IN THE COURT OF APPEALS OF THE STATE OF OREGON

KAREN I. KIRSCH,

Petitioner,

v.

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES and REGENCE BLUECROSS BLUESHIELD OF OREGON,

Respondents.

Department of Consumer and Business Services No. 0807007

CA A143335

RESPONDENT DEPARTMENT OF CONSUMER AND BUSINESS SERVICES' ANSWERING BRIEF

Petition for Judicial Review of the Final Order of the Department of Consumer and Business Services

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RESPONDENT DEPARTMENT OF CONSUMER AND BUSINESS SERVICES' ANSWERING BRIEF

STATEMENT OF THE CASE

Respondent the Department of Consumer and Business Services (DCBS) accepts petitioner's statement of the case, with the following exceptions. DCBS expressly rejects petitioner's summary of facts, which is partially argumentative and does not reflect the department's undisputed findings of fact. DCBS also expressly rejects petitioner's questions presented, which are imprecise.

DCBS also rejects Regence's first question presented, because it raises an issue that is immaterial to this case.

DCBS substitutes the following questions presented.

Questions presented

1. In approving Regence's filed rate increase, did the director exceed the range of her discretion under ORS 742.005(3)?

2. In approving Regence's filed rate increase, did the director exceed her statutory authority under ORS 742.005(4)?

3. In approving Regence's filed rate increase, did the director exceed her statutory authority under ORS 742.005(6)?

4. Was petitioner denied a fundamentally fair hearing because she was not permitted to examine the director or the deputy administrator of DCBS?

5. Was DCBS required to adopt standards by formal rulemaking before approving Regence's filed rate increase?

Summary of arguments

1. Under the statutes in effect at the time, DCBS applied the standards set out in ORS 742.005 in determining whether to approve an insurer's rate filing for individual health insurance plans.[1] Under the standard in ORS 742.005(3), the director is to exercise her judgment to determine whether a filed rate increase "would be prejudicial to the interests of the insurer's policyholders[.]" DCBS's approval of Regence's filed rate increase was a proper exercise of the director's discretion under the standard in ORS 742.005(3). [2]

2. Under the standard stated in ORS 742.005(4), DCBS shall disapprove a filed rate increase "[i]f the director finds" that the rate increase is "unjust, unfair or inequitable." The director did not find that Regence's filed rate increase was unjust, unfair, or inequitable. DCBS's approval of the rate

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[1] The 2009 Legislative Assembly amended the statutory standards and process for rate review. This case involves the statutes that were in effect prior to that time. Unless otherwise stated, all citations to Oregon Revised Statutes are to the 2007 statutes applicable in this case.

[2] The director has delegated approval of individual health insurance premium rates to the Insurance Division Administrator. DCBS asks the court to take judicial notice of that delegation, which is attached as an appendix to this brief. (App-1).

increase was within the scope of the director's discretion under the standard in ORS 742.005(4).

3. Under the standard stated in ORS 742.005(6), DCBS shall disapprove a filed rate increase if "the director finds the benefits provided therein are not reasonable in relation to the premium charged." The director did not find that the benefits provided were not reasonable in relation to Regence's filed rate increase in individual health insurance premiums. DCBS's approval of the rate increase was within the scope of the director's discretion under the standard in ORS 742.005(6).

4. DCBS properly quashed petitioner's subpoenas requiring Director Streisinger and former Deputy Administrator Lundgberg to testify at the hearing. In this case, neither of those officials exercised the authority to make the final decision to approve Regence's rate increase. Petitioner failed to establish that the record is incomplete without their testimony and failed to make any showing of any improper conduct in the decision-making process. Thus, she failed to show that DCBS erroneously interpreted a provision of law *and* that a correct interpretation compels a particular action, as she must do to prevail.

5. The text and context of the pertinent statutes compel the conclusion that the legislature did not intend to require DCBS to adopt standards by formal rulemaking before approving Regence's filed rate increase.

Summary of facts

Petitioner does not challenge any of DCBS's factual findings. Accordingly, those findings are the facts for purposes of judicial review. *Coffey v. Board of Geologist Examiners*, 348 Or 494, 496 n 1, 235 P3d 678 (2010); *see Meltebeke v. Bureau of Labor and Industries,* 322 Or 132, 134, 903 P2d 351 (1995) (so holding under analogous circumstances).

DCBS adopted the following findings of fact:

> 1. On February 28, 2008, Regence submitted a rate filing (SERFF Tracking No. RGAC-125513025) using the Department's electronic system for rates and forms filing (SERFF). Regence sought a 10.3 percent increase on its individual health benefit plan rate effective July 1, 2008 (Individual 2008 Third Quarter Rate Filing). The requested 10.3 percent quarterly rate increase amounted to an average 26 percent increase over the prior year. (Exs. A3 and A4.)
>
> 2. The Department assigned the rate filing to Scott Fitzpatrick, a Life and Health Actuary in the Department's Insurance Division. Fitzpatrick reviewed Regence's rate filing, and determined that Regence could only justify a 2 percent quarterly increase. He emailed his worksheet to coworker David Ball, and asked that Ball check his analysis. (Ex. P53.)
>
> 3. Fitzpatrick also conferred with Scott Kipper, the Department's Insurance Administrator. On March 3, 2008, through the SERFF system, Fitzpatrick issued an Objection Letter to Regence. Fitzpatrick wrote:
>
> > The Oregon Insurance Division has completed its actuarial review of the Company's submission justifying the requested 10.3% rate increase on their Individual Health Insurance effective July 1st, 2008. The Division feels strongly that only a 2.0% increase can be actuarially justified. The major difference in results obtained by the Division and the Company can be narrowed down to two sources: 1) target loss ratio, and 2) accounting for quarterly rate increases rolled forward the past three quarters.

In the paragraphs that followed, Fitzpatrick outlined his concerns about the change in Regence's target loss ratio.[1] He also noted that the annual rate increase that could be actuarially justified was 16.5 percent. He added that, should the 2 percent increase be acceptable to Regence, then it could resubmit the revised documentation and the Department would quickly approve the rate filing. (Ex. A3 at 4; test. of Fitzpatrick.)

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[1] In simple terms, the "target loss ratio" is the amount of incurred claims divided by earned premiums. It is also equal to one minus the retention, where retention (i.e., commissions to be paid, business costs, claims administrative expenses, profit, etc.) is stated as a percentage. (Test. of Fitzpatrick.)

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4. On March 10, 2008, representatives from Regence met with representatives from the Department, including Fitzpatrick, Ball, Kipper and Deputy Insurance Administrator Lundberg, to discuss the rate filing. Regence provided information and documentation in support of its requested rate increase. Regence presented financial projections for the individual line of business based on three different rate increase scenarios. Regence asserted [that] the requested rate increase was necessary to sustain the individual health insurance line. Regence contended that even with a 10.3 percent rate increase, the product line would run at a loss in 2008. (Test. of Wortman; Ex. P17; Ex. I11.) During the meeting, Regence also agreed to provide the Department with further information, including copies of the projections, charts and tables it relied upon at the meeting. (Ex. A3 at 6.)

5. On March 14, 2008, through the SERFF system, Regence submitted a response to the Department's Objection Letter. Regence wrote: "Per our meeting on Monday March 10th, we are rejecting DCBS's proposed rate increase. We will continue to work with DCBS to reach an agreement for the July 2008 rate change." (Ex. A3 at 5.) That same day, Regence submitted copies of the graphs and financial projections it used during the March 10, 2008 meeting with the Department. (Exs. A14 and 16.)

