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Comments on PacificSource's Proposal to Increase Small Business Health Insurance Rates Effective March 2012

Filing # PCSR-128083567

Health Insurance Rate Watch
A Project of OSPIRG Foundation

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Executive Summary

Main features of the rate filing:

PacificSource is proposing to increase rates 5.56% on average, affecting 35,224 Oregonians enrolled in small business plans. If approved, this rate increase will have wide ranging impacts. Most enrollees will see increases of between 6% and 10%. Some will see increases of up to 11.2%. Over 27% will see increases of between 8% and 14%.

The main reason given for this increase is the insurer's prediction that medical costs will increase 8.8% in the year ahead, and prescription drug costs will go up 7.0%.

Given the increasing unaffordability of small business health insurance coverage, and given the fact that most enrollees are in employer plans that will see increases greater than the average increase, it is particularly important for the insurer to thoroughly justify this rate increase.

Key findings:

• **The prescription drug trend numbers are not fully explained in the initial filing.** PacificSource expects drug costs to rise 7% in the year ahead, despite the fact that prescription drug costs fell by almost 1% last year. The insurer did not show the calculations it used to obtain the 7% figure.

• **PacficSource does not show the detail needed to support its medical trend numbers**. In the initial filing, PacificSource did not follow current product standards to explain how it used actual claims data to determine the underlying medical trend for the last year. Supplemental information included only a brief summary of this information, and did not include calculations. The insurer also did not show sufficient support for how it developed anticipated medical trend to enable us to evaluate its reasonableness.

• **PacificSource does not show sufficient support for changing how it varies premiums for different businesses.** The insurer proposes reducing the rating factor for businesses in the Portland metro area, the Salem area, and in the mid-Willamette Valley, while raising the rating factor for those in Eastern Oregon. It is proposing to charge relatively less for businesses that have at least 90% employee participation in the plan, and more for those that fall below that level. It is also changing how much more and less each plan costs relative to each other. PacificSource does not sufficiently detail the support for these rating changes.

• **Premiums and out-of-pocket costs are unaffordable for businesses and employees.** This is true across the board, but particularly notable for businesses with older employees in certain geographic areas of the state. PacificSource plans are not unique in this respect. But with deductibles and other out-of-pocket costs considered in addition to high premiums, it is understandable that the cost of coverage has become untenable for so many of Oregon's small employers and their employees.

• **PacificSource reports making efforts to reduce costs and improve care**. The insurer lists a set of encouraging initiatives to better coordinate care, improve quality and reduce waste in a variety of areas, and indicates some promising results in some areas. It is not clear from the filing whether the insurer is doing everything it can to lower costs. We encourage the insurer to expand its efforts, and share its overall approach in this area as part of its future rate filings.

Recommendations:

Many aspects of the filing appear reasonable, such as stable administrative costs, a medical loss ratio above federal requirements, and a moderate proposed average rate increase.

However, there is not sufficient information in the filing to assess the reasonableness of the medical trend projections and the changes to rating factors. This is of particular concern given the high premiums, and the fact that many enrollees are in employer plans that will see rate increases of 8%-14%.

We recommend that DCBS require PacificSource to provide additional information to fully justify this rate increase proposal.

In addition, in the spirit of DCBS's ongoing improvements to the transparency of the rate review process, we recommend DCBS take steps to ensure rate filings include more of the necessary information at the time they are filed initially, to allow transparency of this information for the full 30 days of the public comment period.

Key Features and Insurer Information

Key features of the proposal to increase premium rates

State tracking # for this filing	PCSR-128083567
Name of health insurance company	PACIFICSOURCE HEALTH PLANS
Type of insurance	Small Grp Hlth Plans (small employers)
Grandfathered under federal health reform?	Non-Grandfathered

Proposed Rate	
Average rate increase	5.56%
Minimum rate increase	-11.20%
Maximum rate increase	14.60%
Number of Oregonians affected	35,224
Anticipated enrollment if approved	40,224
% premium to be spent on medical costs	83.60%
% premium to be spent on administrative costs	14.90%
% premium to be spent on profits	1.50%

Basis for increase	**Observed trend**	**Projected trend**
Medical	7.10%	8.80%
Rx	-0.90%	7.00%

Insurer's history of rate increases	
2008	20.27%
2009	9.23%
2010	15.37%
2011	4.28%

