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Comments on the Providence Health Plan Proposal for Individual Health Rates Effective January 2018

Filing # PROV-131037536

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 104,747 members with individual health insurance plans will see rate hikes of 22.7% on average, and as high as 68.3%, if the premium rate hike proposed by Providence goes forward.[2]

Providence's reasons for the increase include a 7% increase due to the rising cost of medical services and prescription drugs, and an 8% increase due to a projected decrease in enrollment in the market caused by the uncertain future of federal health reform.

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 $1.05 on health care for its Individual members for every premium dollar received in 2016, and sustain a 17.8% loss on its Individual market business. However, Providence already received a rate increase of 29.7% effective January 1, 2017, which is already much larger than the underwriting loss in 2016.

We are deeply concerned about the impact of this large increase on Oregon consumers, and on the Oregon Individual market—especially coming as it does after multiple years of double-digit rate hikes from Oregon insurers. If this rate hike is approved as filed, Providence's rates will have increased by about 80% since 2015. We urge the Oregon Department of Consumer and Business Services (DCBS) to scrutinize this filing closely. We are especially concerned that Providence may be inflating the impact of federal uncertainty, and may wind up overcharging Oregon consumers as a result.

At the same time, we urge DCBS and Oregon policymakers to take stronger steps to address the underlying drivers of health care and prescription drug costs. For too long, Oregon consumers have been asked to foot the bill for waste, estimated to represent a third or more of every dollar we spend on health care.[3]

Key Findings:

- **Providence's 8% rate hike due to federal uncertainty will likely result in inappropriately overcharging consumers.** Although the uncertain future of the Affordable Care Act (ACA) is of great concern to consumers as well as health insurers, Oregon law requires health insurers to set prices based on current law—not possible future legislation—and there is little basis for the claim that current law, or its implementation, has changed in any material way to justify such a large increase. If the ACA is repealed, Providence's rates can and will likely need to be revised, but if it is not, there is a serious danger that consumers will be overcharged.

- **Providence's financial position is improving.** Despite underwriting losses, Providence was able to add to its surplus last year. In this context, we are uncertain about the justification for Providence's proposal to add a 3% margin to its surplus while also proposing a large double-digit rate hike for the

[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] Providence's initial filing proposed an average 20.7% rate increase, but the company submitted a revision upping that value to 22.7%
[3] See, for example, Health Affairs, "Reducing Waste in Health Care"

second year in a row. While it is appropriate for Providence to take steps to avoid additional underwriting losses, it may also be appropriate for its margin to be reduced or removed to provide some premium relief for Providence members.

- **Providence's medical cost trend projections may be excessive.** Providence projects a 7% increase in the cost of health care services, but historical trend data presented by Providence in the filing shows a trend in medical costs of only 3.9% over the past year,[4] and DCBS's independent estimate of market average claims cost suggests that overall medical claims trends were essentially flat from 2015 to 2016.[5]

- **Providence is proposing a large increase in administrative costs.** Providence projects a 32% increase in general administrative costs,[6] an increase greatly in excess of the benchmark DCBS uses to assess whether administrative cost increases are reasonable. Furthermore, the proposed general administrative cost is more than twice the most recent actual value reported for 2016 on a per member, per month basis. This increase, if approved, will increase rates for members by about 2.5%, and merits close scrutiny.

- **A 22.7% increase would have a significant negative impact on affected Oregonians.** 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." While many Providence members will be able to avoid paying the full premium price by taking advantage of the Affordable Care Act's tax credits, or may find a lower-cost option by switching coverage, such a large increase will still be disruptive for many Oregon families. The proposed increase is also unevenly distributed across the state and will have a much bigger impact in parts of rural Oregon, where some families may face $6,000 or more in additional premium next year.

- **When it comes to reducing costs and improving the quality of care, it is unclear whether Providence is doing all it can.** Providence has failed to provide up-to-date quality metrics data in its filing, and does not provide sufficient information to evaluate its efforts to contain costs—or even whether it is appropriately sharing the savings from its cost containment efforts with its members. Providence also appears to have experienced an unexplained spike in emergency room usage and costs, raising questions about the insurer's efforts to contain rising ER costs and prevent unnecessary ER visits.