6. In the updated graphs and projections Regence submitted to the Department following the March 10, 2008 meeting, Regence charted its historical and projected claims costs, incurred and forecasted losses and

the rate history of the individual health insurance line for the previous three years. Regence also updated the graphs and tables by changing the rate increase assumption to 16.5 percent for those policies renewing in the third quarter of 2008 and updated the future quarterly rate changes to equal the trend or 2.94 percent per quarter. (Ex. 16.)

7. On March 18, 2008, Fitzpatrick, Ball, Kipper and Lundberg met to discuss the rate filing. They discussed the premium rate increases on the various plan levels and the number of policyholders that would be impacted at each level. They agreed to allow Regence a larger quarterly increase, to 4 percent, with the expectation that if this was not enough to restore profitability, the company would likely receive a rate increase exceeding trend the following year. (Ex. I11; test. of Fitzpatrick.)

8. After Fitzpatrick reviewed the additional information that Regence had provided, he saw that Regence was losing money on its individual health line each year, with projections out to 2010. Given the circumstances, Fitzpatrick came to believe that the change in Regence's target loss ratio was acceptable.[2] (Test. of Fitzpatrick.)

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[2] According to guidelines published by the National Association of Insurance Commissioners (NAIC), any incurred target loss ratio over 55 percent is acceptable. Fitzpatrick understood that rate approval standards set out in ORS 742.005 implicitly incorporated the NAIC guidelines as the minimum acceptable incurred loss ration. Although Fitzpatrick was concerned that Regence had adjusted its target loss ratio to increase retention by 10 percent in the Individual Third Quarter 2008 rate filing, the new target loss ratio was still well above the minimum acceptable level. (Test. of Fitzpatrick).

---

9. On March 24, 2008, the Department, through Fitzpatrick, issued an updated Objection Letter. The Department asked Regence to respond to certain concerns regarding the rate filing. The Department then offered to approve a 4 percent quarterly rate increase. Fitzpatrick wrote:

> The Oregon Insurance Division has reviewed the Company's March 14, 2008 response to the Division[']s March 3rd, 2008 Objection Letter. This included the updated financial projections provided to the Insurance Administrator in response to his request

> during the March 20th, 2008 meeting with the Company's representatives in our Offices.
>
> The Division will not approve the requested 10.3% quarterly rate increase, because this compounded with the prior 5.0%, 3.6% and 5.0% rate increases results in an annual rate increase of 25.9%.
>
> The Division will approve a 4.0% quarterly rate increase effective July 1st, 2008. This results in an annual rate increase of 18.7%. Approximately one-fifth of those enrolled for coverage will also move to the higher premium of the next five-year age band, so the Company will also receive approximately an additional 3% premium for the aging of the current enrollment.
>
> The Division is attaching the new premium rates at the allowable rate increase, rounded to the nearest dollar, so that there can be no misunderstanding between the Division and the Company.

(Ex. 17.)

10. On April 1, 2008, Regence rejected the Department's offer of a 4.0 percent quarterly rate increase. Through the SERFF system, Regence issued the following response: "The Company is not willing to accept your proposal. We will be in contact with DCBS shortly to further discuss this filing." (Ex. P37.)

11. On April 8, 2008, Fitzpatrick emailed his coworker Ball asking that Ball review excel worksheets he had created regarding Regence's request for the 10.3 percent quarterly rate increase. In the spreadsheets, Fitzpatrick modeled different options available to Regence's individual policy holders to reduce the impact of the proposed rate increase. Using the subject line "Gaming the System," Fitzpatrick wrote:

> David,
>
> See if you like what I put together. It shows how the 26% receivers will be able to pencil out the increase, but it will not be favorable to go from a $500 deductible (if my logic is correct). *See* "TakeaHigherDeductible.xls" attached.

> I also have a HopDown.xls which shows how you can avoid the 26% by going from Premier to Plus, Plus to Basic, or a double step down from Premier to Basic.
>
> Scott F.

(Ex. P39; test. of Fitzpatrick.)

12. Sometime between April 1, 2008 and April 11, 2008, Regence's Chief Executive Officer and other Regence executives met with Department Director Streisinger, Insurance Administrator Kipper and Deputy Administrator Lundberg to discuss Regence's rate filing. Regence contacted Streisinger because the company was not successful negotiating the rate increase with the Department's actuaries. During the meeting, Regence discussed the circumstances leading to its request for a quarterly rate increase, and explained why it need the increase. The Department representatives questioned the impact of the increase on Regence's members, and Regence advised that it could not continue to sustain the losses on the individual health insurance line. (Test. of Wortman.)

13. The financial information and projections that Regence provided to the Department indicated that Regence had experienced losses on its individual health insurance line since 2006, and would likely continue to experience[] losses on this line of business even with the proposed rate increase. (Ex. 16 at 6.) Regence argued that the rate increase was necessary to keep the product line's financial performance sound. Regence also asserted that the individual health line was extremely competitive and rates needed to increase to allow insurers to charge what it cost them to provide the coverage. Regence further noted that its average rate increases over the prior three years was [*sic*] moderate and consistent with or below the prevailing medical trend. (Test. of Wortman; Ex. I13 at 2.)

14. Prior to the meeting, Fitzpatrick had focused on Regence's overall financial position rather than the financial position of the individual health insurance line alone. Based on the information presented at the meeting, the Department's decision-makers agreed to consider the financial position of the individual health insurance line when making the decision to approve or disapprove the requested 10.3 percent quarterly increase. (Ex. I11; test. of Fitzpatrick.)

15. On or about April 9, 2008, through the SERFF system, Regence submitted to the Department a draft renewal letter it proposed to send to members regarding the rate increase in its individual line. (Ex. P42.)

16. On April 11, 2008, Fitzpatrick drafted a confidential memorandum titled "Reasons for Approval." Fitzpatrick set out the history of Regence's rate increases and decreases over the previous few years. He noted that after the Department initially found that a 2 percent quarterly increase and an annual rate increase of 16.5 percent was justified for the current quarter, Regence came to the Department to explain why the full requested rate increase was necessary. Fitzpatrick wrote that when the Department agreed to approve a 4 percent quarterly increase for an 18.7 percent annual rate increase, Regence refused to accept this amount. Fitzpatrick then compared the requested 10.3 percent quarterly rate increase to Regence's claims trend, and discussed the company's stated target loss ratio. Looking at the company's overall performance, Fitzpatrick noted that the company's underwriting and investment gains had been quite small over the prior five years, "with a small loss of $2.2 million for 2007, although their surplus is up 2.8% yearly and assets are up 7% yearly." Fitzpatrick also discussed the company's risk-based capital over the prior two years, compared to the industry average. Fitzpatrick concluded the memorandum with the following paragraph:

> Their actuary, Tom Wortman, and Regulatory Affairs VP Mike Becker made three trips to the Insurance Division to make the company's case that the rate increase was necessary. The last trip, the two brought the CEO, and they met with Scott Kipper and Cory Streisinger.

(Ex. P45.)

17. That same date, April 11, 2008, the Department notified Regence through the SERFF system that it had approved the Individual 2008 Third Quarter Rate Filing with the 10.3 percent quarterly rate increase. (Exs. A16 and P43.) In an accompanying letter addressed to Regence President Bart McMullan, Insurance Administrator Kipper wrote:

The Oregon Insurance Division has approved the above referenced rate request filed by Regence BlueCross BlueShield of Oregon (the Company) after careful review and questioning of your actuarial justification. This review convinced us that this product's performance requires the Insurance Division to monitor certain indicators to demonstrate the appropriateness of this rating action.

Therefore the Company is directed to provide monthly to the Oregon Insurance Division the following information for its Individual Medical product line, beginning with October 2007 and going forward monthly, on both a paid and an incurred basis.

