OSPIRG Foundation

Accountability in Action

Rate Review Cuts Over $24 Million in Waste from 2015 Health Insurance Premiums

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Close scrutiny of proposed health insurance premiums for 2015 has cut over $24 million in waste and unjustified costs from premiums for Oregon consumers and small businesses. This brings the total waste cut by Oregon's rate review program to over $179 million since 2010.

This year, Oregon initiated a new effort to examine the drivers of health care costs as part of the rate review process, an important step forward as the state works to contain unsustainable health care cost growth. While $24 million in waste cut represents progress for Oregon consumers, it is also clear that more work needs to be done. Studies continue to show that a third or more of all health care spending is spent in ways that do not improve health.[1]

Oregon's health insurance rate review program, administered by the Oregon Insurance Division (OID), serves as a critical backstop to protect Oregon individuals, families and small businesses from paying unreasonable premium rates. Insurers offering coverage in the individual and small group markets must justify proposed premium rates in writing, showing that they are not excessive and explaining how the insurer is working to reduce costs. These written justifications are made publicly available on the OID's website, www.oregonhealthrates.org, and the public has opportunities for input through public comments and hearings.

With the federal Affordable Care Act (ACA) bringing important new consumer protections into effect this year, many Oregonians have been able to access coverage for the first time, and health insurance benefits and out-of-pocket costs have improved coverage substantially for many people. At the same time, tens of thousands of Oregonians remain enrolled in older health plans without the ACA's protections that have been extended into next year.

Oregon's insurers filed their proposed rates for 2015 on June 2. The proposals ranged from large increases to large decreases, many of which were eventually cut back or altered by state regulators.

OSPIRG Foundation contributed to the process of reviewing these rate proposals by conducting independent in-depth research into the insurers' filings, focusing especially on proposals from four of Oregon's largest insurers. Moda,[2] PacificSource,[3] and Health Net[4] together proposed increases ranging up to 24% on over 100,000 Oregonians purchasing insurance on their own, while United[5] proposed double-digit increases on over 1,300 small businesses across the state.

Our analysis highlighted some areas of concern for consumers in the insurers' justifications for their proposed rates—some unique to those insurers, others true almost across the board. We brought our concerns to the attention of the OID and encouraged the public to participate in the rate review process by submitting public comments; over 4,000 written comments were ultimately submitted.

In August, the OID began to hand down its decisions about 2015 premium rates, and agreed with many of the concerns raised by OSPIRG Foundation, cutting an estimated $24 million in waste and unjustified costs from premiums.

The tables below detail all of the decisions made for each 2015 rate proposal, including the initial proposed rate, the rate approved by the OID, and an estimate of the dollar total cut out of premiums as a result of these decisions. In a few cases, the OID prevented insurers from lowering rates as much as they initially proposed, due to concerns about the sustainability of the proposed rate; this is recorded as a negative cut and partially offsets cuts to other rates.

These estimates are based on projections provided by the insurers in their rate filings of the total additional premium the company expected to collect from its customers due to the proposed rate.[6]

Affordable Care Act (ACA) Plans

INDIVIDUAL AND FAMILY RATES[7]

Insurer	Requested Rate change	Approved rate change	Proposed total premium change	Approved total premium change	Difference ($ cut)
ATRIO	-16.1%	-20.6%	-$85	-$108	$23
BridgeSpan	3.9%	2.3%	$67,928	$40,060	$27,867
Freelancers CO-OP	-0.6%	8.0%	- $43,696	$582,613.33	-$626,309
Health Net	8.3%	9.4%	$9,578,533	$10,847,977	-$1,269,444
Kaiser	0.2%	-4.1%	$116,220	-$2,382,510	$2,498,730
LifeWise	-13.8%	-11.3%	-$4,440,100	-$3,635,734	-$804,365
Moda	12.5%	10.6%	$10,304,574	$8,738,278	$1,566,295
Oregon's Health CO-OP	-21.0%	-9.9%	-$1,593,737	-$751,333	-$842,404
PacificSource	15.9%	3.9%	$6,085,673.00	$1,492,712	$4,592,960
Providence	-16.3%	-14.0%	-$7,510,960	-$6,451,131	-$1,059,828
Regence	3.2%	1.4%	$1,008,798	$441,349	$567,448
Time	28.0%	6.8%	$2,004,049	$486,697	$1,517,351
				TOTAL CUT	**$6,168,324**

