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January 20, 2009

Health care reform will take center stage in 2009 as a new administration takes office in Washington, D.C., and, here in Oregon, the Legislature considers changes recommended by the Oregon Health Fund Board.

The Department of Consumer and Business Services published this third-annual “Health Insurance in Oregon” report to provide useful information to those who will be engaged in these important policy discussions.

DCBS regulates one component of the health care system: commercial health insurance. Each year, we produce this report that describes the health insurance market in Oregon, the current rules governing the market, and the financial performance of the eight largest health insurers. The 2009 report reflects recent legislative changes and financial data we collected through the third quarter of 2008. The report also outlines some proposals our department has made to improve and further involve the public in some of our processes.

We look forward to participating in the extensive collaboration under way to ensure all Oregonians have access to health care.

Sincerely,

Cory Streisinger
Director, DCBS

Teresa O. Miller
Acting Administrator, Insurance Division
# Table of Contents

Executive Summary: Health Insurance in Oregon .......................................................... i

Section 1: Overview of Health Care Marketplace ...................................................... 1
  Evolution of Employer-Based Health Coverage ...................................................... 1
  Growth in Health Care Spending ........................................................................... 2
  Cost Shifting to Commercial Market .................................................................... 4
  Cost Shifting to Employees .................................................................................. 4

Section 2: Overview of Health Insurance Regulation ................................................. 5
  Health Care Marketplace ...................................................................................... 5
  Financial Regulation ............................................................................................ 7
  Form Regulation .................................................................................................. 8
  Consumer Protection ............................................................................................ 8
  Rate Regulation ................................................................................................... 10
  Commercial Submarkets ...................................................................................... 12
  Individual Market ................................................................................................ 12
  Small Group Market (2-50 employees) ................................................................. 13
  Large Group Market (51 or more employees) ....................................................... 15

Section 3: Financial Status of Largest Health Insurers ............................................ 17
  Key Financial Indicators ....................................................................................... 19
  Profit Margins — Net Income to Premium Earned ................................................. 19
  Capital and Surplus ............................................................................................... 21
  Medical Loss Ratios ............................................................................................. 22
  General Administrative Expenses ....................................................................... 23
  Claims Adjustment Expenses ............................................................................. 24
  Net Underwriting Gain/Loss ................................................................................ 25
  Net Investment Gain ........................................................................................... 26

Section 4: Comparisons of Top Eight Insurers in Specific Market Segments ............ 27
  Individual Market ................................................................................................ 30
  Small Group Market (Employer groups with 2-50 employees) ......................... 33
  Large Group Market (Employer groups with 51 or more employees) ............... 36

Section 5: Insurer Profiles ....................................................................................... 39
  Regence BlueCross BlueShield of Oregon ........................................................... 40
  Kaiser Foundation Health Plan of the Northwest ............................................... 43
  PacificSource Health Plans ................................................................................. 46
  Providence Health Plan ....................................................................................... 49
  Health Net Health Plan of Oregon, Inc. ............................................................... 52
  LifeWise Health Plan of Oregon, Inc. ................................................................. 55
  ODS Health Plan, Inc. ......................................................................................... 58
  PacifiCare of Oregon, Inc. .................................................................................. 61

Appendix: Glossary .................................................................................................. 65

References .............................................................................................................. 67
Executive Summary: Health Insurance in Oregon

In Oregon and across the country, many efforts are under way to reform the health care system in light of rising costs, the uninsured, and an aging, less-healthy population.

In 2007, the Oregon Legislature created the Oregon Health Fund Board to develop a plan to create a health care system where all Oregonians would have access to quality health care. The board released its recommendations in late 2008, and the 2009 Oregon Legislature will consider those proposals in coming months. The proposals include a variety of steps to contain costs, expand coverage to Oregon’s uninsured population, improve quality, and advance the health of Oregonians.

This third-annual “Health Insurance in Oregon” report focuses on one segment of the health care system in Oregon: commercial health insurers. The Department of Consumer and Business Services is the primary regulator of the commercial health insurance market, where roughly 42 percent of Oregonians get their health insurance. This report is intended to provide information about the health insurance market to policymakers who will be making decisions in coming months about how to reform health care in Oregon.

This report explains the department’s role in regulating health insurance companies and highlights recent law changes. It details how the department evaluates insurer solvency and reviews insurance policies and rate requests. It suggests ways to strengthen the department’s rate review standards and improve opportunities for public input during the rate review process. It also includes updated financial information for Oregon’s eight largest health insurers. While most of the report is based on data through 2007, the department included insurers’ financial information through the third quarter of 2008 to provide Oregonians with the latest information. The data comes from insurer financial statements and rate filings.

Key points made in this report

- Only about 42 percent of Oregonians have insurance coverage in the state-regulated individual and group health insurance markets. Another 25 percent receive coverage through government programs (Medicare and Medicaid), while 16 percent receive employer-based coverage through large employers that are self-insured. Approximately 576,000 Oregonians, or 15 percent, are uninsured.

- Financial regulation is a high priority for the department to make certain an insurer can pay claims. The state enforces financial solvency and consumer protection requirements for all health insurers.

- The state regulates rates only in the individual, portability, and small group (2-50 employees) markets. A major role of rate regulation is to ensure the pooling of risks and equitable treatment for those who are not in groups large enough to form separate pools.

- Insurers cannot deny coverage to group policyholders with health problems but can decline coverage to people with pre-existing conditions in the individual market. Those who are declined coverage due to medical conditions are eligible for the Oregon Medical Insurance Pool, which is part of the Department of Consumer and Business Services.

- Premium costs for Oregon consumers continued to rise in 2008, with double-digit rate increases for several insurers. Through the first three quarters of 2008, rates for individual health care plans increased an average of 17.7 percent, and rates for small group health plans increased an average of 11 percent.

- In Oregon, 90 cents of every dollar paid in premiums goes to pay medical claims. Medical costs are currently driving premium increases.
Recommendations

As mentioned earlier, the Oregon Health Fund Board has proposed many fundamental changes to Oregon’s health care system with the goals of containing costs, expanding coverage to Oregon’s uninsured population, improving quality, and bettering the health of Oregonians. The department is offering the following suggestions concerning the health insurance industry, as a supplement to the broader reforms being discussed statewide.

- **Strengthen the Department of Consumer and Business Services’ rate review standards.** Current health insurance rate review standards do not specifically address the key factors used to determine whether a rate increase is justified. Listing the key factors routinely considered as part of the rate review process and explicitly authorizing the department to consider factors such as insurer investment income, profits, and surplus levels would ensure the department has the authority it needs to protect consumers from excessive rate increases.

- **Carry out a recommendation of the Oregon Health Fund Board, which requires insurers to justify increases in administrative expenses above a specified rate.** Increases in administrative expenses that exceed the rate of general inflation should be denied absent sufficient justification by the insurer that the increases are necessary and appropriate.

- **Expand public input into health insurance rate review.** Although the public can now review proposed health insurance rate filing information online, under current law there is no formal process for the public to comment on this information until after the department takes action. Allowing an opportunity for public participation before decisions are made would provide the benefit of additional input as well as greater accountability in the rate review process.
Section 1: Overview of Health Care Marketplace

As health care costs continue to increase, the public asks tough questions about how to make health care more affordable. Many factors affect health care costs. The focus of this report is the commercial health insurance market and the state's authority to regulate premiums for individual, portability, and small group health insurance.

This report addresses many key questions about health insurance: Who is insured in the commercial market? What are the state’s key regulatory responsibilities? 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?

This section presents a short primer on employer-based health coverage and briefly summarizes the growth in health care spending and premiums and cost shifting to the commercial market and employees.

Evolution of Employer-Based Health Coverage

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

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

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

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

Initially, both the hospital and physician prepaid plans were exempted from taxation and insurance regulation. Many BlueCross/BlueShield plans, including plans in Oregon, remain not-for-profits. Oregon, like the rest of the states, gradually expanded regulation of not-for-profits over the past 40 years.

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

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

Commercial insurance companies realized that their earlier concerns over the unpredictability of insuring people’s health could be overcome by providing insurance to groups of employed workers, generally composed of younger, relatively healthy people. Once these commercial insurers entered the market, enrollment in health insurance plans increased almost seven-fold from 1940 to 1950.
Another important event that contributed to the development and growth of employer-sponsored health insurance occurred in 1950 when General Motors (GM) and the United Auto Workers (UAW) negotiated the workers’ contract. GM Chief Executive Charles Wilson favored a company-by-company approach to worker benefits and offered to pay 50 percent of the health care costs of GM employees. Walter Reuther, national president of the UAW, wanted a universal health care system inclusive of all workers and employers that spread the cost across many companies. UAW eventually agreed to the GM proposal and GM entered the health care business.

Throughout the 1940s and 1950s, federal government policy changes reinforced the trend toward employer-sponsored health insurance. In 1954, the Internal Revenue Code exempted employer contributions from employee taxable income and that further fueled the growth of employer-sponsored health insurance. By 1958, nearly 75 percent of Americans had some form of private health insurance.

The government made some recent attempts to promote individual insurance by extending tax breaks for the purchase of individual insurance, but employer-sponsored health insurance remains the cornerstone of the U.S. health care system. More than 50 percent of Oregonians have employer-sponsored health coverage today (insured and self-insured), compared to about 6 percent with individual coverage.

**Growth in Health Care Spending**

In the 50 years since employer-based coverage became widespread, national health care spending has steadily increased at rates far outstripping inflation, wages, and other economic indicators. One aggregate measure of this trend is that national health expenditures more than tripled as a share of the gross domestic product (GDP) in the past four decades: from 5.2 percent of GDP in 1960 to 16 percent in 2007. (Poisal, J.A., et. al., 2007)

**Figure 1-1** illustrates the effect of health care spending on employer premiums compared to inflation and worker earnings. While there were some periods of moderate increases in premiums, the trend is clear: Health premiums are growing much faster than either inflation or wages, especially in recent years. The Kaiser Family Foundation Annual Employer Health Benefits Survey found that the cost of health insurance rose 6.1 percent in 2007, which is lower than the 7.7 percent increase for 2006 but still much higher than the 2.6 percent overall rate of inflation or the 3.7 percent increase in workers’ earnings.

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

**Figure 1-1. Employer health premiums vs. inflation and earnings from 1988-2007**


Correction: Previous “Health Insurance in Oregon” reports had a calculation error for health insurance premiums for 1996 that was corrected in this figure.
Health Insurance in Oregon


Nationally, annual private employer-sponsored health insurance premiums averaged $4,479 for single coverage and $12,106 for family coverage in 2007. Since peaking at an annual growth rate of 18 percent in 1989, national health care premium costs have continued to grow but at a slower rate.

Figure 1-2 illustrates the increases in monthly group health insurance premiums in Oregon since 1996. The average monthly Oregon premium in 2006 was $345 for single coverage and $968 for family coverage.

2008 Oregon Health Premiums
Oregon premium costs continued to rise in 2008 with double-digit rate increases for several insurers. The Oregon health insurance premium dollar in 2007 broke down as follows:
- 90 cents for direct medical care
- 10 cents for insurers’ administrative costs and claim adjustment expenses
- Zero net underwriting gain/loss

This breakdown is similar to the rest of the nation.

Source: Medical Expenditure Panel Survey (MEPS), Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 1996-2006, and Average total family premium (in dollars per enrolled employee at private-sector establishments that offer health insurance by firm size and state: United States, 1996-2006.

Note: the annual Oregon totals are divided by 12 to obtain the average total monthly premiums.
**Cost Shifting to Commercial Market**

The commercial health insurance marketplace bears a disproportionate share of the increases in health care spending. When provider reimbursement rates are not adequate in one area, providers look to the commercial market where there is a greater ability to absorb increased premiums. This fuels increases in commercial health insurance premiums that, in turn, increase the number of people unable to afford coverage. The Families USA study in June 2005 estimated that annual employer-sponsored health insurance premiums in Oregon are $1,128 higher for family coverage as a result of care for the uninsured. The report suggests that by 2010, the annual cost of family coverage in Oregon will be $1,886 higher and individual coverage will be $544 higher because of uncompensated care for the uninsured.

While the magnitude of the cost shift to the commercial market will continue to be debated, there is little question that the cost shift is real and continues to exacerbate affordability. For decades, hospitals have used cost shifting to recover lost revenue from the uninsured, underinsured, those on Medicaid and Medicare, and others who are unable or unwilling to pay the high cost of medical care and treatment. A 2008 study by the PricewaterhouseCoopers Health Research Institute shows that the amount of costs shifted to the privately insured increased 150 percent over the past eight years.

**Cost Shifting to Employees**

Increasing premiums cause employers to shift health care costs to their employees and, in some cases, to end health care coverage. A recent study by the Kaiser Family Foundation of employers nationwide revealed that between 2000 and 2006, the percentage of employers offering health benefits dropped 8 percent. Firms with fewer than 200 workers accounted for most of this trend.

**Figure 1-4** shows similar trends for Oregon. Larger firms are far more likely to offer health insurance than smaller firms. The survey reported that virtually all firms with 100 or more employees offered health insurance while only about 54 percent of firms with fewer than 10 employees offered health insurance to their full-time employees.

The more common strategy for employers struggling with affordability is to shift more of the costs to employees. Employers shift costs to their employees by increasing the portion of the premium that employees pay or by increasing employee cost sharing for medical services through higher deductibles and co-payments. A recent national study by Mercer (2008) noted that the median deductible required by employers for individual coverage in preferred provider organization (PPO) plans jumped to $1,000 in 2008 from $500 in 2007. Only about half of employers in 2000 imposed a deductible for PPO coverage compared to about four-fifths today. PPOs are the most popular type of employer health plan and enroll 69 percent of all covered employees.