- Claims
- Gross Premiums
- Commissions
- OMIP Assessment
- Operating expenses that are directly allocable to this block of business
- General company operating expenses that have been allocated to this block of business
- Sales – numbers of new lives
- Sales – number of new premiums
- Terminations – number of lives
- Terminations – amount of premiums

The monthly reporting will continue through March 31, 2009, or until such time that the Division considers the reporting no longer necessary.

(Ex. A16 at 3; Ex. P44.)

18. In an April 11, 2008 file memorandum, Fitzpatrick wrote:

The Oregon Insurance Division has reluctantly approved this rate filing after the Company has demonstrated the large 26% rate increase is actuarially justified and convincing the Division that consumers will have options to maintain coverage with a smaller rate increase by shifting to a less rich plan. Additionally, the Division and Company have agreed to conditions whereby the Division will be kept aware monthly of the medical loss ratio, company expenses and other indicators for the Division to monitor

> the performance of this product line and to demonstrate the appropriateness of this considerable rating action.
>
> * * *
>
> This agreement is not a penalty for implementing the large rate increase, but rather an understanding by both parties of the seriousness with which the Division views such a large rate increase in the Individual Medical marketplace.

(Ex. P41.)

19. The Department's April 11, 2008 decision to approve Regence's Individual 2008 Third Quarter Rate Filing was based on the following factors: (1) the losses Regence was currently experiencing on the individual health line; (2) the adverse financial projections; and (3) the moderate average rate increases that policyholders would experience over the period of July 1, 2005 through July 1, 2008. (Ex. I11.)

20. On April 16, 2008, Fitzpatrick emailed Kipper regarding the Department's approval of Regence's Individual 2008 Third Quarter Rate Filing. He wrote:

> Scott,
>
> David and I have discussed this briefly. The difference is the $15 million loss on the individual line and my $2.2 million loss was on the whole company.
>
> We will prepare a response to address the concerns.
>
> Scott F.

(Ex. I14.)

21. On or about June 30, 2008, Petitioner Karen Kirsch submitted a petition to the Department challenging its approval of Regence's Individual 2008 Third Quarter Rate Filing. Kirsch asserted that the rate increase was excessive, inequitable, prejudicial to the interests of policyholders and unreasonable in relation to benefits provided. (Ex. P50.)

22. In the opinion of healthcare economist Larry Kirsch, a determination as to whether an insurer's premium rate is prejudicial to the interests of the insurer's policyholders involves an inquiry into the policy's affordability. In Larry Kirsch's opinion, a proposed rate must be evaluated in terms of the policyholders' income. Some states (but not Oregon) have enacted laws to define affordability for individual insurance lines. In Massachusetts, for example, under the Universal Healthcare Plan, the defined relation of premium to income is 6.6 percent, meaning that only 6.6 percent of a person's income should be devoted to health insurance. (Test. of L. Kirsch.)

23. In the opinion of James Swenson, an actuary and technical consultant to the Department, the Department is not statutorily required to consider affordability in terms of policyholders' income. In Swenson's experience, although there are states that have enacted laws that define health insurance affordability as a percentage of income, those states have also had to subsidize premiums to meet the standard, because health care costs are currently at 16 to 17 percent of gross national product. The State of Oregon has not established specific affordability standards for individual health insurance and does not have any mechanism in place to subsidize premiums. In Swenson's opinion, the Department's obligation in reviewing and approving a rate filing is to ensure a good value to policyholders and maintain Oregon's competitive insurance market. When there are several capable competitors in the market, and each company has a respectable market share, the competitive pressure helps keep coverage affordable. (Test. of Swenson.)

ANSWER TO ASSIGNMENT OF ERROR NO. 1

The director did not exceed the range of her discretion in applying the standard in ORS 742.005(3) in approving Regence's filed rate increase.

A. Preservation of error

This claim of error is preserved.

Nevertheless, petitioner fails to "identify precisely the legal, procedural, factual, or other ruling that is being challenged," as required by ORAP 5.45(3).

She also fails to "specify * * * the way in which [the question or issue presented] was resolved or passed on by the lower court," as required by ORAP 5.45(4)(a)(i). She does not "set out pertinent quotations of the record where * * * the challenged ruling was made," as required by ORAP 5.45(4)(a)(ii).

Petitioner's failure to comply with the above cited provisions of ORAP 5.45 is significant, because the lack of specificity in identifying the claimed error resulted in petitioner's incorrect statement of the applicable standard of review.

B. Standard of review

Petitioner's statement of the standard of review is imprecise. As noted, the director's findings of fact are undisputed. Under this assignment of error, petitioner argues that the director's application of the standards in ORS 742.005(3) was in error, and that the director's order fails to "articulate a rational connection between the specific facts and the legal conclusions [she] reached." Pet Br 3.

ORS 742.005(3) expressly authorizes the director to exercise her "judgment" in determining whether the rate "would be prejudicial to the interests of the insurer's policyholders." Thus, the determination is left to the director's discretion.[3] ORS 183.482(7) prohibits the court from substituting its

[3] As noted above, the director delegated the exercise of that discretion to Administrator of the Insurance Division. (App-1).

judgment for that of the agency. This court reviews to determine whether the director's exercise of her discretion under ORS 742.005(3) was outside the range of discretion delegated to the agency by law. *See* ORS 183.482(8)(b). *See*, *e.g.*, *Knutson Towboat Co. v. Board of Maritime Pilots*, 131 Or App 364, 378, 885 P2d 746 (1994) (the court rejected the petitioner's argument that the board acted outside its discretion to establish reasonable and just rates when it refused to consider actual cost as a method for determining the cost of pilot boat service).

Petitioner's argument also implicates the substantial-reason standard of review. ORS 183.482(8)(c). Petitioner's claim that the director's order does not adequately explain the logical connection between the evidence in the record and its conclusion is a substantial reason argument. *Castro v. Board of Parole*, 232 Or App 75, 83, 220 P3d 772 (2009), *citing Martin v. Board of Parole,* 327 Or 147, 157, 957 P2d 1210 (1998) (ORS 183.482(8) requires that the board to provide "some kind of an explanation connecting the facts of the case (which would include the facts found, if any) and the result reached"). *See*, *e.g.*, *Knutson Towboat Co.*, 131 Or App at 379 (the court concluded that the board "adequately explained its reason for disregarding the actual cost method for determining pilot boat expense").

ARGUMENT

Before addressing petitioner's specific assignment of error, DCBS believes a brief description of its authority to regulate individual health insurance will be helpful.

A. DCBS has statutory authority to supervise health insurance rates.

As early as *Lovejoy v. City of Portland*, 95 Or 459, 475, 188 P 207 (1920), the Oregon Supreme Court recognized that one purpose of the 1917 Insurance Code was to authorize the state to supervise insurance rates. The Code "contain[ed] rules designed to secure equal rights and opportunities between insurance companies, to prevent discrimination in rates, and to compel insurers to treat all insured alike," and to "furnish[] safeguards against excessive or unjust premium rates[.]" *Lovejoy*, 94 Or at 461.[4] Once an insurer had filed a schedule of rates rate with Insurance Commissioner, "no other rate

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[4] In *Lovejoy*, the court wrote:

> It is apparent that, among other purposes, the Insurance Code was adopted to encourage the admission of sound and solvent companies *so that adequate service may be given at reasonable rates*; to bring about the appointment as agents of only those persons who possess the requisite qualifications, and to compel them to perform their duties faithfully; *to supervise rates*, and *to place the making of rates upon a uniform and scientific basis*; and to derive such revenue from the business as will pay the expense of supervision by the state without excluding desirable companies or agents or raising rates or otherwise interfering with the general purposes of the law.

94 Or at 475 (emphasis added).

could be lawfully exacted." *Ocean A. & G. Corp., Ltd. v. Albina M. I. Wks.*, 122 Or 615, 617-618, 260 P 229 (1927) (citations omitted).