SMALL GROUP RATES

Insurer	Requested	Approved	Proposed total premium change	Approved total premium change	Difference ($ cut)
ATRIO	-4.0%	-5.6%	-$10	-$14	$4
Freelancers CO-OP	5.6%	6.7%	$565,058	$676,051	-$110,993
Health Net	7.0%	4.9%	$10,466,737	$7,326,715	$3,140,021
Kaiser	5.0%	6.3%	$4,644,854	$5,852,516	-$1,207,662
LifeWise	3.0%	1.2%	$1,187,038	$474,815	$712,222
Moda	6.2%	4.1%	$2,309,980	$1,527,567	$782,412
Oregon's Health CO-OP	-20.0%	-19.1%	-$1,141,722	-$1,090,344	-$51,377
PacificSource	2.2%	-1.6%	$3,422,381.00	-$2,489,004	$5,911,385
Providence	-16.0%	-9.7%	-$4,900,906	-$2,971,174	-$1,929,731
Regence	1.9%	0.1%	$1,324,370	$69,703	$1,254,666
UnitedHealthcare	11.8%	9.9%	$8,697,218	$7,296,818	$1,400,399
				TOTAL CUT	**$9,901,346**

Non-ACA Plans

Some health insurance plans are not currently required to comply with the Affordable Care Act, and are considered separately for rating purposes. Some of these plans, known as "grandfathered" plans, existed prior to the passage of the ACA in 2010 and were exempted from most of its requirements.

In late 2013, the federal government allowed states to exempt some health insurance plans, now known as "transitional" plans, from the consumer protection requirements in the ACA. Oregon policymakers have allowed insurers to continue offering these plans to current enrollees through at least 2015, but they are no longer available for purchase by new customers and not all insurers have decided to continue offering them.

The OID required rate filings for these plans to ensure that their rates were justified, and also used its rate review authority to protect older Oregonians from discriminatory rates by requiring transitional plans to charge older Oregonians no more than three times as much as younger Oregonians, as was already required for ACA-compliant plans.

INDIVIDUAL AND FAMILY RATES

Insurer	Requested	Approved	Proposed total premium change	Approved total premium change	Difference ($ cut)
Kaiser (grandfathered)	9.7%	9.7%	$74,721	$74,721	$0
Kaiser (transitional)	3.7%	3.7%	$12,127	$12,127	$0
LifeWise (grandfathered)	6.4%	4.8%	$2,351,950	$1,763,962	$587,987
LifeWise (transitional)	8.4%	6.8%	$1,994,542	$1,614,629	$379,912
Providence (transitional)	10.0%	7.3%	$919,815	$671,464	$248,350
Regence (transitional)	9.8%	8.1%	$9,482,482	$7,837,561	$1,644,920
				TOTAL CUT	**$2,861,169**

SMALL GROUP RATES

Insurer	Requested	Approved	Proposed total premium change	Approved total premium change	Difference ($ cut)
Health Net (transitional)	7.0%	3.9%	$10,438,494	$5,815,732	$4,622,761
Kaiser (transitional)	0.0%	-0.5%	$0	-$344,601	$344,601
LifeWise (transitional)	1.2%	-1.6%	$275,028.00	-$366,704	$641,732
LifeWise (grandfathered)	1.6%	-0.7%	$38,299	-$16,755	$55,054
PacificSource (transitional)	2.3%	-0.2%	$3,066,777	-$266,676	$3,333,453
Providence (transitional)	-3.1%	2.8%	-$3,189,055	$2,880,436	-$6,069,491
Regence (transitional)	3.1%	1.3%	$1,555,358	$652,246	$903,111
UnitedHealthcare (transitional)	9.4%	5.4%	$3,222,338	$1,851,130	$1,371,207
				TOTAL CUT	**$5,202,428**

Analyzing the Decisions

After making a final decision on any rate proposal, the OID posts an explanation on their website, www.oregonhealthrates.org. Examining these explanations provides some insight into how the Division identified and protected consumers from unjustified costs. Below is a brief overview of some of the key factors considered by the Division.

1. Few of Oregon's insurers had a workable plan to pass along the savings from reductions in uncompensated care for the uninsured due to the expansion of access to health coverage under the Affordable Care Act (ACA).

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 other payers, and is reflected in the reimbursement rates insurers pay hospitals and doctors for various services.

In the past year, 400,000 Oregonians have signed up for coverage under the ACA. Recent studies have suggested that Oregon has been one of the most successful states in the nation in reducing its overall uninsured rate.[8] Unsurprisingly, Oregon is already starting to see rates of uncompensated care go down.