### Figure 1-4. Oregon firms that offer health insurance in 2006

<table>
<thead>
<tr>
<th>Size of firm (number of employees)</th>
<th>Full-time</th>
<th>Part-time</th>
</tr>
</thead>
<tbody>
<tr>
<td>All sizes</td>
<td>92.4%</td>
<td>72.9%</td>
</tr>
<tr>
<td>Less than 10</td>
<td>54.4%</td>
<td>33.7%</td>
</tr>
<tr>
<td>10-24</td>
<td>42.2%</td>
<td>42.2%</td>
</tr>
<tr>
<td>25-99</td>
<td>84.8%</td>
<td>84.8%</td>
</tr>
<tr>
<td>100-999</td>
<td>99.4%</td>
<td>99.4%</td>
</tr>
<tr>
<td>1,000 or more</td>
<td>97.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td>99.6%</td>
<td>88.5%</td>
<td>88.5%</td>
</tr>
</tbody>
</table>

Note: According to the notes from the source study, the part-time, 10-24 figure of 42.2 percent does not meet the standard of reliability or precision due to sample size.

Section 2: Overview of Health Insurance Regulation

Through its Insurance Division, the Department of Consumer and Business Services (DCBS) is the state's primary regulator of all types of insurance companies, including health insurance companies. In this section, we discuss the department’s regulatory authority. This includes an overview of the health care marketplace and how commercial insurance fits into the overall market; general descriptions of the department’s four major regulatory responsibilities (financial solvency, form approval, consumer protection, and rate approval); recommendations on how to improve the rate review process; and more detailed descriptions of the regulations that apply to each of the submarkets within the commercial market.

Health Care Marketplace

The health care marketplace is not one seamless whole, but rather a series of distinct markets, each with its own regulatory features.

Figure 2-1 indicates that 42 percent of Oregonians received health coverage through state-regulated commercial health insurance in 2007. The rest are insured through Medicare, Medicaid, self-insured employers, or are uninsured.

State-Regulated Commercial Health Insurance. The department regulates approximately 800 health insurers that provide health insurance to an estimated 1.6 million Oregonians in the state-regulated commercial health insurance market. Figure 2-1 lists the submarkets of the commercial market and their approximate enrollment figures from 2005 to 2007. The enrollment figures from 2007 follow:

- Individual coverage (235,000) — for individuals and families
- Portability coverage (21,000) — for individuals leaving group coverage
- Small group coverage (257,000) — for employers with 2-50 employees
- Large group coverage (1,047,000) — for employers with 51 or more employees who purchase insurance plans

In addition to the commercial market, a state program called the Oregon Medical Insurance Pool (OMIP) offers coverage to approximately 19,000 high-risk individuals. OMIP is part of DCBS and sets its rates in relation to the commercial insurance market.

Federally Regulated Health Care. The federal government has jurisdiction over three health care markets — Medicare, Medicaid, and self-insured employers — that provide health coverage to an estimated 1.6 million Oregonians. Medicare provides health coverage for people 65 or older and those with certain disabilities. Medicaid provides health coverage for specified categories of people with low incomes. While Medicare and Medicaid are federal programs, the states have some responsibilities for both programs and regulate Medicare supplement insurance.

The federal government has regulatory authority over large employers who self-insure under the 1974 Employee Retirement Income Security Act (ERISA). Self-insured employers cover 611,000 Oregonians.

Uninsured. An estimated 576,000 Oregonians, including 116,000 children, have no health insurance. The department’s role regulating the different health insurance market segments varies widely. Most regulatory attention focuses on the 513,000 Oregonians with individual, small employer, or portability insurance. The department approves rates for these markets. Regulations require insurers to pool risk for these markets so that insurance remains affordable for those who might otherwise be priced out of the market because of health problems.

Larger employers (those with 51 or more employees) that purchase insurance are subject to certain insurance regulations, but not rate regulation. There are various reasons for this, including the fact that larger groups are not subject to the same rate volatility as individuals or small groups, where a single health problem can have a dramatic impact on rates. Another factor has been the concern that regulation of larger groups will encourage those groups to pursue an exemption from state insurance regulation through self-insurance.
## Health Insurance in Oregon

### Figure 2-1. Oregon health insurance enrollment in 2007

<table>
<thead>
<tr>
<th>Enrollment Category</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oregon population</strong></td>
<td>3,631,000</td>
<td>3,691,000</td>
<td>3,746,000</td>
</tr>
<tr>
<td><strong>State regulated commercial health insurance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>204,000</td>
<td>252,000</td>
<td>235,000</td>
</tr>
<tr>
<td>Portability</td>
<td>19,000</td>
<td>20,000</td>
<td>21,000</td>
</tr>
<tr>
<td>Small group 2-50</td>
<td>283,000</td>
<td>253,000</td>
<td>257,000</td>
</tr>
<tr>
<td>OMIP</td>
<td>15,000</td>
<td>15,000</td>
<td>19,000</td>
</tr>
<tr>
<td>Large group</td>
<td>1,059,000</td>
<td>1,020,000</td>
<td>1,047,000</td>
</tr>
<tr>
<td><strong>Total covered under state regulation</strong></td>
<td>1,580,000</td>
<td>1,560,000</td>
<td>1,579,000</td>
</tr>
<tr>
<td><strong>Federal regulated health care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td>532,000</td>
<td>547,000</td>
<td>567,000</td>
</tr>
<tr>
<td>Medicaid</td>
<td>423,000</td>
<td>408,000</td>
<td>402,000</td>
</tr>
<tr>
<td>Self-insured</td>
<td>539,000</td>
<td>569,000</td>
<td>611,000</td>
</tr>
<tr>
<td><strong>Total covered under federal regulation</strong></td>
<td>1,494,000</td>
<td>1,524,000</td>
<td>1,560,000</td>
</tr>
<tr>
<td><strong>Uninsured</strong></td>
<td>617,000</td>
<td>576,000</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

**Note:** Numbers are rounded to the nearest thousand and represent the best data available. Several sources were used to obtain the enrollment figures. As a result, the 2007 figures total 99.7 percent of the estimated Oregon population and provide an approximate distribution. In 2005 and 2006, the enrollment counts total 101.7 percent and 99.2 percent of the estimated Oregon population counts, respectively. Some of the 2005 and 2006 figures in this chart vary from those reported in prior “Health Insurance in Oregon” reports. In some cases, figures have been updated, corrected or obtained from a different source.

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A large employer is self-insured when it pays employees’ health costs itself instead of paying premiums to an insurance company for health coverage. For the largest groups, there is little practical difference between the two options 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 contract with insurance companies to administer the company’s health benefits as third-party administrators (TPAs), making it difficult for employees to know whether their employer is insured or self-insured. For example, assume Jim and Susan are two neighbors with employer-sponsored health coverage through the same insurance company. Their plans might look the same — their insurance cards look similar, their procedures for getting bills paid are similar, and the insurance company processing their claims is the same. In reality, however, the insurance company may be the actual insurer of only Jim, and merely the third-party administrator for Susan’s employer, a self-insured company.

Nevertheless, the insured vs. self-insured distinction has important regulatory implications. If an employee is in an insured plan, the insurer must comply with state benefit mandates, claims-handling standards, privacy rules, and the other regulations described below that are applicable to all health insurers. An insured employee also has access to the department’s staff of consumer advocates, who help consumers resolve hundreds of health insurance complaints each year under state insurance laws. If an insurer violates the law, it can be subject to civil penalties of up to $10,000 per violation.

If the employee is in a self-insured plan, ERISA pre-empts most state insurance regulation, including benefit mandates. Congress enacted some consumer protection laws that apply to both insured and self-insured health plans, but Oregon’s consumer protection laws typically provide additional protections for insured Oregonians. For example, Oregon’s mental health parity law for group policies requires more comprehensive mental health coverage than the federal mental health law. The federal mandate, unlike the Oregon mandate, applies to self-insured plans.

Financial Regulation

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

The purpose of financial regulation is to ensure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company’s assets exceed liabilities.

The department uses technical standards established by the National Association of Insurance Commissioners (NAIC) to evaluate insurer solvency and financial stability. These standards are used widely throughout the country and are known as risk-based capital (RBC) standards. RBC measures financial soundness using risk factors unique to that company. Risk factors taken into account using complex formulas include:

- Size of the insurer
- The number of lives insured
- The recent past and projected future trend in the size of the insurer’s investment portfolio
- The relative risk of the investments in the insurer’s portfolio
- The combined capital and surplus maintained by comparable insurers
- The adequacy of the insurer’s reserves
- The risk characteristics of the business underwritten by the insurer

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
Health Insurance in Oregon

comparing the company’s total adjusted capital and surplus with its RBC requirement. The resulting RBC ratio is used to establish minimum capital and surplus levels and to determine if regulatory intervention is necessary. It is not used to set a maximum capital and surplus level or target capital and surplus level. An RBC ratio of 200 percent is considered the minimum level of financial soundness, while an RBC ratio of less than 150 percent requires the department to take certain actions, including exercising control of the insurer, depending on the severity of the situation.

While 200 percent of RBC sets a minimum regulatory requirement, a company at or near the 200 percent RBC level 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 not-for-profit insurers that do not have the same access to capital markets as for-profit insurers.

The review of companies’ financial soundness and compliance with statutes and recordkeeping standards is carried out primarily through financial examinations and analyses. Financial exams occur on site and are in-depth financial reviews of Oregon domiciled insurers conducted at least once every five years. Financial analyses are in-house desk audits of the company’s annual and quarterly statements, supplemental filings, and other available information that are used to monitor financial solvency, statutory compliance, and use of proper accounting and reporting methods.

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

Form Regulation

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

While insurance policies for groups of 51 or more are not subject to the rating regulations, insurers must file policy forms for approval and provide all mandated health benefits for all group insurance plans. There is an exception to the filing requirement for group health forms that are negotiated and unique to a particular group, though such forms are required to include benefit mandates and otherwise comply with insurance regulations.

Consumer Protection

Health insurers are subject to a wide range of consumer protections under the Insurance Code. Most of these protections apply to all health insurance, though some are more targeted.

Mandates. State and federal law require health insurers to cover certain services and to include certain types of providers in their plans. Some mandates, such as maternity coverage, apply to all insurance policies; others, such as mental health parity, apply only to group coverage. All the Oregon mandates can be viewed online at http://www.cbs.state.or.us/external/ins/sehi/mandated_health_provisions.pdf.

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

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 claims 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 regarding denial of claims, rights to appeals and independent review of adverse decisions, rights to continuity of coverage, the right for women to choose a primary care provider and have access to a women’s health care provider, and specific requirements for a company’s payment of claims.

Consumer advocacy. The department’s consumer advocacy staff handles approximately 15,000 inquiries and 4,000 consumer complaints about all lines of insurance each year. In addition to helping individual consumers solve their insurance problems, the advocates also look for legal violations and broader trends and refer problem cases to market analysts who conduct investigations designed to stop patterns of consumer abuse. The market surveillance process can include market conduct examinations and can result in enforcement actions, with fines of $50,000 or more for serious patterns of consumer abuse.

Transparency. As consumers bear more of their health care costs through higher deductibles, co-payments, and co-insurance, it is important for them to make good, cost-effective health care decisions. To do that, they need to know in advance how much their health care services will cost.

Oregon has many efforts under way to increase transparency in health care costs. For example, the department makes rate filings public. The department also gathers information from insurers to provide consumers with the costs of specific, inpatient medical procedures at all Oregon hospitals. This information is available at the Office for Oregon Health Policy and Research Web site at http://www.oregon.gov/OHPPR/.

2007 Legislation

HB 2213 and Cost Estimates

This new law will help consumers make good, cost-effective decisions about their health care by requiring insurers to provide reasonable cost estimates in advance for common medical procedures.

The estimate must include whether an enrollee has met his or her deductible, the amount of other costs (co-insurance) to be born by the enrollee, and whether there is any applicable benefit maximum.

Insurers must provide the estimates for both in-network and out-of-network services by July 2009 through an interactive Web site and toll-free phone number. Currently this information is often difficult for consumers to find, particularly for out-of-network services.
Rate Regulation

The state must approve health insurance rates in the individual, small group, and portability markets. Health insurance rates are not regulated for large groups with 51 or more employees where the competitive nature of the Oregon market plays a more important role in keeping rates reasonable.

Rate filings for regulated groups must include actuarial documentation. Oregon law provides that rate filings will be disapproved 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.” ORS 742.005.

Department actuaries rely on these laws to answer two basic questions about each rate filing. First, is the aggregate rate request justified? Second, is the request fairly allocated among the ratepayers? In many 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 in health care, where rate regulation focuses on protecting those with the greatest health needs through pooling of risk and blended rates that reduce rate differences.

Below are the key factors used to determine whether the overall rate request is actuarially justified.

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

**Historical and projected trend.** Trend is the rate of increase in the claims portion of an insurance company’s loss ratio, and consists of two components: medical inflation and use. Medical inflation reflects the increase in the unit cost of covered medical services, such as hospital stays, prescription medications, charges by physicians and other medical professionals, and costs for diagnostic services such as tests and imaging. Use reflects the rate at which medical services are used, and can be affected by the health of the insured population, the level of coverage, 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 driving premiums, trend is often a key factor in rate filings.

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**2007 Legislation**

**HB 3103 and Public Disclosure**

This law requires the immediate public disclosure of rate filings for individual, portability, and small group health insurance. Highlights:

- The public can review proposed rates at the Insurance Division’s Web site: [http://www.cbs.state.or.us/ins/insurer/rates_forms/health_rate_filings/health-rate-filing-search.html](http://www.cbs.state.or.us/ins/insurer/rates_forms/health_rate_filings/health-rate-filing-search.html).

- Insurers must summarize the rate filing in plain language. This summary includes the basis for the requested rate change; the average percent change in premium requested from one year earlier; the amount of premiums received versus claims; and the projected impact of the rate change on claims costs, administrative costs, and profits/losses.
**Historical and projected administrative costs.**
Administrative costs are generally higher for individual and small group insurance on a per capita basis, and should decline on a percentage basis as the company’s business volume grows. Short-term administrative costs may increase due to factors such as technology investments designed to improve medical outcomes or reduce long-term costs. Insurers report administrative costs as a percent of total premium in the rate filing process. The department approves a single rate change even though medical and administrative expenses rise or fall at different rates.