It is a general principle of insurance law that "[t]he intended purpose of the regulation of rates is to promote the general welfare by preventing rates which are excessive, inadequate, or unfairly discriminatory." 3 *Couch on Insurance* § 2:31 (2010).

Oregon is "a prior approval state": Oregon law requires prior approval for individual health insurance rates. (Tr 432). ORS 743.018 requires insurers to file "all schedules and tables of premium rates for [individual] life and health insurance," and "any amendments to or corrections of such schedules and tables" with the Director of DCBS. ORS 743.767(1) requires insurers annually to file premium rates with the director. *See also* ORS 743.767(3) ("A carrier may not increase rates of an individual health benefit plan more than once in a 12-month period except as approved by the director.")

B. The director has broad authority to adopt standards for approving health insurance rates.

In charging DCBS with broad regulatory responsibility, the legislature has delegated to the director "almost plenary authority to make the policy decisions, legislative in nature, necessary to accomplish political objectives which the legislature expresses in general terms." *See Springfield Education*

Association v. Springfield School District, 290 Or 217, 229-230, 621 P2d 547 (1980) (describing such delegation to regulatory agencies).

Ratemaking is a quintessential legislative function. As this court wrote in *Knutson Towboat Co*., 131 Or App at 378 n 1: "Ratemaking, even though accomplished through contested case procedures, is a legislative, not a quasi-judicial, function. *American Can v. Lobdell,* 55 Or App 451, 461, 638 P2d 1152, *rev den,* 293 Or 190, 648 P2d 851 (1982). Legislators, as opposed to judges, are expected to bring a number of interests to the table." For example, the Public Utility Commission is required to regulate public utilities so as to allow them rates that are "just and reasonable," ORS 757.210, and to "protect such customers, and the public generally, from unjust and unreasonable extractions and practices and to obtain for them adequate service at fair and reasonable rates," ORS 756.040(1). *Springfield Education Association*, 290 Or at 230.

Similarly, DCBS is empowered to regulate the provision of insurance and is thus charged with "mak[ing] delegated policy choices of a legislative nature within the broadly stated legislative policy." *See id.* In ORS 743.731, the legislature has expressly identified the broad purposes that DCBS's regulation of health insurance is to serve. Most pertinent to individual health insurance are the following:

> (2) To prevent abusive rating practices;

* * * * *

(6) To encourage the availability of * * * individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(8) To improve the efficiency and fairness of the health insurance marketplace[.]

ORS 743.731.

The legislature has authorized the director to "adopt all rules necessary for the implementation and administration of" the statutes specifically governing individual health insurance plans and premiums. ORS 743.773.[5] In addition, ORS 743.010 authorizes the director to:

> [I]ssue rules with respect to policy forms and health benefit plan forms described in ORS 742.005(6)(a) and (b):
>
> (1) Establishing minimum benefit standards; [and]
>
> (2) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance[.]

As of the time of the contested case hearing in this case, the director had not formally adopted rules establishing the applicable standards for approving

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[5] ORS 743.773 provides: "The Director of the Department of Consumer and Business Services shall adopt all rules necessary for the implementation and administration of ORS 743.766 to 743.769."

individual health insurance premiums.[6] Rather, in determining whether to approve an increase in the premium rate for individual health insurance, the director applied the statutory standards set out in ORS 742.005 that require the director's approval of policy forms.[7] As applicable here, ORS 742.005 requires the director to "disapprove any form requiring the director's approval" for the following reasons:

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[6] In 2009, the director adopted OAR 836-053-0475, which provides, in pertinent part: "(1) * * * After conducting an actuarial review of the rate filing, the director may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the director's discretion, the proposed rates meet the requirements of ORS 742.003, 742.005, 742.007 and 743.018." OAR 836-053-0475 does not apply to this case.

[7] ORS 742.005, adopted as section 337 of Oregon Laws 1967 chapter 359, the Insurance Code revision, was derived from ORS 741.440. ORS 741.440 was enacted by Oregon Laws 1961 chapter 182 section 8 (SB 319). SB 319 related to "credit accident and health insurance" and provided that the Insurance Commissioner

> shall * * * disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charged, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive, or encourage misrepresentation of the coverage *** * *.**"

Or Laws 1961, ch 182, § 8(2).

F. Frank Howatt, representing DCBS, testified that SB 318 and SB 319, which contained identical provisions, conformed to the National Association of Insurance Commissioners (NAIC) model bills. Howatt testified that a number of states had already enacted these laws. Minutes, House Committee on Financial Affairs, March 17, 1961, 2.

> (3) If, in the director's judgment, its use would be prejudicial to the interests of the insurer's policyholders;
>
> (4) If the director finds it contains provisions which are unjust, unfair, or inequitable;
>
> * * * * *
>
> (6) If * * * the director finds the benefits provided therein are not reasonable in relation to the premium charged.

After extensive actuarial review and discussion of the rate filing, the Insurance Administrator (as the director's delegatee) applied the above standards and approved Regence's 2008 Third Quarter Rate Filing.

C. The director properly exercised her discretion in determining that the filed rate increase would not be "prejudicial to the interests of the insurer's policyholders."

As already stated, for purposes of approving a rate filing, the director has adopted the standard in ORS 742.005(3), which requires the director to determine whether, "*in the director's judgment*, [approving the rate] would be prejudicial to the interests of the insurer's policyholders[.]" (Emphasis added.) By its plain terms, that standard gives the director discretion to make that determination. Under ORS 183.482(8)(b), this court considers only whether the director (or her delegatee) properly exercised that discretion. ORS 183.482(7) expressly prohibits the court from substituting its judgment for the director's.

Petitioner fails to advance any basis on which this court may reverse the director's determination that Regence's filed rate increase would not be

prejudicial to its policyholders, under the standard in ORS 742.005(3). Therefore, the court must reject petitioner's claim.

D. Petitioner improperly asks this court to reweigh the evidence.

As already noted, petitioner does not dispute any of DCBS's findings of fact. Petitioner contends, however, that "the Department completely failed to provide the minimum evidence to meet the statutory standard" in ORS 742.005(3). Pet Br 23. Given this court's standard of review under ORS 183.482(8)(b), that contention is misdirected.

Petitioner claims—without any supporting citation to the record—that DCBS "intentionally suppresse[d] evidence" relevant to the department's decision to approve the rate increase. Pet Br 17. Petitioner baldly asserts that DCBS "refused to provide evidence about the process," including what occurred at a purportedly "secret meeting" in April 2008. Pet Br 17-18. In addition, petitioner argues that DCBS could have allowed Director Streisinger and Deputy Insurance Administrator Lundberg to testify at the hearing, but refused to do so.[8] Both of those contentions are inapposite to this assignment of error, which challenges the director's application of ORS 742.005(3).

Petitioner's allegation that DCBS failed to prove whether the director had delegated authority to approve the rate filing is likewise inapposite to this

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[8] DCBS addresses this contention under the fourth assignment of error, where petitioner expressly raises the issue.

assignment of error—the claim that the director erred in applying the standard in ORS 742.005(3). Pet Br 17. Therefore, this court should not address any of those allegations.

Petitioner's real complaint is that, in applying the standard in ORS 742.005(3), DCBS did not adopt the theories of "affordability" and "death spiral" articulated by her expert witness, Mr. Kirsch. Pet Br 24-25. She argues: "Mr. Kirsch gave detailed, convincing testimony that the Department failed to satisfy the 'prejudicial' standard of ORS 742.005(3) by: 1) failing to consider policy holder income in making its analysis on affordability, and 2) failing to adequately consider the risk to policy holders of death spiral." Pet Br 25. Petitioner suggests no legal basis for requiring the director to adopt Mr. Kirsch's theories in applying the standard that rates must not be prejudicial to policyholders. She simply argues that Mr. Kirsch's testimony was persuasive and his opinion was entitled to greater weight than the department gave it. Thus, petitioner impermissibly asks this court to reweigh the evidence and to substitute its judgment for the director's, contrary to ORS 183.482(7).

