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Comments on ODS Health Plan's Proposal to Increase Individual Health Insurance Rates

Filing #HL 0408 10

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

ODS Health Plan (ODS) is proposing to raise rates an average of 9.94%, impacting 26,333 Oregon consumers and families with individual plans, effective November 1, 2011. The nearly 10% rate increase comes after two back-to-back years of increases exceeding 17%. If approved, the average rate will have increased 52% for individual policyholders over the last three years.

This rate filing includes some good news for consumers, as well as several areas of concern.

We commend ODS for improvements for enrollees, such as reducing the copay for some generic drugs to $2.00, and reducing rates for children because of a new state reinsurance program that will reduce their costs. We appreciate ODS' straightforward approach to projecting medical trend, basing it on past experience with a few reasonable adjustments. In addition, ODS' enrollment appears stable and growing, a good sign for the stability of future rates.

At the same time, we have several areas of concern that suggest the proposed 9.94% increase may not be fully justified. Especially in the current economic climate, with individuals and families struggling to keep up with rising premiums and out-of-pocket costs, it is critical for rate hikes to be thoroughly justified, and for no excessive costs to be approved.

Our key concerns with the filing include:

1. The percentage of premium expected to go to medical costs is fairly low, and the expected administrative costs are relatively high.

We are concerned that if actual administrative costs come in even slightly above projections, ODS may run afoul of the federal health reform law's requirement that individual plans spend at least 80 percent of premium dollars on care or issue rebates to consumers. If ODS expects to have to issue rebates, it may be better and more efficient for it to simply lower its rate proposal to avoid this outcome.

2. One element of ODS' administrative costs – agent and broker commissions – appears to be growing very fast.

ODS' explanation for this increase is primarily that they pay their commissions based on a percentage of premium. We're concerned that this practice unjustifiably inflates administrative costs, and we believe it may not be considered a reasonable use of premium dollars. Many in the industry have moved to paying commissions based on a flat fee rather than as a percentage of premium, and we urge DCBS to ask ODS to follow their lead.

3. ODS' projections for medical costs may be too high.

ODS does not appear to have adequately taken into account the recent slowdown in health care cost increases largely due to the slow economy. While overall, the method ODS has chosen to predict its medical trend by looking at its past claims history seems reasonable, we believe this recent slowdown in health care costs and usage is significant and deserves ample consideration.

4. ODS may not be doing enough to help lower the cost of care while improving quality.

While ODS' medical trend this year is lower than that used by some other insurers, we are concerned that ODS may not doing enough to help lower the cost of health care and improve its value. Researchers and clinicians have identified a large number of opportunities to promote prevention and effective care while weeding out duplicative and counterproductive treatments. From the filing, it is not clear that ODS is aggressively taking action on many of these opportunities, meaning that their enrollees might experience larger rate increases down the road.

Key Features & Insurer Information

Key features of the proposal to increase premium rates

State tracking # for this filing	HL 0408 10
Name of health insurance company	ODS HEALTH PLAN, INC.
Type of insurance	Major Medical Policy (individual)
Grandfathered under federal health reform?	Non-Grandfathered

Average rate increase	9.94%
Minimum rate increase	5.60%
Maximum rate increase	11.70%

Number of Oregonians affected	26,333
Anticipated enrollment if approved	33,333

Insurer's history of rate increases in this market	
2010	17.54%
2009	17.67%
2008	8.90%
2007	-4.50%

Proposed rate	
% premium to be spent on medical costs	76.40%
% premium to be spent on administrative costs	23.10%
% premium to be spent on profits	0.50%

Effective Date of rate increase	11/1/2011
Date rate filing posted	8/9/2011
Date comments due	9/20/2011
Link to rate filing:	http://tinyurl.com/3lobcnv

Basis for proposed increase	
Increase in medical costs	11.40%
Increase in Rx costs	11.40%

Insurer information company-wide

For profit or non-profit:	For profit
State domiciled in:	OR
Parent company:	Oregon Dental Service

Insurer's financial position	
Year	2010
Surplus	$76,604,830
Investment earnings	$4,818,529

Surplus History Company-Wide	
Year	**Amount in Surplus**
2005	$36,610,475
2006	$37,794,399
2007	$38,281,240
2008	$39,846,144
2009	$71,413,177
2010	$76,604,830

Discussion of the Rate Filing

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

Medical cost trends

Are the projected medical trends, both cost and usage, supported by the data?

