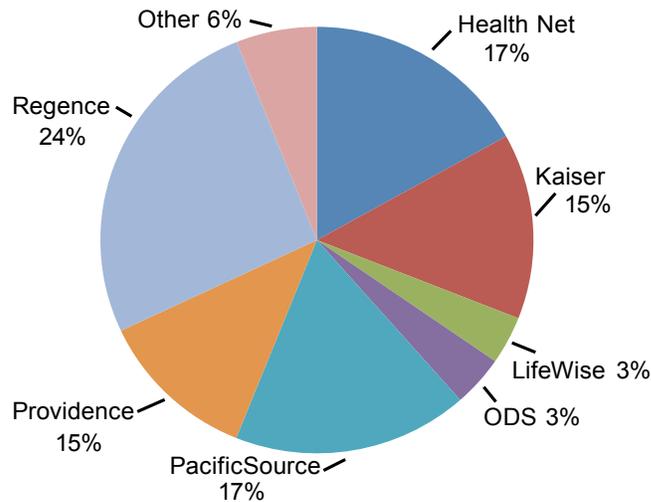
Figure 4-13. Small group plans, seven largest insurers, number of members, 2005 to 2011



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 24 percent of the total.

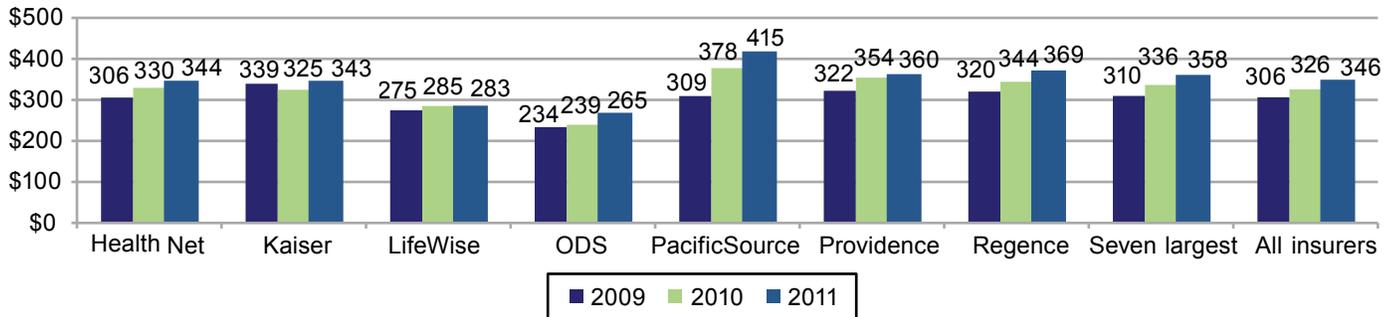
Figure 4-14. Market share by premium, small group market in 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-15 compares the seven largest insurers' average premiums in the small group market from 2009 to 2011 to those of all insurers.

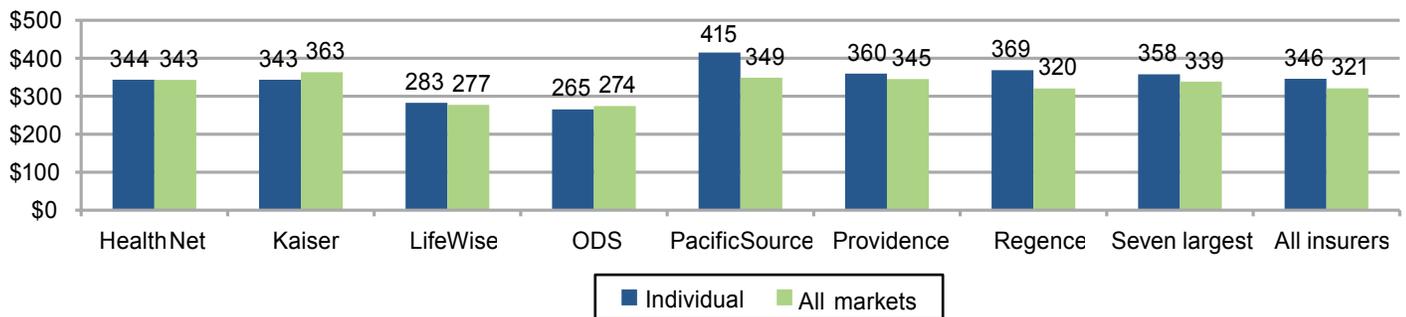
Figure 4-15. Average premium per member per month in small group plans from 2009 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-16 shows that in 2011, the average premium per member per month of \$358 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 2011

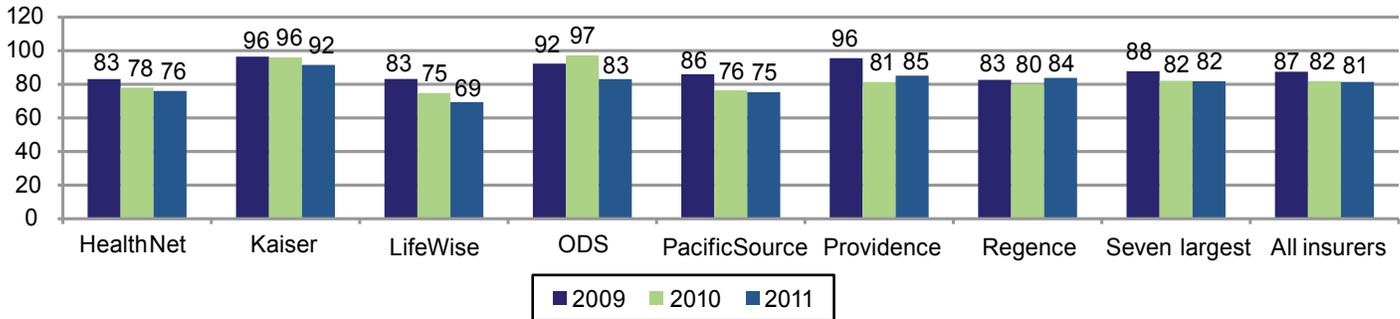


Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 4-17 compares the 2009 to 2011 average medical loss ratios for Oregon’s seven largest insurers in the small group market to those of all insurers. In 2011, the average medical loss ratio for the seven largest insurers was 82 percent.

Figure 4-17. Medical loss ratios, small group plans from 2009 to 2011

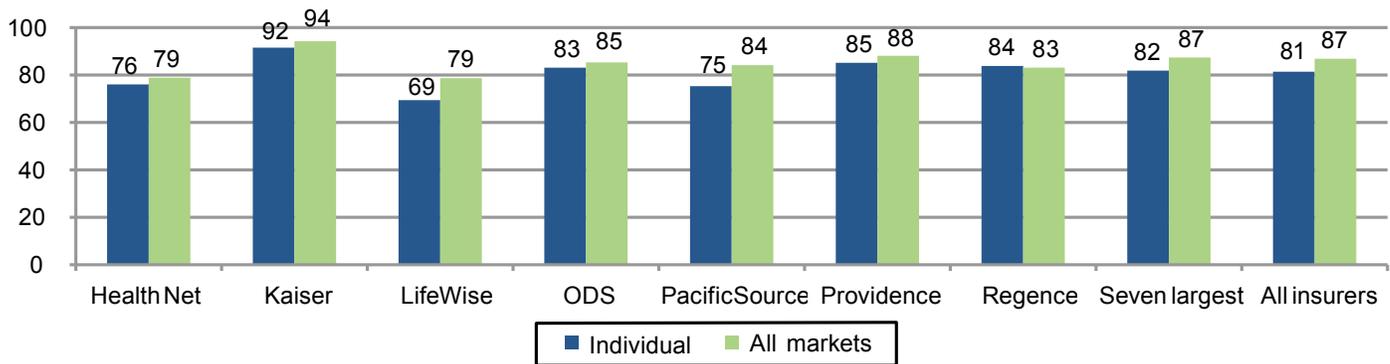


Source: Oregon Insurance Division, Health Benefit Plan Reports.

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 4-18 compares the medical loss ratios for Oregon’s seven largest insurers in the small group market to all markets and all insurers. The overall average medical loss ratio for Oregon’s seven largest insurers in 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 2011



Source: Oregon Insurance Division, 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.

Large Group Market

(Employer groups with 51 or more employees)

Large employers in Oregon represent approximately 4 percent of the state's employers.

Figure 4-19 summarizes the 2011 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 \$371, compared to \$342 for all insurers.

Figure 4-19. Seven largest insurers, large group plans in 2011

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	26,704	\$115.3	80%	\$360
Kaiser	236,470	\$1,069.1	93%	\$377
LifeWise	8,756	\$58.0	83%	\$372
ODS Health Plans	19,132	\$104.3	90%	\$438
PacificSource	80,471	\$323.5	91%	\$353
Providence	77,115	\$347.2	89%	\$355
Regence BCBS	89,235	\$369.3	79%	\$370
Total – above seven insurers	537,883	\$2,386.6	89%	\$371
Total – all insurers	620,250	\$2,545.5	88%	\$342

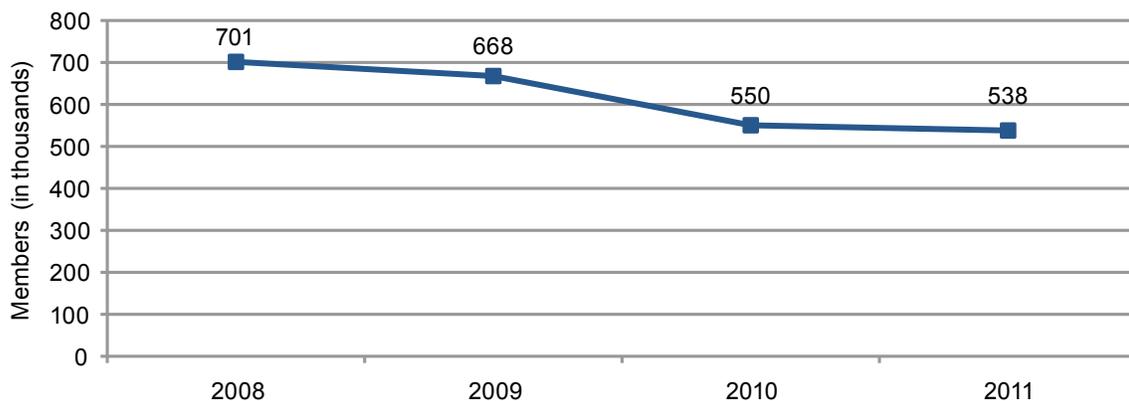
*Rounded in millions.

Source: Oregon Insurance Division, 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 since 2008. 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, 2011



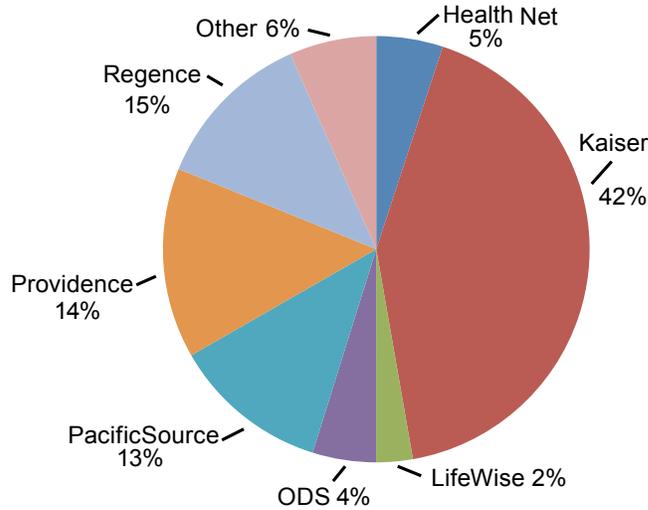
Source: Oregon Insurance Division, Health Benefit Plan Reports.

Note: Blanket student health plan policies were included in large group for the first time in 2011.

Health Insurance in Oregon

Figure 4-21 shows the seven largest Oregon insurers earned about 95 percent of all premiums in the large group market. Oregon's largest insurer, Kaiser, earned 42 percent of premiums in this market.

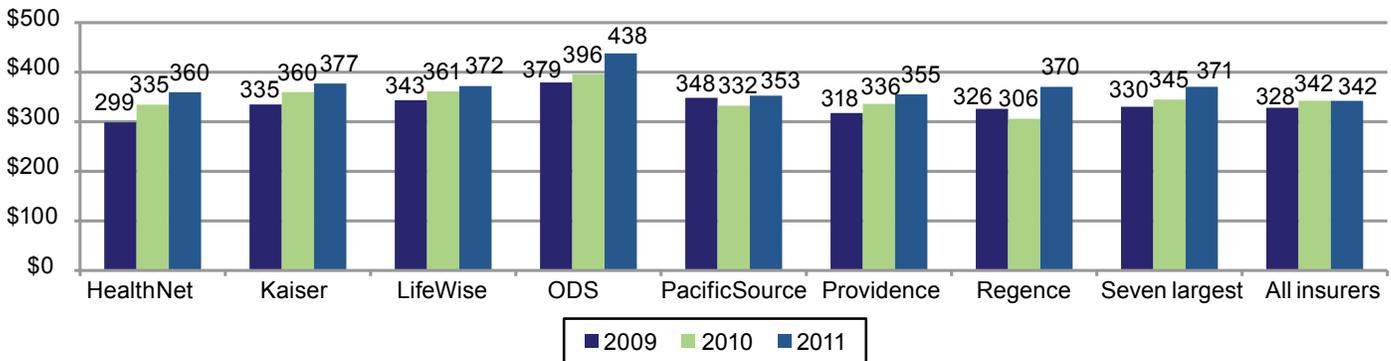
Figure 4-21. Market share by premium, large group market in 2011



Source: Oregon Insurance Division, 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 from \$345 in 2010 to \$371 in 2011.