**Net income target.** Insurance company rate filings include a net income target that is the projected profit or loss after subtracting claims costs and administrative costs from revenue plus investment income. Investment income is not as significant a factor in health insurance as it is in some other lines of insurance where premiums are held much longer and investment earnings are substantial.

For each of these factors, department actuaries evaluate the reasonableness of the assumptions being made by the insurance company in light of the company’s past experience, the impact on policyholders, and the rates being charged by competitors. Although formal disapproval of a rate increase is rare, the actuarial staff often asks for additional information, question an insurance company’s assumptions, and indicate informally that the rate increase should be reduced or spread over time. Companies typically comply with such requests, particularly if they do not have data to further substantiate their initial filing.

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 that a rate request that is reasonable in the aggregate is not inequitable to particular groups or individuals.

**Public input.** The public can now review proposed rate filing information online, but there is no formal opportunity to provide input before the department makes a decision about a proposed rate. Consumers may request a hearing on a rate change but only after the department takes action on the proposed rate request.

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**2009 Recommendations**

**Administrative expenses**
The Oregon Health Fund Board suggests that premium savings could be realized by requiring insurers to justify increases in administrative expenses above a specified rate. Administrative expenses should be separately reviewed, and increases in administrative expenses that exceed the rate of general inflation should be denied by the department absent sufficient justification by the insurer that the increases are necessary and appropriate. Administrative expenses, including claim adjustment expenses, account for approximately 10 cents of every premium dollar, but even modest cost savings could be beneficial to policyholders.

**Rate review standards**
Current health insurance rate review standards do not specifically address the key factors used to determine whether a rate increase is justified. Strengthening the standards would ensure that the department has the clear authority it needs to protect consumers from excessive increases. To strengthen the department’s standards, the statute should list the key factors routinely considered as part of the rate-review process, including loss ratios, medical trend, administrative costs, variation in proposed rates over the population affected, financial strength, and stability.

The statute should also add the following factors:
- investment income
- insurer profits
- surplus levels
- the effect of medical underwriting
- cost control procedures

While this could provide limited relief to consumers from rising insurance premiums, it is important to remember that insurer profits and investment income are relatively low today and are not primary factors driving increases in health insurance rates.

**Public input**
Allowing the public to comment on proposed health insurance rate changes before the department acts would give them the opportunity to influence the process as well as provide greater transparency and public accountability in the rate review process.
Health Insurance in Oregon

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

Individual Market
The individual market includes individuals and families who either do not have access to employer-sponsored group coverage or choose to decline group coverage. Insurers may turn down applicants for individual health insurance coverage. (A few of Oregon’s largest insurers reject about 30 percent of applicants.) Once covered, however, those with individual health insurance have guaranteed renewability — their insurance cannot be canceled due to claims or health conditions. And those who are turned down are automatically eligible for coverage through the Oregon Medical Insurance Pool, the state’s high-risk health plan.

There are 235,000 lives in the individual market and another 19,000 in the state’s high-risk pool for people who are denied coverage because of health problems. This represents about 7 percent of Oregonians, about one-fifth the number in group coverage.

In the individual health insurance market, both the content of insurance contracts and the rates charged for coverage must be approved. The review of the insurance contract ensures that mandated services are included and that consumer protection standards are met. Provisions of Oregon law applicable to the individual market include:

<table>
<thead>
<tr>
<th>Year</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>19.7%</td>
</tr>
<tr>
<td>2004</td>
<td>15.7%</td>
</tr>
<tr>
<td>2005</td>
<td>12.7%</td>
</tr>
<tr>
<td>2006</td>
<td>5.3%</td>
</tr>
<tr>
<td>2007</td>
<td>5.8%</td>
</tr>
<tr>
<td>2008</td>
<td>17.7%</td>
</tr>
</tbody>
</table>

Source: Department of Consumer and Business Services, Insurance Division, approved rate filings and health insurance member enrollment reports.

Standard health statement. Companies that sell in the individual market must use a standard health statement and decide whether to offer coverage based on that health statement. The health statement requests medical information from the past five years. Companies may decline to offer coverage to individuals because of their health experience. However, if the company offers coverage, premium rates cannot be based on an individual’s health experience.

High-risk pool eligibility. Individuals denied coverage in the individual market are eligible for coverage through the Oregon Medical Insurance Pool (OMIP), the state’s high-risk pool. OMIP’s board, which is appointed by the director of the department, determines the coverage to be offered and the rates, which by law cannot exceed 125 percent of individual market rates. OMIP may also serve as the health plan option for individuals qualified for the Federal Health Coverage Tax Credit (HCTC), as well as the portability option for individuals who lose their self-insured employer-based group coverage. The OMIP portability rates are set at the average of current portability market rates. Because OMIP premiums are not sufficient to cover claims costs, the board imposes an assessment on insurance companies and reinsurance companies to cover the shortfall.

Guaranteed renewability. As noted above, all individual health insurance policies are guaranteed renewable, and there are special rules governing withdrawal from the marketplace. A company must renew the individual plan as long as the individual continues to make the required premium payment. A general exception from the guaranteed renewability exists for a company that chooses to withdraw from a particular geographic area or the entire state.

Other 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. Insurers may not use individual characteristics other than age in setting premiums, and rates for an individual cannot be increased more often than annually.
Mandated benefits. All individual health insurance policies must include certain mandated health benefits. Some mandates, such as mental health parity, do not apply to individual insurance. Insurance companies may not impose exclusion periods on individuals for any mandated benefit. A list of mandated benefits can be found at http://www.cbs.state.or.us/external/ins/sehi/mandated_health_provisions.pdf.

Pre-existing conditions. A pre-existing condition exclusion can only be imposed by an insurer for a condition if medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to the effective date of coverage. If an insurer excludes a pre-existing condition from coverage, then there is a six-month limit to the exclusion period. The exclusion period can be reduced by the number of months the individual had continuous prior coverage. 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.

Small Group Market (2-50 employees)

Insurers serving this market must accept all groups regardless of health status. The department approves rates to ensure they meet standards that protect groups with older or less healthy employees. Similar rules apply to “portability” coverage, which is available to Oregonians who leave group coverage and meet certain eligibility standards. Federal law requires all states to offer portability coverage, which is available to Oregonians who leave group coverage and 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

Average annual rate increase in the Small Group Market

<table>
<thead>
<tr>
<th>Year</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>17.1%</td>
</tr>
<tr>
<td>2004</td>
<td>16.5%</td>
</tr>
<tr>
<td>2005</td>
<td>18.1%</td>
</tr>
<tr>
<td>2006</td>
<td>10.1%</td>
</tr>
<tr>
<td>2007</td>
<td>10.3%</td>
</tr>
<tr>
<td>2008</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Source: Department of Consumer and Business Services, Insurance Division, approved rate filings and health insurance member enrollment reports.

2007 Legislation

HB 2002 and Small Group Market Reform

This law expanded the small group market to include employers with 2-50 employees. Previously, employers with 26-50 employees had no rate regulation. The law, portions of which insurers may phase in over a three-year period, is intended to help insurance rates remain stable and affordable for all small employers. The bill:

- Created incentives for businesses to cover more employees, offer dependent coverage, and offer wellness programs.
- Sets new standards so that the most expensive rate charged by an insurer can be no more than three times the lowest rate charged, or a 3-to-1 “rate band.” This allows for a slightly broader range of rates among the former 2-25 employers (prior to HB 2002, these groups had a rate-band limit of 2.5 to 1) but significantly compresses rates in the 26-50 market that previously had no rate regulation. The goal is to ensure that costs are spread more equitably among these groups.
- Limits the factors used to set rates. Factors include age, participation in wellness programs, employer contributions, customer loyalty, tobacco use, and expected claims (limited to a 5 percent increase or decrease). This broadened the factors for the former 2-25 market but limited the discretion insurers had for the former 26-50 market. For example, insurers formerly could charge much higher rates for groups of young women of child-bearing age than for groups of young men in the 26-50 market.

Findings

- Data gathered to date suggests that the law is pushing rates toward the middle, eliminating the extremely low and extremely high rates. As a result, some employers received significant rate increases or decreases in 2008.
- Overall, however, rates are still going up, because of the increase in medical costs. Because of the new law, some employers are seeing their rates change more or less than usual.
Health Insurance in Oregon

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 (OMIP), the state’s high-risk pool, is available to individuals leaving group coverage only where a group insurer’s portability coverage is not available for very specific reasons. There are 257,000 individuals in the small group market and 21,000 in the portability market. This represents approximately 7 percent of Oregonians.

In the small group health insurance market, as with the individual market, the department approves the content of insurance contracts. Provisions applicable to the small group market include:

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

**Guaranteed renewability.** Small employer plans are guaranteed renewable, meaning the coverage continues at the employer’s option. An insurance company must renew the employer’s plan as long as the employer continues to make the required premium payment. A general exception from guaranteed renewability exists for an insurance company that chooses to withdraw from a particular geographic area or the entire state.

**Rating rules.** Insurance companies must pool all of their small group employers and charge blended rates.

**Rate bands.** The most expensive rate charged by an insurer can be no more than three times the lowest rate charged, or a 3-to-1 “rate band.”

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

**Pre-existing conditions.** Small group plans can exclude coverage for certain conditions that an employee had prior to enrollment, but the exclusion period cannot exceed six months (12 months for a late enrollee). Small group plans may not treat pregnancy as a pre-existing condition. The length of the pre-existing condition exclusion must be reduced by the length of time an individual had continuous insurance coverage, with no break of greater than 63 days before enrollment in the plan.

**Mandated benefits.** All small group health insurance policies must include certain mandated health benefits. A list is available at [http://www.cbs.state.or.us/external/ins/sehi/mandated_health_provisions.pdf](http://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 contribute some portion of the health insurance premiums for their employees, and may also require that a certain percentage of eligible employees participate in the plan. However, these requirements must be applied uniformly to all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small group insurer. If a small group health insurance company requires 100 percent participation of eligible employees, the company may not require a small employer to contribute more than 50 percent of the premium cost of an employee-only benefit plan.
2007 Legislation

HB 3321 and Association Plans
This law allows group health insurers more flexibility in selling association and trust health benefit plans to small employer groups, and establishes protections to keep groups insured under these plans from losing coverage due to high claims. It also makes out-of-state association and trust health plans subject to the same requirements as Oregon-based associations. Associations offer group health insurance coverage to their members who are employers or unions.

The bill offers this protection by:

- Prohibiting associations and insurers from denying membership or coverage to any small employer group based on health.
- Limiting how much the initial premium rate may vary between groups of small employers so that rates can’t be used to ward off higher-risk groups.
- Requiring associations to maintain high retention rates or follow the more stringent regulations of small group health insurance laws.

HB 3321 requires the department to monitor association health plans. It sunsets in six years, allowing the Legislature to evaluate its impact on the health insurance market in Oregon.

Large Group Market
(51 or more employees)
The large group market includes Oregon employers with 51 or more employees that choose to purchase insurance rather than self-insure. The insured portion of the market is subject to consumer protection laws, such as mandated benefits and claims-handling rules, but there are no laws regulating rates in this market and no requirement that coverage be offered to all groups. The number of lives in the insured large group market is estimated to be 1 million, representing almost a third of Oregonians.

In the large group health insurance market, the content of insurance contracts must be approved to ensure that mandated services are included and that consumer protection standards are met. Rates for large group health insurance are not subject to review or regulation. As discussed, Oregon laws governing large groups are not applicable to self-insured employer groups. Legal provisions that are the same for both small and large groups are guaranteed renewability, mandated benefits, nondiscrimination, participation requirements, portability, and pre-existing conditions.
Since the last publication of the “Health Insurance in Oregon” report, the federal government is bailing out failing businesses, the economy is in a recession, and the drop in stock values is taking a toll on businesses and individuals.

The Department of Consumer and Business Services monitors the financial condition and operating results of insurers to ensure that each is able to pay policyholder claims and is operating at acceptable levels. Oregon health insurers must submit quarterly and annual financial statements to the department. These statements provide a synopsis of each insurer’s financial status over time and are reviewed by insurance financial analysts.

The department is closely monitoring the financial status of Oregon’s domestic health insurers during this financial downturn. Although Oregon’s health insurers are financially healthy and have enough money to pay claims, they clearly have been affected by the financial markets in 2008. Given the current volatility of the financial markets, the department required all domestic insurers to file as part of their third-quarter statement restated capital and surplus amounts based on October 2008 investment activity. Insurers’ capital and surplus could have changed significantly because of the drop in investment values after Sept. 30, 2008.

Oregon insurers are taking steps to ensure that they remain healthy in the current financial climate. No regulatory action was triggered based solely on the economic downturn.

This section presents an overview of the operating results and financial status of the eight largest Oregon-based health insurers using financial statements over five- and 10-year time spans.

**Section 3: Financial Status of Largest Health Insurers**

**Figure 3-1** shows the total premiums earned by the eight largest Oregon insurers over three years. There are approximately 800 health insurers doing business in Oregon.

**Figure 3-1. Oregon total premiums earned from 2005-2007**

Source: Oregon Insurance Division, 2005-2007 Health Benefit Plan Reports
Figure 3-2 shows that the eight largest Oregon-based insurers earned 91 percent of the $4.8 billion in health premiums for comprehensive health insurance in 2007. The two largest health insurers have 54 percent of the market.

Figure 3-3 shows that four of the top eight insurers are not-for-profit companies. Two of the for-profit insurers (LifeWise and ODS Health Plan) are subsidiaries of not-for-profit companies. Health Net and PacifiCare are subsidiaries of large national for-profit health insurers.