- **Providence's rate hike could go even higher if the American Health Care Act (AHCA) passes, or if the Trump Administration takes action to undermine the ACA.** Providence estimates that aspects of the AHCA could raise rates at least 9% above their current large increase. The insurer also estimates that a Trump Administration decision not to honor the ACA's cost-sharing reduction payment commitment could lead to additional increases as high as $24 per member per month. Together these increases could add up to an additional 15% increase or more. This underscores the stakes of the debate about the future of health reform for Oregon consumers.

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[4] In fact, this is the largest historical trend provided by Providence. The range of "Rolling 12-Month Normalized Trend" shown in the filing is from -14.0% to +3.9%.

[5] For DCBS's 2016 analysis, see http://dfr.oregon.gov/healthrates/Documents/2018-rate-review-preparation.pdf; for the 2015-2016 comparison, see http://dfr.oregon.gov/news/Pages/20170516-2018-proposed-rates.aspx

[6] The current filing uses a General Administrative Expenses PMPM of $52.65, whereas the value in the prior filing was $39.75. 52.65 / 39.75 = 1.32

Key Features & Insurer Information

Key features of the rate proposal	
State tracking # for this filing	PROV-131037536
Name of health insurance company	Providence Health Plan
Type of insurance	Individual

Proposed Rates*	
Standard Bronze	$335
Standard Silver	$414
Standard Gold	$495
% premium to be spent on medical costs	82.7%
% premium to be spent on administrative costs	14.3%
% premium to be spent on profits	3.0%

Basis for rate	
Medical trend	6.0%
Rx trend	12.4%
Admin cost increases	2.5%
Smaller, less healthy risk pool	8.0%

Insurer's history of rate increases		
	Requested	**Approved**
2014	N/A**	N/A**
2015	-16.3%	-14.0%
2016	7.2%	13.8%
2017	29.7%	29.7%

Enrollment	
Year	**Members**
2011	11,186
2012	12,162
2013	13,438
2014	8,205
2015	24,132
2016	105,406
2017	104,747

Insurer information

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

Insurer's financial position	
Year	2016
Surplus	$466,000,000
Investment gain	$13,000,000

Surplus History	
Year	**Amount in Surplus**
2012	$470,267,090
2013	$506,881,809
2014	$530,393,114
2015	$464,000,000
2016	$466,000,000

*"Proposed rates" are for a benchmark population--a 40-year old nonsmoker in the Portland area
A Bronze plan will pay about 60% of the average policyholder's medical costs in a year; a Silver plan will pay about 70%, and a Gold plan will pay about 80%. The Oregon Standard plans are currently being revised for 2018, but information about the 2017 plans can be found at http://dfr.oregon.gov/healthrates/Documents/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 served as the contracted organization under that program from 2011-2016. In 2016, the program was repurposed by the federal government. OSPIRG Foundation's Health Insurance Rate Watch program continues as an independent effort via the generous support of our members and a grant from Consumers Union.

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 in response to questions from DCBS.

Consumers in Oregon and across the country are facing a period of unprecedented uncertainty in health care markets. The future of the key protections in the federal Affordable Care Act, including protections for patients with pre-existing conditions and financial help to purchase health coverage, are currently being debated in Congress, and a bill to partially repeal and replace the ACA, known as the American Health Care Act (AHCA) passed the US House of Representatives in May.[7]

In this climate of uncertainty, with the health and financial security of Oregonians across the state on the line, it is more critical than ever to ensure that health insurance premium rates are justified, and that the state's health insurance market remains viable and competitive.

Regardless of the uncertain future of the ACA and the federal government's role in ensuring access to affordable health coverage, 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.[8] 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.[9] Since health care providers and prescription drug manufacturers 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

[7] OSPIRG, our 501c4 sister organization, has released several statements on the House bill and its possible impact on Oregon consumers, and the State of Oregon released an in-depth study of the legislation in March.
[8] See above, and also http://resources.iom.edu/widgets/vsrt/healthcare-waste.html
[9] 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

costs, and we continue to 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.

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. All of this information is public record and is or will be available on the DCBS rate review website, www.oregonhealthrates.org.

Examining the justification for the proposed premium rates

Cost of federal uncertainty

The single biggest contributor to Providence's rate hike is an estimated 8% increase due to the impact of federal changes that the insurer believes will shrink overall enrollment in the individual health insurance market.

There is ample reason to be very concerned about the potential impact of the American Health Care Act and other federal policy changes under consideration that could destabilize the health insurance market and lead to rate increases—as we discuss below. However, we are concerned that Providence could be dramatically overstating the impact of the federal changes so far, which could lead to overcharging consumers.