Rates of uncompensated care in Oregon hospitals 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.[9] 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.[10] Just this week, it was reported that Salem Hospital is seeing similar reductions.[11]

Since commercial insurers wind up paying more for health care services to cover the costs of uncompensated care, this reduction should be reflected in reduced premium rates, but few Oregon insurers incorporated these savings into their rates. OSPIRG Foundation examined this issue in our analysis of the rate filings and recommended that the OID take action to ensure that consumers were not made to foot the bill for costs that are no longer there in Oregon's health care system.

The Insurance Division took action, finding that while a small number of insurers had reflected these reductions in their rates, most had not. In its rate decisions, the OID cut back most rate proposals by about two percentage points to ensure that rates reflect the reality of Oregon's changing health system.

2. One of Oregon's biggest insurers, PacificSource, made a major error in its initial filing.

Taking all of its lines of insurance together, the cuts applied to the rates proposed by PacificSource amount to over $14 million, or more than half of the total for all Oregon insurers.

PacificSource admitted to making errors in their initial rate request shortly after the filing deadline. The insurer suggested a sizable cut to their proposed rate in follow-up correspondence with the OID, proposing a 10.6% increase instead of the 15.9% increase originally requested. The insurer explained that the initial rate request had reflected a miscommunication between the company's actuaries and the personnel in charge of managing the insurer's reimbursement contracts with health care providers. The Division eventually chose to cut the rate back further than suggested by the insurer, to only 3.9%.

While it is good that this error was caught in time to protect consumers, the fact that the initial rate filing had such a major flaw underscores the need for close scrutiny of the justification of insurers' rate proposals.

3. Some insurers overstated trends in medical costs

A number of national studies have demonstrated a slowdown in health care cost growth in recent years, yet several Oregon insurers projected accelerating cost growth in the year ahead. In some cases, the OID questioned these projections, and cut back those proposals accordingly. For example, United and Time both projected medical cost trends of 8.1%, higher than widely-cited nationwide trend projections from the Altarum Institute (1.8% for medical costs, 3.6% for prescription drugs) and Milliman (5.4% overall). The OID determined that these insurers did not justify their projections and cut back their rates significantly as a result. However, as discussed below, some insurers with somewhat lower cost projections had their proposals approved despite failing to provide sufficient evidence to substantiate those projections.

4. Some insurers overstated the costs associated with the health status of their customers

As of this year, insurers can no longer deny coverage due to pre-existing health conditions; this key consumer protection is known as guaranteed issue. Since it is too early to determine the precise impact of this historic change on the costs facing insurers, Oregon insurers' rate filings represented educated guesses, and spanned a large range.

It is likely that many Oregonians who were previously unable to obtain coverage 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.[12] 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.

The OID examined insurers' cost projections in this area very closely, and cut back a number of insurers' rate hike proposals as a result.[13] For example, Trillium projected that guaranteed issue would raise costs by 14.5%; the OID cut back their proposal to reflect a more modest 5% projection. Kaiser projected that the pent-up demand for medical services from the newly-insured would raise costs by 3.2%; the OID cut back their proposal to reflect a more modest 1.1% projection.

Impact on Oregonians

Cutting $24 million in waste and unjustified costs from 2015 premiums is a step forward for consumers. The resulting savings will make a real difference for Oregon families and small businesses, making it easier to cover other important expenses. To take just one example, $24 million would be enough for over 74,000 Oregonians to purchase basic adult dental coverage, which is often not included in individual and small business plans.[14]

Some initial media reports of 2015 premiums characterized the approved rates as increases for most affected Oregonians.[15] This characterization does not tell the whole story. Since most Oregonians who signed up through Cover Oregon enrolled in a Moda plan, and Moda's rates will increase by 10.6% on average, it is true that many Oregonians will see large rate increases. However, many plans offered on the market next year will cost less than they do this year. The Insurance Division estimates that the average premium for a 40-year-old Portlander on the Oregon Standard Silver plan will go down by about $12 per month, [16] and the rates for many plans will decline by 10% or more. For Oregonians who have seen rate increases every year for decades, this is a welcome development.

Since it is easier than ever for consumers to switch coverage, now that insurers can no longer turn people away due to pre-existing conditions, Oregonians facing a rate increase are not locked into paying more, and many may find better deals elsewhere.

For these Oregonians, it's important to remember that just as it's important to shop before you buy health insurance, it's important to shop before you renew coverage, especially if increasing rates are putting a strain on the pocketbook.