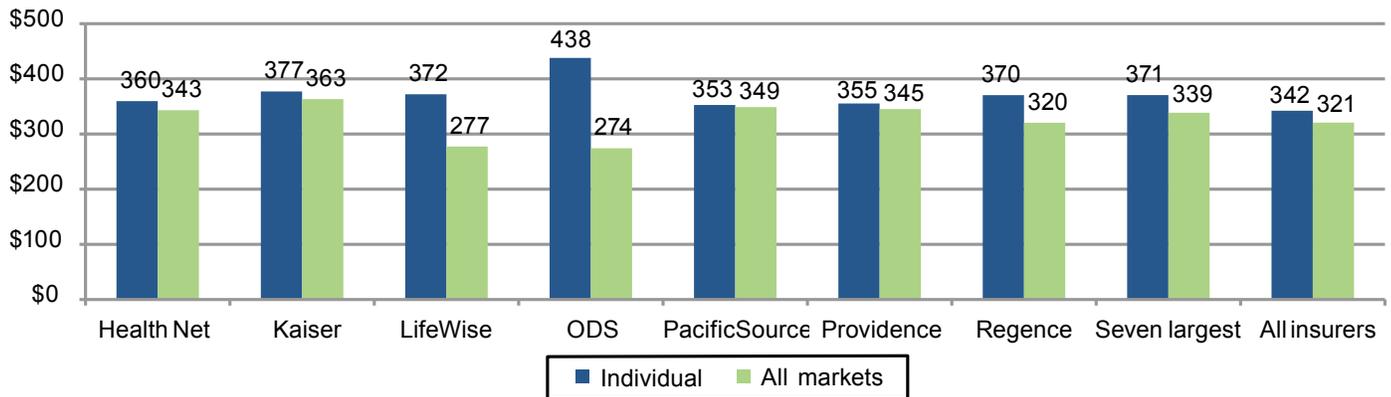
Figure 4-22. Average premium per member per month in large group plans from 2009 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.
 Note: Blanket student health plan policies were included in large group for the first time in 2011.

Figure 4-23 shows that the seven largest insurers' large group market average premium per member per month of \$371 is more than 9 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.

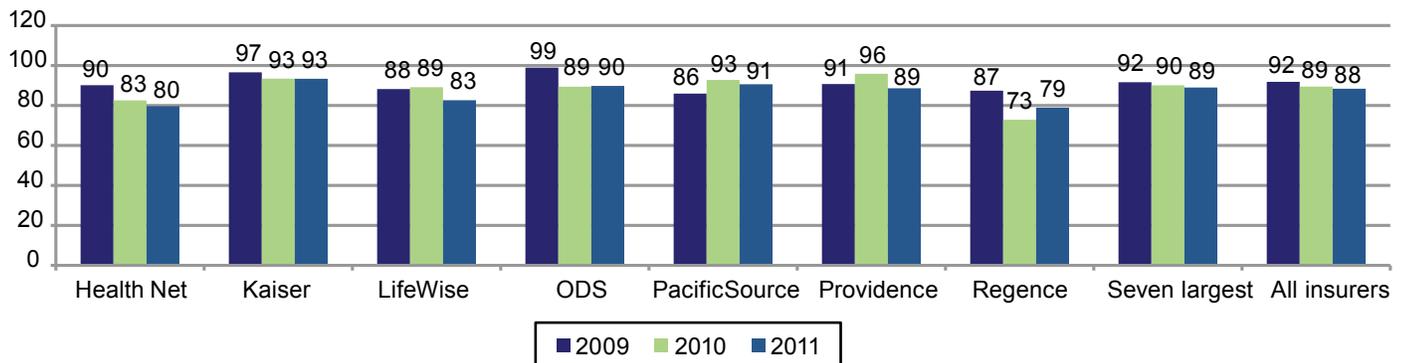
Figure 4-23. Average premium per member per month, large group vs. all markets in 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-24 shows that the seven largest insurers spent an average of 89 cents of every premium dollar on medical claims in 2011.

Figure 4-24. Medical loss ratios, large group plans from 2009 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

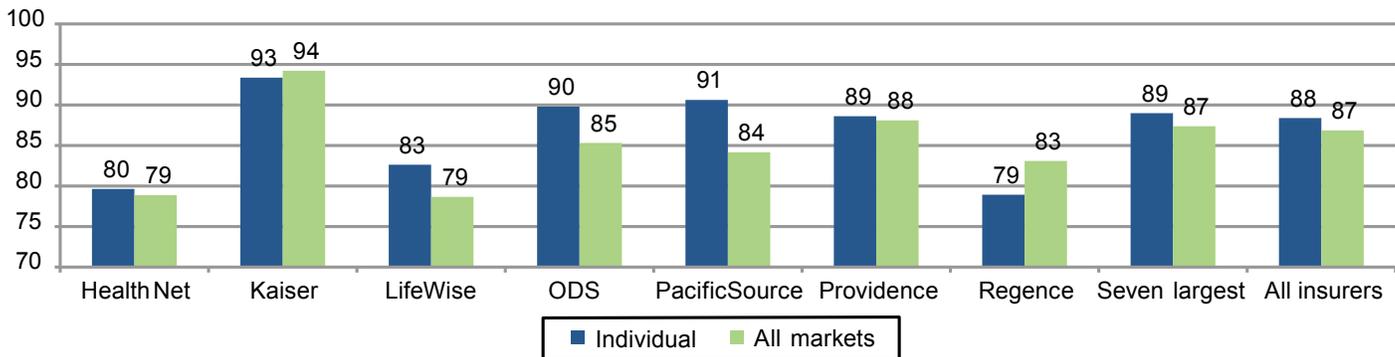
These calculations for medical loss ratio are different than those required by the federal government and cannot be used to determine if an insurance company owes a rebate.

Note: Blanket student health plan policies were included in large group for the first time in 2011.

Health Insurance in Oregon

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 2011



Source: Oregon Insurance Division, 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.

Associations and Trusts

Some employers and individuals purchase health insurance through associations. Associations can 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 division 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 2011. The average premium per member per month was \$313 for the seven largest insurers compared to \$306 for all insurers.

Figure 4-26. Seven largest insurers, associations in 2011

Insurer	Number of members	Premium earned*	Medical loss ratio	Average premium per member per month
Health Net	12,845	\$49.4	84%	\$322
Kaiser	32,562	\$120.0	92%	\$305
LifeWise	8,275	\$14.1	99%	\$262
ODS Health Plans	2,180	\$5.0	76%	\$290
PacificSource	13,277	\$59.4	77%	\$356
Providence	16,920	\$69.6	88%	\$344
Regence BCBS	9,855	\$40.0	80%	\$256
Total – above seven insurers	95,914	\$357.4	86%	\$313
Total – all insurers	110,218	\$425.3	87%	\$306

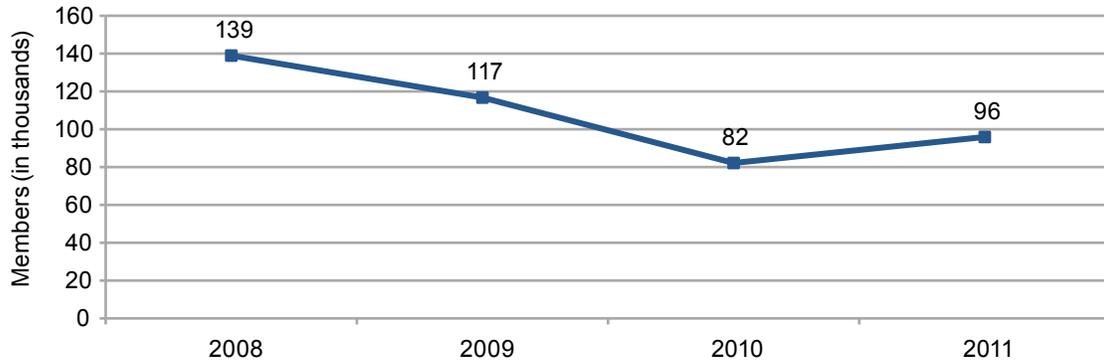
*Rounded in millions.

Source: Oregon Insurance Division, 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 an increase of more than 17 percent in association membership for Oregon’s seven-largest insurers in 2011.

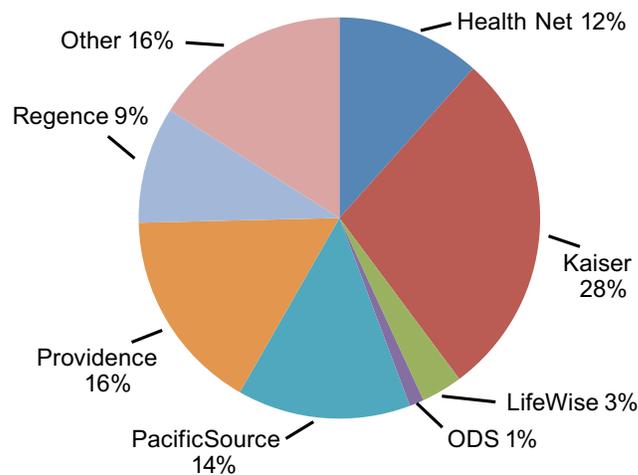
Figure 4-27. Associations and trusts, seven largest insurers, number of members, 2008 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-28 shows that in 2011, the seven largest insurers earned about 83 percent of all premiums in Oregon’s association market.

Figure 4-28. Market share by premium, associations and trusts market in 2011

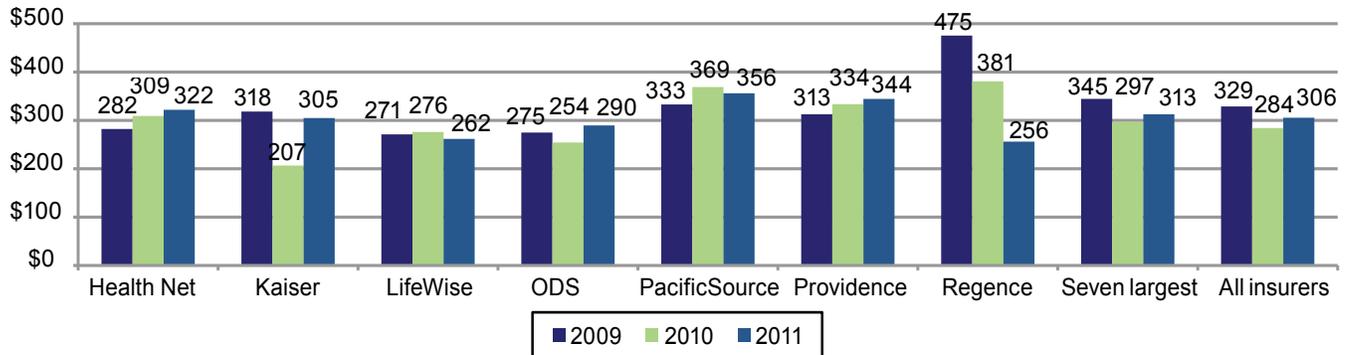


Source: Oregon Insurance Division, Health Benefit Plan Reports.
 Note: Percents do not add to 100 percent due to rounding.

Health Insurance in Oregon

Figure 4-29 shows that in 2011, average association plan premiums for Oregon's seven largest insurers were 2 percent higher than those of all insurers.

Figure 4-29. Average premium per member per month, association and trust plans from 2009 to 2011

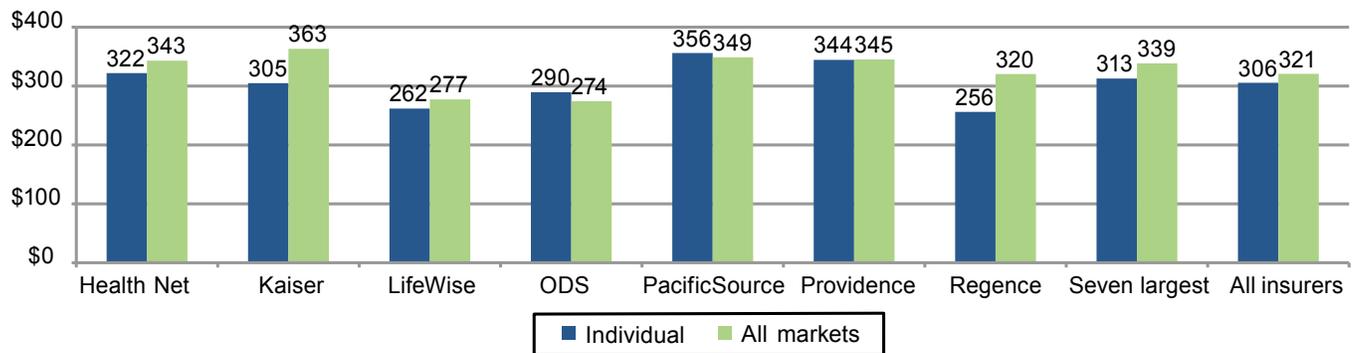


Source: Oregon Insurance Division, Health Benefit Plan Reports.