ODS derives its projected medical trend numbers directly from their actual claims experience, a method that appears reasonable. However, we urge DCBS to examine whether ODS' adjustments of these numbers are justified, and also whether ODS is adequately adjusting for the slowdown in medical trend observed by other insurers.

ODS' filing proposes an identical medical and prescription drug trend of 11.4%, derived from their rolling 12-month claims experience trend.

DCBS has previously indicated that it evaluates an insurer's projected medical trend by comparing it with (1) the insurer's own two year claims experience, and (2) the average medical trend reported by other insurers. DCBS has described this evaluation practice as actuarially acceptable. We examine each of these methods in turn.

1. ODS' two year claim experience

As mentioned above, in this filing ODS proposes to use their most recent 12-month claims experience trend. They perform this calculation by looking to their actual monthly claims paid since January of 2008, adjusting to per-member per-month claims costs, and calculating the 12-month rolling average (p. 9 of the filing). The average of this monthly trend over the past year is 11.4% – averaging out over the entire year will remove the impact of months that are outliers in terms of the amount of claims paid.

The one adjustment that ODS makes to this data is, for recent months, to estimate the difference between claims paid so far and incurred claims that will eventually be paid. This is an appropriate adjustment, as lags in claims processing, audits, and appeals, mean that it may take several months to fully pay for all claims incurred in a given month.

To make these adjustments, ODS' filing uses a series of "completion factors," but the filing does not provide any justification for the specific values chosen. In a response to OSPIRG Foundation questions, ODS stated that these factors are based on historical trends, unprocessed claims volumes, and knowledge of specific large outstanding claims. ODS did not provide supporting data or calculations. In general, these factors are appropriate to consider, but we urge DCBS to require disclosure of the details of these calculations, and to scrutinize them in order to ensure that they are justified.

As ODS' filing notes, simply looking to actual claims experience may in some cases provide a less than completely accurate picture of the expected medical trend. This may be the case where there are significant changes in benefits, or where a static enrollee population ages and thus grows more expensive. ODS, however, does not expect meaningful changes in the benefits enrollees will choose, and

expects their enrollment to continue to grow, and thus, it proposes using its observed trend of 11.4%, adjusting only for claims completion as discussed above.

However, there are factors other than those discussed by ODS that impact future claims costs. In particular, many insurers have noted that the economic downturn has driven a recent decrease in patient utilization of medical services.[1] This decrease may not adequately be reflected in claims experience data going back two years, which would make the proposed medical trend higher than it should be. In response to questions posed by DCBS, ODS has argued that this slowdown in utilization is already reflected in their claims experience, given that the recession formally dates back to December 2007, and that their approach is valid because medical trends would increase "in the near future as our economy returns to an expansionary phase." However, the change in consumer behavior likely would not coincide with the formal econometric beginning of the recession, and current economic projections do not suggest that near-term economic growth will be high.

Because their proposed trend is directly derived from ODS' actual claims experience, we find that ODS' choice of medical trend appears reasonable on this criterion, though we urge DCBS to examine whether ODS' completion factors are justified and whether they are adequately adjusting for the slowdown in trend observed by other insurers.

2. Comparison to other insurers' approved trends

In the Oregon individual market, the weighted average approved medical trend was 13.6%, somewhat higher than ODS' proposed 11.4% trend.[2] However, we continue to be concerned that using the overall industry approved medical trend as a benchmark is flawed, and tends to self-perpetuate the status quo, rather than push each insurer to hold down medical costs.

On both criteria employed by DCBS, we find that ODS' medical trend is not unreasonable on its face – though ODS' completion factors must be validated before ultimately concluding that their methodology is sound, and we are concerned that they do not appear to have adjusted their trend for the recent slowdown in medical cost increases. With that said, using actual claims experience as the basis of predictions is in general a more sound point of departure than engaging in complex normalizations and adjustments, where small changes in assumptions can lead to very different predictions, so we are glad that ODS is taking this approach.

Insurer's efforts to reduce medical costs while improving quality

Is the insurer taking sufficient steps within their power to reduce health care costs while improving quality, and if so, are those steps achieving measurable results?

