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Comments on the PacificSource Health Plans Proposal for Individual Health Rates Effective January 2015

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Health Insurance Rate Watch
A Project of OSPIRG Foundation

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Executive Summary

Most of PacificSource Health Plan's customer base of more than 12,000 Oregonians with individual health insurance plans will see double-digit rate hikes if the premium rate hike proposed by PacificSource goes forward.

Had the rate been approved as initially filed, PacificSource's members would have seen increases of 15.9% on average, ranging as high as 24%. However, shortly after filing, the insurer submitted new information to DCBS indicating that the initial rate proposal had incorporated a major error, and proposed a new, lower average rate increase of 10.8%, ranging as high as 18.7%.

The insurer attributed the error to a miscommunication that resulted in inaccurate contracting assumptions being used in the original rate filing. In other words, the personnel in charge of projecting the medical costs the insurer will face in the future were not on the same page with the personnel in charge of negotiating reimbursement rates with providers, which is the single biggest contributor to increasing health care costs.

PacificSource's customers would benefit from lower premiums. However, a 10.8% increase would still represent one of the highest increases in Oregon's individual market if approved, so the revised proposal deserves close scrutiny. While we do not suggest that comparable errors remain in the revised proposal, the fact that the initially requested rates appear to have been unjustified highlights the urgency of scrutinizing all the factors and procedures used in calculating health insurance rates.

The main reasons given for the proposed increase include the insurer's projection that medical costs will increase by 4.7%, that prescription drug costs will increase by 12.3%, and that the worsening health status of its customers will drive up costs by 8.3% in the coming year.

After analysis of PacificSource's initial filing, the revision to the filing, and the supplemental information provided, we conclude that the insurer has not provided sufficient information to justify their proposed rate increase.

Key Findings:

- **PacificSource did not adjust its cost projections to reflect a reduction in "bad debt" from the Affordable Care Act's expansion of coverage.** With over 400,000 Oregonians newly signed up for coverage in 2014, rates of uncompensated care are beginning to decline. This benefit should be passed along to consumers in the form of lower rates.

- **PacificSource's projection of a 12.3% trend for prescription drug costs is unusually high and has not been supported by sufficient data.** PacificSource's prescription drug trend projection is higher than many of their competitors, and higher than widely-cited independent projections of marketwide trends. It is also nearly twice as large as PacificSource's 6.8% pharmacy trend projection from last year.

- **PacificSource's projection of an 8.3% increase due to the worsening health status of their customers is insufficiently supported.** Next year, many market experts expect that the mix of customers enrolling in health coverage will be younger and healthier than those who signed up for

2014, which may bring down costs. Especially in a context in which some insurers are projecting decreases in costs due to this factor, PacificSource does not provide enough evidence to support their projection.

- **PacificSource includes a 4.99% increase to its calculations for a "Market Risk Adjustment."** However, adequate justification for this value was not provided.

- **PacificSource adds in a cost for reinsurance, in addition to that provided by federal and state programs, that is not adequately documented.** PacificSource has not shown that this additional reinsurance is appropriate or reasonably priced.

- **When it comes to reducing costs and improving the quality of care, it is not clear that PacificSource is doing all it can**. New health care quality, cost and utilization metrics submitted for informational purposes show that PacificSource's utilization and costs for inpatient and specialty care are high in comparison to most of their competitors. In addition, its performance on measures of mental health follow-up care and development screening are below statewide benchmarks. Further inquiry should be made into the causes of these metrics to ensure PacificSource is doing everything possible to cut waste and improve quality of care.

Before deciding to approve, deny or modify this rate request, we urge the Insurance Division to scrutinize the issues raised here, require PacificSource to provide all documentation necessary to evaluate their proposal, and to implement a concrete, achievable plan to contain costs for Oregon individuals and families.