This court may not reverse the director's order unless the court finds the director's exercise of discretion to be outside the range of discretion delegated to the director by law, inconsistent with a rule, officially stated position or a prior practice, or otherwise in violation of a constitutional or statutory provision. ORS 183.482(8)(b). *See Labor Ready Northwest, Inc. v. Bureau of*

Labor and Industries, 208 Or App 195, 202, 145 P3d 232 (2006) (the court's authority to remand under ORS 183.482(8) is limited to those three circumstances). Petitioner cannot—and does not attempt to—make that showing. Because petitioner fails to argue that the director's order is deficient in any of those respects, she presents nothing for this court to address. *See Friends of the Columbia Gorge v. Columbia River* (S055915), 346 Or 415, 431, 212 P3d 1243 (2009) (because petitioners did not argue that the commission abused its discretion, and the court had rejected petitioners' only argument, the dispute was at an end).

E. The director's order is supported by substantial evidence in the record as a whole.

To the extent petitioner argues that there is not substantial evidence that DCBS applied the standard in ORS 742.005(3), petitioner is wrong. The record establishes that the director applied the standard in ORS 742.005(3). As explained in the ALJ's proposed order (which the director adopted), the testimony of the DCBS actuaries and the documentary evidence establish that DCBS considered the impact that the 10.3 percent quarterly increase would have on policyholders. (ER-16). As part of the approval process, the actuaries and decision makers reviewed: Regence's historical and forecasted claims costs and premiums; the incurred and forecasted losses; the rate history of the

individual health insurance line for the previous three years; enrollment projections; and other carriers' rates. (*Id.*).

The record amply demonstrates that potential prejudice to the interests of Regence's policyholders was a consideration in DCBS's review of the rate filing. Actuary Fitzpatrick testified that considered "the consumer impact" in his March 3, 2007, analysis of the rate filing. (Tr 143). He explained that he applied the "not prejudicial" standard in ORS 742.005(3) in his analysis:

> I can read sub 3 and I can pretty much understand – I know how rate increases are felt by the consumer and I * * * have enough guidance from my training and from what I have received from the Division, I can understand when a rate increase would be prejudicial.

(Tr 146). A rate increase would be considered "prejudicial" if it is "too high for the consumer." (Tr 150).

Fitzpatrick testified that he tried to keep the rate increase lower than 26 percent for the protection of Oregon consumers:

> I knew what this would do to Oregon consumers and, based on my work experience of implementing the 26 percent rate increase for a $10 million block back in 1994, it was only dental insurance. A lot of people called that insurance dollar-trading. People can budget that. I had experienced severe backlash.
>
> * * * * *
>
> I was looking for * * * any procedure, policy, I will use the word "trick," anything I could find to possibly get a lower rate increase for Oregon consumers.
>
> [QUESTION BY DCBS COUNSEL]: Even though they [Regence] had satisfied the legal standards (unintelligible)?

FITZPATRICK: Yes.

(Tr 255-256).

Fitzpatrick explained how he ultimately formed the opinion that the 10.3 rate increase was not prejudicial to policyholders:

> I had modeled the choices that the consumers would have in the Oregon marketplace and I had seen the financial statements that indicated this rate increase needed to be approved to stop the losses for Regence and I had also reviewed the rate increases for companies that had suppressed their rates in response to Regence's 16 percent decrease in July of 2006.

(Tr 268).

Petitioner also asserts that the director's order "failed to take into account Mr. Fitzpatrick's astonishing lack of consistency and credibility in explaining the prejudicial standard." Pet Br 26. That contention implicitly asks this court to reweigh the evidence and to make credibility findings ─ something this court may not do. *See AFSCME Council 75 v. Josephine County*, 234 Or App 553, 562-563, 228 P3d 673 (2010) ("Our duty, however, is not to reweigh the opposing testimony to determine which is more persuasive; it is to decide whether a rational person, viewing the whole record, could reach the same findings as ERB. ORS 183.482(8)(c). Under that standard, we reject the county's challenge to ERB's credibility findings.").

Former DCBS Insurance Administrator Jim Swenson reviewed the rate filing and the actuarial documentation. (Tr 438). He concluded that the rate filing met the standards in ORS 742.005, for the following reason:

> [I] should note that one of the things that I was impressed with was the fact that they did consider the number of customers that would be affected by increases at varying percentages * * *.

(Tr 438).

Swenson testified that actuary Fitzpatrick had specifically applied the "not prejudicial" standard of ORS 742.005(3), as follows:

> [I] think Mr. Fitzpatrick's analysis showed what the [*sic*] effect the premium rate increase would have on the premiums paid by members and it showed what the distribution of those members were and how many of them would be affected at different levels. I think that is, in essence, on how I would characterize an adequate – a good response to that issue.
>
> * * * * *
>
> [T]here certainly was not any legal documentation that says, here is what was considered. What I am submitting, however, is that the analysis that Mr. Fitzpatrick did, of looking at what the effect of the rate increase would have on the membership, in essence is – is addressing that very specific type of question that is raised by the subsection.

(Tr 454).

Swenson testified that premiums must be "adequate" and not "unfairly discriminatory." (Tr 438). DCBS's task is "to assure [that] good value is being granted to the policyholder." (Tr 442). He testified that ORS 742.005 requires the department to determine "whether or not the premiums are reasonable in

relationship to benefit, not to assess "affordability" as measured by income levels. (Tr 443). In Swenson's opinion, Regence's rate filing met the test of "good value." (*Id.*).

In sum, it is apparent from the record that DCBS applied the standard in ORS 742.005(3) during the review of Regence's rate filing by considering whether the effect of the rate increase would be prejudicial to the interests of policyholders. The director's judgment that the rate increase comported with ORS 742.005(3) was a proper exercise of her discretion.

F. The director's order is supported by substantial reason.

Petitioner contends that the director's order "completely failed to articulate a rational connection between specific facts and the legal conclusions it reached." Pet Br 3; *see also* Pet Br 6 (asserting that the order "completely fails to 'connect the dots' between the facts and an articulated legal standard"). Petitioner is mistaken. As discussed below, the order rationally explains how the evidence supports each conclusion of law. Thus, the order exhibits the "substantial reason" that the court requires. *See Coffey*, 348 Or at 512 (applying "substantial reason" standard).

The order discusses actuary Fitzpatrick's testimony that,

> as used in ORS 742.005(3), the term "prejudicial" involves an evaluation of a proposed rate increase in light of the medical trend. He explained that, in his opinion, a quarterly increase of more than 15 percent on an individual policy would be prejudicial to the consumer, because the medical trend is in the low teens. Fitzpatrick also asserted that

> "prejudicial" means that the proposed rate increase is so high that the consumer cannot keep his or her coverage intact.

(ER-15). The order points out that Fitzpatrick created spreadsheets specifically for the purpose of considering the impact that the proposed rate increase would have on policyholders. (ER-16). Fitzgerald testified that, despite his concerns, he did not believe the 2008 Third Quarter Rate Filing was unduly prejudicial to policyholders. (ER-16).

The order further notes:

> As part of the approval process, the Department's actuaries and decision makers reviewed Regence's historical and forecasted claims costs and premiums, the incurred and forecasted losses, the rate history of the individual health insurance line for the previous three years, enrollment projections and other carriers' rates.

(ER-16).

In addition, the order states that "[DCBS] consultant Swenson testified that, as part of its review of a rate filing, the Department considers whether the rate provides a good value for the policyholder." (ER-15).