Enrollment	
Year	**Number of Members**
2005	47,498
2006	45,299
2007	42,097
2008	33,012
2009	35,669
2010	32,919
2011	35,224

Insurer information company-wide

Basics	
For profit or non-profit:	Non-profit
State domiciled in:	OR
Parent company:	N/A

Insurer's financial position	
Year	2010
Surplus	$114,107,602
Investment earnings	$5,965,642

Surplus History Company-Wide	
Year	**Amount in Surplus**
2005	$112,814,731
2006	$123,513,415
2007	$124,499,606
2008	$93,239,396
2009	$107,075,852
2010	$114,107,602

Discussion of the Rate Filing

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

Affordability

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

Oregonians would have a difficult time affording the premium rates for these health insurance products, let alone the deductibles and other out-of-pocket costs.

To examine the real-world impact this rate increase could have if approved, we calculated the premium rate several hypothetical businesses would experience for three different benefit plans, based on the information in the initial filing and supplemental information obtained from the insurer. [1] After performing these calculations, we compared the resulting premiums to the median income in Oregon for individuals, two-person households, and families, evaluating whether the premium would exceed 8% of the median monthly income.[2]

As can be seen from the table below, there is a significant variation in the premiums PacificSource enrollees can expect to pay depending on the specific product they choose, and the area of the state in which the business is located. The lowest-benefit plans have employee-only premiums that are just over 8% of a typical Oregonian's income, though the highest-benefit products quickly grow less affordable. For those purchasing family or employee plus spouse coverage, premiums at even the lowest benefit plan are substantially higher than 8%.

With deductibles and other out-of-pocket costs considered in addition to premiums, the cost of coverage would be difficult for many of Oregon's average small employers and covered employees to manage.

Small business profiles

	Eastside Bikes Four employee Average age = 27 Location: Linn County **Employee Rate**	**Al's Garage** Eight employees, Average age = 36 Location: Douglas County **Employee & Spouse Rate**	**ABC Accounting** Forty employees Average age = 50 Location: Coos County **Family Rate**
Lowest benefit plan plus Rx Preferred CoDeduct Value 7500+50/70%	**$176.21**	**$468.30**	**$960.68**
Mid-level benefit plan plus Rx Preferred CoDeduct Value 750+35	**$279.21**	**$747.27**	**$1,532.94**
Highest benfit plan plus Rx Preferred 15/200D	**$433.57**	**$1,165.35**	**$2,390.59**
8% monthly median income	**$161.41**	**$245.22**	**$425.25**

[1] Assumptions: 50% employer contribution for employee and dependents, 100% participation, and median experience factor (1.000). Rates calculated as of August 1, 2012. Eastside Bikes located in the least expensive geographic area, Al's Garage located in a medium-expensive area, and ABC Accounting located in the most expensive area.

[2] The 8% figure is an affordability benchmark drawn from the Affordable Care Act. If a person would have to pay more than 8% of his or her income for health care premiums and out of pocket costs, then that coverage is considered unaffordable and the person would be exempt from the individual coverage requirement.

The lowest benefit plan we examined was the Preferred CoDeduct Value 7500+50/70%. The mid-level benefit plan we examined was the Preferred CoDeduct Value 750+35. The highest benefit plan we examined was the Preferred 15/200D plan. For all these plans, we used the Tiered Rx 15/30/50 plan for prescription drug benefits. Details of these plans, and the potential out-of-pocket costs, including co-pays and deductibles, are shown in the chart below

Plan details and potential out-of-pocket expenses

	Preferred CoDeduct Value 7500+50/70%	Preferred CoDeduct Value 750+35	Preferred 15/200D
Deductible (per person / per family)	**$7,500 / $22,500**	**$750 / $2,250**	**None**
Copay	**$50**	**$35**	**$15 office visits / $200 inpatient hospital per day**
Co-insurance (in network / out of network)	**70% / 50%-70%**	**80% / 50%-80%**	**100% / 80% for some services**
Out-of-Pocket Limit -- In network (per person / per family)	**$6,000 / $12,000**	**$3,500 / $7,000**	**$2,000 / $4,000**
Out-of-Pocket Limit -- Out of network (per person)	**$8,000**	**$5,500**	**$5,000**
Potential annual exposure for an individual, in addition to premium [3]	**21,800**	**9,960**	**7,690**
Potential annual exposure for a family, in addition to premium [4]	**42,800**	**14,960**	**9,690**