Note: In reporting year 2010, Regence BCBS corrected its 2009 reported figures, which differ from what was reported in prior years.

Figure 4-30 shows that in 2011, average premiums for associations and trusts were 8 percent lower than premiums for all markets.

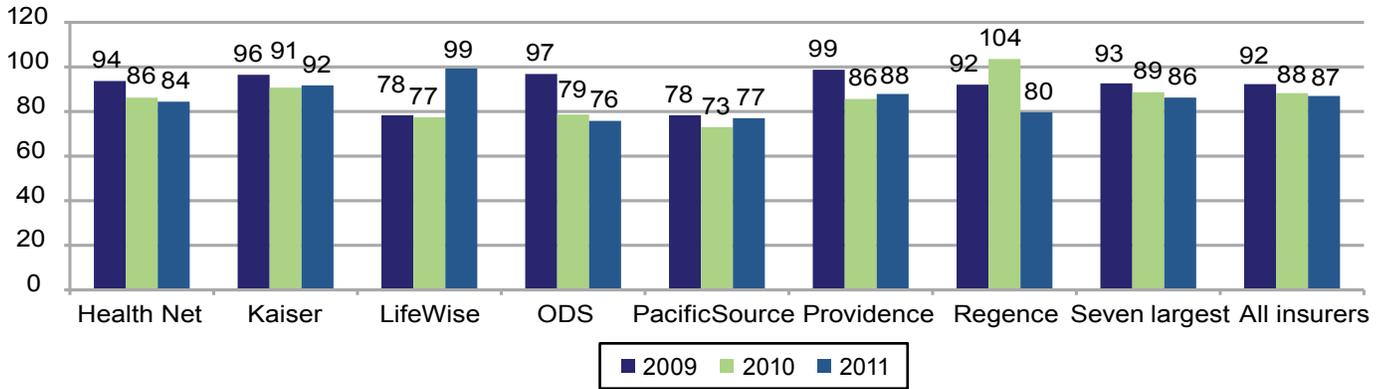
Figure 4-30. Average premium per member per month, associations and trusts vs. all markets in 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 4-31 shows that in 2011, Oregon’s seven largest insurers spent 86 cents of every association and trust premium dollar on medical claims, similar to that of all insurers.

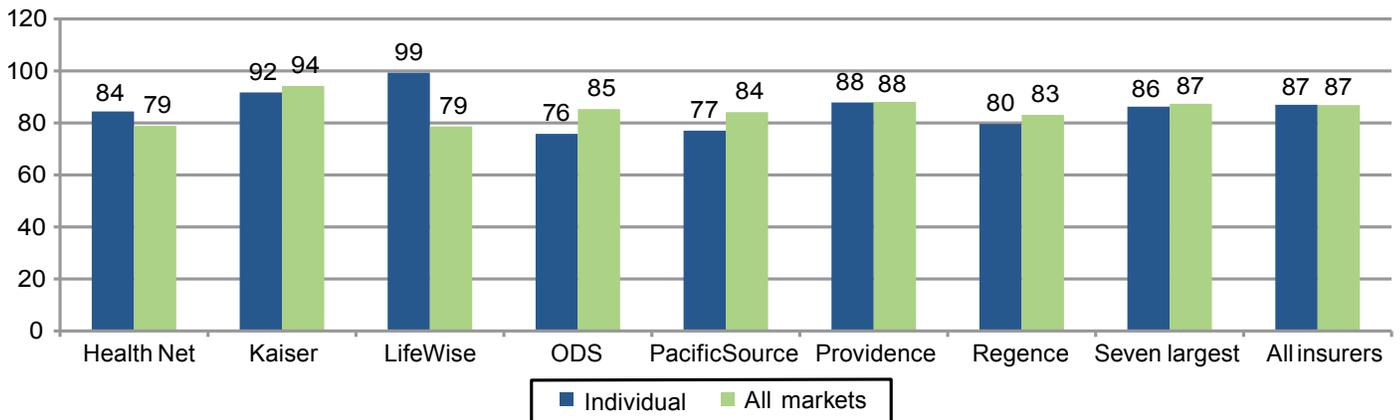
Figure 4-31. Medical loss ratios, associations and trusts from 2009 to 2011



Source: Oregon Insurance Division, 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 4-32 shows insurers spent about the same amount of the premium dollar to pay medical claims for associations and trusts as they did in other insurance markets.

Figure 4-32. Medical loss ratio, associations and trusts vs. all markets in 2011



Source: Oregon Insurance Division, 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.

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 Insurance Division 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 2011:

- Five insurers saw enrollment decreases with LifeWise Health Plan of Oregon, Inc., suffering the steepest loss of 12 percent. Enrollment growth for the remaining two insurers was a 2 percent increase for Providence and a 6 percent growth for PacificSource.
- Three insurers earned less in premiums in 2011 than in 2010, ranging from less than 1 percent to 11 percent.
- All seven companies reported a net gain in income after taxes.
- Only Regence showed a net underwriting loss, meaning it earned less in premiums than it paid in medical claims and total administrative expenses. Net underwriting loss is a measure of the earnings of a company's insurance business and doesn't take into account investments.
- Starting in 2010 and continuing in 2011 and 2012, 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 preceding 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 Advantage plans with care provided at participating facilities. Kaiser also offers point-of-service plans that provide additional locations where enrollees can receive care.

Figure 5-1 shows that Kaiser Foundation Health Plan of the Northwest insured more than 317,000 Oregonians in 2011, about the same as in 2010. Kaiser's approximately \$1.4 billion in Oregon premiums in 2011 was up 7 percent from 2010. However, net income was down 16 percent compared to 2010.

Figure 5-1. Kaiser Foundation Health Plan of the Northwest, 2011 financial data

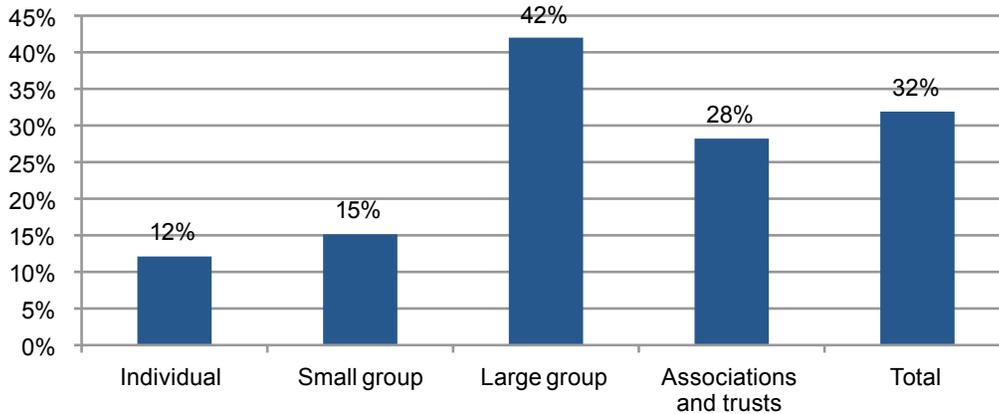
Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	15,469	\$56,372,528	122%	\$314
Small group	32,694	\$134,664,717	92%	\$343
Large group	236,470	\$1,069,092,813	93%	\$377
Associations and trusts	32,562	\$119,980,983	92%	\$305
Total for all markets above	317,195	\$1,380,111,041	94%	\$363
Nationwide for 2011*				
Total surplus.....		\$490,570,548		
Total unpaid claims reserves.....		\$39,157,319		
Net underwriting gain or loss.....		\$11,313,194		
Net income after taxes.....		\$33,004,427		
Oregon Medical Insurance Pool assessment.....		\$14,361,162		
Total general administrative expense.....		\$146,337,443		
Nationwide for 2011				
Largest nonmedical administrative expenses.....			Total year-end	
Salaries, wages, and other benefits.....			\$77,421,614	
Other taxes, licenses and fees.....			\$19,341,893	
Commissions.....			\$17,901,955	
Marketing and advertising.....			\$3,956,184	
Rent (occupancy).....			\$3,462,189	

Source: Oregon Insurance Division, Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, such as Medicare, is included.

Figure 5-2 shows Kaiser’s overall market share and its market share in each market segment. Kaiser earned 32 percent of all premiums in 2011 in four key Oregon health insurance markets. Kaiser had 12 percent of the individual market, 15 percent of the small group market, 42 percent of the large group market, and 28 percent of the associations and trusts market.

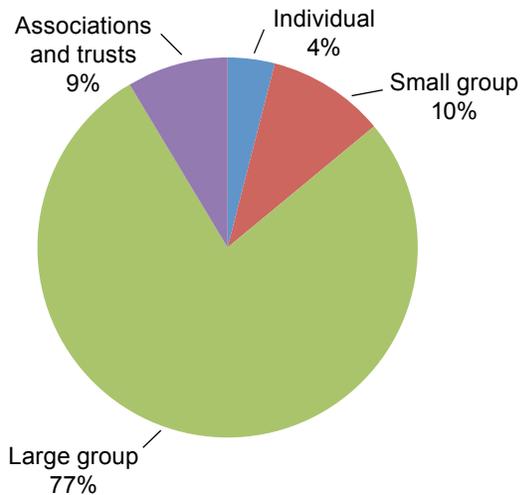
Figure 5-2. Kaiser, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-3 provides a breakdown by market segment of Kaiser premiums. Kaiser earned 77 percent of its premiums from the large group market.

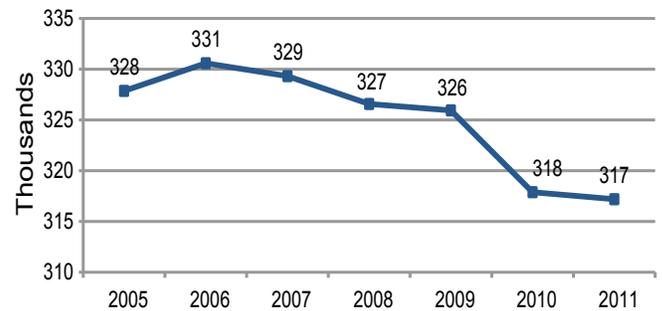
Figure 5-3. Kaiser, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-4 shows enrollment losses for Kaiser since 2006.

Figure 5-4. Kaiser, number of members, 2005 to 2011

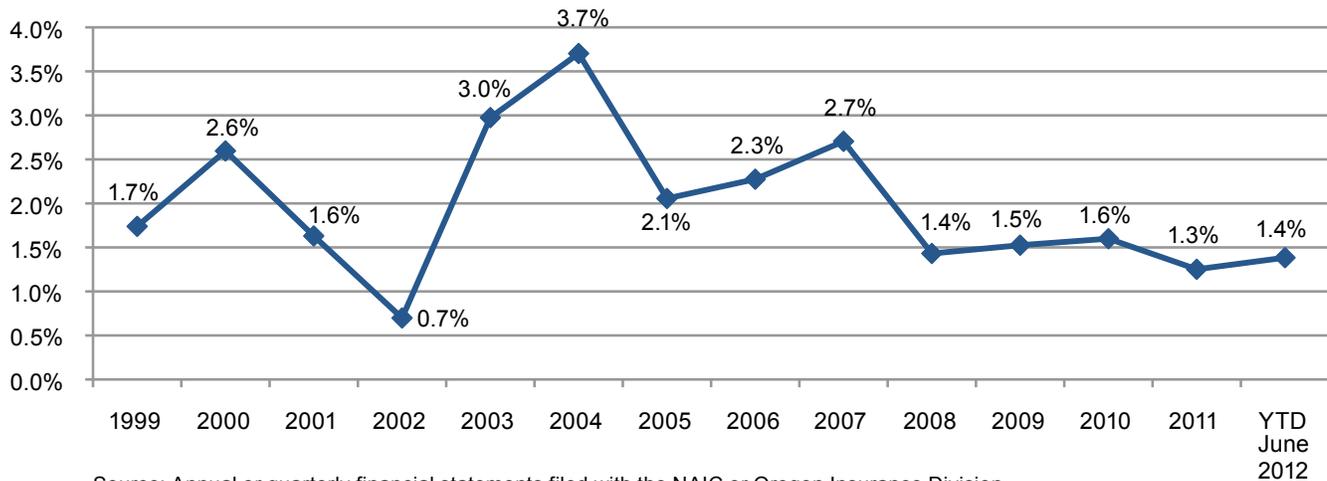


Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 5-5 shows that Kaiser's net income is down compared to pre-recession levels.