Key Features & Insurer Information

Key features of the rate proposal

State tracking # for this filing	PCSR-129549049
Name of health insurance company	PacificSource Health Plans
Type of insurance	Individual

Proposed Rates*

	Rate	Increase from 2014
Standard Bronze	$231	17%
Standard Silver	$290	15%
Standard Gold	$352	11%
% premium to be spent on medical costs		77.50%
% premium to be spent on administrative costs		18.80%
% premium to be spent on profits		3.80%

Insurer's history of rate increases

	Requested	**Approved**
2009	15.40%	15.40%
2010	6.70%	6.70%
2011	5.00%	3.90%
2012	7.70%	7.70%
2013	N/A**	N/A**

Basis for rate - Key factors

Medical cost trend	4.70%
Rx cost trend	12.30%
Cost due to health status of new customers	8.30%

Enrollment

Year	**Members**
2009	10,242
2010	11,114
2011	11,398
2012	12,788
2013	15,391
2014	12,056

Insurer information

Basic Information

For profit or non-profit:	Non-profit
State domiciled in:	Oregon

Insurer's financial position

Year	2013
Surplus	$151,300,000
Investment earnings	$18,400,000

Surplus History

Year	**Amount in Surplus**
2007	$124,500,000
2008	$93,200,000
2009	$107,100,000
2010	$114,100,000
2011	$125,700,000
2012	$126,300,000

*"Proposed rates" are for a benchmark population--a 40-year old nonsmoker in the Portland area
A Bronze plan will pay about 60% of the average policyholder's medical costs in a year; a Silver plan will pay about 70%, and a Gold plan will pay about 80%. For more information about the Oregon Standard plans, see http://www.oregonhealthrates.org/files/plan_summary.pdf
**Due to new consumer protections and coverage standards in the ACA, it is not possible to make an apples-to-apples comparison between the rates filed in 2013 and the rates filed in previous years.

Introduction and Background

Oregon’s health insurance rate review program, administered by the Oregon Department of Consumer and Business Services (DCBS), serves as a critical backstop to protect Oregon individuals and families purchasing coverage on their own from paying unreasonable premium rates.

When health insurers in Oregon wish to increase their rates on small businesses or people purchasing coverage on their own, they must submit a detailed proposal to DCBS laying out the justification for a rate hike. DCBS then determines whether the proposal is reasonable and approves, disapproves or cuts back the proposed rate.

In 2011, DCBS created a formal process for a consumer organization to analyze and comment on rate filings from a consumer perspective, supported by a grant of federal funds. OSPIRG Foundation has been the contracted organization under that program since November of 2011.

As part of this ongoing project, OSPIRG Foundation worked with the actuarial firm AIS Risk Consultants to analyze PacificSource's rate filing. We examined the insurance company's justification for the proposed rates, the financial position of the insurer, and how the proposed rates would impact Oregonians if approved. Our staff and consulting actuary also reviewed additional information made available by PacificSource.[1]

Health care in Oregon is undergoing major changes. For the first time this year, insurers are no longer allowed to deny coverage to people with pre-existing conditions, and many Oregonians have qualified for new financial assistance to help pay for coverage. Also starting this year, many Americans will be required to have health coverage or pay a penalty. These changes make it more urgent than ever to ensure that premium rates are justified, and that consumers receive good value for their premium dollar.

At the same time, studies consistently show that as much as a third of every dollar spent on health care is wasted on something that does not improve health.[2] With rising costs making health care unaffordable for many Oregonians, Oregon needs all insurance companies to redouble their efforts to contain costs by cutting waste and focusing on prevention and other proven strategies that keep patients healthier.

While health insurance rate review cannot solve the myriad problems facing our health care system on its own, rate review does provide an opportunity to strengthen accountability for insurance companies—to ensure that rates do not go up for consumers unless increases are fully justified, and unless insurers are putting in a meaningful effort to keep down costs and improve quality.

Discussion of rate filing

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

In our detailed discussion of the rate filing, we provide analysis of information provided in the initial rate filing as well as supplemental information from the insurer in response to questions from DCBS and OSPIRG Foundation. All of this information is public record and is or will be available on the Oregon Insurance Division's rate review website, www.oregonhealthrates.org.

[1] As part of this process, OSPIRG Foundation submitted questions to the insurer on June 23. PacificSource provided responses on June 27.

[2] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (2012), available at http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

Examining the justification for the proposed premium rates

Impact of federal health reform

PacificSource did not adjust its cost projections to reflect a reduction in "bad debt" from the Affordable Care Act's expansion of coverage. The savings associated with these reductions could be substantial, and should be passed along to consumers in the form of lower rates.

Among the outcomes of this expansion has been a reduction in uncompensated hospital care for uninsured individuals. Since the uninsured often cannot pay for their own care out of pocket, the cost of providing needed care in emergency situations is frequently shifted onto the rest of us and is reflected in the reimbursement rates insurers pay hospitals and doctors for various services. This is the so-called "bad debt" factor, and the anticipated reduction in bad debt should exert substantial downward pressure on hospital rates.