[3] Assumes individual meets the deductible and both in-network and out-of-network out-of-pocket limits, and pays the co-pay six times over the course of the year

[4] Assumes the family meets the family deductible and the the family in-network out-of-pocket limit, plus one family member meets the out-of-network out-of-pocket limit, and pays the co-pay six times

It is important to put these costs into the current economic context. Oregon was hard hit by the recession, with exceptionally high unemployment. Oregon median income has been fairly stagnant since 2005. In this economic climate, health insurance rates rising much faster than the rate of inflation has significant impacts on employers' ability to offer coverage, and employees' ability to take up that coverage.

Economic Indicators

	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%	48,325	25,129	38,177	66,205
2010	1.25%	10.80%	46,560	24,211	36,782	63,787

*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.

Given the high premium and out-of-pocket costs, it is critical for businesses and consumers to be able to have transparent access to this information as part of rate filings. In order for a business owner to understand how a rate increase would impact employees and the businesss' bottom line, rate filings must clearly demonstrate how to calculate any given business' rate.

Unfortunately, PacificSource's initial filing did not include the required sample rate calculation, and omitted a key rate factor table. PacificSource provided this information speedily when its omission was discovered. Going forward, we respectfully encourage the Oregon Insurance Division to only deem a filing complete if it includes this information, so that consumers and businesses may have access to it at the beginning of the 30-day comment period.

Medical cost trends

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

PacificSource must provide more information to justify its projected medical and prescription drug trends. The insurer should also fully explain how it used actual claims data, along with any adjustments to that actual data, to determine the underlying medical trend for the last year, on which trend projections are based.

PacificSource's projected 7% prescription drug trend *increase* is significantly higher than the 0.9% *decrease* in drug costs the insurer reported observing last year. This dramatically higher figure may be reasonable, but PacificSource does not offer an explanation in the filing, other than to refer to a model provided by its Pharmacy Benefit Manager, and to note that costs should be lower due to more drugs going generic in the coming year.

PacificSource projects an 8.8% medical trend figure, but did not show sufficient detail for us to evaluate its reasonableness. The filing states that the observed medical trend over the experience period was 7.1%, but while PacificSource does include monthly claims data (both normalized and unadjusted) in the filing, it does not report how the observed value was derived from this data. Further, the exact normalization factors used in each month were not disclosed, making it impossible to determine the relative impact of benefit changes and shifts in PacificSource's risk pool in the normalized claims values.

In its initial filing, PacificSource did not provide the required information explaining its "normalization" process – how it uses actual claims data to determine the underlying medical trend for the previous year. In response to questions from DCBS, the insurer provided supplemental information listing the categories of factors the insurer uses to normalize claims as part of the trend development process, but not the exact factors themselves.

Going forward, we respectfully encourage the Oregon Insurance Division to only deem a filing complete if it includes this information, so that consumers and businesses may have access to it at the beginning of the 30-day comment period.

In addition, neither the initial filing, nor the supplemental information shows the data behind the methodology used to determine the normalization factors. While this further detail is not currently

required as part of the filing, we believe it is critical to determining the reasonableness of the trend projection, and continue to respectfully encourage DCBS to require insurers to include this information.

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?

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 focusing on prevention and other proven strategies that keep patients healthier.

Reporting on efforts in this area as part of the rate filing is relatively new for insurers. From the consumer perspective, what we look for in these reports is a frank discussion of the insurer's approach. What are they trying, why, and how is it working so far? What aren't they focusing on, and why? What have they determined works and so are rolling out more widely?

As part of our analysis of rate filings, OSPIRG Foundation tracks six widely recognized categories of cost and quality initiatives. PacificSource reports taking steps to reduce health care cost in ways that improve quality for patients in four of the six key areas we track. The insurer does not report efforts to advance payment reform or cost-saving safety measures. We encourage the insurer to continue its efforts, and work to expand them.

It is notable that the insurer is investing in seven medical home pilot programs. Medical homes, which emphasize prevention and patient-centered care coordinated by a team of health providers, hold much promise to both improve health and reduce costs. This investment appears to be delivering results both in terms of reducing costly emergency room visits and hospital readmissions. However, PacificSource did not report the accompanying cost savings associated with these reductions.