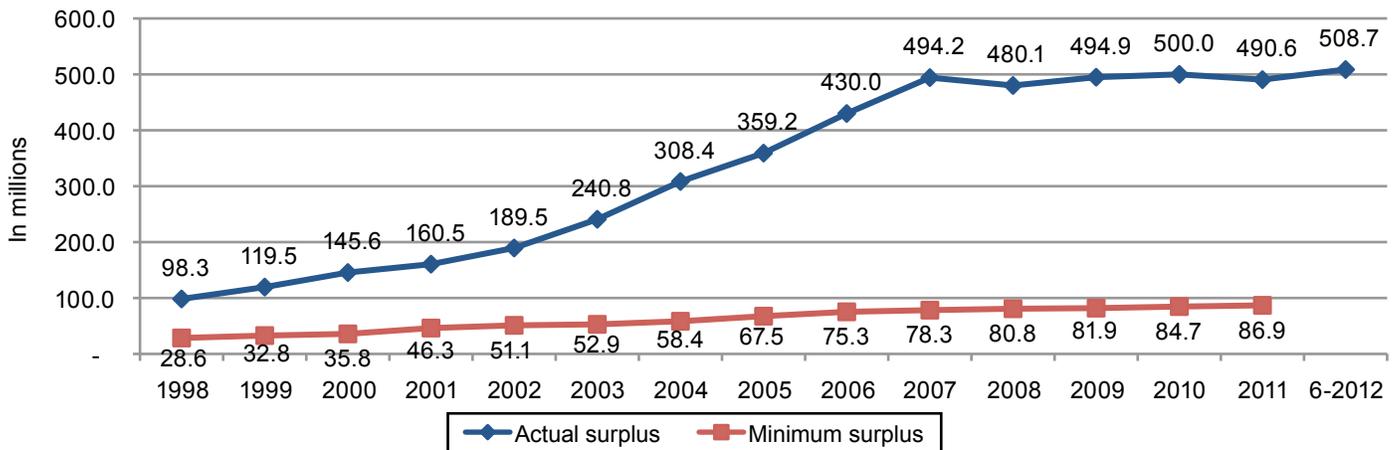
Figure 5-5. Kaiser profitability, net income to earned premium 1999 to June 2012



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

Figure 5-6 shows that Kaiser's surplus decreased 2 percent in 2011 but remains above the minimum required surplus.

Figure 5-6. Kaiser, surplus trend, actual and minimum required from 1998 to June 30, 2012



Source: National Association of Insurance Commissioners (NAIC) annual and quarterly financial statement filings.

Note: The minimum surplus required is not available for June 2012.

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
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%
2012	4.90%	4.30%	5.40%
2008-2012	35.14%	45.94%	34.18%

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 the national association establishes 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 203,000 Oregonians in its health plans in 2011. This is down about 1 percent from 2010. Regence generated nearly \$795 million in Oregon premium in 2011, an increase of less than 1 percent from 2010.

Figure 5-8. Regence BlueCross BlueShield, 2011 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	59,281	\$169,471,131	92%	\$229
Small group	45,193	\$216,016,756	84%	\$369
Large group	89,235	\$369,298,972	79%	\$370
Associations and trusts	9,855	\$39,970,394	80%	\$256
Total for all markets above	203,564	\$794,757,253	83%	\$320
Nationwide for 2011*				
Total surplus.....			\$522,000,538	
Total unpaid claims reserves.....			\$200,851,580	
Net underwriting gain or loss.....			-\$17,311,815	
Net income after taxes.....			\$6,932,273	
Oregon Medical Insurance Pool assessment.....			\$10,686,197	
Total general administrative expense.....			\$142,884,910	
Nationwide for 2011				
Largest nonmedical administrative expenses.....			Total year-end	
Salaries, wages, and other benefits.....			\$67,169,007	
Commissions.....			\$27,093,374	
Other taxes, licenses, and fees.....			\$24,972,361	
Cost depreciation: equipment, software, furniture, etc.....			\$14,518,922	
Third-party administration expenses or fees and other group services or fees.....			\$13,074,240	

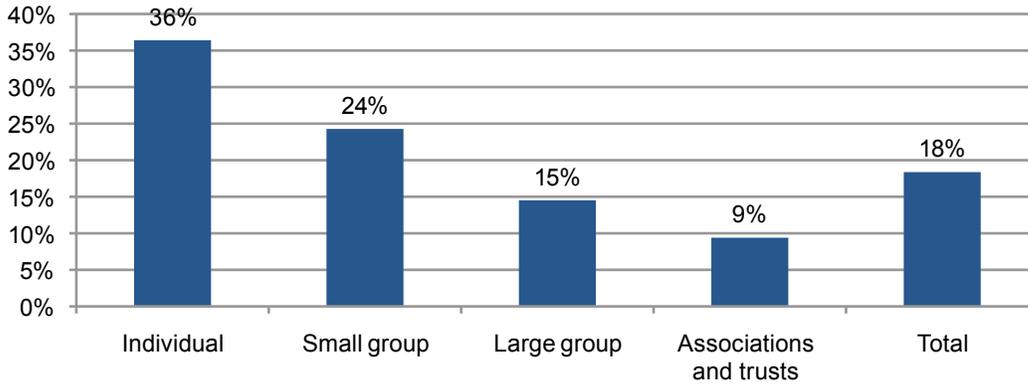
Source: Oregon Insurance Division, 2011 Health Benefit Plan Reports.

*Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, such as Medicare, is included.

Health Insurance in Oregon

Figure 5-9 shows Regence’s overall market share and its market share in each market segment. Regence earned 18 percent of all premiums in 2011 in four key Oregon health insurance markets. Regence had 36 percent of the individual market, 24 percent of the small group market, 15 percent of the large group market, and 9 percent of the associations and trusts market.

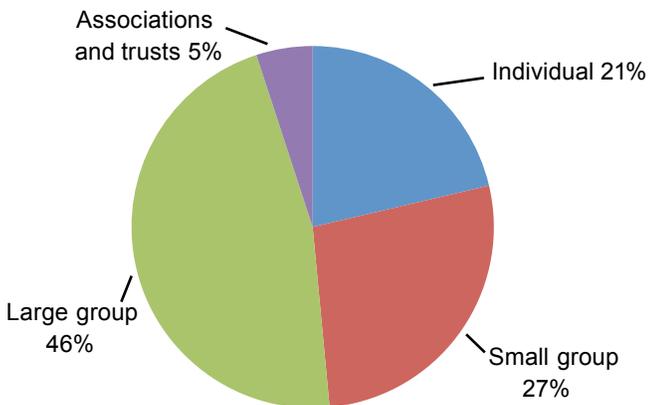
Figure 5-9. Regence, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-10 provides a breakdown by market segment of Regence premiums. Regence earned nearly half of its premiums from large group market.

Figure 5-10. Regence, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

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

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

Figure 5-11. Regence, number of members, 2005 to 2011

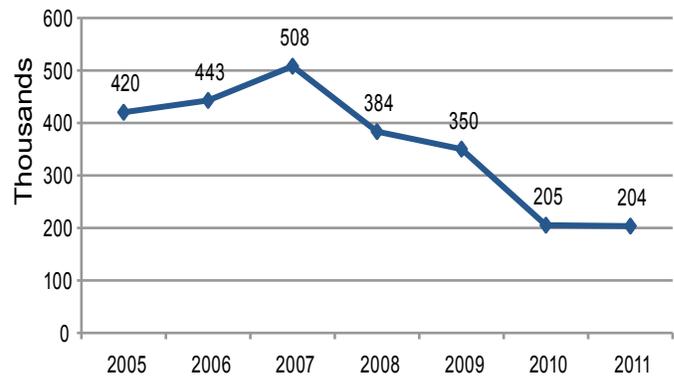


Figure 5-12 shows that Regence’s profitability decreased in 2011. Regence reported net underwriting losses from 2007 to 2009 and again in 2011, contributing to lower net income in those years.

Figure 5-12. Regence profitability, net income to earned premium 1999 to June 2012

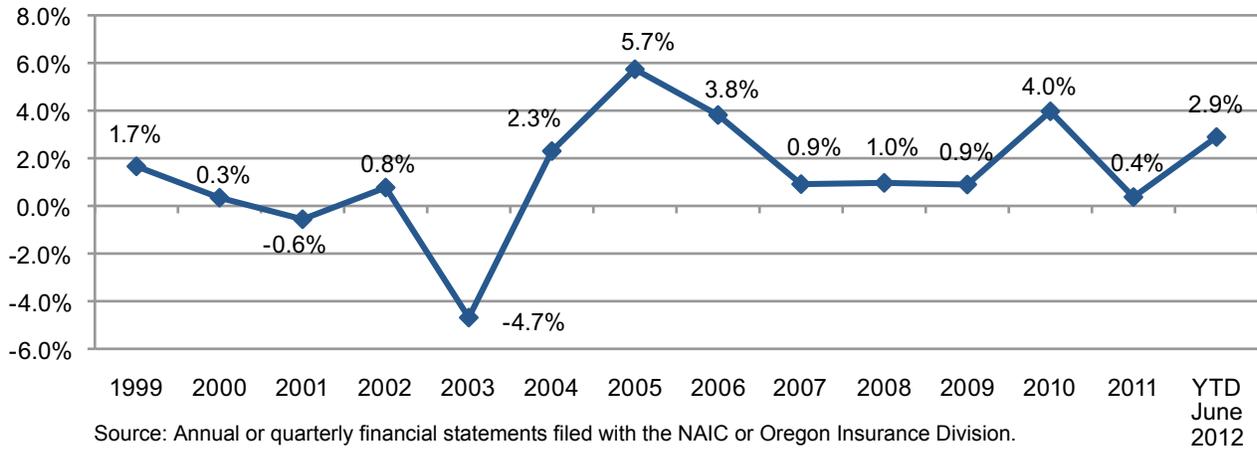


Figure 5-13 shows that Regence’s surplus decreased by about 4 percent in 2011, due in part to a \$56 million distribution to its nonprofit parent company in late 2011. Through June 2012, however, surplus was up 8 percent from 2011. Regence’s surplus remains above the minimum required surplus.

Figure 5-13. Regence, surplus trend, actual and minimum required from 1998 to June 30, 2012

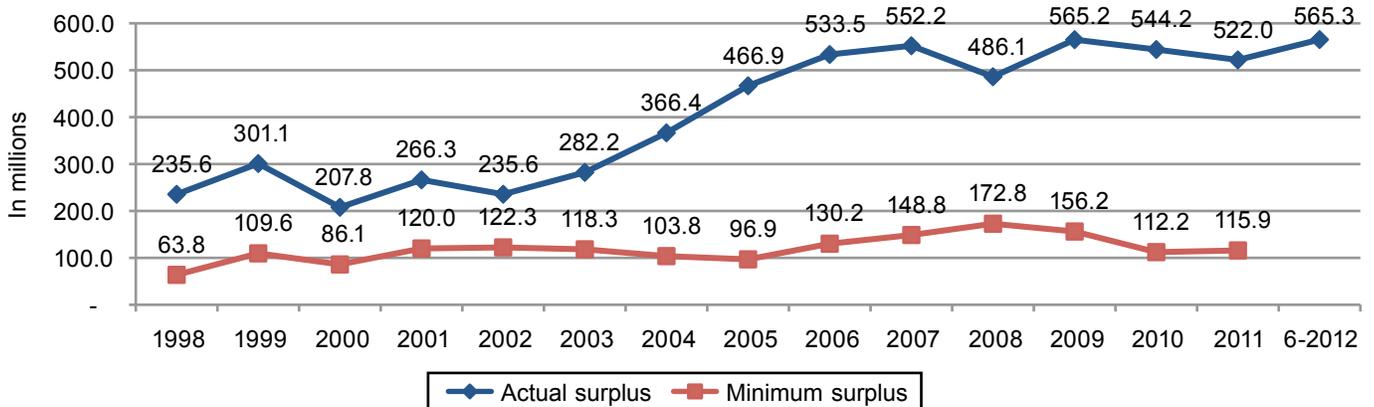


Figure 5-14 shows Regence’s five-year history of rate changes in health insurance markets the state regulates.

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

Year	Individual plans	Small employer plans	Portability plans
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%
2012	8.90%	7.30%	7.40%
2008-2012	109.21%	70.11%	82.15%

Source: Data were obtained from rate filings.

Providence Health Plan of Oregon, Inc.

Providence is an Oregon-based, nonprofit plan sponsored by Providence Health and Services. 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 137,000 Oregonians in its health plans in 2011. That is up 2 percent from 2010. Providence generated more than \$583 million in Oregon premiums in 2011, up nearly 7 percent from 2010.