PacificSource provided the following explanations for their decision:

> From the PacificSource filing: "While savings from a reduction in "bad debt" is implicitly reflected in our unit cost trend as part of our provider contracting efforts, no explicit adjustment for reduction of bad debt is being made. While there may be a reduction in bad debt due to the reduction of uninsured individuals; it is unlikely that the impact will be translated to lower commercial costs in 2015. Most commercial provider reimbursement is based on contracted negotiated fees that are determined in advance. Providers are unlikely to prospectively agree to lower fees based on the possibility of lower uncompensated care. They are also unlikely to adjust charge masters down in advance of actually realizing reductions in bad debt, preferring to take a wait and see approach. Additionally, higher unit costs in the commercial market are influenced not just by cost shifting from bad debt from under or uninsured individuals, but also by cost shifting from other sectors, including Medicare and Medicaid. Continued cost shifting from government programs may offset or even undo any reductions in bad debt."
>
> From PacificSource's response to OSPIRG Foundation questions: "The anticipated reduction of bad debt results in saving for hospitals. We are in constant negotiation with our provider partners, and are working toward controlling the rate of increases. Our trend reflects these contract negotiations but our provider partners do not quantify the specific impact of bad debt reduction."

If PacificSource does not incorporate savings from reductions in bad debt into its negotiated rates with providers, and pass those savings along to consumers, it will represent a major missed opportunity. PacificSource's comments suggest that, while they recognize the opportunity, they have not yet been successful in incorporating these reductions into their rates.

In a state like Oregon that has many insurance carriers competing against each other, provider networks often have more leverage in contract negotiations. Carriers may lose access to provider networks to their competitors if they push too hard, and lose customers as a result. In some situations, this limits the ability of individual insurance companies to drive a hard bargain on cost issues including reductions in uncompensated care.

By using the rate review process to ensure that premium rates accurately reflect reductions in uncompensated care across the board, DCBS can push the market to respond. If no health insurer in Oregon is able to raise rates without incorporating savings from reductions in uncompensated care, no providers or provider networks in the state can continue to expect reimbursement rates that fail to reflect the changes underway in health care in Oregon.

Uncompensated care cost Oregon hospitals over $1 billion in 2008 alone.[3] The primary driver of these costs in past years has been the health needs of Oregon's estimated 636,000 uninsured individuals.[4]

However, at least 400,000 Oregonians have signed up for the Oregon Health Plan or Cover Oregon Qualified Health Plans over the past year, including many previously-uninsured Oregonians. While precise state-level numbers are not yet available, recent studies have suggested that Oregon has been one of the most successful states in the nation in reducing its overall uninsured rate,[5] with some researchers projecting that uninsured rates may have been cut by almost 2/3.[6]

Thus, it is not surprising that rates of charity care in Oregon hospitals have reportedly declined by 40% in the first quarter of 2014, representing a reduction of over 2.6 percentage points as a percent of overall hospital revenue.[7] Oregon Health and Science University (OHSU) reports that the percentage of uninsured patients seeking care has dropped to less than 1% from 5% last year.[8]

The cost impact of reducing bad debt can be expected to become clearer—and to grow—over time. However, it is clear that uncompensated care costs are already going down. Thus, it is reasonable to believe that some health care providers will accept lower fees because of the reduction in bad debt. This position is supported by Milliman, an actuarial firm cited by PacificSource, which stated that "some providers may be willing to accept lower rates than in the past, perhaps due to a reduction in uncompensated care for the uninsured."[9]

These trends are already clear, and will only accelerate in the coming year. If insurance rates are not adjusted to reflect this reality, consumers will be on the hook for unjustified costs. We urge DCBS to consider this issue carefully before making a decision on PacificSource's rate proposal.