In addition, over the next two years, PacificSource is participating in a pilot program led by the Oregon Health Leadership Council to better treat lower back pain, thereby reducing unnecessary and costly tests and surgery. Given Oregon's higher-than average rates for back surgery, we look forward to learning about the results of this pilot.

PacificSource's Cost and Quality Initiatives[3]		
Initiative	**Description**	**PacificSource's current efforts**
1. Reforming methodology of payment to providers	Moving away from a fee-for-service payment model, toward payment methodologies that reward best practices, quality care and outcomes.	Nothing specifically listed.
2. Medical Home initiatives	Patient-centered coordinated care between providers to reduce	Piloting seven medical home programs. Completed assessment of

[3] A summary of PacificSource's efforts across six major areas as reported both in the pending rate filing, and in the insurer's most recent Quality Assessment Annual Summary: http://www.cbs.state.or.us/ins/ppareports/PacificSource_Healthplan/pacificsource10/pacificsource10_qa.pdf

	reliance on emergency and urgent care services.	Bend pilot, showing a 9% reduction in ER visits and a 14% reduction in 30-day hospital readmissions.
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.	Preventive care without cost-sharing, in accordance with requirements under the Affordable Care Act.
4. Prevention and management of prevalent chronic diseases[4] to reduce unnecessary hospital admissions and expensive escalations of these conditions.	This includes provider reimbursement and incentives for patient behavioral changes and clinical treatments that maintain the health of patients suffering from chronic diseases.	Educational pediatric programs encourage recommended immunizations and healthy eating, and discourage drug and tobacco use. Prenatal program and pediatric diabetes program involve educational materials and nurse availability. Participating in new two-year Oregon Health Leadership Council pilot on low back pain focusing on faster access to physical therapy to improve outcomes and reduce the need for more expensive testing and treatment.
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.	Evaluating a readmission prevention pilot project initiated in 2010. Bend medical home has also reduced readmissions. See above.
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 practices.	Nothing specifically listed.

In addition to the above efforts to improve care and thereby eliminate unnecessary costs, PacificSource also reports in this filing on several efforts with the aim of simply reducing costs. For example, the insurer projects saving over $11 million over the next three years due to a new contract with its pharmacy vendor. However it is not clear how, or if, these savings are reflected in the proposed rate request.

Benefits

Is the rate reasonable given the benefits offered?

Can a rate be reasonable if it's not affordable? In the present day, unfortunately, if affordability was the test, the cost of few, if any, insurance plans would be considered reasonable. More must be done by all

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

players in the system, 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.

PacificSource is proposing to spend 83.6% on medical care, which is above the 80% floor set by federal law, and does not seem unreasonably low. Moving forward, we expect this percentage to increase over time as the insurer improves efficiency in its administrative operations – through its own efforts and through state and federal administrative simplification rules, and as the rise in medical costs continue to outpace the overall rate of inflation.

In terms of benefits, PacificSource is proposing to make a set of changes to covered benefits, and to plan design. For all plans, PacificSource is making changes in compliance with the Affordable Care Act's requirements for women's preventive care with no cost-sharing, including contraceptives and breast pumps. Also for all plans, the insurer is adding a benefit to cover wigs for cancer patients. It is also adding a $25 co-pay option for a set of plans, reducing the cost of mail-order prescription drugs, and reducing the co-pay for generic drugs from $15 to $5 for some plans.

PacificSource is also proposing to discontinue ten plans with minimal enrollment. According to the filing, 132 people are covered through the plans to be discontinued. The insurer proposes to offer comparable plans with very similar premiums to these enrollees, which seems reasonable.

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?

Some enrollees will experience rate changes significantly higher or lower than the overall increase. The majority of enrollees in employer plans that will experience increases between 6% and 10%, and 27% will see rate increases in the 8-14% range. Some businesses may see as much as an 11.20% rate decrease, some will see as much as a 14.60% increase.

PacificSource must supply more information to justify the changes causing this wide range of impact, in order to demonstrate that the rates are reasonable and not unfairly discriminatory.

The wide range of impact is due in part to the insurer proposing to change how it varies premiums for businesses depending on three key factors: (1) geographic location, (2) what percentage of the business' employees takes up coverage, and (3) what plan the business has chosen.