### Figure 3-3. For-profit and not-for-profit insurers

<table>
<thead>
<tr>
<th>For-profit:</th>
<th>Not-for-profit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net Health Plan of Oregon</td>
<td>Regence BlueCross BlueShield of Oregon</td>
</tr>
<tr>
<td>LifeWise Health Plan of Oregon</td>
<td>Kaiser Foundation Health Plan of the Northwest</td>
</tr>
<tr>
<td>ODS Health Plan, Inc.</td>
<td>PacificSource Health Plans</td>
</tr>
<tr>
<td>PacifiCare of Oregon, Inc.</td>
<td>Providence Health Plan</td>
</tr>
</tbody>
</table>

The financial data in the remainder of this section is compiled from the insurers’ companywide data and includes financial data from the insurers’ operations in other states.
Key Financial Indicators
The remainder of this section examines key financial indicators for the eight largest companies, beginning with net income, which 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 used to determine an insurer’s net income or loss. See Appendix A for a more detailed explanation of 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. This report uses the term profit margin as synonymous with net income to premium earned.

Figure 3-4 provides a 10-year summary of the eight largest health insurers’ profitability expressed as a percentage of earned premium. The profitability of these eight companies from 1998 to 2007 reflects a cyclical pattern in which all eight insurers were more profitable in the immediate past five years than in the prior five. One of the eight companies reported losses for 1998-2002, and the average profit margin was 1 percent. All eight companies were profitable for the period from 2003-2007, with average profit margins varying from 2 percent to 8 percent, for a combined average of 3 percent.

Figure 3-4. Summary of 10-year profitability

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>0%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>-3%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>-1%</td>
<td>4%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>4%</td>
<td>5%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Providence</td>
<td>0%</td>
<td>8%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>Regence</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>Average all eight</td>
<td><strong>1%</strong></td>
<td><strong>3%</strong></td>
<td><strong>2%</strong></td>
<td><strong>1%</strong></td>
</tr>
</tbody>
</table>

Figure 3-5 shows the most recent five years’ profit margins by year and through Sept. 30, 2008. PacifiCare reported a profit margin of 12 percent during 2008. This profit margin was caused by its profitable Medicare business, which is not regulated by the department.

Figure 3-5. Net income to premium earned from 2003 to Sept. 30, 2008

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>YTD 9-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>-2%</td>
<td>-3%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>-2%</td>
<td>-3%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>-1%</td>
<td>3%</td>
<td>2%</td>
<td>4%</td>
<td>7%</td>
<td>12%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>3%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Providence</td>
<td>6%</td>
<td>8%</td>
<td>9%</td>
<td>8%</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Regence</td>
<td>-5%</td>
<td>2%</td>
<td>6%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Average all eight</strong></td>
<td><strong>1%</strong></td>
<td><strong>4%</strong></td>
<td><strong>5%</strong></td>
<td><strong>4%</strong></td>
<td><strong>3%</strong></td>
<td><strong>1%</strong></td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database. Year-to-date compiled from Sept. 30, 2008, filings with the Oregon Insurance Division.
Capital and Surplus

Insurers must maintain capital and surplus. For-profit insurers report capital and surplus amounts; not-for-profit insurers report only surplus. The combination of capital and surplus is the amount an insurer’s assets exceed its liabilities. Capital and surplus combined exceeds what an insurer expects to pay out for medical claims, expenses, taxes, and other obligations. As discussed in Section 2, insurers, by law, must maintain minimum levels of capital and surplus to ensure they will be able to meet financial obligations to policyholders. Capital and surplus requirements vary by insurer depending on the volume of business, investment portfolio, and other risk factors unique to each insurer’s situation.

See Section 5 for insurers’ surplus requirements. Figure 3-6 shows that Oregon’s largest health insurers, including some that were financially troubled in the late 1990s, increased or maintained surplus from 2001-2007. PacifiCare is an exception. Its surplus was at the same level in 2007 as in 2001, due mainly to dividends paid to its parent company. Collectively, surplus of the eight insurers dropped 3 percent from year-end 2007 to Sept. 30, 2008, due in large part to the reduction in the value of the insurers’ common stock investments. Even with these reductions, insurers possessed surplus well above the minimum required.

Figure 3-6. Surplus levels from 2001-2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Health Net</th>
<th>Kaiser</th>
<th>LifeWise</th>
<th>ODS</th>
<th>PacifiCare</th>
<th>PacificSource</th>
<th>Providence</th>
<th>Regence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$17.6</td>
<td>$160.5</td>
<td>$29.5</td>
<td>$24.5</td>
<td>$46.5</td>
<td>$38.8</td>
<td>$73.5</td>
<td>$266.3</td>
</tr>
<tr>
<td>2002</td>
<td>$24.7</td>
<td>$189.5</td>
<td>$43.4</td>
<td>$26.5</td>
<td>$46.6</td>
<td>$51.3</td>
<td>$81.3</td>
<td>$235.6</td>
</tr>
<tr>
<td>2003</td>
<td>$28.6</td>
<td>$240.8</td>
<td>$58.9</td>
<td>$29.2</td>
<td>$43.2</td>
<td>$64.3</td>
<td>$113.0</td>
<td>$282.2</td>
</tr>
<tr>
<td>2004</td>
<td>$39.5</td>
<td>$308.4</td>
<td>$60.6</td>
<td>$32.4</td>
<td>$39.6</td>
<td>$84.6</td>
<td>$163.9</td>
<td>$366.4</td>
</tr>
<tr>
<td>2005</td>
<td>$49.6</td>
<td>$359.2</td>
<td>$62.8</td>
<td>$36.6</td>
<td>$44.8</td>
<td>$112.8</td>
<td>$224.2</td>
<td>$466.9</td>
</tr>
<tr>
<td>2006</td>
<td>$59.8</td>
<td>$350.0</td>
<td>$74.9</td>
<td>$37.8</td>
<td>$50.9</td>
<td>$123.5</td>
<td>$285.6</td>
<td>$533.5</td>
</tr>
<tr>
<td>2007</td>
<td>$67.4</td>
<td>$430.0</td>
<td>$69.9</td>
<td>$38.3</td>
<td>$46.7</td>
<td>$124.5</td>
<td>$340.5</td>
<td>$552.2</td>
</tr>
<tr>
<td>YTD 9/2008</td>
<td>$58.6</td>
<td>$494.2</td>
<td>$62.7</td>
<td>$34.4</td>
<td>$41.8</td>
<td>$103.8</td>
<td>$346.2</td>
<td>$520.9</td>
</tr>
</tbody>
</table>

Source: Data compiled by NAIC from filings database and Sept. 30, 2008, quarterly statements.
Medical Loss Ratios

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

Figure 3-7 illustrates the medical loss ratios for the eight largest Oregon-based insurers for the past five years and to date in 2008. These insurers spent on average 90 cents of each premium dollar to pay for medical services in 2007. The average medical loss ratio was 91 percent through Sept. 30, 2008. Kaiser’s integrated delivery system creates higher-than-average loss ratios because expenses that other insurers record as administrative are bundled into claims expenses.

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>5-year average</th>
<th>YTD 9-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>82%</td>
<td>81%</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>82%</td>
<td>87%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>96%</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>80%</td>
<td>82%</td>
<td>81%</td>
<td>78%</td>
<td>88%</td>
<td>82%</td>
<td>88%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>86%</td>
<td>84%</td>
<td>86%</td>
<td>84%</td>
<td>84%</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>89%</td>
<td>83%</td>
<td>83%</td>
<td>80%</td>
<td>79%</td>
<td>83%</td>
<td>73%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>86%</td>
<td>85%</td>
<td>83%</td>
<td>86%</td>
<td>89%</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>Providence</td>
<td>86%</td>
<td>84%</td>
<td>83%</td>
<td>85%</td>
<td>88%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Regence</td>
<td>89%</td>
<td>87%</td>
<td>85%</td>
<td>87%</td>
<td>89%</td>
<td>87%</td>
<td>90%</td>
</tr>
<tr>
<td><strong>Average all eight</strong></td>
<td><strong>90%</strong></td>
<td><strong>88%</strong></td>
<td><strong>87%</strong></td>
<td><strong>88%</strong></td>
<td><strong>90%</strong></td>
<td><strong>88%</strong></td>
<td><strong>91%</strong></td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database, and the year-to-date Sept. 30, 2008, quarterly statement filings with the Oregon Insurance Division.

Note: 5-year average includes 2003-2007.
General Administrative Expenses

General administrative expenses are expenses an insurer incurs to run its business and includes all expenses not directly related to paying claims. Included in this category are commissions, marketing and advertising expenses, office supplies, rent, taxes, depreciation, and salaries and benefits.

As mentioned earlier, the Oregon Health Fund Board has recommended that the department review the growth rate in a health insurer’s administrative expenses and deny increases in excess of a published standard, such as the inflation rate.

Figure 3-8 illustrates that general administrative expenses, as a percent of premium, can vary from insurer to insurer, but are generally consistent from year to year. Kaiser’s administrative expenses are consistently lower than average because expenses that other insurers record as administrative costs are bundled into claims costs in Kaiser’s integrated system. The five-year average administrative expense was 7 percent for all eight insurers. The 2008 year-to-date average administrative expense was 6 percent.

The largest general administrative expenses incurred by these insurers in 2007 were commissions, marketing and advertising, salaries and benefits, taxes, and cost depreciation. The top five administrative expenses for all Oregon companies are included in the Health Benefit Plan Reports on the department’s Web site at http://www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html.

**Figure 3-8. General administrative expenses to premium earned from 2003 to Sept. 30, 2008**

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>5-year average</th>
<th>YTD 9-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>12%</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>11%</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>10%</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>7%</td>
<td>6%</td>
<td>5%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>11%</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
<td>11%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>9%</td>
<td>8%</td>
<td>9%</td>
<td>9%</td>
<td>10%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Providence</td>
<td>9%</td>
<td>7%</td>
<td>8%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Regence</td>
<td>9%</td>
<td>8%</td>
<td>6%</td>
<td>8%</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Average all eight</strong></td>
<td><strong>8%</strong></td>
<td><strong>7%</strong></td>
<td><strong>7%</strong></td>
<td><strong>7%</strong></td>
<td><strong>7%</strong></td>
<td><strong>7%</strong></td>
<td><strong>6%</strong></td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database, and the year-to-date Sept. 30, 2008, quarterly statement filings with the Oregon Insurance Division.

Note: 5-year average includes 2003-2007.
Claims Adjustment Expenses

Claims adjustment expenses are expenses to record, adjust, and settle claims.

Figure 3-9 shows claims adjustment expenses for the eight largest Oregon insurers averaged 3 percent since 2005. Claims adjustment expenses are a separate category from general administrative expenses.

Table: Claims adjustment expenses to earned premium from 2003 to Sept. 30, 2008

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>5-year average</th>
<th>YTD 9-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>7%</td>
<td>6%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>7%</td>
<td>7%</td>
<td>6%</td>
<td>8%</td>
<td>8%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Providence</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Regence</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Average all eight</strong></td>
<td><strong>2%</strong></td>
<td><strong>2%</strong></td>
<td><strong>3%</strong></td>
<td><strong>3%</strong></td>
<td><strong>3%</strong></td>
<td><strong>3%</strong></td>
<td><strong>3%</strong></td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database, and the year-to-date Sept. 30, 2008, quarterly statement filings with the Oregon Insurance Division.

Note: 5-year average includes 2003-2007.
Net Underwriting Gain/Loss

Net underwriting gain or loss is not a separate revenue or expense category, but is the bottom-line amount an insurer gains or loses from its insuring activity. When an insurer collects more premiums than it pays 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 collected, 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 3-10 shows that underwriting gains for the eight largest Oregon insurers decreased from an average of 4 percent in 2005 to an average of 0 percent in 2007. Three insurers reported underwriting losses during 2007.

As of Sept. 30, 2008, the average net underwriting gain was 1 percent. PacifiCare reported a net underwriting gain of 17 percent as a result of its profitable Medicare business, which is not regulated by the department.

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>5-year average</th>
<th>YTD 9-2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>4%</td>
<td>6%</td>
<td>4%</td>
<td>4%</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>0%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>-4%</td>
<td>2%</td>
<td>-5%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>-3%</td>
<td>4%</td>
<td>3%</td>
<td>6%</td>
<td>9%</td>
<td>4%</td>
<td>17%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
<td>4%</td>
<td>-2%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Providence</td>
<td>4%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>4%</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>Regence</td>
<td>-3%</td>
<td>2%</td>
<td>4%</td>
<td>1%</td>
<td>-2%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Average all eight</td>
<td>1%</td>
<td>3%</td>
<td>4%</td>
<td>2%</td>
<td>0%</td>
<td>2%</td>
<td>1%</td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database, and the year-to-date Sept. 30, 2008, quarterly statement filings with the Oregon Insurance Division.

Note: 5-year average includes 2003-2007.
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) plus the profit (or loss) realized on the sale of investments. The additional income an insurer earns from its investments must be considered to present a complete picture of an insurer’s total income.

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 collected and when claims payments are made. Health insurers earn investment income too, but the investment income is a smaller factor in the company’s overall profitability because most claims payments are made in the same year that premium is collected.

Figure 3-11 illustrates that these eight health insurers averaged between 1 percent and 2 percent investment gains since 2003. As of Sept. 30, 2008, investment gains averaged 1 percent. Net investment losses incurred during the fourth quarter of 2008 will be included in the companies’ 2008 annual statements. Excluding ODS, insurers earned between 1 percent and 4 percent net investment gain from 2003 to 2007.

Figure 3-11. Net investment gain to earned premium from 2003 to Sept. 30, 2008

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>5-year average</th>
<th>YTD 9-08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Kaiser</td>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>LifeWise</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>1%</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>PacificSource</td>
<td>1%</td>
<td>2%</td>
<td>3%</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Providence</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Regence</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Average all eight</strong></td>
<td><strong>1%</strong></td>
<td><strong>1%</strong></td>
<td><strong>1%</strong></td>
<td><strong>2%</strong></td>
<td><strong>2%</strong></td>
<td><strong>2%</strong></td>
<td><strong>1%</strong></td>
</tr>
</tbody>
</table>

From data compiled by the NAIC from the filings database, and the year-to-date Sept. 30, 2008, quarterly statement filings with the Oregon Insurance Division.