This is especially true for Oregonians who bought plans through Cover Oregon and took advantage of the Affordable Care Act's tax credits. Since these tax credits are pegged to the price of the second-cheapest silver plan on the marketplace, they can change from year to year as premiums change. Next year, the second-cheapest silver plan in many parts of Oregon will be offered by LifeWise, not Moda, meaning that even many Oregonians eligible for tax credits may see their premiums change substantially, and may want to consider seeking a better deal elsewhere.

Next Steps

While cutting $24 million in waste and unjustified costs from 2015 premiums is an important milestone, work remains to be done to ensure that the rate review process is living up to its full potential to protect consumers from paying too much for health care. Some factors that did not play a major role in the rate decisions for 2015 should be seriously considered as Oregon considers next steps to improve the rate review process.

1. Many insurers failed to provide enough information to evaluate their claims about trends in medical costs.

Although some proposed rates were cut back on the basis of overstating medical cost trends, other insurers moved forward with rate increases despite projections of accelerating cost growth and/or costs well exceeding widely-cited estimates of national trends.

When questioned, some insurers attributed their projections to proprietary information that was not made available. For example, in response to OSPIRG Foundation questions, Health Net stated that its 7% medical cost projection was based on "reviewing current and anticipated future provider reimbursement arrangements," without providing further detail.

Especially in a context in which one Oregon insurer (PacificSource) discovered a major error in its calculation of the rate impact of provider contracting, such projections should receive heightened scrutiny in the future.

2. Some Oregon insurers are not doing enough to justify the price differences between their plans

In addition to the Oregon Standard plans, which are offered by all insurers, most insurers also offer a range of non-standard plans. These plans have a number of differences from the Standard plans, including both network differences and different out-of-pocket cost arrangements, and often have different premium costs.

The premium rate for a plan should be based on covering the actual cost of providing medical services to people purchasing the plan, not on other factors. If premiums are based on factors such as encouraging or discouraging people from enrolling in particular plans, this could lead insurers to pursue price discrimination strategies that could steer less healthy individuals away from some plans, or away from the insurer altogether. For this reason, clarifying the basis for premium cost differences between plans is important. However, the rationale for these differences is often unclear from insurers' rate filings.

In some cases, price differences proposed this year did not appear to line up with the actual cost of providing coverage to people who enroll in those plans. To take just one of many examples, Moda's proposed rate for its Oregon Standard Silver plan was significantly higher than the price proposed for its "Be Aligned-Rose City" plan, even though the Standard plan has a lower Actuarial Value (AV)—i.e., it covers less of the cost of a member's health care services. This difference will have a significant impact, because Moda's Standard Silver plan has the highest enrollment of any single plan in the Oregon Individual market, with over 26,000 members.

In response to OSPIRG Foundation questions, a number of insurers (including Moda) pointed out that the AV calculation included in rate filings is imperfect for rate-setting purposes and leaves out a number of key factors, such as network differences between plans. This is true, but without additional information about these factors to justify diverging from AV, it is impossible to evaluate whether price differences between plans are justified.

Price differences between plans should receive additional scrutiny in future years, and more detailed information should be required to demonstrate that differences are based on actual costs.

3. New data on cost, utilization and quality should be expanded, improved and used to inform decisions on health insurance rates

Rate review provides an opportunity to build greater accountability for insurance companies—to ensure that rates do not go up for consumers unless carriers are putting in a meaningful effort to keep down costs and improve quality. Holding carriers to higher standards of accountability in this area represents the single greatest opportunity to build on Oregon's successful rate review program.

For the first time this year, Oregon insurers were required to submit hard data on health care quality, cost and utilization as part of the rate filing process, including measures such as the cost and frequency of emergency room visits as well as the prevalence of key preventative services such as diabetes and breast cancer screening. These metrics represent a step forward for transparency and provided some helpful information to form a baseline to evaluate insurers' efforts to contain costs and improve quality of care. The metrics raised questions for some insurers, but answers were not always available.

For example, some of the insurers requesting large increases also reported high emergency room utilization and costs, raising questions about whether these companies were doing enough to keep their customers healthy and out of the ER. However, there are other factors that may need to be considered, such as insurers' reimbursement policies for emergency services. Health Net stated, in response to OSPIRG Foundation questions, that its costs may appear high due to their policy of fully covering out-of-network ER expenses, though they did not provide specific cost data to support this theory. Other insurers stated that they doubted whether these metrics were collected in a consistent way, raising the possibility that differences in the data might reflect coding practices or other back-end administrative differences rather than differences in health care service delivery.

