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Comments on the Moda Health Plan 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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The authors bear responsibility for any remaining factual errors. The views expressed in this report are those of the authors, 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

Moda Health Plan's membership of more than 95,000 Oregonians with individual health insurance plans will see double-digit rate hikes of 12.5% on average, and as high as 13.7%, if the premium rate hike proposed by Moda goes forward.

Moda currently has the largest market share in Oregon's Individual market. Moda's increase is one of the largest proposed for next year in a context in which many of their competitors are proposing double-digit rate decreases for comparable coverage.

The main reasons given for this increase include the insurer's projection that medical and prescription drug costs will increase by 5.5% in the upcoming year, that the worsening health status of its customers will drive up costs by 3.8%, and that scheduled reductions in federal and state programs to protect insurers from risk will increase costs by 7.2%.

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

Key Findings:

- **Moda 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.

- **Moda's projection of a 7.2% increase due to changes in risk mitigation programs is relatively high and not adequately supported by the data provided in the filing.** In the coming year, state and federal reinsurance programs meant to stabilize premiums and protect insurers from unusually expensive claims from sicker customers will begin winding down, and phase out entirely by 2016. While insurers may be required to pay more of the cost of their members' care as these programs end, Moda's projection of the impact is high relative to other insurers, with reasons unclear. It is also unclear to what degree Moda is working to reduce its exposure to these additional expenses through programs to help higher-cost patients, such as those with chronic diseases, manage their conditions more effectively at a lower cost.

- **Moda's projection of a 3.8% 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, Moda does not provide enough evidence to support their projection.

- **Moda is proposing a significant increase to the provision for expenses on a per member per month basis without sufficient justification.** There is reason to believe those amounts should be rising only slowly, if not remaining level or decreasing.

- **When it comes to reducing costs and improving the quality of care, it is not clear that Moda is doing all it can**. New health care quality, cost and utilization metrics submitted for informational

purposes show that Moda's emergency room costs and specialty care utilization are higher than many of its competitors. In addition, its performance on measures of mental health follow-up care and developmental screening are below statewide benchmarks. Further inquiry should be made into the causes of these metrics to ensure Moda is doing everything possible to cut waste and improve quality of care.

Before deciding to approve or deny this rate request, we urge the Insurance Division to scrutinize the issues raised here, require Moda 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	ODSV-129567101
Name of health insurance company	Moda Health Plan
Type of insurance	Individual

Proposed Rates*	Rate	Increase from 2014
Standard Bronze	$187	13%
Standard Silver	$249	13%
Standard Gold	$302	11%
% premium to be spent on medical costs		80.80%
% premium to be spent on administrative costs		19.20%
% premium to be spent on profits		0.00%

Basis for rate - Key factors	
Hospital trend	3.50%
Non-hospital medical trend	7.00%
Rx cost trend	10.00%
Cost due to health status of new customers	3.80%
Cost due to reductions in reinsurance payments	7.20%

Insurer information

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

Insurer's financial position	
Year	2013
Surplus	$74,888,459
Investment earnings	$5,000,000

Insurer's history of rate increases	Requested	Approved
2009	17.67%	17.67%
2010	20.73%	17.54%
2011	9.94%	8.94%
2012	7.50%	3.80%
2013	N/A**	N/A**

Enrollment	
Year	**Members**
2006	3,352
2007	5,354
2008	11,295
2009	18,903
2010	25,492
2011	26,333
2012	27,748
2013	32,894
2014	95,948

Surplus History	
Year	**Amount in Surplus**
2007	$38,281,240
2008	$39,846,144
2009	$71,413,177
2010	$76,604,830
2011	$80,800,000
2012	$75,878,603

*"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 Moda'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 Moda.[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. Moda 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

Moda 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.

Moda provided the following explanations for their decision:

> From Moda's filing: "The effects of 'bad debt' reduction are expected to be long term, and reflect actual reductions in bad debt rather than anticipated reductions, and will therefore not be realized in the projection period." (This is the same sentence the insurer used in its discussion of bad debt reduction in its filing last year).
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> In response to questions by OSPIRG Foundation: "At this time, we have seen no reduction in provider contracting related to "bad debt" and do not project any reduction in 2014 or 2015 due to the limited market expansion from 2013 to 2014. Additionally, we project that it will take several years for the market expansion to impact cost trends in a credibly measurable way."

We find it difficult to square Moda's statements with the facts on the ground. It is true that 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 it is the case that fewer Oregonians were able to sign up for commercial coverage in the first year of ACA enrollment than might have been expected, likely due in large part to the problems with the Cover Oregon online enrollment system, Oregon's overall expansion of access to health coverage has been remarkably successful. 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]

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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/

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]

No doubt, 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 Moda, 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 Moda's rate proposal.

