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Comments on the Providence Health Plan Proposal for Individual Health Rates Effective January 2014

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Health Insurance Rate Watch
A Project of OSPIRG Foundation

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The authors bear responsibility for any remaining factual errors. The views expressed in this report are those of the authors, and do not necessarily reflect the views of our funders, advisory committee, or those who provided analysis and review.

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Executive Summary

Providence Health Plan has proposed premium rates for its individual and family plans for 2014. The insurer initially filed for significantly higher rates than Oregon's other top insurance companies, [1] but then proposed lowering the rates. Doing so would bring the rates in line with those of competing insurers.

Thanks to a new law requiring all Oregon insurers to offer standard plans, it is now possible to compare proposed rates apples-to-apples across Oregon's insurers for the first time. In our analysis of this and other filings, we examine the premium proposed for one of these standard plans, the Oregon Standard Bronze plan for a 40-year-old nonsmoker in the Portland Metro area. This allows us to make meaningful comparisons across insurance companies.

Providence initially proposed a rate of $290 for this benchmark plan. [2] Providence subsequently submitted a letter to the Oregon Department of Consumer and Business Services (DCBS) proposing a 15-20% reduction to the initially filed rates, and has since suggested that additional reductions may be necessary.

Oregon's health insurance rate review program, administered by DCBS, serves as a critical backstop to protect Oregon individuals and families purchasing coverage on their own from paying unreasonable premium rates.

With federal health reform bringing important new consumer protections into effect in 2014, many more Oregonians will be able to access coverage, and health insurance benefits and out-of-pocket costs will change substantially for many Oregonians. In addition, insurers will no longer be allowed to deny coverage to people with pre-existing conditions, and many Americans will be required to have health coverage or pay a penalty. These changes make it more urgent than ever to ensure that premium rates are justified, and that consumers receive good value for their premium dollar.

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 rates, the financial position of the insurer, and how the rates would impact Oregonians if approved. Our staff and consulting actuary also reviewed additional information made available by Providence.[3]

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[1] The top seven commercial carriers in Oregon by premium are Kaiser, Regence BlueCross BlueShield, Providence, PacificSource, Health Net, Moda and LifeWise. (See DCBS "Health Insurance in Oregon" Report, March 2013, page 25. (ODS Health Plans is now known as Moda.)

[2] Providence received approval for a rate increase for its individual plans last year, a 12.2% change effective as of November 1, 2012. Providence had initially requested an increase of 15.7%, but DCBS approved the lower value. OSPIRG Foundation also commented on Providence's filing. *See* DCBS, Rate Filing Decision Summary – Providence Health Plan Individual Health Plan, *at* http://www.oregonhealthrates.org/index.cfm?B64=nZzVWZjFGdvljbo12bl1TJFJ2cvhyd1UmRvR2Yn1XbmQGdft3cmJ2XpZGbul1Zk92b9MjMzkwM%3D%3D

[3] As part of this process, OSPIRG Foundation submitted questions to the insurer on May 28. Providence provided responses on June 11.

After careful analysis of Providence's initial filing and the supplemental information provided, we have some concerns that we urge DCBS to consider carefully before moving forward with a decision on the final rates.

Key Findings:

- **In proposing a large reduction from the rates initially filed, Providence acknowledged that its original proposal contained significant errors.** This underscores the need to carefully scrutinize all the factors and assumptions used to calculate Providence's rates, and those proposed by all insurers, to make sure that only a fully justified rate is approved.

- **We are concerned that Providence's projection of a 6.6% trend for medical costs has not been justified by the documentation provided.** According to Providence's filing, the insurer experienced an average cost increase of only 1.9% over the past year. With a number of major national studies demonstrating a substantial slowdown in health care cost growth in recent years, Providence's projection of accelerating cost growth deserves close scrutiny.

- **Providence's initial projection of an additional 46.4%[4] increase in claims costs due to the health status of the insurer's new customers under health reform is very high and has not been justified.** The exact cost impact of expanding coverage remains unclear, but Providence's projections are on the high end and should be scrutinized closely. Some experts have predicted that covering the currently uninsured will prove to reduce costs, since many uninsured individuals are young and healthy, and incur few medical costs.