Note: 5-year average includes 2003-2007.
Section 4: Comparisons of Top Eight Insurers in Specific Market Segments

The analysis shifts to the individual, small group, and large group markets in this section. The analysis is based on the Health Benefit Plan Report data submitted to the Department of Consumer and Business Services, as required by Senate Bill 501 (Chapter 765, Oregon Laws 2005). Senate Bill 501 requires health insurers to summarize key data from their annual financial statements and to break down some of that data, such as premiums earned and medical loss ratios, by market segment.

Now that data has been collected for three years, this report provides an overview of each market segment and allows policy makers to begin to see trends in each of the market segments. The department posts the full filings for each insurer on its Web site at www.insurance.oregon.gov/insurer/rates_forms/health-benefit-plan-reports.html.
Figure 4-1 summarizes data by market segment and compares the eight largest Oregon health insurers with all health insurers that filed the Health Benefit Plan Report. These eight insurers have a dominant market share in premiums earned and members enrolled in every market segment.

The average premium per member per month for health insurance sold in Oregon in 2007 was $265 for all companies reporting. The average premium per member per month ranged from $166 to $283 for the eight largest Oregon insurers.

### Figure 4-1. Health Benefit Plan Report, in 2007

#### Totals for eight largest Oregon insurers

<table>
<thead>
<tr>
<th></th>
<th>Number of members</th>
<th>Premium earned*</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>185,229</td>
<td>$358</td>
<td>98.30</td>
<td>$166</td>
</tr>
<tr>
<td>Small group</td>
<td>246,310</td>
<td>$779</td>
<td>86.52</td>
<td>$262</td>
</tr>
<tr>
<td>Large group</td>
<td>964,176</td>
<td>$3,276</td>
<td>89.59</td>
<td>$283</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,395,715</strong></td>
<td><strong>$4,413</strong></td>
<td><strong>89.76</strong></td>
<td><strong>$264</strong></td>
</tr>
</tbody>
</table>

#### Totals for all insurers reporting (including the eight largest Oregon insurers)

<table>
<thead>
<tr>
<th></th>
<th>Number of members</th>
<th>Premium earned*</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>234,744</td>
<td>$498</td>
<td>91.95</td>
<td>$192</td>
</tr>
<tr>
<td>Small group</td>
<td>257,264</td>
<td>$819</td>
<td>86.98</td>
<td>$262</td>
</tr>
<tr>
<td>Large group</td>
<td>1,047,097</td>
<td>$3,524</td>
<td>89.60</td>
<td>$281</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,539,105</strong></td>
<td><strong>$4,841</strong></td>
<td><strong>89.40</strong></td>
<td><strong>$265</strong></td>
</tr>
</tbody>
</table>

* Rounded in millions

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 4-2 reflects that premiums for the eight largest Oregon insurers were consistent with the average premiums of all insurers.

Average premium per member per month is the total premium paid by all members divided by the total number of members and is not representative of what any individual might pay. 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 making comparisons of either insurers or market segments as to premium differentials.

Average premium per member is only one common method of expressing average premiums. Another common method in the group market 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 because the former counts only individual employees as units and the latter counts both employees and dependents as separate units. For example, consider an employer that spends $400 per month to cover an employee and an additional $400 to cover three dependents of that employee. 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 4-2. Average premium per member per month, market segments in 2007

<table>
<thead>
<tr>
<th>Segment</th>
<th>Eight largest Oregon insurers</th>
<th>All insurers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$265</td>
<td>$264</td>
</tr>
<tr>
<td>Large group</td>
<td>$281</td>
<td>$283</td>
</tr>
<tr>
<td>Small group</td>
<td>$262</td>
<td>$262</td>
</tr>
<tr>
<td>Individual</td>
<td>$192</td>
<td>$166</td>
</tr>
</tbody>
</table>

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Individual Market
As discussed more fully in Section 2 of this report, the individual market is composed of individuals with no access to employer-sponsored insurance or who decline group coverage when it is offered. A total of 235,000 Oregonians buy health insurance coverage in the individual market.

**Figure 4-3** summarizes individual market data for 2007. The average monthly premium for the eight largest Oregon insurers was $166 compared to $192 for all insurers.

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>Number of members</th>
<th>Premium earned*</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>7,212</td>
<td>$16.1</td>
<td>97.10</td>
<td>$191</td>
</tr>
<tr>
<td>Kaiser</td>
<td>16,982</td>
<td>$82.1</td>
<td>95.49</td>
<td>$382</td>
</tr>
<tr>
<td>LifeWise</td>
<td>35,826</td>
<td>$73.0</td>
<td>85.63</td>
<td>$164</td>
</tr>
<tr>
<td>ODS Health Plans</td>
<td>5,354</td>
<td>$7.0</td>
<td>69.31</td>
<td>$133</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>307</td>
<td>$1.9</td>
<td>76.77</td>
<td>$441</td>
</tr>
<tr>
<td>PacificSource</td>
<td>12,372</td>
<td>$23.4</td>
<td>107.61</td>
<td>$168</td>
</tr>
<tr>
<td>Providence</td>
<td>4,376</td>
<td>$4.8</td>
<td>65.71</td>
<td>$141</td>
</tr>
<tr>
<td>Regence BCBS</td>
<td>102,800</td>
<td>$149.9</td>
<td>107.35</td>
<td>$127</td>
</tr>
<tr>
<td><strong>Total – above eight insurers</strong></td>
<td><strong>185,229</strong></td>
<td><strong>$358.3</strong></td>
<td><strong>98.30</strong></td>
<td><strong>$166</strong></td>
</tr>
<tr>
<td><strong>Total – all insurers</strong></td>
<td><strong>234,744</strong></td>
<td><strong>$498.1</strong></td>
<td><strong>91.95</strong></td>
<td><strong>$192</strong></td>
</tr>
</tbody>
</table>

* Rounded in millions

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.

**Figure 4-4** shows that the eight largest insurers earn 72 percent of premiums in the individual health insurance market. The individual market has more insurers than other market segments. Smaller Oregon insurers and national insurers write more than a quarter of the individual health insurance policies in Oregon.
Figure 4-5 shows the 2005 to 2007 average premiums for the eight largest insurers in the individual market compared to all insurers. The 2007 average premium per member per month was $166 for the eight largest insurers compared to $192 for all insurers. There were significant variations among insurers that reflect the array of products available in the individual market.

Figure 4-5. Average premium per member per month in individual plans from 2005-2007

Figure 4-6 illustrates the average premium per member per month of $192 in 2007 for individual plans compared to an average premium per member per month of $265 for all markets. Individual premiums tend to be lower because benefit plans are not as rich and because individuals may be denied coverage based on their health status (denials based on health status are not allowed in the group market).

Figure 4-6. Average premium per member per month, individual plans vs. all markets in 2007
Figure 4-7 shows the 2005 to 2007 medical loss ratios for Oregon’s eight largest companies in the individual health market compared to all insurers. Medical loss ratios ranged from 66 percent to 108 percent in 2007.

Figure 4-7. Medical loss ratios, individual plans from 2005-2007

Figure 4-8 shows the 2007 medical loss ratios for individual plans compared to all markets. Insurers paid out more for medical services in the individual market compared to all markets.

Figure 4-8. Medical loss ratio, individual plans vs. all markets in 2007
Small Group Market
(EMPLOYER GROUPS WITH 2-50 EMPLOYEES)

Any small employer in Oregon may purchase health insurance in the small group market and pay a pooled rate that is based on the pool’s experience rather than that of the specific group’s members.

Figure 4-9 summarizes the small group market data for 2007. Average premium per member per month was $262 for the eight largest insurers and all insurers.

**Figure 4-9. Eight largest insurers, small group plans in 2007**

<table>
<thead>
<tr>
<th>Company name</th>
<th>Number of members</th>
<th>Premium earned*</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>31,555</td>
<td>$111.3</td>
<td>75.16</td>
<td>$278</td>
</tr>
<tr>
<td>Kaiser</td>
<td>32,706</td>
<td>$107.0</td>
<td>95.89</td>
<td>$274</td>
</tr>
<tr>
<td>LifeWise</td>
<td>41,677</td>
<td>$115.8</td>
<td>88.96</td>
<td>$233</td>
</tr>
<tr>
<td>ODS Health Plans</td>
<td>8,297</td>
<td>$17.7</td>
<td>81.51</td>
<td>$248</td>
</tr>
<tr>
<td>PacifiCare</td>
<td>206</td>
<td>$1.3</td>
<td>51.53</td>
<td>$389</td>
</tr>
<tr>
<td>PacificSource</td>
<td>42,097</td>
<td>$151.7</td>
<td>87.79</td>
<td>$283</td>
</tr>
<tr>
<td>Providence</td>
<td>46,011</td>
<td>$146.4</td>
<td>86.87</td>
<td>$263</td>
</tr>
<tr>
<td>Regence BCBS</td>
<td>43,761</td>
<td>$127.6</td>
<td>85.50</td>
<td>$248</td>
</tr>
<tr>
<td><strong>Total – above eight insurers</strong></td>
<td><strong>246,310</strong></td>
<td><strong>$778.9</strong></td>
<td><strong>86.52</strong></td>
<td><strong>$262</strong></td>
</tr>
<tr>
<td><strong>Total – all insurers</strong></td>
<td><strong>257,264</strong></td>
<td><strong>$818.8</strong></td>
<td><strong>86.98</strong></td>
<td><strong>$262</strong></td>
</tr>
</tbody>
</table>

* Rounded in millions.

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.

Figure 4-10 shows that 95 percent of small group coverage is provided by the top eight insurers. PacificSource is Oregon’s largest insurer in the small group market with $152 million in premiums or 18 percent of total premiums.

**Figure 4-10. Market share by premium, small group market in 2007**

4.3.3 Health Insurance in Oregon
Figure 4-11 shows the 2005 to 2007 average premium for the eight largest Oregon insurers in the small group market compared to those of all insurers.

Figure 4-11. Average premium per member per month, small group in 2005-2007

Figure 4-12 shows that the average premium per member per month of $262 for 2007 in the small group market is slightly lower than the $265 average for all markets.

Figure 4-12. Average premium per member per month, small groups plans vs. average premium, all markets in 2007
Figure 4-13 shows the 2005 to 2007 average medical loss ratio for Oregon’s eight largest insurers in the small group market, compared to those of all insurers. The average medical loss ratio was 87 percent in 2007.

Figure 4-14 compares the medical loss ratio for the eight largest insurers in the small group market compared to all markets. The small group market paid out less for medical services compared to all markets.

Figure 4-13. Medical loss ratios, small group from 2005-2007

Figure 4-14. Medical loss ratio, small groups plans vs. all markets in 2007
Large Group Market
(Employer groups with 51 or more employees)

The large group market in Oregon is composed of employers with 51 or more employees. Approximately 3,800, or 6 percent of Oregon’s 66,000 employers, are large employers, according to the Oregon Employment Department’s 2005 report. The large group market, with 1 million covered lives in 2007, is more than four times the size of the small group market. Half of large employers have 99 or fewer employees and half have 100 or more employees.

Figure 4-15 summarizes the 2007 Health Benefit Plan Report data for the large group market. The average monthly premium for the eight largest insurers was $283 compared to $281 for all insurers.

<table>
<thead>
<tr>
<th>Insurer name</th>
<th>Number of members</th>
<th>Premium earned*</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Net</td>
<td>78,644</td>
<td>$243.2</td>
<td>84.67</td>
<td>$263</td>
</tr>
<tr>
<td>Kaiser</td>
<td>279,631</td>
<td>$1,000.5</td>
<td>95.48</td>
<td>$300</td>
</tr>
<tr>
<td>LifeWise</td>
<td>35,188</td>
<td>$127.6</td>
<td>88.44</td>
<td>$293</td>
</tr>
<tr>
<td>ODS Health Plan</td>
<td>29,343</td>
<td>$108.3</td>
<td>88.24</td>
<td>$311</td>
</tr>
<tr>
<td>PacificCare</td>
<td>11,651</td>
<td>$48.1</td>
<td>89.47</td>
<td>$312</td>
</tr>
<tr>
<td>PacificSource</td>
<td>79,186</td>
<td>$286.4</td>
<td>88.84</td>
<td>$307</td>
</tr>
<tr>
<td>Providence</td>
<td>88,973</td>
<td>$282.6</td>
<td>89.19</td>
<td>$273</td>
</tr>
<tr>
<td>Regence BCBS</td>
<td>361,560</td>
<td>$1,179.6</td>
<td>86.15</td>
<td>$268</td>
</tr>
<tr>
<td><strong>Total – above eight insurers</strong></td>
<td><strong>964,176</strong></td>
<td><strong>$3,276.3</strong></td>
<td><strong>89.59</strong></td>
<td><strong>$283</strong></td>
</tr>
<tr>
<td><strong>Total – all insurers</strong></td>
<td><strong>1,047,097</strong></td>
<td><strong>$3,524.5</strong></td>
<td><strong>89.60</strong></td>
<td><strong>$281</strong></td>
</tr>
</tbody>
</table>

* Rounded in millions.
Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.

Figure 4-16 shows the eight largest Oregon insurers earned 93 percent of all premiums in the large group market. The two largest insurers control more than 60 percent of this market. The large group market accounts for nearly 73 percent of the total health insurance premiums earned in Oregon (see Figure 4-1). The top eight insurers earned more in the large group market than any other market segment.
Figure 4-17 shows the 2005 to 2007 average premium for the eight largest Oregon insurers in the large group market compared to all insurers. The average premium for the eight largest insurers was $283 compared to $281 for all insurers in the large group market. Average premiums per member per month were within 10 percent of the $283 average for seven of the top eight insurers in the large group market in 2007.

Figure 4-18 shows that the large group market average premium per member per month of $281 is just above the $265 average for all markets and likely is a reflection of the fact that large employers tend to offer richer health benefit plans. Oregon law does not regulate premium rates in the large group market. Larger employers often negotiate both benefit levels and premium rates directly with the insurer.
Figure 4-19 shows the 2005 to 2007 medical loss ratios for the top eight insurers in the large group market compared to those of all insurers. Medical loss ratios were at or above 85 percent for each of the top eight insurers for their large group business in 2007.