These are legitimate concerns. To create meaningful accountability for insurers, it is likely that further action will be necessary to ensure that these metrics are accurate, comprehensive, responsive to context and actionable for Oregon regulators.

This year, some insurers (including major companies like Providence and United) failed to provide some of the key metrics required. For next year, OID should take steps to ensure that this data is available for all insurers.

Two additional policy changes could strengthen the OID's efforts to evaluate insurers' performance in the area of cost containment and quality improvement:

- *Enrich cost and quality measures by using the state's All Payer All Claims database (APAC)*. Established as part of landmark health reform legislation in 2009, the APAC database has been collecting health care claims data from all major Oregon insurers for years, but this data has yet to be used to inform the state's efforts to contain health care costs. This data could not only help inform an independent evaluation of insurers' cost containment and quality improvement efforts—it could do so without imposing additional reporting requirements or administrative burdens on insurers. This year, the Insurance Division entered into a contract with the Oregon Health Care Quality Corporation to explore ways to make this data useful for health insurance rate review. This important effort should be made a top priority to ensure that more robust, independent data on cost and quality is available in time for next year's rate filing period.

- *Adopting a more comprehensive list of cost and quality measures*. The current set of five quality measures is insufficient to evaluate the full scope of an insurer's efforts to improve quality in ways that contain costs. The Health Plan Quality Metrics Workgroup, established by House Bill 2118 (2013) to help align Oregon's efforts to measure health care quality, recommended a comprehensive set of measures in a report released earlier this year.[17] The Insurance Division should consider requiring the full set of “Phase 1” measures recommended in the Workgroup’s report for next year’s rate filings.

In evaluating insurers’ 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.

Cutting $24 million from 2015 premiums demonstrates that increased transparency and accountability works to bring down costs. Now, it is time to take the next step.

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[1] 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

[2] See OSPIRG Foundation's in-depth analysis of the Moda filing here: http://ospirgfoundation.org/reports/orf/comments-moda-health-plans-proposal-raise-individual-health-insurance-rates

[3] See OSPIRG Foundation's in-depth analysis of the PacificSource filing here: http://ospirgfoundation.org/reports/orf/comments-pacificsource-health-plans-proposal-increase-individual-health-insurance-rates

[4] See OSPIRG Foundation's in-depth analysis of the Health Net filing here: http://ospirgfoundation.org/reports/orf/comments-health-nets-proposal-increase-individual-health-insurance-rates

[5] See OSPIRG Foundation's in-depth analysis of the United filing here: http://ospirgfoundation.org/reports/orf/comments-unitedhealthcare-insurance-companys-proposal-increase-small-group-health

[6] The accuracy of these projections cannot be guaranteed, as they are based on predictions about enrollment levels and other factors that are highly uncertain. However, the numbers do provide a reasonable basis for an educated guess.

[7] Two other insurers, Samaritan and Trillium, also proposed rates, but do not currently have significant membership in Oregon's individual and small group markets. These insurers are not included because it is not possible to determine the cost impact of their rates on consumers. The OID cut Samaritan's 0% rate change back by 2%, and cut Trillium's proposal from a 3.6% increase to a 14.5% decrease.

[8] See http://www.statesmanjournal.com/story/news/health/2014/07/14/multiple-studies-show-people-health-insurance/12644779/

[9] See http://www.bizjournals.com/portland/blog/health-care-inc/2014/06/oregon-hospitals-spend-less-on-charity-care-in.html

[10] See http://www.oregonlive.com/health/index.ssf/2014/06/oregon_health_science_universi_28.

[11] See http://www.statesmanjournal.com/story/news/health/2014/09/08/report-medicaid-expansion-reflects-salems-story/15312693/

[12] 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."(http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes)

[13] However, since the impact of this factor varies significantly from insurer to insurer, some large projections were approved. For example, Moda projected that guaranteed issue would drive up their costs by 27.9%, and the OID accepted the company's argument. In other cases, such as LifeWise and Oregon's Health CO-OP, the OID actually increased rates above what was proposed due to low projections in this area that regulators considered unrealistic.

[14] ODS's popular PPO dental plan costs $27 per month, or $324 per year, for a 40-year-old Portlander. $24,000,000 divided by $324 = 74,074.

[15] See, e.g., http://www.bendbulletin.com/home/2289506-151/health-insurance-rates-will-increase-for-most

[16] See http://www.oregon.gov/DCBS/docs/news_releases/2014/News-release-final-decisions-8-1.pdf

[17] See https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf for the full report from the Workgroup.