[1] *See* Aetna Reports First-Quarter 2011 Results, http://www.aetna.com/news/newsReleases/2011/pr_1stquarter2011_earnings.html; UnitedHealth Group Reports First Quarter Results, http://www.unitedhealthgroup.com/invest/2011/UNH-Q1-2011-release.pdf; Health Net Reports First Quarter 2011 GAAP Net Loss of $108.2 Million, or $1.16 a Share, http://healthnet.tekgroup.com/article_display.cfm?article_id=5538; see also Reed Abelson, *Health Insurers Making Record Profits as Many Postpone Care*, N.Y. TIMES, May 13, 2011, http://www.nytimes.com/2011/05/14/business/14health.html.

[2] Industry-wide annualized trend information is derived from data provided by DCBS to OSPIRG in March 2011.

Because DCBS rules require insurers to only include new initiatives launched since their last rate filing, it is sometimes difficult to fully answer this question. We are pleased to see that ODS' filing includes both new and ongoing cost and quality efforts. We recommend that DCBS require insurers to detail all of their cost control and quality improvement initiatives in rate filings, which will help the public make apples to apples comparisons of what different insurers are doing.

We reviewed the list of initiatives ODS says that it is undertaking to lower costs and improve the quality of care, and compared it with a master list of six important practices, outlined below, that can address the largest factors driving up medical costs. Based on the information below, it appears that ODS could be doing significantly more to promote high-quality, high-value treatment through payment and delivery reforms, as they are pursuing only limited efforts in one of the six categories. Again, it may be that ODS is pursuing efforts in more areas, but that they are not new efforts and so are not listed.

Six major initiatives to lower costs and improve quality, compared to ODS' current efforts		
Initiative	**Description**	**ODS' current efforts**
1. Reforming methodology of payment to providers	This includes initiatives such as moving away from a fee-for-service payment model, toward payment methodologies that reward best practices, quality care and outcomes.	None listed.
2. Medical Home initiatives	This includes paying providers differently to best provide coordinated care.	None listed.
3. Benefit designs that encourage effective care, such as prevention and chronic disease management.	This includes no co-pays for essential preventative care treatments, low co-pays for treatments proven to be effective, and higher cost sharing for unnecessary procedures.	Differential cost-sharing for prescription drugs that incentivize lower-cost treatments.
4. Management of prevalent chronic diseases[3] to reduce unnecessary hospital admissions and expensive escalations of these diseases.	This includes provider reimbursement and incentives for patient behavioral changes and clinical treatments that maintain the health of patients suffering from chronic diseases.	None listed.
5. Reduce hospital readmissions	This includes giving preference to providers who make efforts to ensure that a discharged patient has adequate follow up care post-discharge, not reimbursing for preventable readmissions, and other strategies.	None listed.
6. Reduce errors and adverse events in a clinical setting	This includes not reimbursing for "never events," and using payment methodologies and other incentives to encourage provider safety	None listed.

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

	practices.	

Besides the initiatives discussed above, ODS also reports that they have created new options for enrollees to receive plan information electronically, reducing paperwork, and leveraging their increased membership to negotiate lower provider rates. They also cite a Diagnostic Imaging Management program aimed at ensuring the medical necessity of medical imaging claims.

While these approaches may help lower costs in the short-term, they appear to be inadequate to the task of significantly bending the long-term increase in health care costs. DCBS should urge ODS to more aggressively promote the six initiative areas discussed above.

ODS estimates the premium impact of its efforts has delivered a 1.1 percentage point reduction in the medical trend used in this filing. However, we have concerns about the reliability of this estimate. In responses ODS provided to OSPIRG Foundation questions, ODS clarified that the 1.1% reduction is not based on the change in observed medical trend between this filing and the previous year's, but rather reflects a best estimate of the impact of all cost containment efforts in aggregate. However, they have not quantified the impact of individual programs cited in the filing, and provide no explanation for the origin of the 1.1% estimate.

Age and Family Tiers

Are changes to the rates paid by enrollees of different ages and family sizes reasonable?

ODS proposes only one change to the way they charge enrollees of different ages and family sizes, to reverse a previously approved increase on enrollees under 20 years old now that it is unnecessary. We commend ODS's move in this direction.