Figure 4-20 compares the 2007 medical loss ratio for the top eight insurers in the large group market to all markets.
Section 5: Insurer Profiles

This section provides profiles of the eight largest Oregon-based health insurers. It includes market segment data from the Health Benefit Plan Reports. The market segment data is only available for 2005 through 2007. The annual Health Benefit Plan Reports permit the Department of Consumer and Business Services to analyze trends in enrollment, premiums, and medical loss ratios for the insurers in each market segment.

The data presented for each company is limited to its business in the defined market segments and does not cover other business of these companies, such as Medicare and Medicaid business, dental insurance, and claims management and other third-party administrator services for self-insured employers. The insurer profiles are arranged in order of the largest to smallest premium earned in 2007.
Regence BlueCross BlueShield of Oregon

The Regence Group is the Pacific Northwest’s largest affiliation of health care plans, including Regence BlueCross BlueShield of Oregon; Regence BlueShield, serving parts of Washington; Regence BlueShield of Idaho; and Regence BlueCross BlueShield of Utah. Collectively, the four plans serve more than 2 million people in four states with more than $5.8 billion in combined annual revenue.

Regence BlueCross BlueShield of Oregon is an independent licensee of the BlueCross and BlueShield Association and operates under a Certificate of Authority issued in Oregon in 1942. Prior to 1983, Regence was incorporated and operated as Oregon Physician’s Service (Blue Shield). Regence BlueCross BlueShield of Oregon (Regence) is a not-for-profit company serving 508,000 Oregonians.

Figure 5-1 summarizes key data submitted by Regence in its 2007 Health Benefit Plan Report. Regence enrolled 508,000 Oregonians in its health plans: 362,000 in the large group market, 103,000 in the individual market, and 44,000 in the small group market. The company earned $1.5 billion in premiums in 2007. It had net income after taxes of $21 million and maintained a surplus of $552 million.

The largest nonmedical administrative expenses in 2007 were for salaries, benefits, and commissions, and the total general administrative expense was $183 million.

Regence BlueCross BlueShield, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>102,800</td>
<td>$149,928,094</td>
<td>107.35</td>
<td>$127.41</td>
</tr>
<tr>
<td>Small group</td>
<td>43,761</td>
<td>$127,624,859</td>
<td>85.50</td>
<td>$247.66</td>
</tr>
<tr>
<td>Large group</td>
<td>361,560</td>
<td>$1,179,600,202</td>
<td>86.15</td>
<td>$268.28</td>
</tr>
<tr>
<td>Total for all markets above</td>
<td>508,121</td>
<td>$1,457,153,155</td>
<td>88.27</td>
<td>$239.31</td>
</tr>
</tbody>
</table>

Comprehensive products nationwide for 2007

- Total surplus maintained..........................$ 552,188,131
- Total unpaid claims reserves maintained..........................$ 252,022,948
- Net underwriting gain or loss ..................................$ -56,018,977
- Net income after taxes ..................................$ 20,851,464
- Oregon Medical Insurance Pool ..........................$ 15,969,965
- Total general administrative expense ..................................$ 182,674,067

Largest nonmedical administrative expenses..........Total year-end

- Salaries, wages, employment taxes, and other benefits .......... $ 85,472,661
- Commissions ......................................... $ 31,034,380
- Cost depreciation: Equipment, software, furniture, etc......... $ 20,364,329
- Other taxes, licenses, and fees .................................. $ 27,902,382
- Legal fees, expenses, and other professional or consulting fees ....$ 15,818,740

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-2 shows Regence’s overall market share and its market share in each market segment. Regence earned 30 percent of all premiums in 2007 in all Oregon health insurance markets. Market shares were 34 percent in the large group market, 30 percent in the individual market, and 16 percent in the small group market.

Figure 5-3 provides a breakdown by market segments of where Regence earned its $1.5 billion in total premiums. Regence earned more than $1 billion, or 81 percent, in the large group market, followed by 10 percent in the individual market, and 9 percent in the small group market in 2007.
Figure 5-4 shows Regence’s surplus increased from $235 million in 1998 to $552 million in 2007. Surplus was $521 million as of Sept. 30, 2008, down 6 percent from 2007. The current surplus level is comfortably above the minimum required surplus. Regence’s profit margin averaged 1 percent for 1998-2002, 2 percent for 2003-2007, and 0 percent through Sept. 30, 2008, as shown in Section 3.

**Figure 5-4. Regence BlueCross BlueShield:**
Surplus trend, actual vs. minimum required from 1998-2008

Note: The minimum surplus required is not available for YTD Sept. 2008.

Figures 5-5, 5-6, and 5-7 show Regence’s average rate changes over the past four years.

**Figure 5-5. Regence BlueCross BlueShield rate changes, individual plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>13.17%</td>
</tr>
<tr>
<td>2006</td>
<td>-2.37%</td>
</tr>
<tr>
<td>2007</td>
<td>2.18%</td>
</tr>
<tr>
<td>2008</td>
<td>21.42%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>37.08%</td>
</tr>
</tbody>
</table>

**Figure 5-6. Regence BlueCross BlueShield rate changes, small group plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>11.20%</td>
</tr>
<tr>
<td>2006</td>
<td>-0.05%</td>
</tr>
<tr>
<td>2007</td>
<td>5.38%</td>
</tr>
<tr>
<td>2008</td>
<td>10.73%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>29.69%</td>
</tr>
</tbody>
</table>

**Figure 5-7. Regence BlueCross BlueShield rate changes, portability plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>-13.73%</td>
</tr>
<tr>
<td>2006</td>
<td>-23.48%</td>
</tr>
<tr>
<td>2007</td>
<td>-1.80%</td>
</tr>
<tr>
<td>2008</td>
<td>26.63%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>-17.92%</td>
</tr>
</tbody>
</table>

1 The division approved a 26 percent rate increase July 1, 2008. The annual rate change calculation includes the first six months before the rate increase began. Rate increases can occur only once every 12 months for each policy.
Kaiser Foundation Health Plan of the Northwest

Kaiser was granted a Certificate of Authority in 1948. Kaiser is part of a national network headquartered in Oakland, Calif. Kaiser Permanente enrolls members in nine states and Washington, D.C. The Oregon-based Kaiser operation encompasses Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; and the Permanente Medical Groups, and is affiliated with Group Health Cooperative based in Seattle.

Kaiser was historically an integrated health care organization offering only managed care health plans, but the company added more choices that allow members to choose between in-network care from Kaiser Permanente and out-of-network care from community providers.

Figure 5-8 summarizes key data submitted by Kaiser in its 2007 Health Benefit Plan Report. In 2007, Kaiser insured 329,000 Oregonians and earned $1.2 billion in Oregon premiums in 2007. The company reported $59 million net income after taxes and maintained $494 million in surplus in 2007.

The company’s largest nonmedical administrative expenses in 2007 were for salaries and marketing, and the company’s total general administrative expense was $86 million.

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>16,982</td>
<td>$82,105,997</td>
<td>95.49</td>
<td>$382.455</td>
</tr>
<tr>
<td>Small group</td>
<td>32,706</td>
<td>$107,013,809</td>
<td>95.89</td>
<td>$274.23</td>
</tr>
<tr>
<td>Large group</td>
<td>279,631</td>
<td>$1,000,514,339</td>
<td>95.48</td>
<td>$300.28</td>
</tr>
<tr>
<td>Total for all markets above</td>
<td>329,319</td>
<td>$1,189,634,145</td>
<td>95.52</td>
<td>$302.18</td>
</tr>
</tbody>
</table>

Comprehensive products nationwide for 2007

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total surplus maintained</td>
<td>$ 494,196,039</td>
</tr>
<tr>
<td>Total unpaid claims reserves maintained</td>
<td>$ 49,216,400</td>
</tr>
<tr>
<td>Net underwriting gain or loss</td>
<td>$ 26,517,339</td>
</tr>
<tr>
<td>Net income after taxes</td>
<td>$ 59,041,115</td>
</tr>
<tr>
<td>Oregon Medical Insurance Pool</td>
<td>$ 11,501,649</td>
</tr>
<tr>
<td>Total general administrative expense</td>
<td>$ 85,560,724</td>
</tr>
</tbody>
</table>

Largest nonmedical administrative expenses............Total year-end

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages, employment taxes, and other benefits</td>
<td>$ 45,813,585</td>
</tr>
<tr>
<td>Marketing and advertising</td>
<td>$ 17,424,742</td>
</tr>
<tr>
<td>Other taxes, licenses, and fees</td>
<td>$ 13,706,368</td>
</tr>
<tr>
<td>Rent</td>
<td>$ 2,659,686</td>
</tr>
<tr>
<td>Legal fees, expenses, and other professional or consulting fees</td>
<td>$ 1,795,444</td>
</tr>
</tbody>
</table>

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-9 shows Kaiser’s overall market share and its market share in each market segment. Kaiser earned 24 percent of all Oregon premiums in 2007.

Figure 5-10 provides a breakdown by market segments of where Kaiser earned its $1.2 billion in total premiums. Kaiser earned $1 billion, or 84 percent, in the large group market, followed by 9 percent in the small group market, and 7 percent in the individual market in 2007.
Figure 5-11 shows that Kaiser increased its surplus from $98 million in 1998 to $494 million in 2007. Kaiser’s surplus through Sept. 30, 2008, was $513 million. The current surplus level is comfortably above the minimum required surplus. Kaiser’s profit margins averaged 2 percent for 1998-2002, 3 percent for 2003-2007, and 1 percent as of Sept. 30, 2008, as shown in Section 3.

Figure 5-11. Kaiser Foundation Health Plan: Surplus trend, actual vs. minimum required from 1998-2008

Figures 5-12, 5-13, and 5-14 show Kaiser’s average rate changes over the past four years.

Figure 5-12. Kaiser Foundation Health Plan rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>9.92%</td>
</tr>
<tr>
<td>2006</td>
<td>7.54%</td>
</tr>
<tr>
<td>2007</td>
<td>11.56%</td>
</tr>
<tr>
<td>2008</td>
<td>6.98%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>41.08%</td>
</tr>
</tbody>
</table>

Figure 5-13. Kaiser Foundation Health Plan rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>9.00%</td>
</tr>
<tr>
<td>2006</td>
<td>9.90%</td>
</tr>
<tr>
<td>2007</td>
<td>14.30%</td>
</tr>
<tr>
<td>2008</td>
<td>7.64%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>47.39%</td>
</tr>
</tbody>
</table>

Figure 5-14. Kaiser Foundation Health Plan rate changes, portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>1.33%</td>
</tr>
<tr>
<td>2006</td>
<td>3.80%</td>
</tr>
<tr>
<td>2007</td>
<td>17.30%</td>
</tr>
<tr>
<td>2008</td>
<td>5.20%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>29.79%</td>
</tr>
</tbody>
</table>

Note: The minimum surplus required is not available for YTD Sept. 2008.
**PacificSource Health Plans**

PacificSource is an Oregon-based, not-for-profit health care service contractor. The company was granted a Certificate of Authority in Oregon in 1940 and is based in Eugene. PacificSource is authorized to transact insurance in Oregon and Idaho. PacificSource serves 134,000 Oregonians.

Figure 5-15 summarizes key data submitted by PacificSource in its 2007 *Health Benefit Plan Report.* The company insured 134,000 members and earned $462 million in Oregon premiums in 2007. PacificSource had net income after taxes of $10 million and maintained $125 million in surplus.

The largest nonmedical administrative expenses in 2007 were for salaries and marketing, and the total general administrative expense was $49 million.

### Figure 5-15. PacificSource Health Plans, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>12,372</td>
<td>$23,426,819</td>
<td>107.61</td>
<td>$167.58</td>
</tr>
<tr>
<td>Small group</td>
<td>42,097</td>
<td>$151,722,977</td>
<td>87.79</td>
<td>$282.59</td>
</tr>
<tr>
<td>Large group</td>
<td>79,186</td>
<td>$286,354,030</td>
<td>88.84</td>
<td>$306.61</td>
</tr>
<tr>
<td><strong>Total for all markets above</strong></td>
<td><strong>133,655</strong></td>
<td><strong>$461,503,826</strong></td>
<td><strong>89.45</strong></td>
<td><strong>$286.54</strong></td>
</tr>
</tbody>
</table>

**Comprehensive products nationwide for 2007**

- Total surplus maintained………………………………………………………………………… $124,499,606
- Total unpaid claims reserves maintained………………………………………………………… $ 50,105,226
- Net underwriting gain or loss………………………………………………………………………. $ -8,880,854
- Net income after taxes………………………………………………………………………………….. $ 9,901,134
- Oregon Medical Insurance Pool ……………………………………………………………………… $ 5,065,355
- Total general administrative expense ………………………………………………………………. $ 48,700,819

**Largest nonmedical administrative expenses…………. Total year-end**

- Salaries, wages, employment taxes, and other benefits…………………………………………… $ 19,471,176
- Commissions…………………………………………………………………………………………… $ 15,168,030
- Other taxes, licenses, and fees………………………………………………………………………… $ 5,065,355
- Cost depreciation: equipment, software, furniture, etc.……………………………………………… $ 5,151,841
- Legal fees, expenses, and other professional or consulting fees…………………………………… $ 4,881,190

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.

The amount of total surplus maintained originated from PacificSource’s amended financial statements.
**Figure 5-16** shows PacificSource’s overall market share and its market share in each of the market segments. PacificSource earned 9 percent of all premiums in Oregon. PacificSource had 8 percent share of the large group market, 18 percent of the small group market, and 5 percent of the individual market. PacificSource was Oregon’s largest insurer in the small employer market in premium earned.