If PacificSource believes that cost-shifting from other sectors may offset or undo the impact of these reductions, further evidence should be supplied to support this theory. While increased enrollment in Medicaid will certainly have an impact on the bottom lines of Oregon hospitals, it is far from clear that this impact will be negative. Oregon's Medicaid transformation efforts and the ongoing development of Coordinated Care Organizations (CCOs) can help offset the phenomenon of cost-shifting, in whole or in part. CCOs have already shown success in reducing emergency room utilization and other preventable

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[3] See http://www.oregon.gov/oha/OHPR/RSCH/docs/uncompensated_care/uncompensatedcaretrends_08.pdf
[4] See http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf, page 14.
[5] http://www.statesmanjournal.com/story/news/health/2014/07/14/multiple-studies-show-people-health-insurance/12644779/
[6] http://wallethub.com/edu/rates-of-uninsured-by-state-before-after-obamacare/4800/
[7] See http://www.bizjournals.com/portland/blog/health-care-inc/2014/06/oregon-hospitals-spend-less-on-charity-care-in.html
[8] See http://www.oregonlive.com/health/index.ssf/2014/06/oregon_health_science_universi_28.
[9] See 2014 Milliman Medical Index, page 9, available at http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf

drivers of increased health care costs, which could help reduce hospitals' need to shift costs to commercial insurers.[10]

Prescription drug costs

PacificSource's projection of a 12.3% trend for prescription drug costs is unusually high and has not been supported by sufficient data.

PacificSource's prescription drug trend projection is higher than many of their competitors, and higher than widely-cited independent projections of marketwide trends.[11] It is also nearly twice as large as PacificSource's 6.8% pharmacy trend projection from last year.

In their justification for this projection and their responses to questions from OSPIRG Foundation, PacificSource mentions, but does not provide, a trend model developed by the insurer's pharmacy benefit manager (PBM), Caremark. The insurer did provide a breakdown of their pharmacy costs into specialty drugs (26.4%) and non-specialty drugs (4.5%), but did not provide further information regarding the basis for this projection. Given that this model is projecting costs higher than the market norm, more specific information should be supplied.

Express Scripts, another PBM, publishes a drug trend report that contains much lower values than those used by PacificSource. [12] That report shows annual trends for 2014 and 2015 for traditional drugs of about 2% a year and for specialty drugs of about 17-18% a year. This gives an overall drug trend of about 7% a year, which is close to the value used by PacificSource in its prior filing.[13]

PacificSource suggests in its responses to questions that a reduced rate of generic drug introduction is partly responsible for this increase. In testimony at the public hearing on the rate proposal on July 9, PacificSource representatives also mentioned the high cost of new hepatitis C drugs as an important factor. However, these trends are market-wide, and do not explain why PacificSource's projection for increased costs is so much larger than their competitors. The Express Scripts drug trend projections mentioned above took both of these issues into account.[14]

We urge DCBS to scrutinize this projection closely before making a decision on PacificSource's proposal.

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[10] See a summary of the latest CCO data at http://www.oregon.gov/oha/Metrics/Documents/2013%20Performance%20Report%20Executive%20Summary.pdf

[11] Most nationwide studies suggest that prescription drug cost growth remains slow. *National trends in prescription drug expenditures and projections for 2014* gave a range for "a projected 3–5% increase in total drug expenditures across all settings." (www.ashpmedia.org/AJHP/DrugExpenditures-2014.pdf) *According to CMS, "Projected prescription drug spending growth for 2014 is 5.2 percent" and "For 2015 through 2022 […] 6.5 percent per year." (National Health Expenditure Projections 2012-2022)*

[12] "The 2013 Drug Trend Report", April 2014; http://lab.express-scripts.com/drug-trend-report/introduction/year-in-review

[13] It should be also noted that PBMs could have incentives to publish inflated drug trend projections. This could be used up-front as a marketing device to sell services to control drug costs, as well as afterwards to show that the actual costs using the PBM services was less than the projected value.

[14] The Express Scripts drug analysis takes into account Brand-Name Drug Pipeline and Approvals, as well as Recent and Upcoming Drug Patent Expirations. It also includes increases in drug costs for treating Hepatitis C of more than 100% for 2014 and more than 200% for 2015.

Morbidity

PacificSource's projection of an 8.3% increase due to the health status of their customers is higher than many of their competitors, and is insufficiently supported.

As of this year, insurers can no longer deny coverage due to pre-existing health conditions. While it is too early to determine the precise impact of this historic change on the costs facing insurers, it is likely that many Oregonians who were previously unable to obtain coverage for this reason are now beginning to sign up, some of whom may have health conditions that are expensive to manage and treat.