As a general rule, when a health insurance market shrinks, it is likely that the people who remain in the risk pool will tend to be in worse health, since people with greater health care needs are more likely to try to keep their coverage. The question is whether there is sufficient evidence that Oregon's Individual health insurance market will shrink at all, let alone as much as Providence projects in the coming year.

Providence attributes this 8% increase to two federal policy changes: A shorter open enrollment period and weaker enforcement of the tax penalty for individuals who go without health insurance (also known as the individual mandate).

- Shorter open enrollment

For 2018, the open enrollment period for Individual market coverage under the ACA will be half as long as the previous year—only 45 days, from November 1 – December 15. This change was made in part due to insurers' concerns that extending open enrollment through the beginning of the year caused many

partial-year enrollments, and may in some cases have created "opportunities for adverse selection"[10] by enabling some to consumers wait until they got sick to sign up for coverage.[11]

There are legitimate reasons for insurers and consumers to be concerned about the impact of a shorter enrollment period. The change may be confusing for some consumers. The shorter time frame also means that all of the work of open enrollment, including the critical in-person help from health insurance agents, brokers and community groups, will have to be done in only half the time.

However, it is far from clear how much, or even whether, the shorter open enrollment period will result in lower enrollment in Oregon. The open enrollment period has been shortened every year since the beginning of full implementation of the ACA in 2014, and yet every year Oregon's enrollment in the ACA's marketplace has increased.

Perhaps more importantly, the state of Oregon's commitment to continuing to expand access to coverage remains strong. The Oregon Health Insurance Marketplace's leadership and key stakeholders have clearly expressed the goal of maintaining at least the current enrollment levels and not letting anyone fall through the cracks, despite the challenges posed by the shorter open enrollment period.[12] There are a variety of strategies the state can undertake to meet that goal, including investments in marketing and outreach, or increased support for agents, brokers and enrollment assisters to mitigate their increased workload.

It is hard to predict the impact of a shortened enrollment period with any precision, but we believe it would be problematic to approve a rate increase premised on the assumption that the state will fail to meet its goals.

- Weaker enforcement of the individual mandate

One of President Trump's first acts in office was the signing of an Executive Order instructing administrative agencies to waiver or defer provisions of the ACA that impose fees or other "economic burdens."[13] This was interpreted by some as a move that would effectively eliminate the ACA's penalty for going without health insurance. Eliminating the IRS's enforcement of this penalty, which was intended to spur more people to enroll, could potentially lead to lower overall enrollment and a sicker, more expensive risk pool, as healthy people would be more likely to be motivated by the penalty than sicker people, who already have a strong incentive to enroll in health coverage.

However, it appears that the only concrete action the IRS has taken in response to this Executive Order so far is to walk back an effort to strengthen enforcement of the mandate. The agency had been planning to institute a policy of rejecting tax returns that did not indicate whether the filer had health insurance; this now-abandoned policy had not yet been implemented.[14] In other words, the policy

[10] As stated in the federal rule implementing this change: https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-07712.pdf (pg. 3)
[11] There is little evidence to support this contention, and it is revealing that no Oregon insurers included any rate decreases due to this change.
[12] Most recently, at the Oregon Health Insurance Marketplace Advisory Committee meeting on June 8.
[13] Read the text of the Executive Order here: https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and
[14] For background, see, e.g., http://thehill.com/policy/healthcare/319672-irs-takes-step-against-obamacare-mandate

status quo has not actually changed. In fact, through the most recent tax filing season, the IRS has continued to enforce the penalty.[15]

It is of course possible that the federal government will take more substantive action to weaken the enforcement of the penalty, or that the penalty could be repealed altogether by Congress. But in lieu of these changes, we do not think it is appropriate to charge Oregonians more for coverage based solely on the executive action taken in this area so far.

It is possible that some consumers' health insurance purchasing behavior will be influenced (correctly or incorrectly) by reports of a weaker individual mandate, or by (understandable) confusion about the status and future of the ACA. But public awareness of the details of the ACA and its implementation and enforcement has long been quite low—past polls have shown that surprisingly high numbers believe the ACA has already been repealed, for example[16]—and it seems unlikely that the details of IRS tax penalty enforcement are widely known, or will have a big impact on consumer behavior.