In ODS' previous rate filing in December of 2010, they received approval to increase the rates paid by enrollees 0-19 years of age, and for families with children, to offset the ACA's new prohibition on pre-existing condition exclusions for children under the age of 19. The overall rate impact of this change was 1.9%.[4] However, as of September 1, 2011, ODS is participating in the new reinsurance pool set up by the Division, which will help to spread out and thereby mitigate the costs especially sick children might impose on any given insurer. ODS proposes to roll back the age and family tier changes approved in December, for a net reduction in premiums of 0.73%.

In a response to DCBS questions, received by OSPIRG Foundation on the day this comment must be submitted, ODS clarified that its December increase consisted of two parts: a rate-neutral adjustment to age and family tiers, and an overall 1.9% premium increase. They now propose to roll back the elements of the age and family tier revision that would require children and families to pay higher rates, and are not adjusting their claims experience to incorporate the previously-approved 1.9% premium increase.

We are glad that ODS is sharing these savings with consumers, and we urge DCBS to carefully review ODS' methodology to confirm its validity.

[4] See ODS Health Plan Individual Health Benefit Non-Grandfathered Plan Renewal, HL 0408 10, Effective Date 12/1/10, Projected Health Care Reform Impacts.

Variation in Rate Impact

Will the rate increase be uniform over most enrollees, or will some enrollees experience rate changes that are substantially higher or lower than the overall increase?

The rate increase will not be uniform over most enrollees. Consumers will see rate increases ranging from a low of 5.6% to a high of 11.7%, with an average rate increase of 9.94%. The variation depends on the age of enrollees, the size of families, and the benefit plan chosen.

The ODS filing provides a helpful breakdown of the distribution of the increases. The significant majority of enrollees will experience an increase of between 9 and 11% (roughly 19,500 enrollees, out of a total of 26,333 covered by this filing), with about a further 1,300 seeing increases between 11 and 11.7%, and roughly 3,000 seeing increases in the 8-9% range. The remaining 2,500 enrollees will pay rates that are between 5 and 8% higher.

Enrollees aged 19 and below, and families with children, will see comparatively lower increases, due to the changes discussed immediately above. Enrollees choosing the Beneficial Rx plans will see comparatively higher increases, due to a new vision benefit being added only to these plans.

From this data, it does not appear that many enrollees will have to pay rate increases that are significantly above average. The variation in rate impact is reasonably limited across the enrollee population.

Administrative Costs

Do the administrative expenses seem reasonable?

We are concerned that ODS' administrative costs may be unreasonably high.

Oregon's rate review program empowers DCBS to reject or modify an insurer's rate filing if the administrative costs are not reasonable.[5] Given that administrative costs are not medical costs, they should not, as a rule, increase according to medical inflation. Instead, they should increase more in line with overall inflation rate. The Producer Price Index (PPI) for Direct Health and Medical Insurance Carriers Industry is a helpful index to compare with an insurance company's proposed increase in administrative costs.[6] In 2010, the PPI increased 3.9 percent.

ODS expects its per-member per-month administrative costs for this market segment to increase by an annualized rate of 4.1 percent.[7] This is above the PPI benchmark, which showed a 3.9 percent increase in 2010, but ODS has not justified these expenses in the filing. In response to questions submitted by DCBS, ODS argued that its administrative cost increases are below the PPI benchmark, if certain expenses, such as premium taxes and agent commissions, are excluded. At least as to agent commissions, such an exclusion is unwarranted, as these are straightforwardly administrative costs, rather than medical costs, and should therefore increase at the PPI or below.

[5] Oregon rule (OAR 836-053-0475).
[6] *Id.*
[7] Note that the top three administrative expenses sum to less than the total administrative expenses per member per month, as ODS lists ten separate categories in total.

Does the loss ratio seem reasonable?

The loss ratio is the percentage of premium spent on medical claims, instead of profits or administration. ODS' proposed loss ratio of 76.4% appears low, and potentially unreasonable. Federal law requires plans on the individual market to meet an 80% medical loss ratio standard, but allows for an alternate method of calculating the loss ratio. In responding to OSPIRG questions, ODS indicated that it expects to report a loss ratio of 80.7% under the federal rubric, narrowly meeting the requirement.