![Figure 5-16. PacificSource Health Plans: Premium as percent of Oregon market in 2007](image)

**Figure 5-17** illustrates the percentage of PacificSource’s $462 million in premiums earned in each of the three health insurance markets. The company earned 62 percent, or $286 million of its premiums, in the large group market, 33 percent ($152 million) in the small group market, and 5 percent ($23 million) in the individual market.

![Figure 5-17. PacificSource Health Plans: Premium as percent of its Oregon 2007 business](image)
Figure 5-18 illustrates that PacificSource’s surplus increased from $22 million in 1998 to $125 million in 2007. The surplus as of Sept. 30, 2008, was $104 million, down 17 percent from 2007, yet still comfortably above the minimum required.

PacificSource’s profit margin increased from an average of 4 percent for 1998-2002 to an average of 5 percent for 2003-2007 and was down to 1 percent through Sept. 30, 2008, as shown in Section 3.

Figures 5-19, 5-20, and 5-21 show PacificSource’s average rate changes over the past four years.

### Figure 5-19. PacificSource Health Plans rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>5.60%</td>
</tr>
<tr>
<td>2006</td>
<td>11.44%</td>
</tr>
<tr>
<td>2007</td>
<td>3.20%</td>
</tr>
<tr>
<td>2008</td>
<td>16.90%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>41.97%</td>
</tr>
</tbody>
</table>

### Figure 5-20. PacificSource Health Plans rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>26.26%</td>
</tr>
<tr>
<td>2006</td>
<td>19.13%</td>
</tr>
<tr>
<td>2007</td>
<td>11.37%</td>
</tr>
<tr>
<td>2008</td>
<td>12.45%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>88.37%</td>
</tr>
</tbody>
</table>

### Figure 5-21. PacificSource Health Plans rate changes, portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>17.88%</td>
</tr>
<tr>
<td>2006</td>
<td>17.29%</td>
</tr>
<tr>
<td>2007</td>
<td>12.79%</td>
</tr>
<tr>
<td>2008</td>
<td>12.89%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>76.05%</td>
</tr>
</tbody>
</table>

Note: The minimum surplus required is not available for YTD Sept. 2008.
Providence Health Plan of Oregon, Inc.

Providence Health Plan is an Oregon-based, not-for-profit plan sponsored by Providence Health System and is authorized to do business in Oregon and Washington. Providence received an Oregon Certificate of Authority in 1984. Providence entered the Oregon individual health insurance market in 2005.

Figure 5-22 summarizes key data submitted by Providence in its 2007 Health Benefit Plan Report. Providence insured 139,000 members and earned $434 million in premiums in 2007. The company’s net income after taxes was $58 million and it maintained a surplus of $341 million.

The largest nonmedical administrative expenses were for salaries, benefits, and commissions, and its total general administrative expense in 2007 was $34 million.

Figure 5-22. Providence Health Plan, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>4,376</td>
<td>$4,801,583</td>
<td>65.71</td>
<td>$141.14</td>
</tr>
<tr>
<td>Small group</td>
<td>46,011</td>
<td>$146,420,558</td>
<td>86.87</td>
<td>$262.82</td>
</tr>
<tr>
<td>Large group</td>
<td>88,973</td>
<td>$282,559,231</td>
<td>89.19</td>
<td>$272.72</td>
</tr>
<tr>
<td><strong>Total for all markets above</strong></td>
<td>139,360</td>
<td><strong>$433,781,372</strong></td>
<td><strong>88.15</strong></td>
<td><strong>$266.58</strong></td>
</tr>
</tbody>
</table>

Comprehensive products nationwide for 2007

- Total surplus maintained.......................................................... $340,519,671
- Total unpaid claims reserves maintained........................................ $ 64,009,443
- Net underwriting gain or loss ................................................. $ 36,370,043
- Net income after taxes ........................................................... $ 58,467,917
- Oregon Medical Insurance Pool .................................................. $ 5,035,470
- Total general administrative expense ........................................ $ 33,821,777

Largest nonmedical administrative expenses............................ Total year-end

- Salaries, wages, employment taxes, and other benefits ....................... $ 34,805,770
- Commissions .................................................................................. $ 11,960,269
- Other taxes, licenses, and fees ....................................................... $ 5,543,032
- Marketing and advertising ............................................................. $ 5,796,745
- Rent .............................................................................................. $ 2,943,973

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-23 shows Providence’s overall market share and its market share in each of the market segments. Providence earned 9 percent of all premiums in Oregon. Providence earned 18 percent of all small group premiums, 8 percent of large group premiums, and 1 percent of individual premiums in 2007.

Figure 5-23. Providence Health Plans:
Premium as percent of Oregon market in 2007

<table>
<thead>
<tr>
<th>Market segment</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>1%</td>
</tr>
<tr>
<td>Small</td>
<td>18%</td>
</tr>
<tr>
<td>Large</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>9%</td>
</tr>
</tbody>
</table>

Figure 5-24 provides a breakdown by market segments of where Providence earned its $434 million in premiums. Providence earned 65 percent, or $283 million, in the large group market, $146 million (34 percent) in the small group market, and $5 million in the individual market.

Figure 5-24. Providence Health Plan:
Premium as percent of its Oregon 2007 business

- **Small**: 34%
- **Large**: 65%
- **Individual**: 1%
Figure 5-25 shows that Providence’s surplus increased from $54 million in 1998 to $341 million in 2007. As of Sept. 30, 2008, the surplus was $346 million. The current surplus level is comfortably above the minimum required surplus. Providence’s profit margins increased from an average of 0 percent for 1998-2002 to 8 percent for 2003-2007 and as of Sept. 30, 2008, was 3 percent as shown in Section 3.

Note: The minimum surplus required is not available for YTD Sept. 2008.

Figures 5-26, 5-27, 5-28, and 5-29 show Providence’s average rate changes over the past four years.

### Figure 5-26. Providence Health Plan rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>N/A</td>
</tr>
<tr>
<td>2006</td>
<td>-8.93%</td>
</tr>
<tr>
<td>2007</td>
<td>2.58%</td>
</tr>
<tr>
<td>2008</td>
<td>14.54%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>1.62%</td>
</tr>
</tbody>
</table>

### Figure 5-27. Providence Health Plan rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>19.41%</td>
</tr>
<tr>
<td>2006</td>
<td>7.91%</td>
</tr>
<tr>
<td>2007</td>
<td>8.69%</td>
</tr>
<tr>
<td>2008</td>
<td>4.74%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>46.68%</td>
</tr>
</tbody>
</table>

### Figure 5-28. Providence Health Plan rate changes, large group portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>20.60%</td>
</tr>
<tr>
<td>2006</td>
<td>2.10%</td>
</tr>
<tr>
<td>2007</td>
<td>-1.10%</td>
</tr>
<tr>
<td>2008</td>
<td>6.60%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>29.82%</td>
</tr>
</tbody>
</table>

### Figure 5-29. Providence Health Plan recent rate changes, small group portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>7.80%</td>
</tr>
<tr>
<td>2006</td>
<td>7.80%</td>
</tr>
<tr>
<td>2007</td>
<td>4.10%</td>
</tr>
<tr>
<td>2008</td>
<td>10.00%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>33.07%</td>
</tr>
</tbody>
</table>
Health Net Health Plan of Oregon, Inc.

Health Net Health Plan of Oregon, Inc. is a subsidiary of Health Net, Inc., a national publicly traded managed health care company and a member of an insurance holding company system with 53 affiliated entities, including 12 insurance companies. Health Net has operated under a Certificate of Authority in Oregon since 1989 and provides health benefits to 117,000 Oregonians. Figure 5-30 summarizes key data submitted by Health Net Health Plan of Oregon in its 2007 Health Benefit Plan Report. Health Net insured 117,000 members and earned $371 million in premiums in 2007.

The company maintained a surplus of $67 million in 2007 with a net income after taxes of $12 million. The largest nonmedical administrative expenses were salaries and commissions, and its total general administrative expense was $46 million in 2007.

Figure 5-30. Health Net Health Plan, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>7,212</td>
<td>$16,149,949</td>
<td>97.10</td>
<td>$190.56</td>
</tr>
<tr>
<td>Small group</td>
<td>31,555</td>
<td>$111,301,718</td>
<td>75.16</td>
<td>$277.97</td>
</tr>
<tr>
<td>Large group</td>
<td>78,644</td>
<td>$243,220,151</td>
<td>84.67</td>
<td>$262.99</td>
</tr>
<tr>
<td><strong>Total for all markets above</strong></td>
<td><strong>117,411</strong></td>
<td><strong>$370,671,818</strong></td>
<td><strong>82.35</strong></td>
<td><strong>$262.89</strong></td>
</tr>
</tbody>
</table>

Comprehensive products nationwide for 2007

<table>
<thead>
<tr>
<th>Summary</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total surplus maintained</td>
<td>$67,435,509</td>
</tr>
<tr>
<td>Total unpaid claims reserves maintained</td>
<td>$27,543,723</td>
</tr>
<tr>
<td>Net underwriting gain or loss</td>
<td>$13,517,192</td>
</tr>
<tr>
<td>Net income after taxes</td>
<td>$12,097,948</td>
</tr>
<tr>
<td>Oregon Medical Insurance Pool</td>
<td>$3,945,196</td>
</tr>
<tr>
<td>Total general administrative expense</td>
<td>$46,278,452</td>
</tr>
</tbody>
</table>

Largest nonmedical administrative expenses...........Total year-end

<table>
<thead>
<tr>
<th>Administrative expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages, employment taxes, and other benefits</td>
<td>$18,662,313</td>
</tr>
<tr>
<td>Commissions</td>
<td>$11,310,622</td>
</tr>
<tr>
<td>Other taxes, licenses, and fees</td>
<td>$8,359,607</td>
</tr>
<tr>
<td>Marketing and advertising</td>
<td>$2,481,974</td>
</tr>
<tr>
<td>General office expenses: sundries, supplies, telephones, etc</td>
<td>$1,914,826</td>
</tr>
</tbody>
</table>

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-31 shows Health Net’s overall market share in Oregon and its market share in each market segment. Health Net earned 8 percent of all Oregon premiums in 2007. Health Net earned 14 percent of all small group premiums, 7 percent of large group premiums, and 3 percent of individual market premiums in 2007.

Figure 5-31. Health Net Health Plan: Premium as percent of Oregon market in 2007

![Bar chart showing market share by segment](image)

Figure 5-32 provides a breakdown by market segments of where Health Net earned its $371 million in premiums. Health Net earned 66 percent, or $243 million, in the large group market, $111 million (30 percent) in the small group market, and $16 million (4 percent) in the individual market.

Figure 5-32. Health Net Health Plan: Premium as percent of its Oregon 2007 business

![Pie chart showing market share by segment](image)
Figure 5-33 shows Health Net increased its surplus from $18 million in 1998 to $67 million in 2007. The surplus through Sept. 30, 2008, was $59 million, down 13 percent from 2007. The current surplus level is comfortably above the minimum required surplus. Health Net had a 0 percent profit for 1998 through 2002, an average profit margin of 3 percent from 2003 through 2007, and as of Sept. 30, 2008, profit of 1 percent as shown in Section 3.

Figure 5-33. Health Net Health Plan: Surplus trend, actual vs. minimum required from 1998-2008

Note: The minimum surplus required is not available for YTD Sept. 2008.

Figures 5-34, 5-35, and 5-36 show Health Net’s average rate changes over the past four years.

Figure 5-34. Health Net Health Plan rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>6.36%</td>
</tr>
<tr>
<td>2006</td>
<td>4.59%</td>
</tr>
<tr>
<td>2007</td>
<td>8.37%</td>
</tr>
<tr>
<td>2008</td>
<td>10.39%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>33.07%</td>
</tr>
</tbody>
</table>

Figure 5-35. Health Net Health Plan rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>13.93%</td>
</tr>
<tr>
<td>2006</td>
<td>10.61%</td>
</tr>
<tr>
<td>2007</td>
<td>10.17%</td>
</tr>
<tr>
<td>2008</td>
<td>7.88%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>49.77%</td>
</tr>
</tbody>
</table>

Figure 5-36. Health Net Health Plan rate changes, portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>12.83%</td>
</tr>
<tr>
<td>2006</td>
<td>5.05%</td>
</tr>
<tr>
<td>2007</td>
<td>4.33%</td>
</tr>
<tr>
<td>2008</td>
<td>10.60%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>36.76%</td>
</tr>
</tbody>
</table>
**LifeWise Health Plan of Oregon, Inc.**

LifeWise Health Plan of Oregon, Inc. has operated as a health insurer in Oregon since 1986. LifeWise is a privately held, for-profit company serving 113,000 members in Oregon and is a part of the group of Premera companies whose ultimate parent is Premera Inc., a Washington not-for-profit.

Figure 5-37 summarizes key data submitted by LifeWise in its 2007 *Health Benefit Plan Report*. LifeWise insured 113,000 Oregonians and earned $316 million in premiums in its health benefit plans in 2007.

**Figure 5-37. LifeWise Health Plan, Oregon 2007 financial data**

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>35,826</td>
<td>$73,013,063</td>
<td>85.63</td>
<td>$163.57</td>
</tr>
<tr>
<td>Small group</td>
<td>41,677</td>
<td>$115,795,909</td>
<td>88.96</td>
<td>$232.90</td>
</tr>
<tr>
<td>Large group</td>
<td>35,188</td>
<td>$127,608,844</td>
<td>88.44</td>
<td>$293.09</td>
</tr>
<tr>
<td><strong>Total for all markets above</strong></td>
<td><strong>112,691</strong></td>
<td><strong>$316,063,816</strong></td>
<td><strong>87.98</strong></td>
<td><strong>$229.47</strong></td>
</tr>
</tbody>
</table>

**Comprehensive products nationwide for 2007**

- Total surplus maintained................................................................. $ 69,922,493
- Total unpaid claims reserves maintained........................................... $ 38,067,868
- Net underwriting gain or loss ......................................................... $-14,099,234
- Net income after taxes ...................................................................... $ -5,273,580
- Oregon Medical Insurance Pool .......................................................... $ 4,478,293
- Total general administrative expense ................................................ $ 32,278,689

**Largest nonmedical administrative expenses.................. Total year-end**

- Salaries, wages, employment taxes, and other benefits .................. $ 11,144,431
- Commissions .................................................................................... $ 13,807,424
- Cost depreciation: equipment, software, furniture, etc. ................. $ 1,908,352
- Marketing and advertising ............................................................... $ 770,101
- Legal fees, expenses, and other professional or consulting fees .... $ 812,564

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-38 shows LifeWise’s overall market share and its market share in each of the market segments. LifeWise earned 7 percent of all Oregon premiums earned in 2007. LifeWise earned 15 percent of premiums in the individual market, 14 percent in the small group market, and 4 percent in the large group market in 2007.