Finally, the order explains: "Indeed the fact that the Department twice rejected the proposed increase and required Regence to actuarially justify the rate change before it granted approval shows that the Department carefully considered the policyholders' interests." (ER-16).

The order articulates the rational connection between the detailed facts above and the legal conclusion it draws from them that the director considered

whether the rate increase was prejudicial to policyholders before approving it. *Coffey*, 348 Or at 512, *citing Ross v. Springfield School Dist. No. 19,* 294 Or 357, 370, 657 P2d 188 (1982). The order meets the standard of "substantial reason" with regard to the standard in ORS 742.005(3).

ANSWER TO ASSIGNMENT OF ERROR NO. 2

The director did not exceed the scope of her discretion under ORS 742.005(4) in approving Regence's rate increase.

A. Preservation of error

Petitioner preserved this claim of error. As above, however, petitioner failed to identify a disputed ruling or where in the record and how petitioner's objection was resolved.

B. Standard of review

This assignment raises the question of whether the director failed to apply the standard in ORS 742.005(4). As above, this court reviews to determine whether the director's exercise of discretion in approving Regence's rate filing was outside the range of discretion delegated to the agency by law. *See* ORS 183.482(8)(b). ORS 183.482(7) expressly prohibits the court from substituting its judgment for that of the director.

ARGUMENT

The director informally adopted the standard in ORS 742.005(4) for approving a filed rate increase in individual health insurance plan premiums.

That standard permits the director to approve the rate increase unless "the director finds it contains provisions which are unjust, unfair or inequitable." ORS 742.005(4). Like the standard in ORS 742.005(3), that standard is discretionary to the director.

Petitioner contends that the director failed entirely to apply the requirements of ORS 742.005(4) in approving Regence's rate increase. Pet Br 29. She asserts, incorrectly, that "the Department admits that it made no effort to apply the requirement of ORS 742.005(4)." Pet Br 29. Petitioner mistakenly relies on the testimony of DCBS actuary Fitzpatrick that he "would not have applied that" statute. Pet Br 28, quoting Tr 151. Petitioner's reliance on that testimony is misplaced, because the director (or her delegatee), not the DCBS actuaries, applies the discretionary standards for approving filed rates. Accordingly, Fitzpatrick's opinion regarding the standard to be applied by the director, in her discretion, is beside the point.

As under the first assignment of error, petitioner argues that the testimony of her witness, Mr. Kirsch, is persuasive. For the reasons discussed above, the director was not compelled to accept Mr. Kirsch's opinion. Petitioner offers no basis on which this court could conclude that the director exceeded the range of her discretion in applying ORS 742.005(4).

Finally, petitioner contends that the director's order fails to explain the standard of "unjust, unfair, or inequitable" and fails "to connect any specific

piece of evidence to the statutory standard." Pet Br 30. Thus, she appears to argue that the order is not supported by substantial reason. Petitioner misunderstands the director's order. The director (adopting the ALJ's proposed opinion) explained:

> [T]he record establishes that [Fitzpatrick] and other Department reviewers considered whether the proposed rate increase was unfair or inequitable. As discussed above, Fitzpatrick considered the impact of the rate increase on Regence's policy holders. On his first review of the filing, which resulted in the Department's offer to approve a 2 percent quarterly increase, Fitzpatrick's intention was to keep the quarterly rate increase to less than five percent or less than 20 percent on an annual basis. While the filing was pending before the Department, Fitzpatrick created spreadsheets that modeled different options available to policyholders to reduce the impact of the proposed increase. He calculated how a member in the Premier or Plus plans could minimize the increase by stepping down to the Basic plan. In addition, during their meetings with Regence, the Department's representatives questioned the impact of the increase on Regence's members. The Department also required Regence to explain and justify, through projections and financial information, the need for such a substantial rate increase.
>
> The record sufficiently demonstrates that, before approving Regence's Individual 2008 Third Quarter Rate Filing, the Department considered whether the filing contained provisions which were unjust, unfair, or inequitable. The Department therefore complied with the requirements of ORS 742.005(4).

In sum, the order amply explains that the director applied the standard in ORS 742.005(4) in approving Regence's Third Quarter Rate Filing. Petitioner's second assignment of error lacks merit.

ANSWER TO ASSIGNMENT OF ERROR NO. 3

The director did not exceed the scope of her discretion under ORS 742.005(6) in approving Regence's rate increase.

A. Preservation of error

As above, petitioner preserved this claim of error.

B. Standard of review

The standard of review is as above.

ARGUMENT

The director informally adopted the standard in ORS 742.005(6), under which the director will approve the filed rate increase unless "the director finds the benefits provided therein are not reasonable in relation to the premium charged[.]" Like ORS 742.005(3) and (4), subsection (6) provides a standard that is discretionary to the director.

As in the first two assignments of error, petitioner simply disagrees with the director's exercise of her discretion. She relies, again, on the testimony of DCBS actuary Fitzpatrick and of petitioner's witness Mr. Kirsch, arguing that the director should have applied a different methodology for evaluating the filed rate increase. Pet Br 33-37. Petitioner's argument is misdirected. The director was not required to accept the opinion of any witness in determining whether "the benefits provided" were "reasonable in relation to the premium charged," under the standard in ORS 742.005(6). Petitioner cannot prevail unless the

director's application of the standard exceeded the range of her discretion. Petitioner has not made that showing, nor can she do so.

Petitioner contends that the final order "fails to articulate any coherent legal standard" and that it "never explains what specific evidence meets what statutory standard." Pet Br 37. Thus, she argues that the director's order is not supported by substantial reason. That argument lacks merit.

The director's order (by adopting the ALJ's proposed order) explains:

> Fitzpatrick testified that, in reviewing Regence's Individual 2008 Third Quarter Rate Filing, he considered the relationship between the proposed premium rates and the benefits provided. He was confident that the filing met this requirement. In Fitzpatrick's opinion, ORS 742.005(6) incorporates the NAIC guidelines for minimum incurred target loss ration. Because Regence's projected target loss ration exceeded the NAIC's minimum acceptable level of 55 percent, the benefits provided met the statutory standard and were reasonable in relation to premium charged.
>
> Fitzpatrick also considered actuarial data provided by Regence indicating that the company had been incurring a significant loss on its individual health insurance line. He recognized that the company needed to adjust its target loss ratio to sustain the line of business. Although Fitzpatrick remained concerned about the impact the 10.3 percent rate increase would have on policyholders, he, Ball and the Department's decision-makers were nevertheless satisfied that Regence's projected target loss ratio was appropriate and the benefits provided were reasonable in relation to the premium charged. The record therefore demonstrates that the Department considered the requirements of ORS 742.005(6) in approving Regence's Individual 2008 Third Quarter Rate Filing.
>
> In summary, the record establishes that the Department applied and considered the statutory standards when it reviewed Regence's Individual 2008 Third Quarter Rate Filing. The Department considered the rate increase in light of medical trend and impact on the policyholders. The

> Department modeled different options available to policyholders to minimize the impact of the rate increase. After agreeing to approve smaller increases, the Department eventually determined that although the 10.3 percent rate increase was significant, it was necessary to keep the product line financially sound. The Department also determined that the benefits provided were reasonable in relation to premium charged and that the rate continued to provide a good value to the policyholder. In approving the rate filing, the Department relied upon the losses Regence was experiencing on this insurance line, the adverse financial projections and the average rate increase percentage over the previous three years. Although Petitioner and others may not agree with the Department's reasoning and determination, the record fails to establish that the Department abused its discretion or acted outside its statutory authority in approving the rate filing.

(ER-17-18).