More broadly, we are concerned that a large rate increase based on a projection of a smaller overall health insurance market cannot be justified based on any concrete changes that have *yet* been made to the law, regulation or implementation of the ACA. We are concerned that Providence's effort to increase rates based on these projections may not actually be premised on changes to the open enrollment period or the enforcement of the mandate, but on the risk of possible future changes. While that possibility exists, it is not appropriate for health insurers to inflate costs on that basis.

DCBS's guidance to Oregon insurers has been quite clear: Health insurance rates must be based on actual claims experience and current law, not on speculation about possible future changes to the law. We think this policy is important because it is impossible to predict future cost changes due to possible unknown revisions in statutes or regulations with any precision or actuarial soundness. The law is always in flux and there is always some possibility of policy decisions affecting the costs facing health insurers; if all of those risks of potential cost changes were priced in, consumers would frequently be overcharged for coverage.

If the AHCA is signed into law or other major changes are made—such as cutting off the funding for the ACA's cost-sharing reductions—Providence's rates will need to be revisited, along with those of their competitors.

Oregon regulators have the flexibility to reconsider rates for a period of time even after officially announcing their decisions on rates. If House Bill 2342, currently under consideration in the Legislature, is signed into law, DCBS will have even more tools, including emergency powers to reconsider rates that have already gone into effect. We believe these tools will suffice for regulators to adjust rates if necessary, and that in lieu of major concrete changes to law or policy, an 8% increase to hedge against hypothetical market instability is inappropriate and should be denied in its entirety.

[15] See, e.g., http://www.politico.com/story/2017/05/03/trump-obamacare-mandate-enforcement-237937
[16] See, e.g.,: http://washington.cbslocal.com/2013/08/29/poll-44-percent-of-americans-unsure-if-obamacare-is-still-a-law/

Insurer's financial position

Despite underwriting losses of $41 million, Providence's financial position improved last year, with its surplus rising slightly, from $465 million to $466 million.

Providence also received a rate increase of 29.7% for 2017, which is already much larger than the underwriting loss in 2016. The additional 22.7% increase requested by Providence effective January 1, 2018 would result in a combined rate increase over two years of more than 55%. It is unclear why such a large increase in rates would be needed to prevent a repeat of losses in 2016.

Providence's surplus is more than large enough to ensure financial stability without the need for major contributions to surplus. This is especially true in the context of the decline in membership that the insurer expects in the coming year, from 104,747 to 56,397—a 46% decrease. With a smaller membership, less surplus is necessary to provide a margin for unexpectedly high costs. In a context where Providence is proposing to increase its rate by 2.5% due to higher administrative costs per member caused primarily by a projected overall decline in membership, it seems reasonable to ask whether members should also see some offsetting savings as a result of this decline.

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 continue to increase from investment gains.

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 7% increase in medical costs is out of step with other information supplied in Providence's filing, and with publicly available data about marketwide trends in Oregon. We are concerned that it may be overstating health care cost growth trends, and may overcharge consumers as a result.

The historical data presented by Providence shows a maximum increase of only 3.9% in the "rolling 12-month normalized trend."[17] Moreover, comparing Providence's cost metric data from the past three years' filings suggests that their costs have actually decreased on a per member per month basis.[18] While this trend data only reflects the insurer's historical experience, and it is certainly possible that health care cost trends will increase, the insurer has not provided a sufficient basis for their higher trend projection for the coming year.

[17] See Exhibit 4: Trend Information and Projection; the range in the rolling 12-month normalized trend is from -14.0% to +3.9%
[18] See Appendix A.

Given the widespread reports of rapidly rising prescription drug costs, it is hard to dispute Providence's pharmacy trend, though its projected 12.4% increase is alarming high. However, the insurer's trend rate for other medical services—approximately 6%—may be inflated, and merits close scrutiny.

Providence's filing includes the following explanation for its trend projection for medical services:

> **Medical trends are driven by:** changes in the mix of intensity of services within a major service category; movement of utilization between service categories; new medical technology; changes in the number of services provided; changes in negotiated reimbursement levels between PHP and providers. Recent experience shows shifting utilization from inpatient to outpatient settings.

In the absence of specific evidence that these factors will accelerate health care cost growth in the coming year, it is hard to evaluate Providence's trend projection. The one specific claim—a shift from inpatient to outpatient utilization—would actually tend to undercut Providence's projection, since outpatient hospital services are generally much less expensive than inpatient hospitalizations.