However, next year, it is likely that the mix of customers enrolling in health coverage will be younger and healthier than those who signed up for 2014. This expected difference in the health status between the early enrollees in 2014 compared to later enrollees is a generally recognized actuarial concept, as expressed by the American Academy of Actuaries: "In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases."[15]

This is especially true in Oregon, where Cover Oregon's difficulties made it especially difficult for consumers to enroll, contributing to lower overall enrollment and likely contributing to Oregon having some of the lowest rates of commercial ACA enrollment for young adults in the nation. Since it is expected that Oregon will have a fully functioning online enrollment system for the next open enrollment period, it is likely that many more people, including many healthy, young people, will sign up.

Especially in a context in which some of PacificSource's competitors are projecting a decrease in costs due to decreasing population morbidity,[16] PacificSource does not provide sufficient justification to support their projection of an 8.3% increase. We urge DCBS to scrutinize this projection closely.

Market Risk Adjustment

The PacificSource rate calculation includes an increase of 4.99% for an "Average Market Risk Adjustment."[17] The basis for this increase was explained in the filing with the following statement:

> "Adjusting PacificSource experience to the 2013 market average based on historical data. This adjustment was calculated based on the results of continued demographic and risk studies by Wakely Consulting, Inc. These studies showed that PacificSource had a population that was both younger and better risk than market average in 2013."[18]

However, no data, documentation or calculations were shown in the filing to support this value.

[15] "Drivers of 2015 Health Insurance Premium Changes," http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes
[16] LifeWise, for example, is projecting a cost decrease of 11.7% due to lower morbidity.
[17] PacificSource rate filing, Exhibit 1, Line (K) – shown as a factor of 1.0499
[18] PacificSource rate filing - Actuarial Memorandum - V.a.1.

OSPIRG Foundation asked for additional information regarding the derivation of this value, including the underlying data, calculations and analyses.[19] PacificSource did not provide additional information, instead restating the above explanation.

It is our understanding that PacificSource's position is that the Wakely studies are proprietary and that PacificSource will not provide that information. This means that there is no way for OSPIRG, DCBS or the public to verify that the Wakely studies showed a 4.99% value for PacificSource, or if such a value was accurately derived.

In the absence of additional information, it is impossible to discount the possibility that insurance companies that can benefit from using the Wakely studies to determine market risk adjustment scores in the form of higher rates will rely on their projections in rate filings, while other insurance companies which have rates that should go down in accordance with study findings may not provide those results.[20]

We urge DCBS to carefully consider PacificSource's projection, and to consider, more broadly, whether it is appropriate to rely on proprietary studies with undocumented values to justify raising rates for Oregon consumers.

Cost of Additional Reinsurance

The PacificSource rate calculation includes provisions for corporate reinsurance, both credits and assessments. This net cost (assessments less credits) is included with the total estimated incurred claims and increases that amount by about 0.8%. It is not clear from PacificSource's filing that the additional cost associated with this reinsurance is justified.

PacificSource has not shown that it needs to have this extra reinsurance in addition to the reinsurance provided by the Federal and State programs. If this reinsurance is not needed, it represents an unnecessary extra cost that is being passed through to policyholders. PacificSource has also failed to provide any details regarding the reinsurance provisions or the derivation of the amounts shown for the credits and assessments. Without that information, it is difficult to evaluate the justification for this expense.

In addition, the amount of credit relative to the amount of assessment seems unreasonably low. The credit is only about 39% of the assessment. That means that out of every $100 paid in premium for the reinsurance, only $39 is expected to be paid back in the form of claim reimbursements, with the remaining $61 going towards the reinsurer. In the absence of further explanation of the purpose of this reinsurance coverage, these costs seem excessive in relation to the benefits being received.

DCBS should carefully evaluate whether the cost impact of this corporate reinsurance is appropriate.

[19] OSPIRG question 15
[20] Since this factor is based upon a comparison to the overall market average, the factor across all companies (i.e., the market average) should be 1.00. Hence, there should be about as many insurance company policyholders with rates that are decreased from this factor as there are that are subject to increases.

Cost impact of proposed rates

Total cost of PacificSource's plans

Taking into account premiums, deductibles, coinsurance and other forms of cost-sharing, the total cost of coverage for PacificSource's plans as proposed in the filing would be substantial.

Federal tax credits will help eligible individuals and families cover some of the cost of premiums and out-of-pocket expenses,[21] but the cost of the proposed rates should be considered on its own merits. The role of rate review is to ensure that the rate is appropriate for the benefits offered, whether the cost is borne by the policyholder directly or by the taxpayer in the form of subsidies.