This 0.7% margin is not very large; meaning that slight differences between projection and reality could mean that ODS falls short of the federal requirement. If ODS fails to meet this standard, it will have to issue refunds to its enrollees. Because paying out refunds could be a time-consuming process, it might be more efficient for ODS to simply lower its rate increase proposal so that consumers receive the savings immediately. In addition, offering rebates to consumers later on does not help those who drop coverage because it is unaffordable. We urge DCBS to ask ODS to disclose whether in previous years, its projected loss ratios have proven high relative to those actually experienced before assessing the reasonableness of this portion of the filing.

As noted in the previous section, administrative costs should rise more slowly than medical costs. This means that the loss ratio should generally increase over time. In this market segment, ODS has seen substantial variation in its loss ratio. In 2007, when its enrollment began to substantially increase, it was 69.31%, rising to 85.25% in 2008 and remaining at 85.00% in 2009 before falling to 74.7% in 2010. The decrease between 2009 and 2010 may be related to the expansion of ODS' enrollment – new enrollees tend on average to be healthier than existing ones, and agent and broker commissions are often highest in the first year of enrollment. Because ODS does expect its enrollment to continue to increase over the next year, it should be careful to make sure that it does not allow these dynamics to push its loss ratio still lower, given how close it plans to be to the federal minimum.

Does any particular expense seem unreasonable, and why?

There is one element in ODS' proposed administrative costs about which we have particular concerns, which is the amount ODS expects to pay in agent and broker commissions. As the chart above notes, in 2010, commission expenses broken down to a per-member per-month (PMPM) amount came to $8.09. In the filing, ODS projects that it will spend $10.04 PMPM in the next year (between November 2011 and October 2012) on such expenses.

This 24% increase is spread over two years. In a response provided to OSPIRG Foundation, ODS provided a breakdown of the increase into roughly a 16% rise between November 2010 and October 2011, and 8.4% increase from November 2011 through October 2012. Still, these are both significant yearly increases, well above the benchmark PPI mentioned earlier. These increases are especially noteworthy in the wake of the passage of the federal health reform law, because most observers have suggested that the new medical loss ratio rules will put downward pressure on agents' and brokers' commissions in the individual market.[8]

[8] See, e.g., a recent GAO report, at http://www.gao.gov/products/GAO-11-711.

In their response to OSPIRG Foundation questions, ODS noted that these increases are partially due to paying commissions on a percentage of premium basis. We do not believe this payment practice should be considered reasonable, since it ties agent commissions – an ordinary administrative cost – to rise at the much faster rate of overall medical costs.[9] This is likely the reason that ODS expects that commissions will increase so substantially, when many other insurers are expecting them to decrease. We ask DCBS to encourage ODS to end this outdated and expensive payment practice.

Stability of the Plan and the Insurer

Looking at the historical context of the insurer's rate filing, does it appear the requested rate maintains rate stability and operates in a way to prevent excessive rate increases in the future? Are enrollment numbers stable, increasing, or decreasing?

Overall, ODS appears to have a stable risk pool in this market segment, with increasing enrollment numbers. Its current surplus is well above its required levels of authorized control risk-based capital, and has not seen substantial fluctuations in recent years, suggesting that its financial health is also sound. Below, we examine these issues of enrollment, risk pool, and financial stability in turn.

1. Enrollment trends

Enrollment in ODS individual plans has grown substantially over the past few years, from just over 3,000 in 2006 to 26,333 in 2010. It appears that this growth was partially spurred by ODS' rate decrease of 4.5% in 2007. Enrollment continued to grow despite large rate hikes of over 17% in both 2009 and 2010, perhaps because, while high, the increases still put ODS' individual insurance products' costs below many of its competitors.

With this year's lower proposed rate increase of 9.94%, ODS expects that its enrollment will continue to grow by a further 7,000 over the next year. ODS does not provide a specific rationale for this expectation in the filing. While past enrollment growth despite large rate increases may indicate this is a reasonable assumption, especially in this economy, a nearly 10% average rate will impact consumers severely, especially on top of 17%+ increases in the last two year, and some of ODS' competitors are implementing lower rate increases this year than they did in previous years.

In a response to DCBS questions, ODS further explained its projections, which are based on in large part on having comparatively low rates for its most popular plan design (which are the highest-deductible XX products), even after the proposed rate increase. We urge DCBS to confirm that ODS' assessment of relative premium rates is correct, and that its enrollment projections are therefore sound.

