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Comments on the Providence Health Plan Proposal for Individual Health Rates Effective January 2017

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Health Insurance Rate Watch
A Project of OSPIRG Foundation

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The author bears responsibility for any factual errors. The views expressed in this report are those of the author, and do not necessarily reflect the views of our funders, advisory committee, or those who provided analysis and review.

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Executive Summary[1]

Providence Health Plan's 105,406 members with individual health insurance plans will see rate hikes of 29.6% on average, and as high as 72.3%, if the premium rate hike proposed by Providence goes forward.

Providence's reasons for the increase include a projected 6.1% increase in the cost of providing medical services, 8.8% due to the end of federal and state reinsurance programs, 5% due to a sicker customer base, 3.7% due to less success in managing the cost of care than expected, and 2.5% for a higher targeted profit.

After analysis of Providence's initial filing and the supplemental information provided, we acknowledge some of the factors that concern Providence and that prompted the rate hike proposal. Providence projects it will spend $1.15 on health care for its Individual members for every premium dollar received in 2015, and sustain a 38% loss on its Individual market business. In such a situation, it is not unreasonable for an insurer to seek a rate increase.

However, we are deeply concerned about the impact of this large increase on Oregon consumers, and on the Oregon Individual market. While ongoing insurer financial losses are not sustainable for the long term, it is also unsustainable to continue hiking rates without addressing the drivers of health care cost growth.

We urge the Oregon Department of Consumer and Business Services (DCBS) to scrutinize the filing closely. We are concerned that, in some areas, Providence has not provided enough information to justify some elements of their case for a rate hike.

At the same time, we urge DCBS and Oregon policymakers to take stronger steps to address the underlying drivers of health care costs and instability in the Individual market. Action is urgently needed to ensure that Oregon consumers are not subjected to unreasonable and unsustainable rate increases going forward, and that they are not being asked to foot the bill for waste, estimated to represent a third or more of every dollar we spend on health care.[2]

Key Findings:

- **It is unclear from the information provided whether Providence is sufficiently adjusting its cost projections to reflect reductions in costs to Oregon hospitals.** Public filings from Oregon hospitals continue to demonstrate that factors including record-low levels of uncompensated care are contributing to large hospital profit margins across the state. Providence Health and Services, Providence Health Plan's provider affiliate, has accumulated nearly $6 billion in cash reserves.[3] In light of these surpluses, it seems reasonable for insurers to expect commensurate savings on hospital costs. Providence claims that savings from reductions in uncompensated care are incorporated into its medical cost trend projections but does not provide a specific estimate of the savings.

[1] OSPIRG Foundation's analysis is based upon the information currently available. OSPIRG Foundation reserves the right to submit further comments if additional relevant information becomes available.
[2] See, for example, Health Affairs, "Reducing Waste in Health Care"
[3] See http://www.wweek.com/news/2016/04/13/the-five-things-hospitals-dont-want-you-to-know-about-obamacare/

- **Providence's cost projections for covering their current members and future enrollees may be overestimated.** The costs of providing health care services to Oregonians who signed up in 2014 and 2015 have been higher than Oregon insurers initially projected, but there are reasons to doubt whether these trends will continue. Many uninsured young Oregonians remain eligible for tax credits under the Affordable Care Act, and may be motivated to enroll by improved outreach efforts and/or increases in the ACA's tax penalty for going without insurance. Moreover, Providence states in its own filing that large rate increases are likely to worsen these trends, not alleviate them, suggesting that a strategy of rate hikes may be self-defeating.

- **Providence's medical and administrative cost trend projections may be excessive.** While Providence projects a 6.1% increase in the cost of health care services, historical trend data presented by Providence in the filing shows a downward trend in medical costs of around -4% a year. Providence has not explained why it projects an upward trend when its own experience suggests a downward trend. Providence has also not supported its proposed +26% increase in general administrative costs.