Even the smaller 3.9% increase in Providence's historical trend is out of line with DCBS's estimate of marketwide trends in claims cost. DCBS has examined financial filings of all Oregon health insurers in the Individual market and determined that the average per member per month claims cost actually declined from 2015 to 2016, from $385 to $384, respectively.[19] This number is not far from the "Rolling 12-Month Normalized PMPM" claims cost experience supplied by Providence, which averages to about $390, suggesting that Providence's experience is not especially atypical for the Oregon market.

In this context, it is critical for Providence to provide more support for their claim that medical cost trends will significantly increase next year. In the absence of such information, we would urge DCBS to consider reducing the insurer's rate to reflect a trend that would be less likely to result in overcharging consumers.

Administrative costs

Providence is proposing to increase its general administrative expenses from $39.75 to $52.65; a 32% increase. Furthermore, the proposed general administrative cost PMPM of $52.65 is more than 110% higher than the most recent actual value during 2016, which was $24.71.[20] This substantial increase impacts the proposed rates by 2.5%, and is far above the health care services Producer Price Index benchmark DCBS uses to assess whether an administrative cost increase is reasonable.[21]

Providence attributes this change primarily 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.

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[19] DCBS highlighted this finding in their press release announcing the beginning of the current rate review period: http://dfr.oregon.gov/news/Pages/20170516-2018-proposed-rates.aspx

[20] See Exhibit 5: Statement of Administrative Expenses, 52.65 / 24.71 = 2.13

[21] 1.5% from May 2016 to May 2017. Source: US Department of Labor, May 2017 PPI report, available at http://www.bls.gov/ppi/

It is worth observing that in last year's filing, Providence's per member administrative costs were projected to increase dramatically from 2016 to 2017 due to a projected decrease in membership from over 105,000 to less than 86,000. In fact, Providence's membership barely declined at all during that period. It is unclear whether such a large increase in administrative expenses is warranted given the information provided in the filing.

Impact of proposed rates

Total cost of Providence's plans

Taking into account premiums, deductibles, coinsurance and other forms of cost-sharing, the total cost of coverage in 2018 for Providence's plans as proposed in the filing would be a dramatic increase from the 2017 cost.

A 22.7% increase would be almost 12 times the rate of inflation in the broader economy (1.9%) and more than 9 times the rate of inflation in the cost of medical services (2.5%).[22] Although Oregon's economy has been improving in recent years, this increase would still take place against a backdrop of relatively slow 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."[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.

Assuming that the core provisions of the ACA remain in place in 2018, 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 2018 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 increase even larger than 22.7% on average; if all insurers' rates were approved as filed, Providence's plans would likely be more expensive relative to the second-cheapest Silver plan in many parts of the state than they are today, meaning that tax credits would cover 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]

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[22] Source: US Department of Labor, May 2017 CPI report, available at https://www.bls.gov/cpi/

[23] See Appendix 1: Insurer's Financial Position

[24] For information about eligibility for these federal tax credits, see www.healthcare.gov, Oregon's health insurance marketplace.

[25] 2017 premium and tax credit values are averages for Oregon, and can be found in the Center for Medicare and Medicaid Services "2017 Marketplace Open Enrollment Period Public Use Files," available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Plan_Selection_ZIP.html

Monthly Amount	2017 Value	Increase in 2018	2018 Value
Premium Before Tax Credit	$385	22.7%	$472
Value of Tax Credit	$309	10%*	$340
Premium After Tax Credit	$76	74%	$132

*A tax credit increase of 10% is an assumed value for illustrative purposes. Actual tax credit increases will not be available until 2017 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 3/4, 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.[26]

Policyholders	**Plan**	**Annual premium (Increase from 2017)**	**Out-of pocket max (deductible + coinsurance + copays)[27]**	**Total potential cost**
Sam, 33	Oregon Standard Bronze	$3,876 ($612)	$6,550	$10,426
Sarah and George, 50	Oregon Standard Silver	$14,316 ($2,388)	$14,700	$29,016
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$19,704 ($2,880)	$13,700	$33,404

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.

[26] These case studies are all based on proposed Portland metro area rates for Providence's "Signature Network" plan. Providence's "Choice Network" plans are marginally less expensive, but not available in some parts of the state.