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.

Reinsurance

Starting this year, temporary reinsurance programs at the state and federal level provided a cushion for insurers to help ease the transition as the ACA comes into full effect. The programs lower costs for insurers by picking up the tab for a portion of especially expensive insurance claims, such as costly surgeries. These programs will phase out in stages over the coming years, starting with a reduction in payments in 2015.

By buying some needed time, the risk mitigation programs in the ACA, and Oregon's own efforts, create an opportunity for insurers to prepare for a new way of doing business—one where insurers work to cut costs by helping their customers better manage their health problems through focusing on prevention, instead of working to avoid having to cover expensive claims and pre-existing conditions. If insurers simply raise rates to cover the cost of these programs phasing out, this opportunity will have been lost.

While the phase out of these programs could have an effect on insurers' bottom lines, Moda's projection that this factor will have a 7.2% impact is significantly higher than some of its competitors,[10] and the reason why is not clear from the information presented in the filing.

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[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

[10] For instance, Oregon's Health CO-OP used a value of +1% as a contributing factor for "Fed & State Reins Changes." (SERFF Tracking #: OHCO-129528995)

Moreover, in response to questions from OSPIRG Foundation about the development of this projection, the insurer provided a calculation suggesting a lower value for the impact, 6.9%, without providing additional supporting data.

Moda, in selecting a value for the impact of the reinsurance changes, appears to have relied upon the work of an advisory group convened by DCBS: "Both state and federal reinsurance estimates are directly from analysis from the Oregon Reinsurance Technical Advisory Group." Moda did not provide any documentation of the technical advisory group's (TAG's) results, calculations or analyses in its filing.

From the documentation of the TAG's work that is available, it is not clear that it is appropriate to be relied upon for rating purposes. The workgroup was tasked with developing recommendations regarding the structure of Oregon's state supplemental reinsurance program, not with providing parameters for rate filings. It is also unclear how the TAG's recommendations relate to Moda's estimate, which is not reflected in the documentation available.[11]

Moda also stated "For further validation of the federal reinsurance estimate, we did develop a CPD using a credible set of Moda Health Commercial paid claims data, which showed substantially similar results to the TAG estimate," but Moda did not provide this data, or any further documentation of this result.

We urge the Insurance Division to take steps to ensure that the benefits of the state and federal reinsurance programs are appropriately represented in Moda's rates, and that that any rate increase imposed on consumers in this regard is necessary and justified.

Morbidity

Moda's projection of a 3.8% increase due to the health status of their customers 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."[12]

[11] OSPIRG Foundation obtained a copy of a document entitled "Oregon Reinsurance Technical Advisory Group - Reinsurance Parameters Recommendation" from DCBS, which may have been what Moda relied upon. The 7.2% figure is not clearly supported by this document.

[12] "Drivers of 2015 Health Insurance Premium Changes," http://www.actuary.org/content/actuaries-shed-light-2015-health-insurance-premium-changes

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 Moda's competitors are projecting a decrease in costs due to decreasing population morbidity,[13] Moda does not provide sufficient justification to support their projection of a 3.8% increase. The 3.8% figure appears to have been based upon a proprietary study, conducted by Wakely Consulting,[14] about which no information has been provided. We urge DCBS to scrutinize this projection closely.

Expenses

Moda's filing for 2014 rates reflected expenses (excluding margin) of $49.16 per member per month (PMPM). The current filing used a value for expenses of $59.83 per member per month (PMPM), which is an increase of +21.7%. A breakdown of the expense increases by category is given in the following table.[15]

Category	2014 Projected	2015 Projected	Percent Increase
Internal Expenses	$24.10	$29.11	+20.8%
Commission	$ 7.76	$12.18	+57.0%
Fees, Taxes, and Assessments	$17.30	$18.54	+ 7.2%
Total	$49.16	$59.83	+21.7%

With regard to the +57.0% increase in commissions, Moda stated: "Commission as a PMPM value increased as a result of the increase in premium levels as well as higher utilization of producers (60% in 2014 to 65% in 2015)".[16]

However, it is unclear that these two items would result in such a large increase, and Moda did not provide a specific numerical analysis to support this projection. A 12.5% rate increase, as proposed, and a 5 percentage point increase in producer utilization, as projected, do not by themselves add up to a 57% increase in total commissions. DCBS should closely scrutinize the rationale for this large proposed increase in commissions to ensure that Moda's customers are not made to pay more than they should.