Figure 5-15. Providence Health Plan, Oregon 2011 financial data

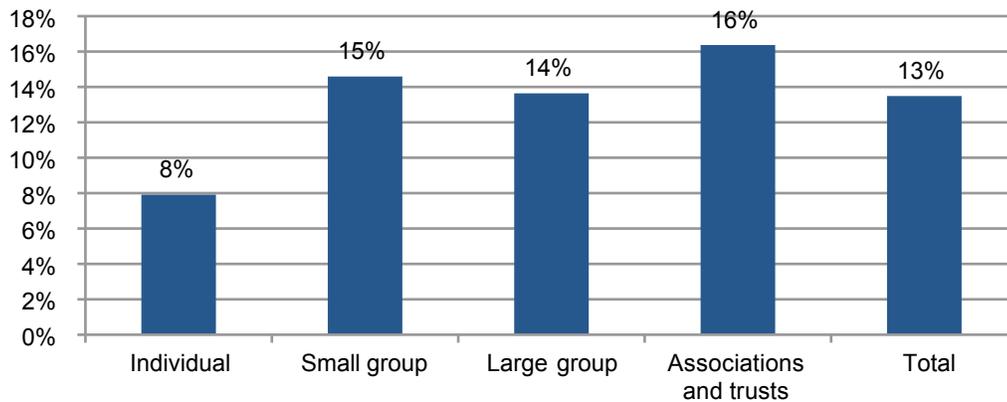
Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	13,047	\$36,841,611	94%	\$245
Small group	30,422	\$129,804,661	85%	\$360
Large group	77,115	\$347,181,330	89%	\$355
Associations and trusts	16,920	\$69,615,944	88%	\$344
Total for all markets above	137,504	\$583,443,546	88%	\$345
Nationwide for 2011*				
Total surplus.....		\$431,504,027		
Total unpaid claims reserves.....		\$75,023,953		
Net underwriting gain or loss		\$42,217,001		
Net income after taxes		\$68,956,244		
Oregon Medical Insurance Pool assessment.....		\$6,597,262		
Total general administrative expense		\$47,030,726		
Nationwide for 2011				
Largest nonmedical administrative expenses.....		Total year-end		
Salaries, wages, and other benefits		\$15,544,061		
Commissions.....		\$13,199,240		
Third-party administration expenses or fees or other group service expenses or fees		\$6,559,482		
Marketing and advertising		\$6,206,726		
Other taxes, licenses and fees		\$6,125,518		

Source: Oregon Insurance Division, Health Benefit Plan Reports.

Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, 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 four key Oregon health insurance markets. Providence had 8 percent of the individual market, 15 percent of the small group market, 14 percent of the large group market, and 16 percent of the associations and trusts market.

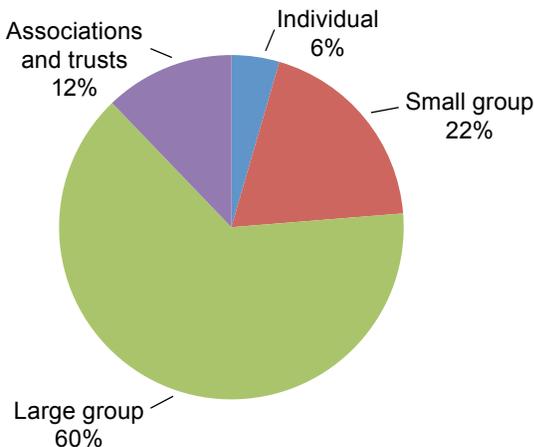
Figure 5-16. Providence, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-17 provides a breakdown of Providence premiums by market segment. In 2011, Providence earned 60 percent of its premiums from the large group market.

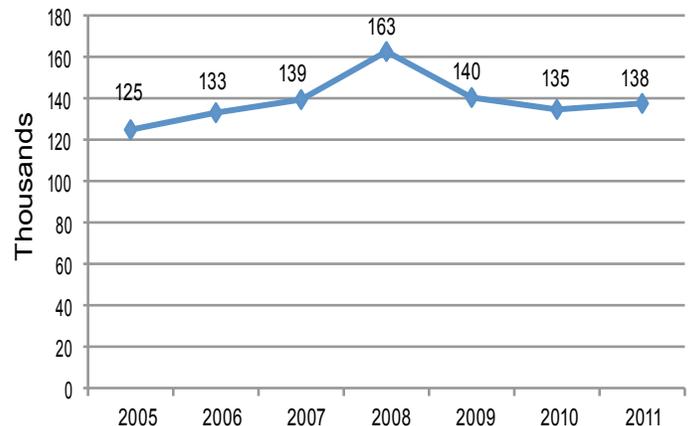
Figure 5-17. Providence, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-18 shows enrollment growing for Providence for the first time since 2008.

Figure 5-18. Providence, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 5-19 shows that after losing money in 2008, Providence's profitability has 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 2012

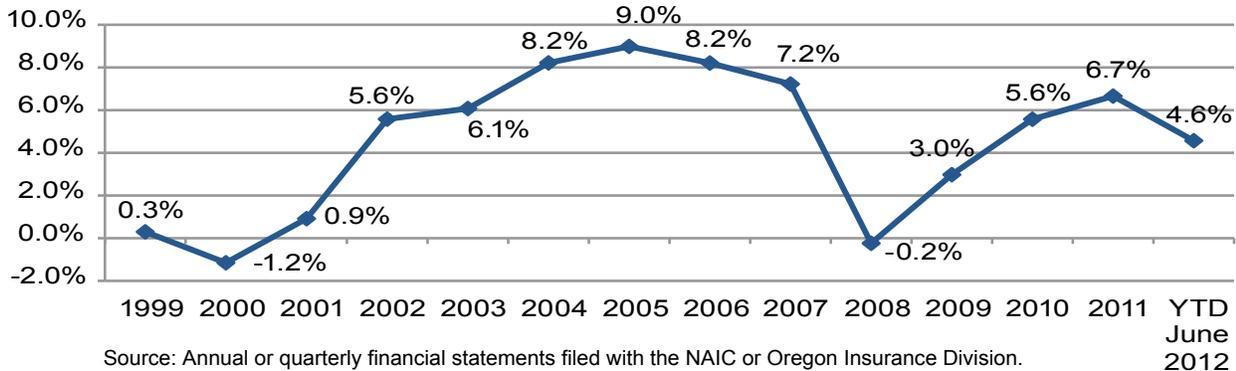


Figure 5-20 shows that Providence's surplus increased by about 3 percent in 2011 and was up 4 percent after the first six months of 2012. In 2011, Providence distributed \$53 million to its nonprofit parent company to support an electronic medical records system. Providence's surplus remains above required surplus levels.

Figure 5-20. Providence, surplus trend, actual and minimum required from 1998 to June 30, 2012

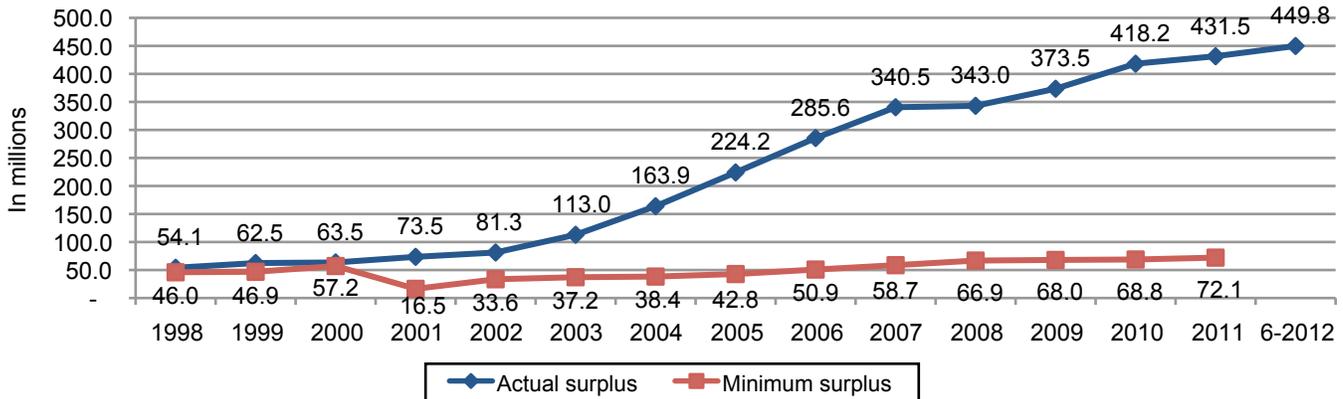


Figure 5-21 shows Providence's five-year history of rate changes in health insurance markets the state regulates.

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

Year	Individual plans	Small employer plans	Portability plans	
			Large group	Small group
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%
2012	12.20%	2.20%	6.00%	9.50%
2008-2012	75.57%	24.96%	32.32%	46.00%

Source: Data were obtained from rate filings.

PacificSource Health Plans

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, Washington, and Montana.

Figure 5-22 shows that PacificSource had more than 139,000 Oregonians enrolled in health plans in 2011, up 6 percent from 2010. PacificSource generated more than \$564 million in Oregon premiums, up nearly 8 percent from 2010.

Figure 5-22. PacificSource Health Plans, 2011 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	13,926	\$27,921,782	73%	\$170
Small group	31,657	\$153,419,001	75%	\$415
Large group	80,471	\$323,503,706	91%	\$353
Associations and trusts	13,277	\$59,382,323	77%	\$356
Total for all markets above	139,331	\$564,226,812	84%	\$349
Nationwide for 2011*				
Total surplus.....				\$125,718,050
Total unpaid claims reserves.....				\$51,946,409
Net underwriting gain or loss				\$9,307,994
Net income after taxes				\$10,919,667
Oregon Medical Insurance Pool assessment.....				\$6,225,201
Total general administrative expense				\$72,191,308
Nationwide for 2011				
Largest nonmedical administrative expenses.....				Total year-end
Salaries, wages, and other benefits				\$19,031,408
Commissions.....				\$17,962,120
Cost depreciation: equipment, software, furniture, etc.....				\$8,901,218
Legal fees, expenses, and other professional or consulting fees				\$6,453,762
Other taxes, licenses and fees				\$6,428,694

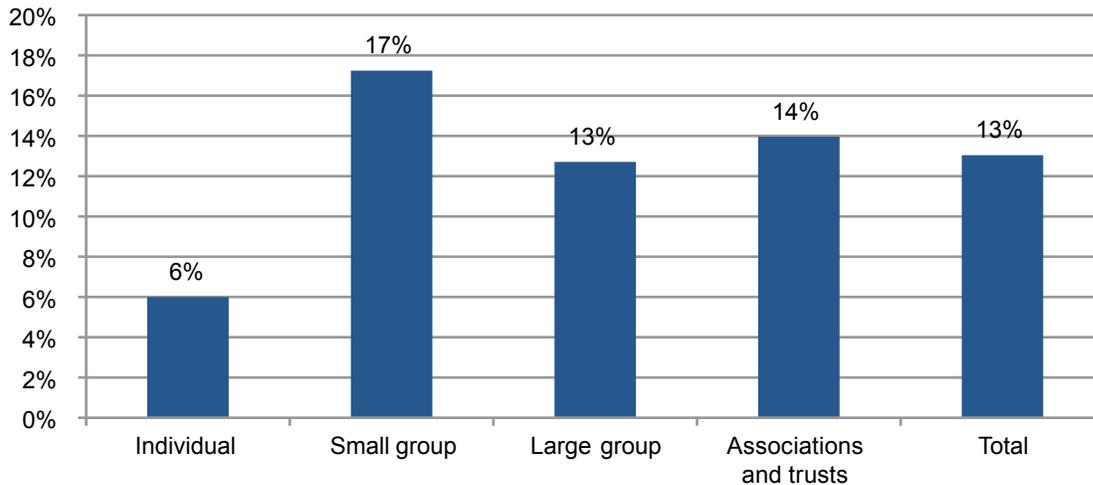
Source: Oregon Insurance Division, Health Benefit Plan Reports.

Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, such as Medicare, is included.

Health Insurance in Oregon

Figure 5-23 shows PacificSource’s overall market share and its market share in each market segment. PacificSource earned 13 percent of all premiums in 2011 in four key Oregon health insurance markets. PacificSource had 6 percent of the individual market, 17 percent of the small group market, 13 percent of the large group market, and 14 percent of the associations and trusts market.

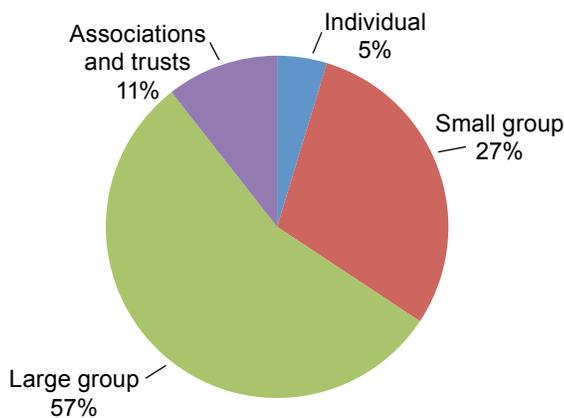
Figure 5-23. PacificSource, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-24 provides a breakdown of PacificSource premiums by market segment. In 2011, PacificSource earned more than half of its premiums from the large group market.