[27] These values throughout this analysis assume that DCBS's proposed rules for the 2018 Oregon Standard Bronze and Silver Plans are finalized in their current form. See http://dfr.oregon.gov/laws-rules/Pages/proposed-rules.aspx for more information about DBCS's Standard Plan rules. The Standard Gold plan details are available at http://healthcare.oregon.gov/Documents/2018-standard-gold-plan.pdf

Policyholders	**Plan**	**Annual premium (Increase from 2017)**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Sam, 32	Oregon Standard Bronze	$3,876 ($612)	$6,550	$11,026
Sarah and George, 50	Oregon Standard Silver	$14,316 ($2,388)	$5,000 + $2,250	$21,566
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$19,704 ($2,880)	$1000 + $1,800	$22,504

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[28] 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.

It is also worth highlighting that, if approved, the impact of Providence's rate hike will be unevenly distributed across the state. Consumers in Oregon's mostly rural 7th rating area, which includes the Columbia River Gorge and large swaths of Central and Eastern Oregon, will see much larger rate increases, as the following case study illustrates:

Policyholders	**Plan**	**Annual premium (Increase from 2017)**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Hannah and Jeremy, 50, Hood River	Oregon Standard Silver	$17,899 ($5,971)	$5,000 + $2,250	$25,149

A nearly $6,000 annual premium increase is a remarkable burden on a family budget, by itself representing nearly 12% of Oregon median household income.[29] While there are real differences in the cost of providing health care between different parts of Oregon, this remarkably high rate of premium growth underscores the urgency of close scrutiny of health insurance premiums.

[28] 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%).
[29] $51,241 in 2015. Source: US Census Bureau, http://factfinder.census.gov/

Possible Impact of Future Federal Action

This year's health insurance rate filings dramatically underscores the stakes for Oregon consumers in the federal debate about the future course of health reform. Providence's filing suggests that if the American Health Care Act (AHCA) is signed into law, or if the Trump Administration pursues executive action or other strategies to undermine the implementation of the ACA, its rates could spike up even more dramatically.

As discussed above, Oregon insurers must provide rates premised on the status quo, so Providence's proposed 22.7% average rate hike does not itself include a projection of the impact of the AHCA, the new US Senate bill called the "Better Care Reconciliation Act," or other possible federal changes. Since federal action may occur at any time during or after the rate review process, however, DCBS did ask all Oregon health insurers to answer some questions about possible impacts, and their answers shed some light on how much more Oregonians may have to pay for health coverage as a result of changes being debated at the federal level.

Providence estimates that the outright repeal of the ACA's tax penalty (also known as the individual mandate) would by itself increase costs by about 9% on top of the double-digit increase already proposed. The insurer cautions that the legislation should be considered as a whole and does not provide a specific estimate of the cost impact of all of the provisions in the legislation together—which is appropriate, since the final form of the legislation is not yet determined. However, its analysis of the AHCA's proposed penalty for consumers who go without continuous coverage suggests that this provision may actually provide a disincentive for health consumers to enroll and raise costs even further.

Another possible federal policy change would be a decision by the Trump Administration to withhold the payments that support the ACA's cost-sharing reduction (CSR) provisions.[30] These payments help cover the cost for insurers to reduce cost-sharing for qualified members. The payments are currently the subject of a federal lawsuit called *House v. Price*, and the Trump Administration has yet to decide whether it intends to continue making these payments.[31]

If the CSR payments are not made, the ACA requirement for insurers to offer lower cost-sharing plans to qualifying members will remain in place, but insurers will no longer have the funds available to cover the extra cost of these plans, so they will be forced to raise rates. Providence estimates that this could lead to an additional cost of as much as $24.03 per member per month. There is some debate among experts about how these costs should be distributed among the plans an insurer offers, should this come to pass. If it were distributed evenly across all plans,[32] it would represent an additional increase of nearly 6% for a 40-year-old in the Portland area on an Oregon Standard Silver plan.

[30] For some background on the CSR program, see https://www.healthcare.gov/glossary/cost-sharing-reduction/
[31] For an overview of the lawsuit and the debate over the issue, see http://healthaffairs.org/blog/2017/05/22/insurers-marketplaces-face-uncertainty-as-parties-seek-further-house-v-price-delay/
[32] It should be noted that consumer advocates generally prefer "loading" the increase into the Silver plans because it could have the counter-intuitive effect of increasing financial help for many consumers. See an in-depth analysis of the issue here: http://health.oliverwyman.com/transform-care/2017/05/impact_defunding_CSR_payments.html

Although these federal changes may never come to pass and may never need to be reflected in premium rates, Oregonians should know how much their rates may increase as a result of federal action.