- **A 29.6% increase would have a significant negative impact on affected Oregonians, representing more than $2,000 in additional premium costs per year for many Providence members.** Such a large increase would be highly disruptive for consumers and does not seem consistent with Providence's stated intent to "maintain reasonable rate stability over an extended period of time." While many Providence members can avoid or mitigate this impact via the Affordable Care Act's tax credits, or by switching coverage, such a large increase will still be disruptive for many Oregon families.

- **Providence has chosen to stop offering coverage in Central, Southern and most of Eastern Oregon.** This will have a disruptive effect not only for current Providence members living in these areas, but for the competitive landscape in these regions. With fewer insurance companies competing for members in these places, the remaining insurers will have less incentive to keep down costs going forward. While this move may cut costs for Providence, since these areas may be higher cost for insurers, we urge DCBS to consider the impact of this decision and develop a strategy to ensure sustainable access to reasonably-priced health coverage in all parts of the state.

- **Despite financial losses in 2015, Providence's financial position remains stable.** Providence is also proposing to add to its surplus, and is actually seeking a higher profit margin than in prior filings, while also proposing one of the largest rate increases in recent Oregon history. While it is appropriate for Providence to take steps to avoid additional large losses next year, it may also be appropriate for its profit margin to be reduced or removed to provide some premium relief for Providence members.

- **When it comes to reducing costs and improving the quality of care, it is unclear whether Providence is doing all it can.** Providence has many cost containment and quality improvement programs in place that may be worthwhile, but the insurer is also proposing to raise rates based in part on failing to realize savings from medical management programs, raising questions about the carrier's programs and commitments in this key area.

Key Features & Insurer Information

Key features of the rate proposal	
State tracking # for this filing	PROV-130548777
Name of health insurance company	Providence Health Plan
Type of insurance	Individual

Proposed Rates*	
Standard Bronze	$290
Standard Silver	$355
Standard Gold	$431
% premium to be spent on medical costs	83.5%
% premium to be spent on administrative costs	13.5%
% premium to be spent on profits	3.0%

Basis for rate	
Medical trend	6.10%
Rx trend	13.80%
End of state and federal reinsurance programs	8.80%
Health status of customers	5.00%
Unsuccessful cost containment efforts	3.70%

Insurer's history of rate increases	Requested	Approved
2013	15.70%	12.20%
2014	N/A**	N/A**
2015	-16.30%	-14.00%
2016	7.20%	13.80%

Enrollment	
Year	Members
2010	10,676
2011	11,186
2012	12,162
2013	13,438
2014	8,205
2015	24,132
2016	105,406

Insurer information

Basic Information	
For profit or non-profit:	Non-Profit
State domiciled in:	Oregon

Insurer's financial position	
Year	2015
Surplus	$464,000,000
Investment gain	$12,000,000

Surplus History	
Year	Amount in Surplus
2011	$431,504,027
2012	$470,267,090
2013	$506,881,809
2014	$530,393,114

*"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 for 2014 and the rates filed for previous years.

Introduction and Background

Oregon's health insurance rate review program, administered by the Division of Financial Regulation of 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 change the rates charged to small businesses or people purchasing coverage on their own, the insurer must submit a detailed proposal to DCBS laying out a

justification. DCBS then determines whether the proposal is reasonable and approves, disapproves or modifies 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 Providence'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 Providence.[4]

Health care in Oregon is undergoing major changes. As of 2014, insurers are no longer allowed to deny coverage to people with pre-existing conditions, and many Oregonians are receiving financial assistance to help pay for coverage. Also starting that year, many Americans were required to have health coverage or pay a penalty; this penalty is scheduled to increase next year. 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.[5] 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 strategies to keep patients healthier.