2. Risk pool health and stability

From the information available, we believe the ODS risk pool in the individual market is relatively stable. As a rule, enrollment growth helps contribute to stable rates, both by increasing the size of the risk pool,

[9] They also note that with the passage of the ACA, consumers may be turning to brokers and agents with more questions about their coverage, but it is unclear why this would translate into higher commissions being paid.

and by bringing in new enrollees, who tend to be healthier given the fact that health insurance companies are allowed (until 2014) to reject applications of adults over 19 with pre-existing conditions.

ODS' sizable enrollment growth over the last several years suggests that its risk pool is likely reasonably stable. That said, when faced with a nearly 10% average rate increase, healthier consumers may drop coverage, or drop to a lower-benefit plan, both of which would have negative impacts on the health of the risk pool.

3. Financial stability

As ODS' enrollment has increased, so too has its surplus. As of the end of 2010, the ODS surplus stood at $76.6 million, slightly more than seven times higher than its authorized control level risk-based capital. It projects a profit margin of 0.5% in this market segment over the next year, and its investment gains have been steady over the past few years, with the exception of a loss of roughly $1 million in 2008. All told, ODS' financial health appears to be stable.

Affordability

Are the rates and out-of-pocket costs affordable for a range of Oregonians?

Taken together, the rates and out-of-pocket costs of these ODS individual plans are not reasonably affordable for Oregonians.

Affordability matters. It impacts individual and family finances. It forces enrollees and prospective enrollees to decide how much they can afford for health care, and how much risk they can bear themselves so they may "buy down" that premium price in exchange for higher deductibles. In some cases, individual families decide the price is too high, and go without. These individual decisions combine to have a social impact, including an impact on hospitals for "uncompensated care" and an impact on social programs charged with filling the coverage gap.

But what is especially relevant here is that the decisions that individuals and families make based on the affordability of insurance directly impact the stability of the insurer's risk pool, and the insurer themselves. If the healthier people leave the risk pool, or buy down coverage, premium dollars shrink while claims costs continue their upward climb. It is not sustainable for the consumer; it is not sustainable for the insurer.

Getting affordable coverage was already a challenge before the recession. Now, it is even more difficult. Oregon has been hard hit by the recession, with exceptionally high unemployment. Oregon median income has been fairly stagnant since 2005. In this economic climate, when health insurance rates rise much faster than the rate of inflation, it has significant impacts on Oregonians' ability to afford coverage.

Economic Trends

	Annual CPI increase (Portland-Salem OR-WA)	Unemployment Rate - OR	Median Household Income - OR	Median Income - individual*	Median Income - two person household*	Median Income - family of 3+*
2005	2.56%	6.20%	44,159	22,963	34,886	60,498
2006	2.60%	5.30%	47,091	24,487	37,202	64,515
2007	3.71%	5.10%	50,236	26,123	39,686	68,823
2008	3.28%	6.50%	51,727	26,898	40,864	70,866
2009	0.12%	11.10%	49,098	25,531	38,787	67,264

*Note: Estimates of income for individuals, 2-person households, and 3+ person households derive from U.S. Census data, Table H-11AR, which provides median income data by size of household. Taking a five-year average, individual income is estimated at 52% of total median household income; income for a two-person household is estimated at 79% of the overall number; and for families of 3+, income is estimated at 137% of overall median household income. This data is available at http://www.census.gov/hhes/www/income/data/historical/household/index.html.

To examine the real-world impact this ODS individual rate increase could have if approved, we calculated the premium rate the following hypothetical individuals and families would experience, if they were enrolled in one of three different products included in the filing.

The highest-benefit product we examined was the Beneficial Rx 1000. For an individual plan, its features include:

• For a single individual, a $1,000 deductible, and a $3,000 post-deductible out of pocket maximum for in-network care, with a separate $6,000 maximum for out of network care.[10]
• For families, the deductible is three times higher, and the out of pocket maximums are assessed per member.
• Up to three office or urgent care visits are covered with a copay of $15; after those initial three, deductibles and coinsurance apply to subsequent visits.
• Coverage for prescription drugs includes a $2 copay for some generics, a $15 copay for other generics, and 50% coinsurance for name-brand drugs.
• Coinsurance (the percentage of the medical bill covered by the enrollee, after the deductible) is 20% for in-network providers, 40% for out-of-network providers.