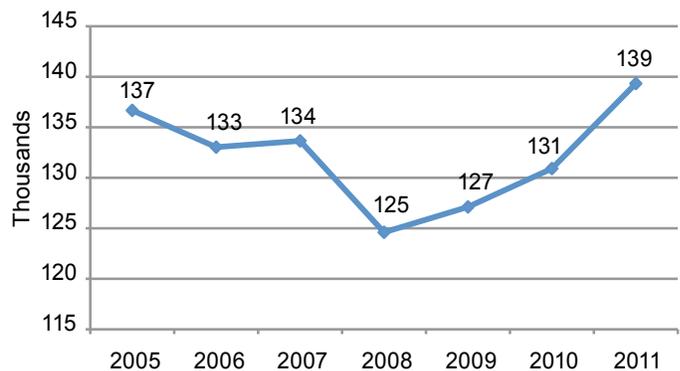
Figure 5-24. PacificSource, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-25 shows that PacificSource enrollment has climbed three years straight, and now exceeds its pre-recession levels.

Figure 5-25. PacificSource, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-26 shows PacificSource’s profitability improving from 2008 through 2011. The first half of 2012, however, PacificSource lost money.

Figure 5-26. PacificSource profitability, net income to earned premium 1999 to June 2012

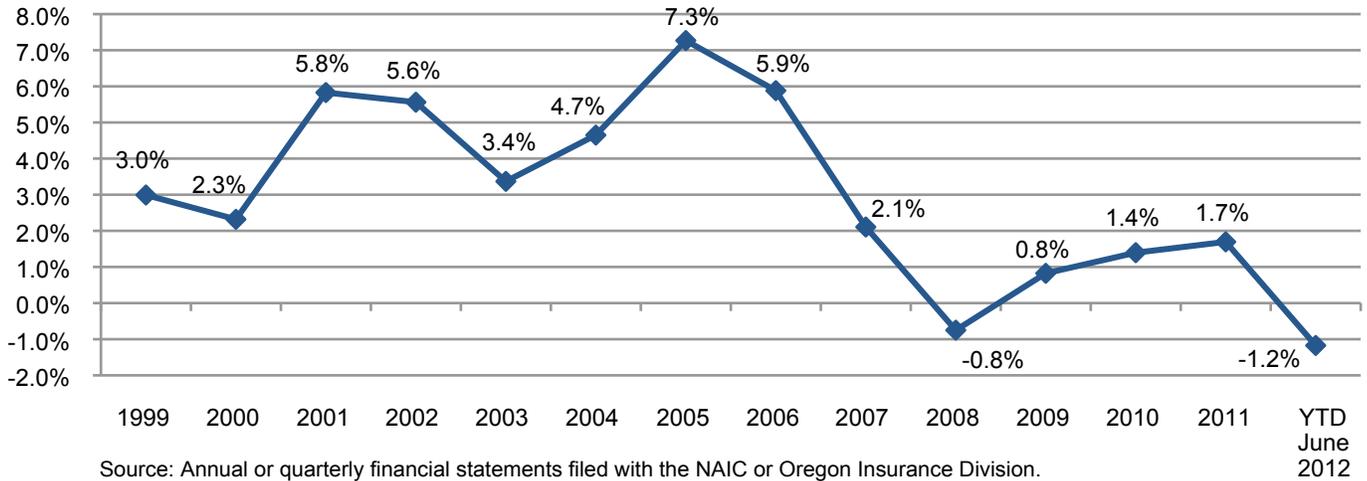


Figure 5-27 shows that PacificSource’s surplus has increased by about 10 percent through June 2012 from 2010. PacificSource’s surplus exceeds the minimum required surplus.

Figure 5-27. PacificSource, surplus trend, actual and minimum required from 1998 to June 30, 2012

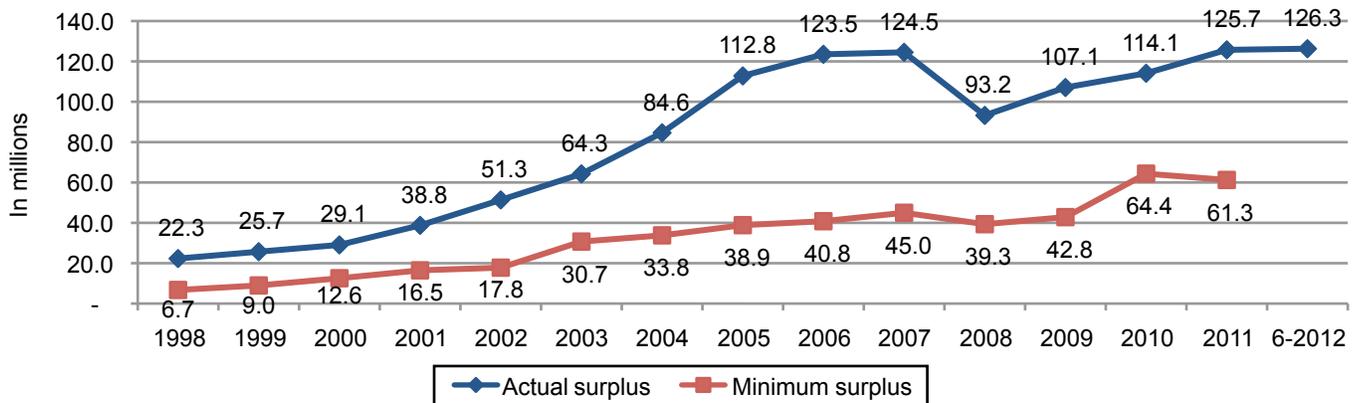


Figure 5-28 shows PacificSource’s five-year history of rate changes in health insurance markets the state regulates.

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

Year	Individual plans	Small employer plans	Portability plans
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%
2012	3.90%	4.20%	3.40%
2008-2012	88.95%	62.15%	75.86%

Source: Data were obtained from rate filings.

Health Insurance in Oregon

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 more than 80,000 Oregonians in its health plans in 2011, down nearly 5 percent from 2010. Health Net's approximately \$333 million in Oregon premium was down about 4 percent from the prior year, although net income was up 29 percent.

Figure 5-29. Health Net Health Plan of Oregon, 2011 financial data

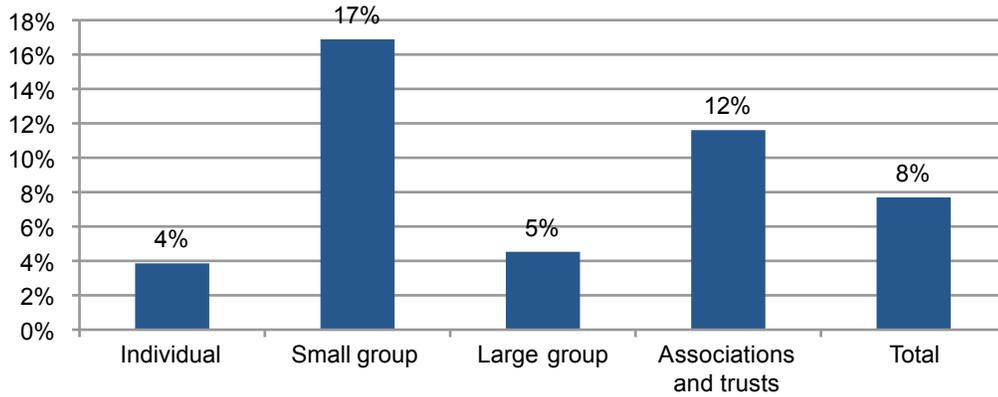
Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	4,190	\$17,951,881	82%	\$305
Small group	36,751	\$150,212,147	76%	\$344
Large group	26,704	\$115,288,687	80%	\$360
Associations and trusts	12,845	\$49,359,496	84%	\$322
Total for all markets above	80,490	\$332,812,211	79%	\$343
Nationwide for 2011*				
Total surplus.....				\$69,990,980
Total unpaid claims reserves.....				\$29,499,155
Net underwriting gain or loss.....				\$27,376,187
Net income after taxes.....				\$21,486,203
Oregon Medical Insurance Pool assessment.....				\$3,584,213
Total general administrative expense.....				\$36,134,004
Nationwide for 2011				
Largest nonmedical administrative expenses.....				Total year-end
Salaries, wages, and other benefits.....				\$10,990,232
Commissions.....				\$9,981,828
Other taxes, licenses, and fees.....				\$7,380,184
Legal fees, expenses, and other professional or consulting fees.....				\$1,627,864
General office expenses: sundries, supplies, phones, printing, postage, etc.....				\$1,572,124

Source: Oregon Insurance Division, Health Benefit Plan Reports.

Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, 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 2011 in four key 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.

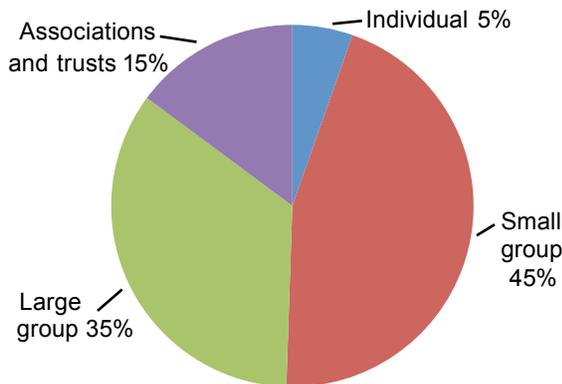
Figure 5-30. Health Net, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-31 provides a breakdown by market segment of Health Net premiums. Health Net earned 45 percent of its premiums from the small group market.

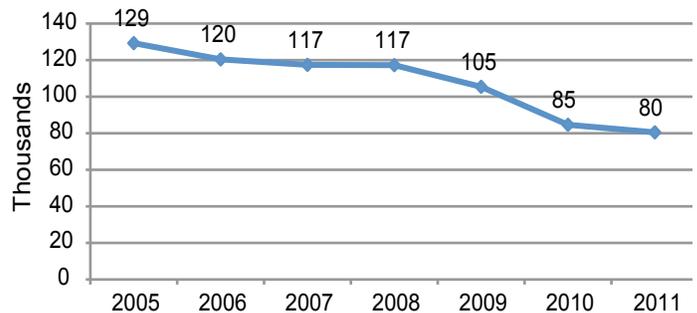
Figure 5-31. Health Net, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

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

Figure 5-31. Health Net, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 5-33 shows that Health Net's profit of 6.1 percent in 2011 was its best in more than a decade.

Figure 5-33. Health Net profitability, net income to earned premium 1999 to June 2012

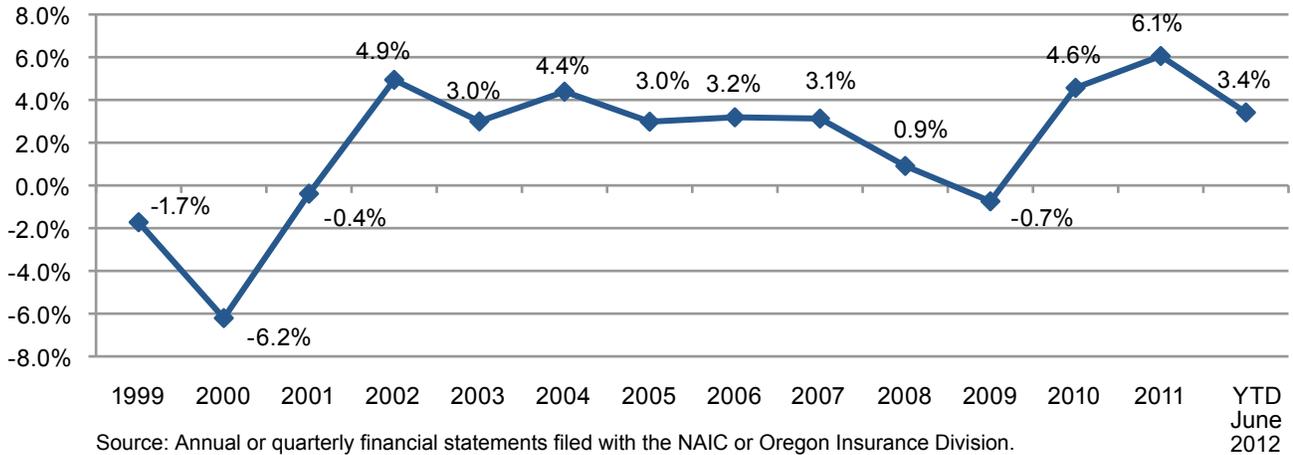
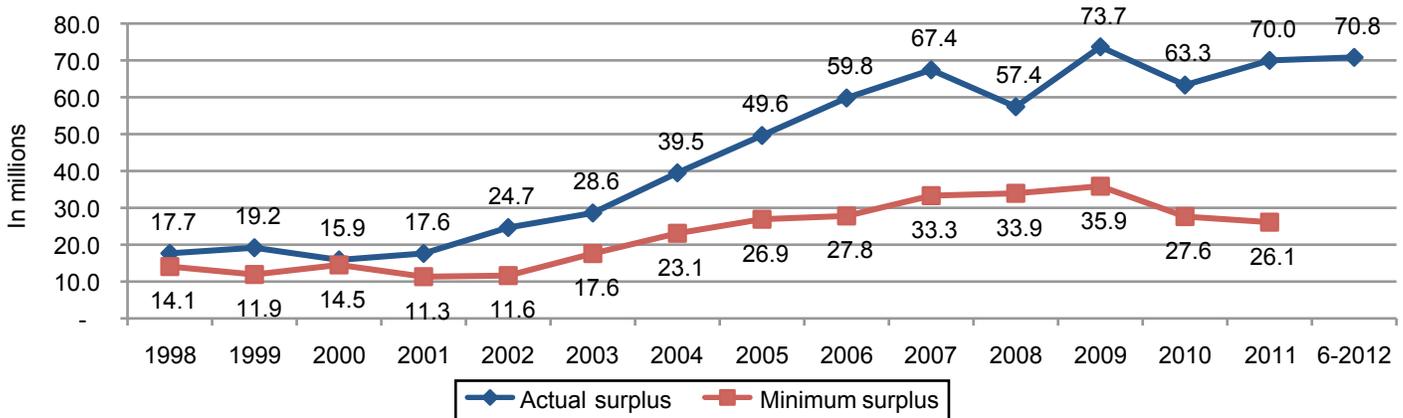


Figure 5-34 shows that Health Net's surplus increased by approximately 11 percent in 2011. The company paid stockholders \$9 million in dividends in September 2011 and \$6 million in dividends in 2011. Through June 2012, surplus was up slightly. Health Net's surplus remains above the minimum required amounts.