But research continues to show that rising costs are due to unit costs as well as utilization, and that unit costs are driven by market power and provider consolidation as well as by increases in the actual cost of providing care.[6] Since health care providers have a role in rising unit costs for care as well as rising costs associated with inappropriate and wasteful health care practices, we recognize that insurers do not always have complete control to restrain overall cost increases. The broader health care industry also bears a great deal of responsibility for rising overall costs, and we urge DCBS and Oregon policymakers to consider options for broadening accountability for the industry as a whole going forward.

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.

[4] As part of this process, OSPIRG Foundation submitted questions to the insurer on May 18, as well as a follow-up question on May 25. Providence provided responses on June 2nd and 3rd.
[5] See above, and also http://resources.iom.edu/widgets/vsrt/healthcare-waste.html
[6] See, for example, http://www.catalyzepaymentreform.org/images/documents/Market_Power.pdf and http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective

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.

Examining the justification for the proposed premium rates

Hospital Costs

Many Oregon hospitals are currently enjoying unusually wide profit margins and growing operating surpluses. As has been widely reported,[7] this is due in large part to record-low levels of uncompensated care, thanks to the ACA's expansion of health coverage.[8]

Providence Health and Services in particular, Providence Health Plan's provider affiliate, has accumulated nearly $6 billion in cash reserves. In light of these surpluses, it seems reasonable for insurers to expect commensurate savings on hospital costs, and to pass those savings along to consumers in the form of lower premiums. Providence claims that savings from reductions in uncompensated care are incorporated into its medical cost trend projections but does not provide a specific estimate of the savings.

In response to questions about this issue from DCBS on a public conference call on 6/1, Providence stated that their medical trend already incorporates the most aggressive reimbursement rates the insurer could negotiate with providers—including Providence Health and Services, which is not fully integrated with Providence Health Plan. This is the same explanation included in the Providence rate filing – that any reduction in uncompensated care is already reflected in the medical trend.[9] These responses imply either that Providence has already realized these savings in its medical trend, in which case it should be able to quantify them, or that it is unable to realize these savings in lower premiums due to insufficient pricing power and leverage in its negotiations with hospitals. Furthermore, the medical trend of +6.1% selected by Providence appears high, calling into question how it could reflect a reasonable provision for a reduction in uncompensated care.

In response to an OSPIRG Foundation question about Providence Health and Services' large cash surplus and Providence Health Plan's effort to ensure that its members benefit from reduced costs and high profit margins at its provider affiliate and other Oregon hospitals, the insurer responded with the following:

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[7] E.g., http://www.oregonlive.com/business/index.ssf/2016/03/insurers_lose_hospitals_win_in.html; http://www.wweek.com/news/2016/04/13/the-five-things-hospitals-dont-want-you-to-know-about-obamacare/

[8] Uncompensated care occurs because the uninsured are rarely in a position to pay for their own care out of pocket, and underinsured individuals are frequently unable to cover all of their out-of-pocket costs. The cost of providing needed care to these individuals is often shifted onto the rest of us, but as the uninsured and underinsured rates in Oregon have declined, these costs have declined dramatically.

[9] Providence filing, TREND INFORMATION AND PROJECTION - EXHIBIT 4, Reduction in Uncompensated Care.

> "As Providence Health and Services provider affiliates are separate entities, Providence Health Plan does not consider their performance or cash reserves in developing premium rates for insurance products and services sold by the plan. The plan negotiates competitive rates with affiliated and non-affiliated hospitals and incorporates these rates into the plan's premium calculations. It should be noted that the $6 billion cash reserve referenced is the total system amount for Providence Health and Services and is not solely an Oregon affiliate reserve amount."

It is unclear from this response why Providence would not consider performance or cash reserves of hospitals in its provider network in developing premium rates, whether affiliated or not. However, it does seem reasonable to expect that hospital systems experiencing historic surpluses should use those windfall profits to reduce the charges, or at least the rate of increases in charges, for insurance companies and other health care payers, and that those savings should be passed along to consumers in the form of lower premiums.