That explanation in the ALJ's proposed order, which the director adopted, logically connects the evidence in the record and the director's conclusion. Substantial reason supports the director's application of the standard in ORS 742.005(6).

ANSWER TO ASSIGNMENT OF ERROR NO. 4

DCBS did not violate petitioner's statutory or constitutional rights by quashing the subpoenas to compel the director and the deputy insurance administrator of DCBS to testify at the contested case hearing.

A. Preservation of error

This claim of error is preserved.

B. Standard of review

Petitioner's standard of review is imprecise. In this assignment, petitioner claims that DCBS erred as a matter of law in granting the motion to

quash subpoenas requiring the director and deputy administrator to testify at the hearing. Petitioner asserts that DCBS's interim order quashing the subpoenas violated ORS 731.240 and petitioner's constitutional right to due process of law. Pet Br 40-41. This court reviews those claims for legal error under ORS 183.482(8)(a).

ARGUMENT

Petitioner challenges DCBS's interim order quashing petitioner's subpoenas issued to Director Cory Streisinger and former Deputy Administrator Carl Lundberg, that required them to appear and testify at the hearing in this case. (Rec 335). Petitioner contends that the interim order violated ORS 731.240, in that it deprived her of "a contested case hearing which afforded the petitioner all rights available under the Administrative Procedures Act of ORS Chapter 183."[9] Pet Br 40. According to petitioner, that deprivation

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[9] ORS 731.240 provides, in pertinent part:

> (2) To the extent applicable and not inconsistent with subsection (1) of this section, the provisions of ORS chapter 183 shall govern the hearing procedure and any judicial review thereof.

ORS 183.440 provides, in pertinent part:

> (2) * * * [A]n agency or hearing officer in a contested case may issue subpoenas upon the request of a party to a contested case upon a showing of general relevance and reasonable scope of the evidence sought. * * *

constituted a denial of due process under the Due Process Clause of United States Constitution.

Specifically, petitioner claims violation of the following purported "rights":

> Petitioner had a right to know whether the Director Streisinger personally exercised her judgment on the rate increase or whether she delegated that authority. Petitioner had a right to know what facts the decision-maker relied upon and how she weighed competing facts and applied them to the legal standards. This judgment was never put in writing, so it was crucial to hear the director's testimony on this subject at the hearing.

Pet Br 41.

Petitioner's claims are incorrect, for the following reasons. First, petitioner identifies no statutory source for either of the purported "rights to know." Second, she does not contend that the director could not lawfully delegate approval of the rate increase or that such a delegation would have any effect on the validity of the approved rate increase. Therefore, she has not shown that whether the director delegated that authority was in any way material to the outcome of the hearing. Even if that information was legally significant to this proceeding, petitioner has not alleged that she was deprived of obtaining it in some other way.

In the event, the premise of petitioner's claim is mistaken, because the record reveals that former Insurance Administrator Scott J. Kipper, as the director's delegatee, issued the written approval of Regence's rate increase on

April 11, 2008. (Regence Ex 9, SER-1). Thus, petitioner's assertion that the director's "judgment" regarding the rate increase was "never put in writing" is also mistaken. Pet Br 41. To the extent further documentation of the director's delegation to Insurance Administrator Kipper is warranted, DCBS has asked this court to take judicial notice of the director's order delegating that authority. (App-1).

Third, the facts underlying the director's decision and the applicable legal standards were developed through the evidence at hearing. Petitioner contends that she required the director and the former deputy administrator to appear at the hearing "to testify as to what occurred at the crucial secret meeting of early April or how they may have exercised their judgment on this rate filing." Pet Br 40. Because the record reveals that Insurance Administrator Kipper exercised delegated authority to make that judgment, the testimony of Streisinger and Lundberg would have been immaterial.

In any event, the department properly quashed the subpoenas based on the well-established principle that inquiry into the mental processes of administrative decision-makers is usually inappropriate absent "a strong showing of bad faith or improper behavior." *See Citizens to Preserve Overton Park v. Volpe*, 401 US 402, 420, 91 S Ct 814, 28 L Ed 2d 136 (1971). The actual subjective motivation of agency decision-makers is immaterial as a matter of law-unless there is a showing of bad faith or improper behavior. *In re*

Subpoena Duces Tecum, 156 F3d 1279, 1279-1280 (DC Cir 1998) (citations omitted). *See also Portland Audubon Society v. Endangered Species Comm.,* 984 F2d 1534, 1549 (9th Cir 1993) (noting that "neither the internal deliberative process of the agency nor the mental processes of individual agency members" are proper components of the administrative record).

The prohibition on examining the thought processes of agency decision-makers in the exercise of their legislative functions, such as rulemaking and ratemaking, is even more explicit. *See Wolf v. Oregon Lottery Commission*, 344 Or 345, 355, 182 P3d 180 (2008) ("Indeed, an inquiry into the thinking processes of administrators and agency heads who were performing their quasi-legislative function as rule-makers is impermissible, given the limited scope of the issues under ORS 183.400(3).").

Petitioner incorrectly asserts that the interim order quashing the subpoenas was in error because *Citizens to Preserve Overton Park* allows discovery of the agency decision-making process. *Overton Park* allows discovery of the agency decision-making process on judicial review only in two circumstances: when there has been a strong showing of bad faith or improper behavior and when such examination provides the only possibility for effective judicial review and when there have been no contemporaneous administrative findings. 401 US at 420, 91 S Ct at 825.

Relying on *Overton Park*, petitioner argues that Director Streisinger and

former Deputy Administrator Lundberg could be compelled to testify, for both reasons: "1) there is no adequate record explaining the basis of the agency's decision, [and] 2) there is a strong showing the agency acted in bad faith or with improper behavior." Pet Br 42-43. Petitioner's reliance on *Overton Park* is also misplaced. In that case, the United States Supreme Court wrote: "[H]ere there are no such formal findings and *it* may be that the only way there can be *effective judicial review* is by examining the decisionmakers themselves. [Citation omitted.]" 410 US at 420, 91 S Ct at 825-26 (emphasis added). But the Court added that the absence of formal findings in that case did not *compel* examining the decisionmakers: "The District Court is not, however, required to make such an inquiry. * * * If the District Court decides that additional explanation is necessary, that court should consider which method will prove the most expeditious so that full review may be had as soon as possible." 401 US at 420-421, 91 S Ct at 826.

According to petitioner, the record is incomplete precisely *because* those DCBS officials did not testify. That argument is circular. Nothing in *Overton Park* suggests that the record of an evidentiary hearing is inadequate for effective judicial review unless the decision-makers' testimony is compelled. The judicial review record is more than sufficiently developed to show that DCBS considered the relevant criteria in approving the rate increase.

Petitioner's assertion of "a strong showing of bad faith or improper motive" is also unsupported. Her assertion is based exclusively on the absence of notes or minutes of the alleged "secret meeting" attended by Bart McMullan, the president of Regence ("a person of considerable political influence"). Pet Br 43-45. Petitioner's speculation that the testimony of the director and the former deputy administrator might reveal "secret" evidence about the decision making process was not a valid basis for requiring those officials to testify at the hearing, but rather "in the nature of a fishing expedition." *See Spray v. Board of Medical Examiners*, 50 Or App 311, 332, 624 P2d 125 (1981) (the petitioner sought process for any official of the agency in order to question them on whether or not the agency's initial complaint was an intentional overcharging designed to induce compromise; such testimony would have been irrelevant, and "the request was in the nature of a fishing expedition").

Because petitioner advanced no evidence showing that the director exercised her discretion contrary to law, she provides this court no basis for concluding that DCBS erred in quashing the subpoenas.