The following case studies illustrate the total potential costs that PacificSource policyholders may accrue in the event of serious illness or other medical need.[22]

Policyholders	**Plan**	**Annual premium (Increase since 2014)**	**Out-of pocket max (deductible + coinsurance + copays)**	**Total potential cost**
Sam, 21	Oregon Standard Bronze	$2,076 ($228)	$6,350	$8,426
Sarah and George, 40, and their two children	Oregon Standard Silver	$9,507 ($888)	$12,700	$22,207
Eric and Cynthia, 60	Oregon Standard Gold	$17,184 ($1,056)	$12,700	$29,884

These total potential cost calculations represent worst-case scenarios, but whether these costs are borne directly by policyholders or covered in part by taxpayers, they are substantial.

The case studies below illustrate the financial impact of a more likely, though still expensive, scenario: The total cost of an individual medical expense (such as childbirth or an inpatient hospitalization) costing $10,000.

[21] For information about eligibility for these federal tax credits, see www.coveroregon.com, Oregon's health insurance marketplace. Since the amount of premium assistance available via tax credit is pegged to the second-cheapest Silver plan available in a state's Individual market, and Oregon premium rates for 2015 have not yet been approved, it is impossible to project the impact of financial assistance precisely at this time.
[22] Each of the members in these case studies is a non-smoker in the Portland metro area.

Policyholders	Plan	Annual premium (Increase since 2014)	Deductible + Coinsurance	Total cost after premium and $10,000 claim
Sam, 21	Oregon Standard Bronze	$2,076 ($228)	$5,000 + $1,350	$8,426
Sarah and George, 40, and their two children	Oregon Standard Silver	$9,507 ($888)	$5,000 + $1,500	$16,007
Eric and Cynthia, 60	Oregon Standard Gold	$17,184 ($1,056)	$2,600 + $740	$20,524

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[23] plan reduce out-of-pocket exposure to financial risk in the case of medical need, but total costs remain high and will be burdensome on Oregon families and federal budgets.

The out-of-pocket maximums above were established by the ACA and cannot be changed in the rate review process, but we urge DCBS to take these costs into account when evaluating whether the coverage provided by PacificSource's insurance products is worth the proposed premium cost.

The impact of this high rate of increase should also be considered when evaluating the impact of the rate. As detailed above, some families could see an annual premium increase of over $1,000. To put this in perspective, an increase of $1,000 a year in health insurance premiums is significantly more than the total average annual premium paid in Oregon for either automobile insurance or home insurance.[24]

Insurer's efforts to reduce medical costs while improving quality

Rising medical and prescription drug costs are far and away the most significant driver of rising health insurance costs. Health insurance companies have a significant role to play to help lower these underlying costs – not by cutting access to needed care – but by cutting waste and working with providers in their networks to focus on prevention and other proven strategies that keep patients healthier.

In this analysis, OSPIRG Foundation looks at two data sources: newly required quantitative data reported by the insurer, and the insurer's qualitative description of its efforts to implement six strategies understood to be effective in reducing costs and improve quality.

[23] Gold plans can be expected to cover about 80% of the average person's medical cost in a year, which is higher than Silver (70%) or Bronze (60%).
[24] National Association of Insurance Commissioners Reports: "Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners Insurance: Data for 2011" and "2010/2011 Auto Insurance Database"

In future years, we hope that both types of data are integrated, and presented in detail sufficient to evaluate the effectiveness of insurers' broader cost containment strategies. From the data available, it is not clear whether PacificSource is doing all it can in this critical area.

New quantitative data on cost and quality

For the first time this year, every Oregon insurer submitted hard data on health care quality, cost and utilization as part of the rate filing process. These metrics represent a step forward for transparency and provide some helpful information to form a baseline to evaluate insurers' efforts to contain costs and improve quality of care.

These metrics show that PacificSource's costs and utilization for inpatient ($23,259 per admission, 197 days of inpatient care per 1,000 members per year) and specialty care (3,733 visits per 1,000 members per year at a cost of $88 per member per month) are higher than many of their competitors. In addition, its performance on measures of mental health follow-up care (60%) and developmental screening (31%) are below statewide benchmarks (68% and 50%, respectively).

For this initial year, these metrics have been submitted for informational purposes only, and should be taken with a grain of salt, as the data is not current enough to reflect the changes underway with health reform. In future years, DCBS and the public will have the ability to compare multiple years of data to evaluate insurers' progress on these metrics and begin to hold insurers accountable for delivering results.