With regard to the issue of internal expenses Moda provided the following table showing total and PMPM internal expenses by year split between fixed and variable.[17]

[13] LifeWise, for example, is projecting a cost decrease of 11.7% due to lower morbidity.
[14] Moda filing, Actuarial Memorandum, Pages 3 and 5 "The assumption in this filing is based on on-going national risk studies by Wakely Consulting".
[15] Moda response to OSPIRG request 25
[16] *Ibid.*
[17] Moda response to DCBS objection 11-2

	2013		2014		2015	
Fixed	$3,263,333	$8.71	$7,397,544	$6.07	$7,857,418	$4.68
Variable	$6,622,546	$17.68	$26,513,071	$21.76	$41,041,799	$24.43
	$9,885,879	$26.39	$33,910,614	$27.83	$48,899,216	$29.11

It is not clear how Moda split internal expenses into fixed and variable components. It would not appear that any internal expenses fall into the category of what is commonly referred to as variable expenses for insurance ratemaking purposes. Actuarial Standard of Practice (ASOP) 29 refers to variable expenses as "Those expenses that vary in direct proportion to premium, e.g., premium taxes."[18] The components of an insurer's internal costs, such as employee salaries, are not generally variable in this way, and treating them as such could lead to inflated costs.[19] Moda should provide a clear explanation for which costs it is treating as variable and why to ensure that its customers are not being overcharged.

In addition, at least some of the items that Moda includes in its projection of increasing expenses could be considered to be one-time start-up costs, which could be amortized over time, and not costs incurred in every subsequent year.

Some of the start-up items listed by Moda as expenses are as follows: "Creation of new processes to support the financial accounting for the 3R programs" and "Creation of new online enrollment system, which includes option for direct enrollment on the federal facilitated exchange." While there will be some continuing expenses associated with these items, the creation of the new processes involves a large component of start-up expenses which are not expected to be repeated in the future, and which should not be repeatedly charged to policyholders.

This issue is also addressed by ASOP 29 which states "Start-Up Costs—The actuary may amortize start-up or development costs using an appropriate amortization period." If Moda is projecting that start-up expenses will be repeatedly incurred, that could result in an inflated expense amount being passed through to policyholders.

Finally, Moda's statement in the filing that "a greater than expected influx of membership resulted in significant internal growth [and] increased overall administrative costs" does not necessarily support a higher value for internal expenses on a PMPM basis. A larger membership can allow expenses to be spread out over more policyholders, therefore resulting in a decreased cost PMPM.

Neither Moda's initial filing, nor the responses provided by Moda in response to the OSPIRG and DCBS inquiries, supports the large increase in expenses proposed by Moda. We urge DCBS to carefully evaluate the expense provisions proposed by Moda to ensure that policyholders do not pay excessive expense amounts in the rates charged.

[18] Actuarial Standard Of Practice No. 29 - Expense Provisions In Property/Casualty Insurance Ratemaking, Section 2.7, www.actuarialstandardsboard.org/asops.asp

[19] "Typically, overhead costs associated with the home office are considered a fixed expense. Variable expenses vary directly with premium; in other words, the expense is a constant percentage of the premium. Premium taxes and commissions are two examples of variable expenses." Basic Ratemaking - Chapter 7: Other Expenses and Profit, by Casualty Actuarial Society, 2010

Cost impact of proposed rates

Total cost of Moda's plans

Taking into account premiums, deductibles, coinsurance and other forms of cost-sharing, the total cost of coverage for Moda'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,[20] 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 Moda policyholders may accrue in the event of serious illness or other medical need.

Policyholders	**Plan**	**Annual premium (Increase since 2014)**	**Out-of pocket max (deductible + coinsurance + copays)**	**Total potential cost**
Sam, 33	Oregon Standard Bronze	$2,100 ($228)	$6,350	$8,450
Sarah and George, 50	Oregon Standard Silver	$8,352 ($816)	$12,700	$21,052
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$11,662 ($1,026)	$12,700	$24,362

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.

[20] 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.

Policyholders	**Plan**	**Annual premium (Increase since 2014)**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Sam, 32	Oregon Standard Bronze	$2,100 ($228)	$5,000 + $1,350	$8,450
Sarah and George, 50	Oregon Standard Silver	$8,352 ($816)	$5,000 + $1,500	$14,852
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$11,662 ($1,026)	$2,600 + $740	$15,002

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[21] 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 Moda'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 $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.[22]

Comparison of rates between Moda products

In addition to the Oregon Standard plans at the Gold, Silver and Bronze level, Moda is offering 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 Moda's filing proposes significantly different premium costs for them. Clarifying the basis for these cost differences is important to ensure that consumers can rely on the premium to be an accurate signal of the value of the coverage they are purchasing. However, the rationale for these differences is not clearly spelled out in Moda's filing.