The insurer proposes relatively lower rates for businesses in the Portland metro area, the Salem area, and in the mid-Willamette Valley, while raising the rating factor in Eastern Oregon. It explains these changes simply by saying they are based on "experience by geographic areas and expectations of developments in

provider contracting." PacificSource does not detail the claims experience, or the expected changes in provider contracts to support these rating changes.

PacificSource is also proposing to change how it rewards businesses with high employee participation in the plan. This change accompanies PacificSource's proposed change to allow groups with 26 or more employees to have employee participation rates of as low as 75%, in contrast with its current requirement of 90% participation. If approved, the rating factor changes will result in an effective 8% discount for employers with at least 90% participation, a discount currently only available to businesses with 100% participation. The insurer explained in supplemental information that it believes reducing the participation requirement will allow it to compete for the business of additional small employers.

It is also changing how much more and less each plan costs relative to each other. Some of these factors are changing by 10% or more and will have a significant impact on rates. PacificSource says that it used a proprietary model to develop these new plan relativities. We are unable to evaluate the reasonableness of these changes without more information, and encourage DCBS to require further transparency in this area.

Administrative Costs

Do the administrative expenses seem reasonable?

PacificSource's administrative costs overall seem reasonable.

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 2011 the PPI increased 3.9%.

PacificSource expects its non-claims related per-member per-month administrative costs for this market segment to change from $40.63 to $41.43, which is only a 1.97% increase. This is of course below the PPI increase of 3.9%. The overall change in administrative costs thus does not appear to be unreasonable, as measured against the PPI.

Does the loss ratio seem reasonable?

The loss ratio is the percentage of premium spent on medical claims, instead of profits or administration. PacificSource's proposed loss ratio of 83.6% appears reasonable.

Federal law requires plans on the small group market to meet an 80% medical loss ratio standard or issue rebates to consumers, but allows for an alternate method of calculating the loss ratio that generally serves to increase the loss ratio. Though the filing does not reveal what loss ratio PacificSource expects to report under the federal definition, it will likely be substantially above the 80% floor, meaning that it will likely not be required to pay any rebates.

[5] Oregon rule (OAR 836-053-0475).
[6] *Id.*

Does any particular expense seem unreasonable, and why?

None of PacificSource's administrative expenses seem immediately unreasonable, as most of the largest expenditures are stable, including agent and broker commissions, which have come in under $13 per-member per month since 2009. We are glad to see that PacificSource, like many insurers, pays commissions on a flat rate per member, as opposed to as a percentage of premium, an approach that can artificially raise costs without adding value.

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?

Enrollment: PacificSource's enrollment in the small group market has declined significantly since 2005, but appears to have been at a fairly stable level since 2008. The insurer expects enrollment to rise to over 40,000 if this increase is approved.

Enrollment

Year	Number of Members
2005	47,498
2006	45,299
2007	42,097
2008	33,012
2009	35,669
2010	32,919
2011	35,224

Financial Position: PacificSource's financial situation appears stable and healthy, with a surplus level increasing by roughly $7 million per year since 2008.

Surplus History Company-Wide

Year	Amount in Surplus
2005	$112,814,731
2006	$123,513,415
2007	$124,499,606
2008	$93,239,396
2009	$107,075,852
2010	$114,107,602

Conclusion

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

Many aspects of the filing appear reasonable, such as stable administrative costs, a medical loss ratio above federal requirements, and a moderate proposed average rate increase.

However, there is not sufficient information in the filing to assess the reasonableness of the medical trend projections and the changes to rating factors.

This is of particular concern given the wide range of the impact of the rate increase. Many enrollees are in employer plans that will experience increases between 6% and 10%, and 27% will see rate increases in the 8-14% range.

Are there areas in the rate filing where DCBS should seek additional information from the insurer?

As noted throughout this comment, there are several areas where we respectfully urge DCBS to ask PacificSource for additional information.

Full details of the calculations and methodology used to support the proposed medical and prescription drug trend may help show whether these figures are justified, and full explanation is needed to support the proposed factor changes to ensure they are justified and not unfairly discriminatory.

Finally, we want to acknowledge our appreciation for the continual improvement that DCBS is making to the transparency of the process. In that vein, we respectfully recommend DCBS consider taking steps to ensure rate filings include more of the necessary information at the time they are filed initially, as opposed to having critical information come in as part of supplemental information just days before the close of the public comment period. This may require the product standards to lay out more precisely what is required in a rate filing, stricter enforcement of those standards, or both.