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.

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. 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.

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.

This is the fourth 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.

Unfortunately, it is impossible to evaluate Providence's progress on the key quality metrics included in rate filings, because the company appears to have re-submitted the data from the previous year's rate filing, which covers the company's performance in 2015. It is unclear why Providence did not submit more current data; its competitors have done so. These quality metrics are an important source of information about the performance of Oregon insurers and we urge DCBS to require Providence to submit more current data as the review process moves forward to give the public more insight into the context of this proposed rate increase.

The cost metrics submitted by Providence suggested that its members' utilization and cost for most categories of health care service were up only modestly from the previous year. However, emergency department visits nearly doubled, from 71.5 to 134.9 per 1,000 members, and the per member per month cost of ER visits soared from $1.84 to $14.42. This dramatic increase is not explained in the filing, raising questions about Providence's efforts to contain rising ER costs and prevent unnecessary ER visits.

It is clear from their qualitative description of their efforts that Providence has constructive initiatives underway to contain costs and improve quality of care, including an effort initiated in late 2016 to better manage emergency department utilization that may help address the increase detailed above. However, since Providence insists that "savings are not possible to quantify at this time due to the many interactions between programs, populations, and environment," it is impossible to evaluate the adequacy of these efforts—or even to determine whether the insurer is appropriately passing along any savings to its members.

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.

APPENDIX A—See next page

Providence Health Plan

Utilization Per 1,000 Members and Per Member, Per Month Costs

Data In Filings for Rates in Following Year

Utilization Per 1,000 Members, Per Year

		Utilization in Filings for			Percent Change	
Major Medical Service Category	Count Type	2016	2017	2018	2016 to 17	2017 to 18
Inpatient	Admissions	57.7	49.0	105.5	-15.1%	115.3%
	Days	205.4	185.7	216.6	-9.6%	16.6%
Outpatient	Visits	2,363.4	2,532.5	2,566.1	7.2%	1.3%
Emergency Room	Visits	135.2	71.5	134.9	-47.1%	88.7%
Primary Care Physicians	Visits	1,666.0	793.6	3,169.2	-52.4%	299.3%
Specialty Care Physicians	Visits	9,622.2	9,796.9	1,080.1	1.8%	-89.0%
Pharmacy - Outpatient	Scripts	9,125.3	10,587.6	10,945.0	16.0%	3.4%
Other	Misc	12,402.7	12,313.4	12,156.1	-0.7%	-1.3%

Cost Per Utilization

		Cost per Utilization in Filings for			Percent Change	
Major Medical Service Category	Count Type	2016	2017	2018	2016 to 17	2017 to 18
Inpatient	Admissions	$19,735.14	$20,608.36	$10,268.68	4.4%	-50.2%
	Days	$5,540.96	$5,443.33	$5,005.69	-1.8%	-8.0%
Outpatient	Visits	$518.69	$465.29	$431.34	-10.3%	-7.3%
Emergency Room	Visits	$180.53	$309.65	$1,282.39	71.5%	314.1%
Primary Care Physicians	Visits	$167.00	$180.67	$115.22	8.2%	-36.2%
Specialty Care Physicians	Visits	$150.24	$152.07	$190.82	1.2%	25.5%
Pharmacy - Outpatient	Scripts	$94.46	$72.66	$59.12	-23.1%	-18.6%
Other	Misc	$29.79	$32.85	$80.62	10.3%	145.4%

Cost Per Member, Per Month

		Cost PMPM in Filings for			Percent Change	
Major Medica Service Category	Count Type	2016	2017	2018	2016 to 17	2017 to 18
Inpatient	Admissions	$94.83	$84.23	$90.25	-11.2%	7.1%
	Days	$94.83	$84.23	$90.33	-11.2%	7.2%
Outpatient	Visits	$102.16	$98.20	$92.24	-3.9%	-6.1%
Emergency Room	Visits	$2.03	$1.84	$14.42	-9.4%	683.7%
Primary Care Physicians	Visits	$23.18	$11.95	$30.43	-48.4%	154.6%
Specialty Care Physicians	Visits	$120.47	$124.15	$17.17	3.1%	-86.2%
Pharmacy - Outpatient	Scripts	$71.83	$64.11	$53.92	-10.7%	-15.9%
Other	Misc	$30.79	$33.71	$81.67	9.5%	142.3%
Total		$445.29	$418.19	$380.18	-6.1%	-9.1%