For example, the rate proposed for Moda's Be Aligned-Rose City plan ($193 PMPM) is lower than the increased rate proposed for its Oregon Standard Silver Plan ($221 PMPM),[23] despite the fact that the Be Aligned plan has a slightly higher Actuarial Value (AV)—i.e., it covers more of the average patient's medical costs. Since the Standard Silver plan is Moda's most popular plan, with over 26,000 members, the potential impact of this difference is substantial.

[21] 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%).

[22] 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"

[23] Both listed prices are the monthly premiums proposed for an individual 30-year-old nonsmoking Moda member.

The purpose of allowing insurers to offer non-standard plans was to give them the freedom to offer innovative, higher value products. However, absent a clear explanation, we are concerned that the result of this kind of price difference could be to steer unhealthy individuals away from some plans, or away from the insurer altogether.

In response to OSPIRG Foundation questions, Moda points out that the AV filed for each plan is determined using the AV calculator developed by the federal government, which does not include a number of key factors, including the relative cost of different provider networks, and that the insurer does not use this calculator in developing its rates. Instead, the insurer states that it uses "a separate model that has a different methodology that is calibrated specifically for rating purposes," without providing any information about the details of this methodology.

While it is true that the federal AV calculator does not take all potential rating factors into account, its methodology is transparent and its results are independently verifiable. Where insurers' rating practices differ enough from the AV calculator to raise questions about the basis of pricing differences, the insurer must provide enough information to enable regulators to verify the validity of the rating methodology.

We urge the Insurance Division to scrutinize these differences carefully to make sure that they are based on legitimate differences between the plans and not on potentially market-distorting practices like attempting to price plans to select for healthy customers.

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.

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 Moda 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 Moda's emergency room costs ($1,827 per 1,000 members per year) and specialty care utilization (3,265 visits per 1,000 members per year) are higher than many of their

competitors. In addition, its performance on measures of mental health follow-up care (64.40%) and developmental screening (40.50%) 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 Moda. 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 Moda's ER costs per utilization are higher than many of their competitors, their rates of ER utilization are relatively low. This may be due to steps the insurer has taken to limit their members' exposure to a major driver of health care costs, or it may be due to random variation, meaning that Moda's customers may be left on the hook for high ER costs in the future.

In response to OSPIRG Foundation questions, Moda did not provide additional information to help evaluate its ER and specialty cost and utilization data in context, stating that the insurer "cannot compare to responses submitted by other carriers without confirmation that each figure has been calculated on a consistent basis." The carrier did explain that it is working to improve its performance in the area of mental health follow-up, and that it is working with its provider networks to improve documentation practices in the area of developmental screening, which may currently be under-reported, artificially depressing Moda's score.

In evaluating Moda'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.

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.	Not specified.	Not specified
"Medical Home" initiatives	Coordinated patient-centered care that focuses on prevention and keeping patients healthy and out of the ER.	Not specified	Not specified
Value based benefits	Plans with lower co-pays for treatment proven to be effective, and higher cost sharing for unnecessary procedures.	Not specified.	Not specified
Chronic disease management	Case management and other tools to improve the health of patients with chronic disease. [24]	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.	Admissions reduction programs, length-of-stay review, post-hospitalization care management	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, Moda reported taking steps to reduce health care cost in ways that improve quality for patients in only two of the six key areas we track. In response to OSPIRG Foundation questions, Moda provided some limited additional information but did not outline any other initiatives or specify savings projections, goals or benchmarks.

Moda estimates that their suite of cost containment programs will save approximately $27,000,000 in 2015. However, the steps Moda reports to reduce health care cost in ways that improve quality for patients are not described in detail and their effectiveness is not supported with data. Moda also does not break down the savings from each cost containment effort, making it difficult to evaluate the success of these efforts, whether the savings are higher or lower than anticipated, and whether the efforts are effective at controlling costs in ways that maintain or improve quality.

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

In a couple of cases, Moda provides some information about the impact of specific programs, including a 4% decrease in advanced imaging utilization associated with an Advanced Imaging Review program, but does not provide data about associated cost reductions.

There do appear to be encouraging efforts underway at Moda. They have programs in the area of case management and care coordination. However, without much more detailed savings and effectiveness data, it is not possible to evaluate the adequacy of the insurer's strategy.

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 Moda is not taking steps to pass along the savings from reductions in uncompensated care, and that its projections of cost impacts associated with the ongoing implementation of health reform are insufficiently justified.

We are also concerned that Moda 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 Moda'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.