Also, while it is true that Providence Health and Services operates provider systems in five states, a $6 billion cash surplus is large for any non-profit corporation and much larger than all but the biggest health insurance companies in the country, despite the fact that Providence Health and Services is not subject to anything close to the same level of financial risk as an insurance company. It does not seem unreasonable to believe that the savings generating that surplus should be shared with the company's insurer partners in Oregon, and shared with Oregon consumers in the form of lower premiums.

From the information currently available, it is impossible to evaluate whether Providence is doing enough to ensure that its members realize savings instead of paying more than necessary for costs that no longer exist in our health care system. We urge DCBS to look into this matter closely, and to take action if necessary to ensure that Oregon consumers are not being overcharged due to unjustified and excessive hospital costs.

Cost of Current and Future Members

Unlike a number of other insurers, Providence assumes that the cost of covering its current and future members will increase in 2017 due to worsening health status and healthy members dropping Individual coverage. We do not believe these assumptions have been sufficiently supported, and we are concerned that Providence members will be overcharged as a result.

We do not dispute that the cost of covering the new members that enrolled in health coverage in 2014 and 2015 was higher than Providence initially projected. However, there are reasons to believe that these costs may go down in 2016 and 2017, as more young and healthy Oregonians sign up for coverage and the newly-insured individuals from 2014 and 2015 used their benefits to improve their health status and reduce their need for health care services going forward. In fact, a number of Providence's competitors with smaller rate increase proposals project that these factors should reduce rates.

In addition, the tax penalty for going without health coverage goes up each year, which will increase incentives for young and healthy Oregonians to sign up. For tax year 2016 and beyond, the tax penalty will be 2.5% of income or $695 (adjusted for inflation after 2016) for an individual (up to $2,085 for a family), whichever is greater. Although the penalty will likely remain lower than the cost of purchasing

insurance, there is a substantial body of evidence indicating that these kinds of fees are a strong incentive for young and healthy people to sign up for coverage.[10]

Instead of taking these factors into account, Providence's filing includes an upward "morbidity adjustment" of +5.8%, consisting of a +3.7% increase to go from the Providence to market average morbidity and +2.0% for an increase in market average morbidity from 2015 to 2017. In other words, Providence is projecting that its own customer base is somewhat healthier than the rest of the Individual market, and that they need to increase rates to ensure that their premiums would cover the cost of a market average population.

It is difficult to independently evaluate the justification for the +3.7% increase from Providence to market average morbidity based on the filing submitted by Providence. While Providence did include some general description, it did not provide detailed support, data and calculations.

With respect to the +2.0% increase in market morbidity, that appears to have been based upon two main assumptions – that a significant portion of the unsubsidized individual population will drop coverage in 2017and that those individuals dropping coverage will have lower than average relative risk.[11] Support for those assumptions was not provided. In addition, it does not appear that the projected increase in morbidity from 2015 to 2017 took into account that the highest morbidity members were likely to have joined the pool in the early years of the ACA, and that whatever pent-up demand for health care services existed previously has likely dissipated, at least to some extent.

Furthermore, an increase in morbidity seems contrary to other statements made by Providence – e.g., "[i]nvestments in cost containment programs … are starting to pay off, and the illness level of our 2016 individual members appears to be improving".[12]

In response to OSPIRG Foundation questions about these issues, Providence has stated that the insurer "has seen the 2016 vs 2015 morbidity of our population, as measured by ImpactPro, decrease by 0.6%. This measurement reflects data through the first 4 months of the year."[13] Yet the insurer continues to assume that marketwide morbidity will increase next year, even though its own current membership of over 100,000 represents a large percentage of the entire Individual market, and its experience this year seems likely to be representative of trends in the broader market.

In addition, it is important to note that Providence's own projection of increased morbidity is premised on the notion that large rate increases will tend to worsen market average morbidity and raise costs. As the Milliman report puts it,

> "Due to the high market-wide rate changes between 2015 and 2016 […] we assumed that a significant portion of the unsubsidized individual population will drop coverage in 2017. Further, we have assumed that those individuals dropping coverage will have lower than average relative risk (i.e. risk score divided by age factor) than the average of the overall individual population, as the coverage will have less value to these healthier individuals."