Figure 5-34. Health Net, surplus trend, actual and minimum required from 1998 to June 30, 2012



Source: National Association of Insurance Commissioners (NAIC) annual and quarterly financial statement filings.

Note: The minimum surplus required is not available for June 2012.

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
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%
2012	6.30%	1.40%	3.50%
2008-2012	67.61%	41.91%	69.54%

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 58,000 Oregonians in 2011, down nearly 4 percent from 2010. ODS generated nearly \$190 million in Oregon premiums in 2011, nearly the same as in 2010.

Figure 5-36. ODS Health Plan, 2011 financial data

Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	28,392	\$52,232,079	78%	\$158
Small group	8,011	\$28,135,564	83%	\$265
Large group	19,132	\$104,270,252	90%	\$438
Associations and trusts	2,180	\$4,951,899	76%	\$290
Total for all markets above	57,715	\$189,589,794	85%	\$274
Nationwide for 2011*				
Total surplus.....				\$80,826,023
Total unpaid claims reserves.....				\$22,484,000
Net underwriting gain or loss.....				\$2,130,051
Net income after taxes.....				\$5,861,685
Oregon Medical Insurance Pool assessment.....				\$3,110,155
Total general administrative expense.....				\$10,279,235
Nationwide for 2011				
Largest nonmedical administrative expenses.....				Total year-end
Salaries, wages, and other benefits.....				\$16,784,790
Cost depreciation: equipment, software, furniture, etc.....				\$6,850,004
Commissions.....				\$6,712,657
Other taxes, licenses and fees.....				\$2,288,699
Third-party administration expenses or fees and other group service expenses or fees.....				\$1,413,184

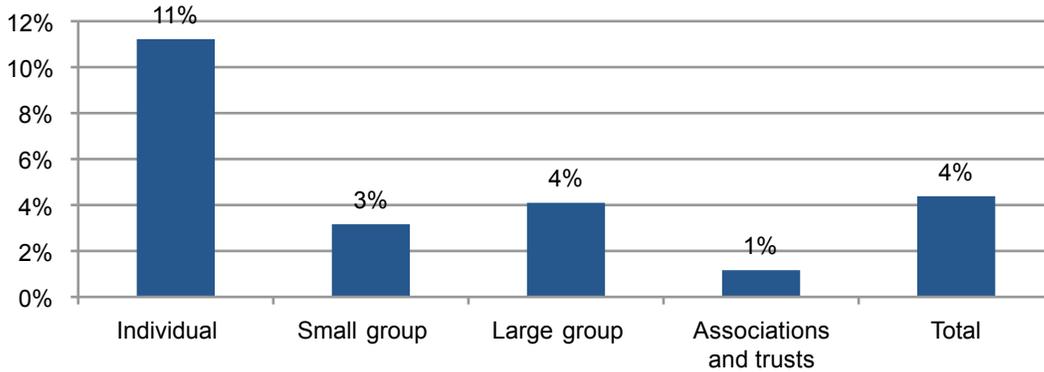
Source: Oregon Insurance Division, Health Benefit Plan Reports.

Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, such as Medicare, is included.

Health Insurance in Oregon

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 2011 in four key Oregon health insurance markets. ODS had 11 percent of the individual market, 3 percent of the small group market, 4 percent of the large group market, and 1 percent of the associations and trust market.

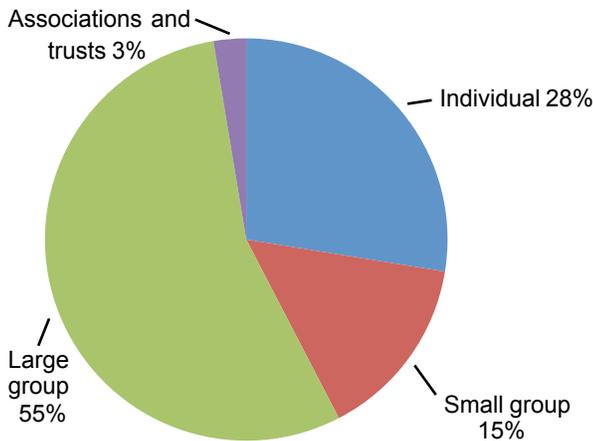
Figure 5-37. ODS, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-38 provides a breakdown by market segment of ODS premiums. ODS earned 55 percent of its premiums from the large group market.

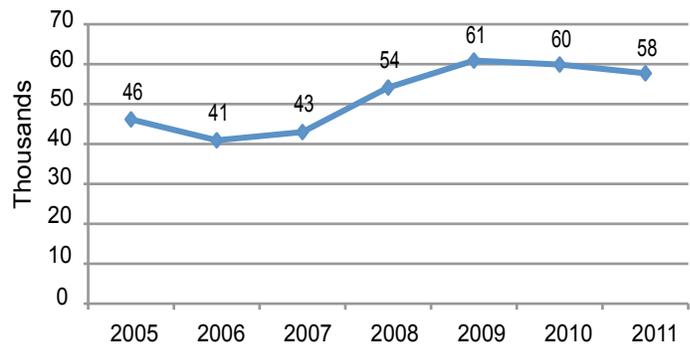
Figure 5-38. ODS, premium as percent of its Oregon 2011 business



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

Figure 5-39 shows ODS enrollment declining slightly since 2009.

Figure 5-39. ODS, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-40 shows ODS was more profitable in 2011 than 2010.

Figure 5-40. ODS profitability, net income to earned premium 1999 to June 2012

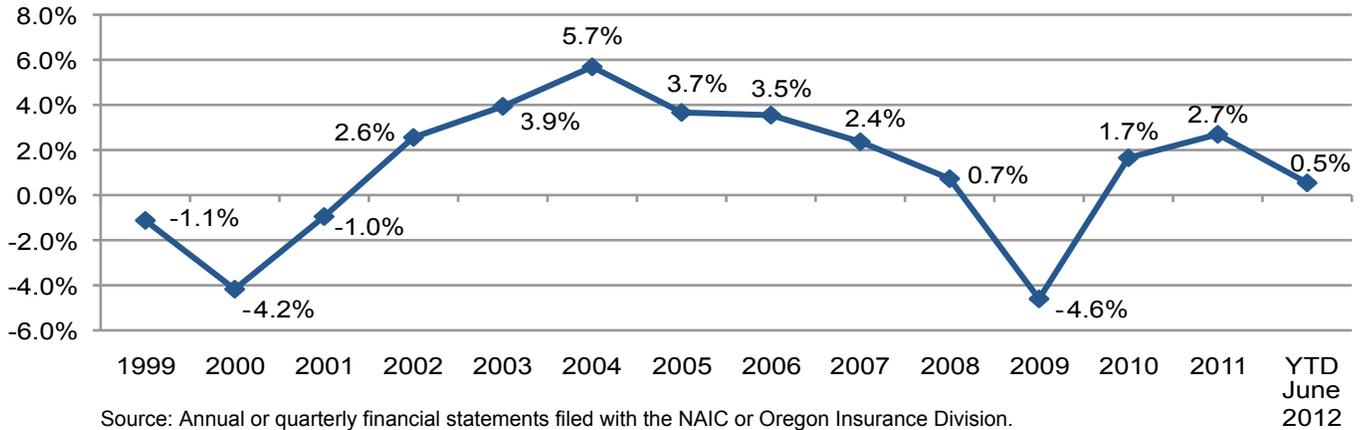


Figure 5-41 shows that ODS increased surplus by approximately 5 percent in 2011. (The sharp increase in 2009 was primarily the result of issuing surplus notes, a type of indebtedness, totaling \$23 million.) Through June 2012, surplus was down 15 percent from 2011. The company’s surplus exceeds the minimum required surplus.

Figure 5-41. ODS, surplus trend, actual and minimum required from 1998 to June 30, 2012

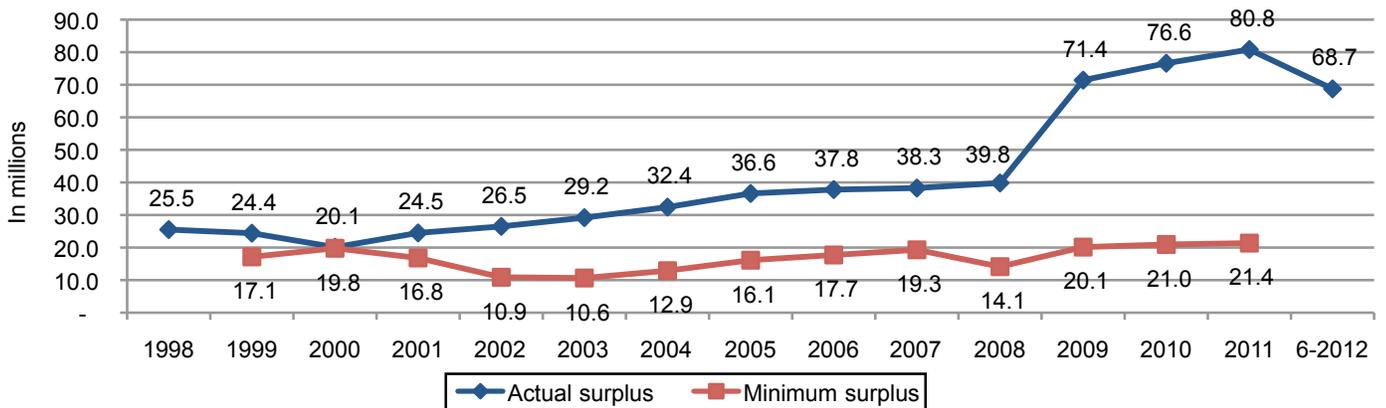


Figure 5-42 shows ODS’s five-year history of rate changes in health insurance markets the state regulates.

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

Year	Individual plans	Small employer plans	Portability plans
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%
2012	3.80%	-0.20%	8.40%
2008-2012	70.32%	67.13%	48.41%

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 more than 47,000 Oregon members in 2011. That's down 12 percent from 2010. LifeWise generated \$163 million in Oregon premiums in 2011, a decrease of 11 percent from 2010. LifeWise's net income gain of more than \$4 million in 2011 compares to a net loss of more than \$4 million in 2010.