Figure 5-38. Lifewise Health Plan: Premium as percent of Oregon market in 2007

<table>
<thead>
<tr>
<th>Market segment</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>15%</td>
</tr>
<tr>
<td>Small</td>
<td>14%</td>
</tr>
<tr>
<td>Large</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>7%</td>
</tr>
</tbody>
</table>

Figure 5-39 shows that in 2007 LifeWise earned 40 percent of its $316 million in premiums in the large group market. Thirty-seven percent, or $116 million, was earned in the small group market and 23 percent, or $73 million, was earned in the individual market.

Figure 5-39. LifeWise Health Plan: Premium as percent of its Oregon 2007 business

- Small: 37%
- Large: 40%
- Individual: 23%
Figure 5-40 shows that LifeWise increased its surplus from $17 million in 1998 to $70 million in 2007. The surplus through Sept. 30, 2008, was $63 million, down 10 percent from 2007. The current surplus level is comfortably above the minimum required surplus. LifeWise’s profit margins averaged 2 percent for 1998-2002, 3 percent for 2003-2007, and as of Sept. 30, 2008, was a 3 percent loss, as shown in Section 3.

Figure 5-40. LifeWise Health Plan: Surplus trend, actual vs. minimum required from 1998-2008

Figures 5-41, 5-42, and 5-43 show LifeWise’s average recent rate changes over the past four years.

Figure 5-41. LifeWise Health Plan rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>12.76%</td>
</tr>
<tr>
<td>2006</td>
<td>9.88%</td>
</tr>
<tr>
<td>2007</td>
<td>7.78%</td>
</tr>
<tr>
<td>2008</td>
<td>17.96%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>57.53%</td>
</tr>
</tbody>
</table>

Figure 5-42. LifeWise Health Plan rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>22.76%</td>
</tr>
<tr>
<td>2006</td>
<td>7.51%</td>
</tr>
<tr>
<td>2007</td>
<td>10.68%</td>
</tr>
<tr>
<td>2008</td>
<td>21.15%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>76.98%</td>
</tr>
</tbody>
</table>

Figure 5-43. LifeWise Health Plan rate changes, portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>9.10%</td>
</tr>
<tr>
<td>2006</td>
<td>3.77%</td>
</tr>
<tr>
<td>2007</td>
<td>-0.26%</td>
</tr>
<tr>
<td>2008</td>
<td>10.67%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>24.96%</td>
</tr>
</tbody>
</table>

Note: The minimum surplus required is not available for YTD Sept. 2008.
ODS Health Plan, Inc.

ODS Health Plan, Inc., a for-profit company, was first issued a Certificate of Authority in Oregon in 1988. ODS Health Plan is a subsidiary of the not-for-profit Oregon Dental Service (ODS), whose board of directors is appointed by the not-for-profit Oregon Dental Association. ODS Health Plan also serves more than 700,000 Oregonians with its dental plans. ODS Health Plan is headquartered in Portland.

Figure 5-44 summarizes key data submitted by ODS Health Plan in its 2007 Health Benefit Plan Report. ODS Health Plan insured 43,000 Oregonians and earned $133 million in premiums in 2007.

ODS Health Plan maintained a surplus of $38 million in 2007 with a net income after taxes of $4 million. Its largest nonmedical administrative expenses were salaries, benefits, and commissions, and the total general administrative expense was $12 million in 2007.

### Figure 5-44. ODS Health Plan, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per member per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>5,354</td>
<td>$7,019,563</td>
<td>69.31</td>
<td>$133.39</td>
</tr>
<tr>
<td>Small group</td>
<td>8,297</td>
<td>$17,660,587</td>
<td>81.51</td>
<td>$247.97</td>
</tr>
<tr>
<td>Large group</td>
<td>29,343</td>
<td>$108,317,529</td>
<td>88.24</td>
<td>$311.04</td>
</tr>
<tr>
<td>Total for all markets above</td>
<td>42,994</td>
<td>$132,997,679</td>
<td>86.35</td>
<td>$281.72</td>
</tr>
</tbody>
</table>

**Comprehensive products nationwide for 2007**

- Total surplus maintained.......................... $38,281,240
- Total unpaid claims reserves maintained.................. $17,550,335
- Net underwriting gain or loss ................................ $ 449,784
- Net income after taxes ........................................ $ 3,537,754
- Oregon Medical Insurance Pool ........................................ $ 3,076,176
- Total general administrative expense ......................... $12,293,498

**Largest nonmedical administrative expenses............... Total year-end**

- Salaries, wages, employment taxes, and other benefits........................ $ 8,930,148
- Commissions.......................................................... $ 2,822,055
- Cost depreciation: equipment, software, furniture, etc. ........................ $ 4,171,185
- Marketing and advertising............................................ $ 965,222
- Legal fees, expenses, other professional or consulting fees ................ $ 2,827,302

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
**Figure 5-45** shows ODS’s overall market share and its market share in each of the market segments. ODS had 3 percent of all Oregon premiums earned in 2007. ODS earned 3 percent of premiums in the large group market, 2 percent in the small group market, and 1 percent in the individual market in 2007.

**Figure 5-46** shows that ODS Health Plan earned 82 percent of its $133 million in premiums in the large group market, 13 percent in the small group market, and 5 percent in the individual market.
Figure 5-47 shows that ODS Health Plan increased its surplus from $26 million in 1998 to $38 million in 2007. The surplus through Sept. 30, 2008, was $34 million, down 10 percent from 2007. The current surplus level is comfortably above the minimum required surplus. ODS’s profit margin for 1998-2002 averaged negative 1 percent, increased to 4 percent for 2003-2007, and was 1 percent through Sept. 30, 2008, as shown in Section 3.

Figure 5-47. ODS Health Plan: Surplus trend, actual vs. minimum required from 1998-2008

![Surplus trend graph]

Note: The minimum surplus required is not available for YTD Sept. 2008.

Figures 5-48, 5-49, and 5-50 show ODS’s average rate change over the past four years.

Figure 5-48. ODS Health Plan rate changes, individual plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>6.75%</td>
</tr>
<tr>
<td>2006</td>
<td>9.99%</td>
</tr>
<tr>
<td>2007</td>
<td>-4.50%</td>
</tr>
<tr>
<td>2008</td>
<td>8.90%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>22.10%</td>
</tr>
</tbody>
</table>

Figure 5-49. ODS Health Plan rate changes, small group plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>10.46%</td>
</tr>
<tr>
<td>2006</td>
<td>9.93%</td>
</tr>
<tr>
<td>2007</td>
<td>8.18%</td>
</tr>
<tr>
<td>2008</td>
<td>9.17%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>43.40%</td>
</tr>
</tbody>
</table>

Figure 5-50. ODS Health Plan rate changes, portability plans

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>11.40%</td>
</tr>
<tr>
<td>2006</td>
<td>-6.41%</td>
</tr>
<tr>
<td>2007</td>
<td>0.03%</td>
</tr>
<tr>
<td>2008</td>
<td>11.40%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>16.18%</td>
</tr>
</tbody>
</table>
PacifiCare of Oregon, Inc.

PacifiCare of Oregon, Inc., received a Certificate of Authority in Oregon in 1987. In 2006, it became a member of the United Health Group, Inc., holding company system, one of the nation’s largest for-profit health insurers.

Figure 5-51 summarizes key data submitted by PacifiCare in its 2007 Health Benefit Plan Report. PacifiCare insured 12,000 Oregonians and earned $51 million in premiums in 2007. Its net income after taxes was $21 million and it maintained a surplus of $47 million. The company’s largest nonmedical administrative expenses were salaries and other taxes, licenses, and fees, and it had $33 million in total general administrative expenses.

### Figure 5-51. PacifiCare, Oregon 2007 financial data

<table>
<thead>
<tr>
<th>Market</th>
<th>Total members</th>
<th>Premium earned</th>
<th>Medical loss ratio</th>
<th>Average premium per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual health benefit plans</td>
<td>307</td>
<td>$1,855,658</td>
<td>76.77</td>
<td>$441.40</td>
</tr>
<tr>
<td>Small group</td>
<td>206</td>
<td>$1,343,636</td>
<td>51.53</td>
<td>$388.56</td>
</tr>
<tr>
<td>Large group</td>
<td>11,651</td>
<td>$48,076,160</td>
<td>89.47</td>
<td>$311.81</td>
</tr>
<tr>
<td><strong>Total for all markets above</strong></td>
<td><strong>12,164</strong></td>
<td><strong>$51,275,454</strong></td>
<td><strong>88.01</strong></td>
<td><strong>$316.82</strong></td>
</tr>
</tbody>
</table>

**Comprehensive products nationwide for 2007**

- Total surplus maintained ................................................................. $46,677,304
- Total unpaid claims reserves maintained ................................................ $20,890,313
- Net underwriting gain or loss ............................................................ $26,009,769
- Net income after taxes .............................................................. $21,376,025
- Oregon Medical Insurance Pool ....................................................... 764,236
- Total general administrative expense ............................................. $33,106,754

**Largest nonmedical administrative expenses.........Total year-end**

- Salaries, wages, employment taxes, and other benefits ......................... $20,226,977
- General office expenses: sundries, supplies, telephone, etc. ............... $ 3,030,720
- Other taxes, licenses, and fees ......................................................... $ 4,329,658
- Travel expenses .................................................................................. $ 1,233,531
- Rent ....................................................................................................... $ 824,060

Source: Oregon Insurance Division 2007 Health Benefit Plan Reports.
Figure 5-52 shows PacifiCare’s overall market share and its market share in each of the market segments. PacifiCare earned 1 percent of the Oregon premium dollars in 2007. PacifiCare earned 1 percent of all premiums in the large group market and less than 1 percent in the small group and individual markets.

Figure 5-52. PacifiCare Health Plan: Premium as percent of Oregon market in 2007

Figure 5-53. PacifiCare Health Plan: Premium as percent of its Oregon 2007 business

Figure 5-53 shows PacifiCare earned 93 percent of its $51 million in premiums from the large group market, 4 percent in the individual market, and 3 percent in the small group market.
Figure 5-54 shows that PacifiCare’s surplus increased from $35 million in 1998 to $47 million in 2007*. The surplus, through Sept. 30, 2008, was $42 million, down 10 percent from 2007. The current surplus level is comfortably above the minimum required surplus. PacifiCare’s average profit margins were 2 percent for 1998-2002, 3 percent for 2003-2007, and 12 percent through Sept. 30, 2008, as shown in Section 3. The company’s profit margin is growing substantially due to its Medicare business, which is not regulated by the department.

* Its surplus was at the same level in 2007 as in 2001, due mainly to dividends paid to its parent company.

Figures 5-55, 5-56, and 5-57 show PacifiCare’s average rate changes over the past four years.

**Figure 5-55. PacifiCare rate changes, individual plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>17.00%</td>
</tr>
<tr>
<td>2006</td>
<td>14.19%</td>
</tr>
<tr>
<td>2007</td>
<td>9.61%</td>
</tr>
<tr>
<td>2008</td>
<td>9.31%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>60.09%</td>
</tr>
</tbody>
</table>

**Figure 5-56. PacifiCare rate changes, small group plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>19.10%</td>
</tr>
<tr>
<td>2006</td>
<td>24.66%</td>
</tr>
<tr>
<td>2007</td>
<td>11.47%</td>
</tr>
<tr>
<td>2008</td>
<td>15.89%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>91.80%</td>
</tr>
</tbody>
</table>

**Figure 5-57. PacifiCare rate changes, portability plans**

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Rate Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>16.70%</td>
</tr>
<tr>
<td>2006</td>
<td>-0.70%</td>
</tr>
<tr>
<td>2007</td>
<td>4.32%</td>
</tr>
<tr>
<td>2008</td>
<td>0.00%</td>
</tr>
<tr>
<td>2005-2008 Cumulative</td>
<td>20.89%</td>
</tr>
</tbody>
</table>

Note: The minimum surplus required is not available for YTD Sept. 2008.
Appendix: 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 is claims incurred divided by net premium earned.

**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. This report uses the term *profit margin* as synonymous with net income.

**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 state is authorized to take regulatory action against an insurer that fails to maintain surplus equal to 200 percent of its authorized control level.
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.

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.

Insurance Company Financial Information

Premium and Expense Reports
The financial data used in this report was developed from the annual statements filed by each insurer. The Insurance Division of the Department of Consumer and Business Services created a report by insurer that summarizes 2007 premium, expense, and financial status. These summaries are available at http://www.cbs.state.or.us/external/ins/insurer/financial_regulation/expense_summary/reports.html.

Financial Statements
Each insurer files detailed financial statements covering its financial status and income and expense activity for each calendar quarter and each calendar year. The annual statement (prepared as of Dec. 31 of each year) must be filed with the department by March 1 of each year. The quarterly statements are prepared as of March 31, due to be filed May 15; as of June 30, due to be filed Aug. 15; and Sept. 30, 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 (5 cents per page) for public use.

Data from the NAIC
Insurers also file their financial statements electronically with the National Association of Insurance Commissioners (NAIC). State insurance departments also file summarized information with the NAIC about consumer complaints against insurers. The NAIC makes basic financial and complaint information available on its Web site, 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 first five, there is a charge. To access the NAIC’s insurer information, go to the NAIC Web site, select “Consumer Information Source,” and follow the directions.
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