[10] For example, this study explores the experience of Massachusetts, which instituted a similar tax penalty scheme prior to the ACA: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408001/
[11] Milliman report, page 6.
[12] Providence response to DCBS objection dated 5/9/16, item 7.
[13] Providence response dated June 3, 2016; item 5.

If this line of reasoning is sound, it would suggest that Providence's own large rate increase—coming as it is from the Individual market leader—would itself be a significant contributor to this dynamic, and that Providence's strategy of rate increases may actually worsen the problem. In response to OSPIRG Foundation questions about these issues, Providence stated that

> "premium increases will likely improve stability over the long run, as they will help align projected premiums with projected claims. However, we believe that these rate increases will result in a market-wide increase in morbidity in the short term."[14]

The problem with this reasoning is that if a market-wide increase in morbidity does occur, it makes the alignment of premiums with claims more difficult, potentially creating a self-reinforcing cycle known as a "death spiral". Preventing this dynamic is a key role of rate review. To the extent that rate increases themselves may actually push up costs for the Individual market, thereby leading to future rate increases, we would strongly urge DCBS to take action to keep this dynamic in check.

Insurer's financial position

Providence's financial position has declined since last year, with surplus shrinking from over $530 million to $464 million. Nonetheless, the insurer's surplus remains more than large enough to ensure financial stability without the need for major contributions to surplus.

We urge DCBS to consider whether it is appropriate for Providence to contribute to growing its surplus at this time. Even in the absence of a 3% margin from underwriting, Providence could still expect surplus to increase from investment gains. During 2014 and 2015, Providence had investment gains of $15.1 million and $12.5 million, respectively.[15]

Ensuring the financial health of insurers is a key consumer protection role of insurance regulators, and Providence's many customers are counting on them to have enough money to pay claims and ensure their access to needed services. But a contribution to surplus from underwriting profits is not necessary to protect consumers at this time, and we believe it would be appropriate for DCBS to consider reducing Providence's contribution to surplus to provide some premium relief for members facing another year of large double-digit rate increases.

Medical cost trends

Providence's projection of a 6.1% increase in medical costs is larger than many of their competitors and out of step with other information supplied in Providence's filing. We are concerned that it may be significantly overstating health care cost growth trends, and may overcharge consumers as a result.

The historical trend data presented by Providence shows a downward trend in the "rolling 12-month normalized PMPM" medical costs of around -4% a year. Providence has not explained why it selected an upward trend when its own experience shows a downward trend. This decrease in costs is consistent with the "Change in Experience" impact value of -3.0% provided by Providence. A decrease in costs is

[14] Providence response dated June 3, 2016; item 7.
[15] These values reflect both investment income and realized capital gains (losses). These investments gains, as a percent of beginning of year surplus, were 3.0% in 2014 and 2.3% in 2015.

also suggested by the Cost and Quality Metrics document Providence supplied with the filing, which indicates that Providence's overall costs for the seven major medical service categories included declined from $445.29 PMPM in last year's filing to $418.19 PMPM in this year's.

In response to OSPIRG Foundation questions about the development of trend, Providence broke down their projected trend by service category with the following chart:[16]

Service Category	**Unit Cost Increase**
Inpatient Hospital	3.8%
Outpatient Hospital	4.2%
Professional	2.1%
Other Medical	3.8%
Capitation	3.0%
Prescription Drug	11.7%

While this breakdown provides some insight into Providence's perspective on the drivers of increasing costs, it does not supply additional information to assist in evaluating their projection of increased medical costs, as this simply repeats values already included in the filing,[17] and does not provide the basis for those values. Providence declined to provide more detailed information about the basis for these projections, stating that such detail would "reflect proprietary and competitive information pertaining to PHP's contracted rates with various providers. We believe that publicly disclosing PHP's proposed contracted provider rates will create an anti-competitive market."