Figure 5-43. LifeWise Health Plans of Oregon, 2011 financial data

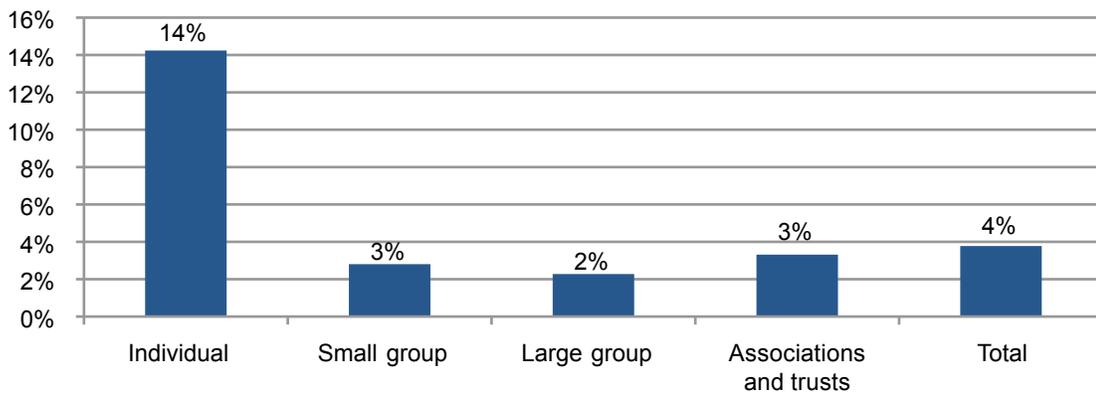
Oregon Market*	Total members	Premium earned	Medical loss ratio	Average premium per member per month
Individual health benefit plans	22,766	\$66,293,652	74%	\$228
Small group	7,396	\$24,963,084	69%	\$283
Large group	8,756	\$57,957,877	83%	\$372
Associations and trusts	8,275	\$14,096,170	99%	\$262
Total for all markets above	47,193	\$163,310,783	79%	\$277
Nationwide for 2011*				
Total surplus.....		\$62,480,141		
Total unpaid claims reserves.....		\$16,558,758		
Net underwriting gain or loss.....		\$1,919,923		
Net income after taxes.....		\$4,261,632		
Oregon Medical Insurance Pool assessment.....		\$2,508,593		
Total general administrative expense.....		\$21,531,932		
Nationwide for 2011				
Largest nonmedical administrative expenses.....			Total year-end	
Salaries, wages, and other benefits.....			\$8,294,957	
Commissions.....			\$7,248,739	
Other taxes, licenses, and fees.....			\$2,012,322	
Cost depreciation: equipment, software, furniture, etc.....			\$1,377,229	
Marketing and advertising.....			\$1,254,637	

Source: Oregon Insurance Division, Health Benefit Plan Reports.

Oregon market data reflect a company's business in Oregon in key state-regulated markets. Nationwide data include companywide business, so if an insurer operates outside of Oregon, that business is included. Also, business from other markets, 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 2011 in four key Oregon health insurance markets. LifeWise had 14 percent of the individual market, 3 percent of the small group market, 2 percent of the large group market, and 3 percent of the associations and trusts market.

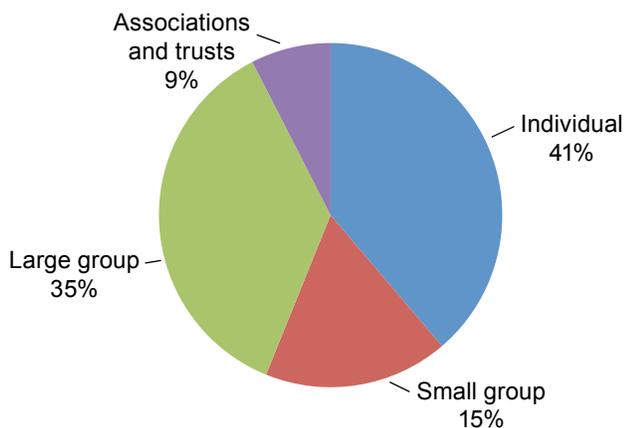
Figure 5-44. LifeWise, premium as percent of 2011 Oregon market



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Figure 5-45 provides a breakdown by market segment of LifeWise premiums. LifeWise earned 76 percent of its premiums from the large group and individual markets.

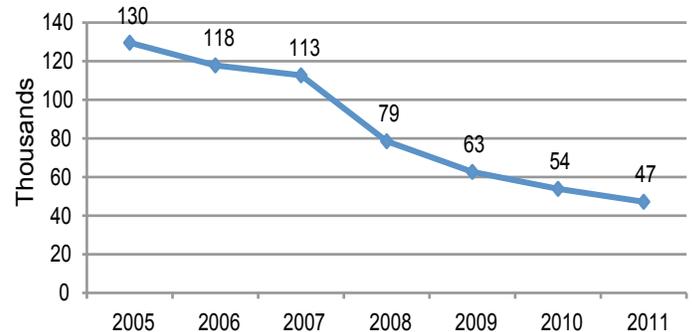
Figure 5-45. LifeWise, premium as percent of its Oregon 2011 business



Source: Oregon Insurance Division, Health Benefit Plan Reports.

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

Figure 5-46. LifeWise, number of members 2005 to 2011



Source: Oregon Insurance Division, Health Benefit Plan Reports.

Health Insurance in Oregon

Figure 5-47 shows that LifeWise’s profitability has been up and down in recent years.

Figure 5-47. Lifewise profitability, net income to earned premium 1999 to June 2012

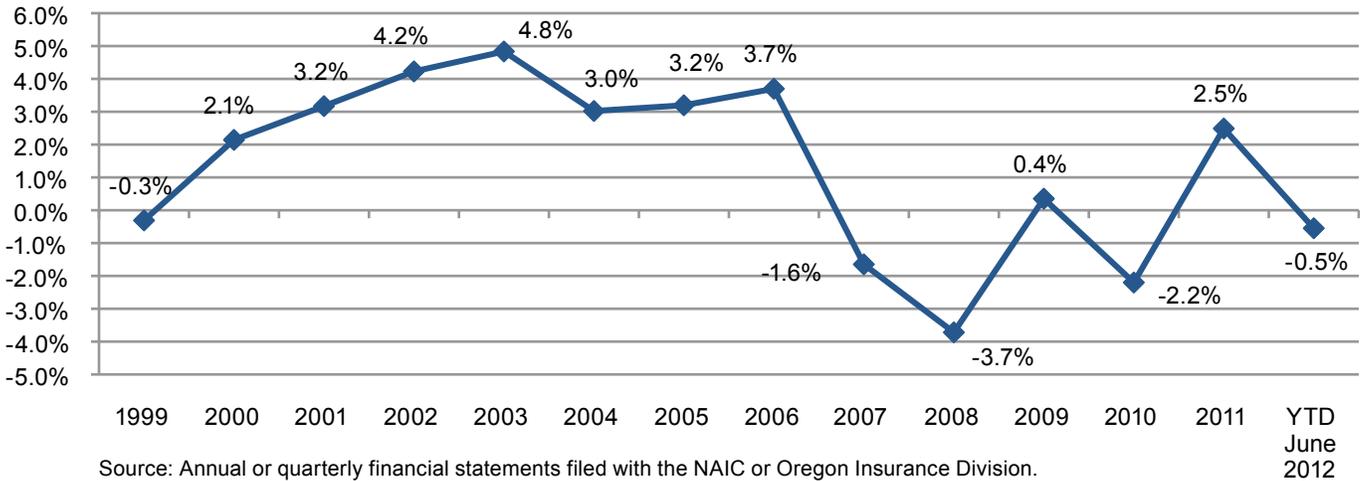
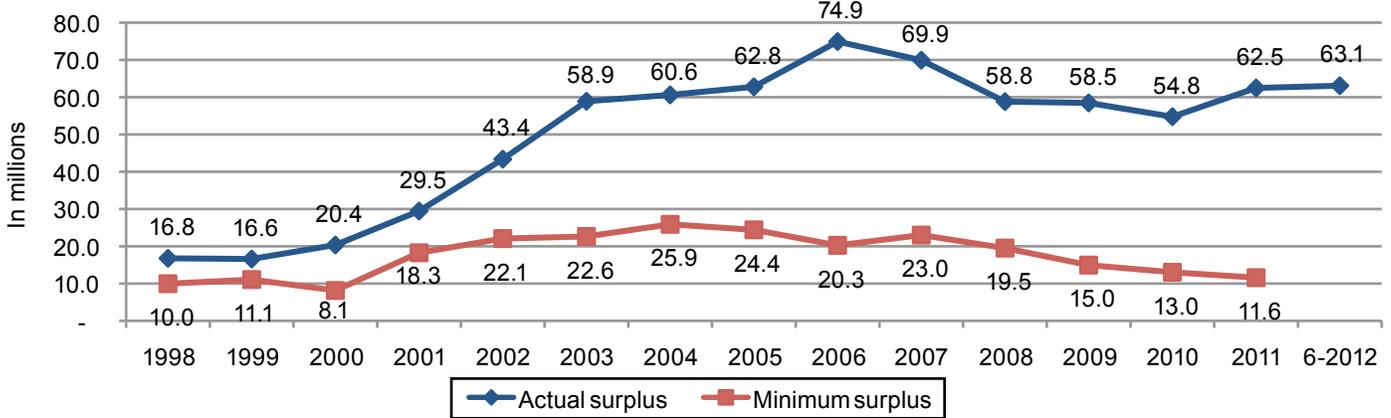


Figure 5-48 shows that LifeWise’s surplus in 2011 increased by 14 percent and was up through June 2012. LifeWise’s surplus remains above minimum requirements.

Figure 5-48. Lifewise, surplus trend, actual and minimum required from 1998 to June 30, 2012



Source: National Association of Insurance Commissioners (NAIC) annual and quarterly financial statement filings.
 Note: The minimum surplus required is not available for June 2012.

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
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%
2012	2.80%	-0.30%	3.20%
2008-2012	85.50%	37.85%	92.38%

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 2011 medical loss ratio reported in Figure 3-6 differs slightly from the 87 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://www.meps.ahrq.gov/mepsweb/about_meps/survey_back.jsp.

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 division 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 division 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 division 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

Family coverage

Individual (single employee) coverage			Family coverage		
National Average		\$5,258	National Average		\$14,086
Alaska	1	\$7,629	Alaska	1	\$18,303
Delaware	2	\$6,374	New York	2	\$16,969
Massachusetts	3	\$6,231	Massachusetts	3	\$16,677
Connecticut	4	\$6,089	District of Columbia	4	\$16,528
New York	5	\$6,007	Connecticut	5	\$16,039
New Jersey	6	\$5,869	New Jersey	6	\$15,613
Rhode Island	7	\$5,710	New Mexico	7	\$15,267
West Virginia	8	\$5,685	Wisconsin	8	\$15,232
New Mexico	9	\$5,673	New Hampshire	9	\$15,187
New Hampshire	10	\$5,649	Delaware	10	\$15,159
Wyoming	11	\$5,645	Illinois	11	\$14,830
District of Columbia	12	\$5,606	Rhode Island	12	\$14,826
Illinois	13	\$5,521	Maine	13	\$14,698
Vermont	14	\$5,488	Florida	14	\$14,698
Colorado	15	\$5,418	Pennsylvania	15	\$14,692
Montana	16	\$5,393	West Virginia	16	\$14,625
Florida	17	\$5,391	Minnesota	17	\$14,609
Georgia	18	\$5,278	Texas	18	\$14,598
Minnesota	19	\$5,267	Wyoming	19	\$14,574
Maine	20	\$5,260	Arizona	20	\$13,919
Wisconsin	21	\$5,257	California	21	\$13,861
Texas	22	\$5,247	Virginia	22	\$13,847
Kansas	23	\$5,209	Michigan	23	\$13,553
Pennsylvania	24	\$5,166	Indiana	24	\$13,364
California	25	\$5,146	South Carolina	25	\$13,350
Alabama	26	\$5,136	Colorado	26	\$13,334
South Carolina	27	\$5,135	Vermont	27	\$13,321
Ohio	28	\$5,101	Hawaii	28	\$13,271
Michigan	29	\$5,096	Missouri	29	\$13,241
Nevada	30	\$5,095	Kansas	30	\$13,230
Oregon	31	\$5,074	Oregon	31	\$13,058
Virginia	32	\$5,062	Nebraska	32	\$13,003
Maryland	33	\$5,059	Maryland	33	\$12,999
Oklahoma	34	\$5,041	Montana	34	\$12,938
Missouri	35	\$4,991	Oklahoma	35	\$12,935
Tennessee	36	\$4,976	South Dakota	36	\$12,755
Hawaii	37	\$4,974	Utah	37	\$12,738
Louisiana	38	\$4,968	North Dakota	38	\$12,728
North Carolina	39	\$4,932	Georgia	39	\$12,529
Arizona	40	\$4,928	Nevada	40	\$12,517
South Dakota	41	\$4,914	Ohio	41	\$12,488
North Dakota	42	\$4,769	Louisiana	42	\$12,459
Indiana	43	\$4,754	Kentucky	43	\$12,201
Iowa	44	\$4,720	Washington	44	\$12,048
Idaho	45	\$4,706	Mississippi	45	\$11,851
Nebraska	46	\$4,705	Alabama	46	\$11,820
Mississippi	47	\$4,692	Arkansas	47	\$11,736
Washington	48	\$4,591	North Carolina	48	\$11,705
Utah	49	\$4,451	Iowa	49	\$11,494
Kentucky	50	\$4,396	Tennessee	50	\$11,289
Arkansas	51	\$4,226	Idaho	51	\$11,130

Source: Medical Expenditure Panel Survey (MEPS), 2011. Table II.C.1 (2011) 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, 2011.

Source: Medical Expenditure Panel Survey (MEPS), 2011. Table II.D.1 (2011) 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, 2011.



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