Even though this is comparatively richer than the other products ODS offers, consumers will still pay significant out of pocket costs. A very sick consumer could face up to $10,000 in out of pocket costs in addition to the premium and co-pays, if they exhaust their deductible and hit out of pocket maximums for both in-network and out-of-network care.

The lowest-benefit product we considered was the Beneficial Value 7500, without prescription drug coverage. For this product, an individual plan features:

[10] Product descriptions are drawn from ODS' website, as they were not included in the filing. Thus, some changes requested in the filing, such as the introduction of the $2 generic drug tiers, were not reflected in the website materials we reviewed. *See* http://www.odscompanies.com/plans/individual/101101/med_plans.shtml.

• For a single individual, a $7,500 deductible, with in-network and out-of-network out of pocket maximums of $5,000 and $10,000, respectively.
• For families the deductible is three times higher, and the out of pocket maximums are per member.
• Up to three in-network office or urgent care visits are covered with a copay of $25.
• Coinsurance is 30% for in-network providers, 50% for others.
• There is no prescription drug coverage.

Clearly, this product features significant cost-sharing, and could quickly impose very high costs on a consumer with high health needs. Leaving aside the issue of non-covered medicines, an individual running through their deductible and both out of pocket maximums would pay $22,500.

Finally, we looked at a mid-range product, the Maximizer PPO 2500. Features include:

• For a single individual, a $2,500 deductible, with in-network and out-of-network out of pocket maximums of $5,000 and $10,000, respectively
• For families the deductible is three times higher, and the out of pocket maximums are per member.
• Up to six in-network office or urgent care visits are covered with a $20 copay.
• Coinsurance is 30% for in-network providers, 50% for others.
• Drug coverage is identical to that in the Beneficial Rx 1000 plan discussed above.

In this plan, potential yearly out of pocket costs come to $17,500 for an individual on this plan.

After calculating the premium rate for three hypothetical Oregon families, we compared the resulting premiums to the median income in Oregon for individuals, two-person households, and families, evaluating whether premium would exceed 8% of the median monthly income. Note that ODS does not employ geographic rating for these products, so these premiums are Oregon-wide.

Individual Consumer Profiles

	Sally Age: 28 Plan type: Individual			Gladys and Eddy Ages: 54 and 53 Plan type: Individual + Spouse			The Hendersons Ages: 43, 44, 20, 15 Plan type: Family		
	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost	Monthly Premium	Potential Max Out of Pocket	Total Potential Monthly Cost
Maximizer PPO 2500	**$163**	**$17,500**	**$1,621**	**$715**	**$35,000**	**$3,632**	**$685**	**$52,500**	**$5,060**
Beneficial Rx 1000	**$236**	**$10,000**	**$1,069**	**$1,032**	**$20,000**	**$2,699**	**$990**	**$30,000**	**$3,490**
Beneficial Value 7500 no Rx	**$72**	**$22,500**	**$1,947**	**$320**	**$45,000**	**$4,070**	**$304**	**$67,500**	**$5,929**
8% monthly median income	**$170.21**			**$258.58**			**$448.43**		

Plan details

Plan Name	**Maximizer PPO 2500**	**Beneficial Rx 1000**	**Beneficial Value 7500 no Rx**
Deductible (individual / family)	$2,500 / $7,500	$1,000 / $3,000	$7,500 / $22,500
OOP Max, per enrollee, after deductible (in-network / out of network)	$5,000 / $10,000	$3,000 / $6,000	$5,000 / $10,000
Drug Coverage (generic copay / brand coinsurance)	$15 / 50%	$15 / 50%	No coverage
Hospitalization Coinsurance (in-network / out of network)	30% / 50%	20% / 40%	30% / 50%

As can be seen from the above table, there is a significant variation in the premiums ODS enrollees can expect to pay depending on the specific product they choose. The lowest-benefit plans have premiums that are either lower than or roughly comparable to 8% of a typical Oregon family's income, though the highest-benefit products quickly grow less affordable. And for individuals and families with significant health needs, the relatively high cost sharing of most of these products would pose a high, possibly impossible, financial burden.

Benefits

Is the rate reasonable given the benefits offered?