Whether revealing the referenced information would harm market competition is unclear from what Providence has provided, but we believe that in the absence of additional specific evidence in support of their projections, there should be a strong presumption that Providence's medical trend is likely to be inflated.

In considering Providence's claims about medical trend, consideration should be given that the impact of leverage is considered elsewhere ("Deductible leveraging has been accounted for in the updated 2017 plan relativity factors") and that the trend allegedly takes into account the impact of reductions in bad debt and uncompensated care ("We have applied the known unit cost increases from 2015 to 2016 which includes any savings related to reduction in uncompensated care"). Providence should be required to more completely provide the basis and support for its selected trends.

Administrative costs

Providence is proposing to increase its general administrative expenses from $31.58 to $39.75, a 26% increase. This substantial increase impacts the proposed rates by +1.5%, and is far above the Medical Producer Price Index benchmark DCBS uses to assess whether an administrative cost increase is reasonable.[18]

[16] Providence response dated June 3, 2016; items 28, 29 & 31.
[17] Providence filing, Exhibit 4.
[18] 1.2% from April 2015 to April 2016. Source: US Department of Labor, April 2016 PPI report, http://www.bls.gov/ppi/

Providence attributes this change to a decrease in projected membership. However, Providence has not explained how the projected decrease in membership translates into such a large increase in administrative costs, or what steps are being taken to control those expenses.

In response to OSPIRG Foundation questions about administrative costs, Providence pointed out that they are expecting administrative costs to decrease 15% per member per month from 2015 to 2017.[19] It is not clear how relevant this may be to the increase projected from 2016 to 2017. If Providence's membership projections are correct, it will have 85,947 members in 2017, which is more than three times its membership in 2015. Combining these figures shows a total increase in administrative expenses from 2015 to 2017 of more than 160%.[20] Providence has not explained why it expects total administrative expenses to increase so much from 2015 to 2017, especially considering that 2015 was early in the implementation of the ACA, when start-up costs could have been more significant, and those costs could be expected to be smaller in 2017.

Providence also reports that "We are working on several key operational initiatives designed to improve efficiency and quality for our members. This may help to offset an increase in expenses as membership declines from 2016 to 2017." Without greater detail, it is impossible to evaluate the adequacy of these efforts.

Impact of proposed rates

Service Area Changes

Providence will stop offering Individual coverage in Central, Southern and most of Eastern Oregon in 2017. This withdrawal contributes to leaving several Oregon counties with only two insurers competing on the Health Insurance Marketplace: Baker, Curry, Harney, Grant, Lake, Malheur, Umatilla, Union, and Wallowa counties. It also leaves Bend, the state's fifth-largest metro area, with only three Marketplace insurers.

This will have a disruptive effect not only for current Providence members living in these areas, but for the competitive landscape in these regions. With fewer insurance companies competing for members in these places, the remaining insurers will have less incentive to keep down costs, improve quality and provide good customer service going forward.

This move may cut costs for Providence, since these areas may be higher cost for insurers. Most of these areas have highly concentrated and uncompetitive markets for health care services, which reduces insurer pricing power and tends to lead to higher costs for health care services.

Ordinarily, insurers can compensate by charging members in high-cost areas more for coverage than members in lower-cost areas, and while that is not an ideal solution for consumers, it at least preserves market competition and provides consumers with more options. That Providence apparently thinks even this strategy will not work is concerning.

[19] Providence response dated June 3, 2016; item 33.
[20] 85,947 (2017 projected membership) / 27,836 (2015 membership) X .85 = 2.62.

Although we would not expect DCBS to block this service area change through the rate review process, we do strongly urge DCBS to consider the impact of this decision and develop a strategy to ensure sustainable access to reasonably-priced health coverage in all parts of the state.