Considered as a baseline, this data raises some important questions for PacificSource. More information is necessary to fully understand the insurer's performance, as well as what improvement efforts the insurer may be undertaking.

For example, while PacificSource's inpatient and specialty costs and utilization are higher than some of the competition, this may be due to a number of factors. It is possible that PacificSource's customer base is unusually unhealthy and required more intensive and and/or specialized treatment,[25] but it is also possible that PacificSource is not doing enough to prevent unnecessary hospital trips by providing proactive, coordinated, preventive care.

In response to OSPIRG Foundation questions, PacificSource did not provide additional information to help evaluate this data in context, stating that the insurer "cannot verify responses submitted by other carriers to confirm whether calculations were performed on a consistent basis."

In evaluating PacificSource's performance in these areas, comparing trend lines year-over-year will be critical. Some insurers may serve a less healthy customer base than others, and this may be reflected in their performance on some of these metrics, but if insurers implement adequate, comprehensive cost containment and quality improvement efforts, consumers should be able to expect continuous improvement on these metrics as insurers work to bend the cost curve for quality care.

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[25] Though it should be noted that PacificSource states in the filing that "studies showed that PacificSource had a population that was both younger and better risk than market average in 2013." See ACTUARIAL MEMORANDUM - V. Projection Factors - A. Changes in the Morbidity of the Population Insured

Qualitative reporting on cost and quality initiatives

Insurer's Cost and Quality Initiatives

Initiative	**Description**	**Insurer's current efforts**	**Projected Savings**
Quality pricing, also known as "payment reform"	In contrast with the fee-for-service payment model, this model rewards providers that use best practices to help keep patients as healthy as possible.	Initiatives in this area are described in the filing as "innovative provider contracting," but few details are available.	Not specified
"Medical Home" initiatives	Coordinated patient-centered care that focuses on prevention and keeping patients healthy and out of the ER.	Medical home initiatives mentioned but not described in detail.	Not specified
Value based benefits	Plans with lower co-pays for treatment proven to be effective, and higher cost sharing for unnecessary procedures. Some insurers use this term to describe plans with higher cost sharing for specialty care or brand-name drugs.	Evidence-based formulary initiative described in the filing appears to be value-based pharmacy benefit, but no medical value-based benefits are detailed in the filing.	Not specified
Chronic disease management	Case management and other tools to improve the health of patients with chronic disease. [26]	Case management and care coordination programs mentioned but not described in detail.	Not specified
Reducing hospital readmissions	Working with providers to ensure that discharged patients have adequate follow up care.	Not specified	Not specified
Reducing errors, hospital-acquired infections and other adverse events.	This includes not reimbursing providers for "never events," and incentives to encourage provider safety practices.	Not specified	Not specified

In its initial filing, PacificSource reported taking steps to reduce health care cost in ways that improve quality for patients in three of the six key areas we track. In response to OSPIRG Foundation questions, PacificSource provided some additional information, including several initiatives not included in the original filing, but did not specify savings projections, goals or benchmarks.

In response to OSPIRG Foundation questions, the insurer stated that many of the cost containment and quality improvement initiatives outlined in the filing are less than a year old, meaning that little effectiveness data is currently available. While this is a legitimate obstacle to providing information about new programs, it does prevent effective evaluation of the adequacy of the insurer's current strategy to keep down costs. We urge PacificSource to redouble its efforts in this critical area, and look forward to evaluating the evidence for the effectiveness of these programs in future filings.

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

Conclusion

Before deciding to approve or deny any increase, we urge the Insurance Division to obtain all necessary documentation to justify any increase, scrutinize the details of this filing carefully, and consider the consequences of the rate for individuals and families in Oregon.

OSPIRG Foundation is concerned that PacificSource is not taking steps to pass along the savings from reductions in uncompensated care, and in many areas has not provided enough information to justify its projections of increased costs. This is especially troubling in a context in which the insurer has admitted to including a major error in its initial filing.

We are also concerned that PacificSource has not provided information about its cost containment and quality improvement programs sufficient to enable independent evaluation of adequacy of the insurer's strategy in this key area, raising the possibility that PacificSource's customers are being asked to pay more than they should.

We respectfully urge DCBS to closely examine these issues, as well as all the others raised through these comments, as it completes review of this rate proposal.