Even if petitioner had shown any error, however, she has not demonstrated that such an error would compel any different action by the board. *See* ORS 183.482 (providing that the court shall set aside the order, modify the order, or remand the case to the agency where the court finds that the agency "has erroneously interpreted a provision of law *and* that a correct interpretation

compels a particular action * * *."); *Shank v. Board of Nursing*, 220 Or App 228, 237-238, 185 P3d 532 (2008). Accordingly, this court has no basis for disturbing the director's final order.

ANSWER TO ASSIGNMENT OF ERROR NO. 5

DCBS was not required to formally adopt administrative rules defining the terms in ORS 742.005 before approving Regence's rate increase.

A. Preservation of error

Petitioner preserved this claim of error.

B. Standard of review

Whether an agency is required to promulgate rules in advance of an adjudication is "a matter of statutory interpretation." *Coffey*, 348 Or at 497-498, *citing Trebesch v. Employment Division,* 300 Or 264, 267, 710 P2d 136 (1985), *and Forelaws on Board v. Energy Fac. Siting Council,* 306 Or 205, 214, 760 P2d 212 (1988). This court reviews the director's interpretation of law for legal error under ORS 183.482(8)(a).

ARGUMENT

Petitioner contends that DCBS was required to engage in formal rulemaking "defining all of the terms of ORS 742.005(3), (4), and (6)." Pet Br 46. She relies generally on *Megdal v. Board of Dental Examiners*, 288 Or 293, 605 P2d 273 (1980), arguing only that "[w]hen delegative terms are ambiguous, the agency must carry out rulemaking to determine how those terms will be

interpreted and applied." Pet Br 45-46. That is not a correct statement of the analysis for determining whether prior rulemaking is required.

In *Coffey*, the Supreme Court made clear that "the nature of the statutory term in question, *i.e.,* whether the term is inexact or delegative, does not determine the necessity of rulemaking to define the term prior to its application in an adjudication":

> *"Megdal* does not mean that all terms delegating policymaking discretion can be applied only after rulemaking. Nor does *Ross* [*v. Springfield School Dist. No. 19,* 294 Or 357, 657 P2d 188 (1982)] mean that terms delegating interpretive responsibility may always be applied as the agency chooses, either by rule or by adjudication. Both cases address only the requirement for rulemaking in the individual agencies at issue in the cases."

348 Or at 503 n 12, *quoting Trebesch*, 300 Or at 270. Rather, "[*T]rebesch* requires examination of not only the statutory term in question but also the scope of the agency's responsibility, the agency's structure for performing mandated tasks, and any other factor that bears on the legislature's intent regarding rulemaking. *Id.*" 348 Or at 503 n 12.

In *Coffey*, the court described the methodology as follows:

> When no statute expressly requires an agency to make rules before selecting a disciplinary sanction, a reviewing court examines the statutory text and context pertaining to the agency's delegated responsibilities regarding the disciplinary process to discern whether the legislature nonetheless impliedly intended to require the agency to make rules concerning the subject matter in question before selecting an otherwise authorized sanction.

348 Or at 498.

Accordingly, the *Coffey* court examined the statutes identifying the board's responsibilities, which "charged the board with regulation of the professional practice of geology in this state" and gave the board certain specific kinds of authority to accomplish that mandate. 348 Or at 499. In addition, the court noted that the legislature gave the board "broad rulemaking authority." *Id.* at 500.

Unlike the statutory term of delegation "unprofessional conduct" in *Megdal*, the statute in *Coffey* required the board to apply "specified graduated sanctions to the facts underlying the charges of negligence and gross negligence"–a function "more analogous to the interpretation and application of existing law than to the making of new law or the completion of an incomplete legislative policy." 348 Or at 503.

The fact that the legislature expressly required the board to adopt rules under related statutes, but "did not include a similar express rulemaking requirement in ORS 672.675 with regard to the board's choice of sanctions provides some indication that it did not so intend." 348 Or at 504.

In addition, the legislature provided that the board will use contested case proceedings to discipline geologists and unambiguously specified the authorized range of sanctions available to the board in a contested case. *Id.* The court concluded from those provisions that the legislature intended the board "would select a sanction, if appropriate, from the range of legislatively

authorized sanctions on a case-by-case basis, and that the board's resulting final order would be subject to judicial review under ORS 183.482." 348 Or at 504. The court further concluded that "a disclosure through advance rulemaking of the board's criteria for choosing a particular sanction" was not required "to ensure the fairness of the contested case or any later judicial review proceedings." *Id*. For those reasons, the court concluded that "it is not likely that the legislature intended in ORS 672.675 to require prior rulemaking concerning the board's criteria for selecting a disciplinary sanction." 348 Or at 504.

Applying the *Coffey* methodology here compels the conclusion that the legislature did not intend to require DCBS to adopt rules before applying the standards for approving or disapproving rates. The broad scope of the director's authority in ratemaking, which is a legislative function, has already been discussed. Here, as in *Coffey*, petitioner has not identified any statute that expressly requires the board to adopt rules specifying the standards that it will follow in approving filed rates. *Id*. at 501. Rather, in related statutes, the legislature has authorized the director to "adopt all rules necessary for the implementation and administration of" the statutes specifically governing individual health insurance plans and premiums–thus leaving the rulemaking decision to the director's judgment. ORS 743.773. Consistently, ORS 743.010 authorizes, but does not require, the director to issue certain specified rules

"with respect to policy forms and health benefit plan forms described in ORS 742.005(6)(a) and (b)[.]"[10]

In contrast, when the legislature intended to require DCBS to adopt rules, the statutes says so. For example, ORS 743.013(1) requires the director to "adopt by rule requirements for disclosure by group and individual health insurers to individual and group health insurance policyholders the difference between coverage under the existing policy and coverage being offered to replace that coverage." Subsection (3) of the same statute requires the director to "adopt by rule requirements for nonduplication and replacement of major

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[10] ORS 743.010 provides:

> In addition to all other powers of the Director of the Department of Consumer and Business Services with respect thereto, the director may issue rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b):
>
> (1) Establishing minimum benefit standards;
>
> (2) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance; and
>
> (3) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies.

medical, Medicare supplement, long term care and special illness policies for applicants 65 years of age and older."

Applying the *Coffey* methodology, it is apparent that the statutes in effect in this case did not require DCBS to engage in formal rulemaking prior to approving Regence's filed rate increase.

CONCLUSION

For all the above reasons, the court should affirm the director's final order.

Respectfully submitted,

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SUPPLEMENTAL EXCERPT OF RECORD

Pursuant to ORAP 5.50, respondent submits the following, as indexed below.

INDEX

Document	SER #
Letter from Scott Kipper to Bart McMullan, Regence Ex 9	1

APPENDIX

Pursuant to ORAP 5.50, respondent submits the following, as indexed below.

INDEX

Document	APP #
Memorandum	1

NOTICE OF FILING AND PROOF OF SERVICE

I certify that on August 27, 2010, I directed the original Respondents Department of Consumer and Business Services' Answering Brief to be electronically filed with the Appellate Court Administrator, Appellate Records Section, by using the court's electronic filing system. I further certify that on August 27, 2010 I directed the Respondents Department of Consumer and Business Services' Answering Brief to be served upon Charles A. Ringo, attorney for petitioner, and Robyn Ridler Aoyagi, attorney for respondent Regence BlueCross BlueShield of Oregon, by mailing two copies, with postage prepaid, in an envelope addressed to:

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CERTIFICATE OF COMPLIANCE WITH ORAP 5.05(2)(d)

I certify that (1) this brief complies with the word-count limitation in ORAP 5.05(2)(b) and (2) the word-count of this brief (as described in ORAP 5.05(2)(a)) is 10,973 words. I further certify that the size of the type in this brief is not smaller than 14 point for both the text of the brief and footnotes as required by ORAP 5.05(4)(f).

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