Furthermore, it is not clear where, if at all, Providence took its decreased service area into account in projecting costs, and we would urge DBCS to clarify this before making a final decision on Providence's 2017 rates. To the extent that the reduction in the service area reduces cost for Providence, or slows the rate of medical inflation, those savings should be passed on to consumers in the form of a lower rate.

In response to OSPIRG Foundation questions about the service area changes, the insurer stated that[21]

> "Providence Health Plan's decision to stop offering Individual coverage in Rating Areas 4 and 7 was based on our ability to better manage the Individual costs in the remaining rating areas. If Providence Health Plan (PHP) were to continue offering coverage in the rating areas identified, we anticipate that there would be a minimal impact to the rates for the other regions."

If Providence expects to be able to better manage Individual costs in the remaining rating areas, it seems reasonable to expect that this should have a measurable impact on claims costs and premium rates in those regions. If not, it is unclear how Providence, its remaining members, or the market as a whole benefit from these changes. We urge DCBS to look into the matter further.

Total cost of Providence's plans

Taking into account premiums, deductibles, coinsurance and other forms of cost-sharing, the total cost of coverage in 2017 for Providence's plans as proposed in the filing would be a dramatic increase from the 2016 cost.

A 29.6% increase would be more than 14 times the rate of inflation in the broader economy and nearly 10 times the rate of inflation in the cost of medical services.[22] Although Oregon's economy appears to be improving, this increase would still take place against a backdrop of largely stagnant wage growth.

Such a large increase would be highly disruptive for consumers and does not seem consistent with Providence's stated intent to "maintain reasonable rate stability over an extended period of time."[23] While most Oregonians have access to a competitive health insurance marketplace and consumers have the option of shopping around, large year-to-year premium fluctuations can be highly disruptive for consumers and for the stability of the health insurance market as a whole.

Federal tax credits will help eligible individuals and families cover some of the cost of premiums and out-of-pocket expenses.[24] 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 2017 have not yet been approved, it is impossible to project the impact of financial assistance precisely at this time. However, it is worth noting that Providence customers who rely on tax credits may face an

[21] Providence response dated June 3, 2016; item 8.
[22] Source: US Department of Labor, April 2016 CPI report, available at http://www.bls.gov/cpi/cpid1604.pdf
[23] See "Insurer's Financial Position – Appendix I."
[24] For information about eligibility for these federal tax credits, see www.healthcare.gov, Oregon's health insurance marketplace.

increase even larger than 29.6% on average; if all insurers' rates were approved as filed, Providence's plans would be much more expensive relative to the second-cheapest Silver plan than they are today, meaning that tax credits would cover much less of the cost.

If the premium for an individual's plan goes up faster than the premium of the second-cheapest Silver plan, the percent increase in the net cost to that individual, after the tax credit, can be much larger than the proposed rate increase, as the following chart illustrates:[25]

Monthly Amount	2016 Value	Increase in 2017	2017 Value
Premium Before Tax Credit	$273	29.6%	$355
Value of Tax Credit	$176	10%	$194
Premium After Tax Credit	$97	66%	$161

*A tax credit increase of 10% is an assumed value for illustrative purposes. Actual tax credit increases will not be available until 2016 premium rates are approved.

After consideration of the impact of tax credits, the net increase in premiums can be far higher than the requested rate increase—in this hypothetical case, increasing by nearly 2/3, or more than twice as much as the insurer's rate change. Such a large increase in effective premium could be highly disruptive for consumers and underlines the importance of scrutinizing proposed premium rates closely.

Regardless of the availability of tax credits, the cost of the proposed rates should also 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 Providence policyholders may accrue in the event of serious illness or other medical need.

Policyholders	**Plan**	**Annual premium (Increase from 2016)**	**Out-of pocket max (deductible + coinsurance + copays)**	**Total potential cost**
Sam, 33	Oregon Standard Bronze	$3,260 ($824)	$7,150	$10,410
Sarah and George, 50	Oregon Standard Silver	$11,918 ($2,774)	$13,700	$25,618
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$16,641 ($4,161)	$13,700	$30,341

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.