Can a rate be reasonable if it's not affordable? In this day and age, unfortunately, if affordability was the test, few if any insurance plans would pass. The reality is that given the very high cost of medical care, it is reasonable for a consumer who may become very sick to pay for coverage, as opposed to paying 100% out of pocket costs. Also given the high cost of medical care, it is often reasonable for the insurers to charge high rates for coverage, so that they may pay claims.

More must be done, and faster, to lower the cost of care so that what's "reasonable" and what's "affordable" are not so far apart.

In general, the simplest way to compare the value of the benefits enrollees receive with the premiums they pay is by looking at the medical loss ratio of their plan. Because this measures the percentage of dollars going to medical care, it provides a rough estimate of return on value. Of course, this is a crude measure, because different enrollees will have very different experiences; those who stay healthy and only have a few doctor visits in a year will pay more in and get less out, while those who need high-intensity services will pay more out of pocket but have their insurer pay out significantly more in benefits. Still, on the whole, the medical loss ratio is a useful guide.

As discussed above, ODS is proposing to spend 76.4% on medical care (80.7% under the federal calculation methodology, only 0.7% above the floor set by law). This suggests that relative to the benefits enrollees are receiving, they are paying a comparatively high price.

Looking more specifically at the *changes* to benefits reflected in this rate filing, it appears that the changes in the rate due to those changes are reasonable on the whole. ODS proposes several benefit changes, some of which expand benefits while others narrow them for consumers. On balance, they amount to improved coverage for consumers and add less than 1% to the premium.

For all plans, consumers will see:

•The annual maximums that ODS will pay in claims increased from $750,000 to $2 million. This change will increase rates 0.1%;
• The addition of a separate out-of-network annual out-of-pocket maximum. This means that consumers who see providers both inside and outside the network will likely pay more in out of pocket costs. This change will reduce rates 0.2%; and
• A new provider network for enrollees traveling outside of their home regions. This benefit addition will increase rates 0.1%.

For the Beneficial Rx plans, consumers will see a new vision benefit covering bi-annual vision exams, with an overall rate impact of 0.09%.

In addition, several plans will see the introduction of a new prescription drug co-pay tier, which will reduces the copay enrollees must pay to $2 for certain low-cost generic drugs. ODS expects the reduced cost-sharing to be offset by the savings caused by enrollees shifting to less-expensive medicines, and as a result do not predict that this change will have an impact on rates.

Altogether, the combined impact of these comparatively minor benefits changes is to increase premiums by 0.09%, which appears to be a reasonable estimate.

Conclusion

Is the rate reasonable considering the proposed profit or contribution to surplus and other factors?

While many aspects of ODS' proposed rate increase appear reasonable and in line with overall industry trends, and some changes are to the welcome benefit of enrollees, we have concerns about a few specific aspects of the filing which we believe must be resolved before a final rate is approved.

First, ODS' administrative costs are relatively high and thus its medical loss ratio is fairly low, and if reality deviates even slightly from projections, may run afoul of the ACA's requirement that individual plans spend at least 80 percent of premium dollars on care. Further, while the current low MLR may be in part due to ODS' enrollment growth, it should demonstrate that their MLR will soon stabilize at a reasonable level.

Second, one element of ODS' administrative costs – agent and broker commissions – appears to be growing very fast, at a time when most industry observers expect commissions to shrink. ODS' explanation for this increase is primarily that they pay their commissions based on a percentage of premium. This is an unreasonable practice that unjustifiably inflates administrative costs, and should be stopped.

Third, while ODS' medical trend this year is lower than that used by some other insurers, we are concerned that ODS is not doing enough to help lower the cost of health care and improve its value. Researchers and clinicians have identified a large number of opportunities to promote prevention and effective care while weeding out duplicative and counterproductive treatments. Unfortunately, ODS does not appear to be aggressively taking action on many of these opportunities, meaning that their enrollees might experience larger rate increases down the road. We urge DCBS to work with ODS to ensure that they do more to bend the cost curve and make health care more affordable in the future.

Beyond these concerns, we note that ODS' individual market risk pool appears to be stable, and its financial health sound. The method it has chosen to predict its medical trend does not appear unreasonable, though we are concerned that ODS' projections may not adequately take account of the recent slowdown in health care cost increases.

Given these concerns, we are concerned that the request to raise rates 9.94% has not yet been adequately justified. We encourage DCBS to continue its close scrutiny of rate filings, and to reduce the increase if it finds aspects of this increase are excessive and unjustified.