[25] 2016 Values from the ASPE research brief "Health Insurance Marketplaces 2016: Average Premiums After Advance Premium Tax Credits In the 38 States Using The Healthcare.Gov Eligibility and Enrollment Platform"; available at https://aspe.hhs.gov/sites/default/files/pdf/172176/2016HealthInsurance.pdf

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.

Policyholders	**Plan**	**Annual premium (Increase from 2016)**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Sam, 32	Oregon Standard Bronze	$3,260 ($824)	$7,150 + $0	$10,410
Sarah and George, 50	Oregon Standard Silver	$11,918 ($2,774)	$5,000 + $1,500	$18,418
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$16,641 ($4,161)	$2000 + $1,600	$20,241

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[26] 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 the federal budget.

Out-of-pocket maximums 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 Providence'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, a family of four could see an annual premium increase of over $4,000. To put this in perspective, this increase by itself is more than 8% of Oregon median household income.[27]

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: quantitative data reported by the insurer, and the insurer's qualitative description of its efforts to implement strategies effective in reducing costs and improve quality. 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.

[26] 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%).
[27] $50,521 in 2014. Source: US Census Bureau, http://factfinder.census.gov/

Now that insurers cannot discriminate against individuals with pre-existing medical conditions, insurers can no longer base their business models on managing risk and exposure to potentially unhealthy members. Instead, insurers must redouble their efforts to help their members manage their health. These efforts are especially important in light of unexpectedly high costs in 2014 and 2015. Providence members will be expecting progress in bending the cost curve in coming years, and DCBS should take steps to hold all insurers accountable for this.

This is the third year that Oregon insurers 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.

In evaluating Providence's performance in these areas, comparing trend lines year-over-year is 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.

The metrics submitted by Providence suggested that its members' costs and utilization were down overall relative to last year. Individual services experienced minor increases in utilization and/or cost, but key areas including Emergency Room services declined significantly. In the case of the ER, utilization dropped nearly in half, from 135.2 to 71.5 per 1,000 members, potentially an encouraging sign that Providence's efforts to keep its members out of the ER are bearing fruit.

The insurer's performance on key quality metrics has been mixed, with some metrics improving and others declining. The company's scores on access to care and mental health follow-up care remain below statewide benchmarks.

It is clear from their qualitative description of their efforts that Providence has many constructive initiatives underway to contain costs and improve quality of care, and improving cost and utilization metrics are consistent with the insurer's claim, in response to questions posed by DCBS on May 9, that their "continued investments in cost containment programs […] are starting to pay off, and the illness level of [their] 2016 individual members appears to be improving."

However, this progress does not appear to be reflected in the company's proposed rates, and in fact, the company's rate hike is in part attributed to a failure of prior medical management programs to contain costs. As the Milliman memo puts it:

> "In the 2016 individual rate filing, Providence assumed additional medical management savings, based on the projected impact of various programs. Based on more recent information, Providence revised its prior estimate of medical management savings."

This revision adds 3.7% to the company's rate hike. Including this increase without a clear accounting of why these savings were not realized, and without a clear explanation of the disconnect between these claims and the evidence of reduced cost and utilization included in the filing, raises concerns about the insurer's efforts to reflect its cost containment programs in rates.

There do appear to be a number of encouraging efforts underway at Providence. However, for Providence to demonstrate success, the insurer will need to demonstrate that these initiatives are having an impact in cost, utilization and quality of care for Providence members, and that they are being shared with consumers in the form of lower rates.

Rate review provides an opportunity to hold insurers accountable for doing everything they can to contain costs; if an insurer is not first doing all it can to bring down costs for its members, a premium increase cannot be justified. We urge Providence to redouble their efforts, and we urge DCBS to continue taking steps to advance transparency and accountability in this critical area.