- **It is unclear whether Providence has adequately adjusted its cost projections to reflect a reduction in "bad debt" due to the expansion of coverage as the Affordable Care Act (ACA) comes fully into effect.** With hundreds of thousands of Oregonians newly eligible for coverage in 2014, uncompensated care is sure to decline, and this benefit should be passed along to consumers in the form of lower rates. Providence's filing indicates a number of areas where ACA provisions may increase costs, but does not include this key area where reform will lead to lower costs.

- **When it comes to reducing costs and improving the quality of care, the filing lacks the quantitative measures and benchmarks needed to demonstrate Providence is pursuing an effective strategy**. While Providence appears to be employing a broad and comprehensive approach to reducing the cost of care by cutting waste and improving quality, it remains unclear from the information provided so far whether Providence is doing all it can in this area because no specific measures or benchmarks for cost and quality have been outlined for its many programs.

Before deciding to approve or deny this rate request, we urge the Insurance Division to scrutinize the issues raised here, require Providence to provide all documentation necessary to evaluate their proposal, and to clearly outline a concrete, achievable plan to contain costs for Oregon individuals and families.

[4] This projection included a 20% increase in costs due to the health status of the newly insured combined with an additional 22% for the merger of the high risk and Portability pools with the Individual market. 1.464 = 1.20 X 1.22

Key Features & Insurer Information

Key features of the rate proposal	
State tracking # for this filing	PROV-128987243
Name of health insurance company	Providence Health Plan (all information below from original filing)
Type of insurance	Individual

Proposed Rates*	
Standard Bronze	$290
Standard Silver	$342
Standard Gold	$400
% premium to be spent on medical costs	74.96%
% premium to be spent on administrative costs	23.54%
% premium to be spent on profits	1.50%

Basis for rate	
Medical cost trend	6.60%
Rx cost trend	6.60%
Cost due to health status of new customers (under federal health reform)	46.40%

Insurer's history of rate increases		
	Requested	Approved
2009	15.50%	15.50%
2010	17.70%	12.90%
2011	-0.50%	-4.00%
2012	15.70%	12.20%

Enrollment	
Year	Members
2006	1,398
2007	4,376
2008	7,943
2009	9,590
2010	10,676
2011	11,186
2012	12,162

Insurer information

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

Insurer's financial position	
Year	2012
Surplus	$459,600,000
Investment earnings	$21,100,000

Surplus History	
Year	Amount in Surplus
2006	$285,601,556
2007	$340,519,671
2008	$343,049,903
2009	$373,505,101
2010	$418,180,948
2011	$431,504,027

*"Proposed rates" are for a benchmark population--a 40-year old nonsmoker in the Portland area
A Bronze plan will pay about 60% of the average policyholder's medical costs in a year; a Silver plan will pay about 70%, and a Gold plan will pay about 80%. For more information about the Oregon Standard plans, see http://www.oregonhealthrates.org/files/plan_summary.pdf

Discussion of rate filing

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

In our detailed discussion of the rate filing, we provide analysis of information provided in the initial rate filing as well as supplemental information from the insurer in response to questions from DCBS and OSPIRG Foundation. All of this information is public record and is or will be available on the Oregon Insurance Division's rate review website, www.oregonhealthrates.org.

Examining the justification for the proposed premium rates

In proposing a large reduction from the rates initially filed, Providence acknowledged that its original proposal contained significant errors.

In a letter to DCBS posted online on May 16, Providence stated that the insurer wished to make changes to its initial filing, including its administrative cost projections, its projections of the cost impact of covering the population that will be newly insured in 2014, and its projections of the impact of risk adjustment programs. Providence indicated in the letter that these changes could reduce the premium rates proposed in the filing by 15-20%.

In the letter, Providence explained that the insurer reevaluated its administrative cost projections after the rate request was filed and determined that they were unnecessarily conservative, and inappropriately passed along to policyholders instead of deferring the costs associated with implementing some long-term programs. Providence also clarified that its proposed revision of some of its assumptions in the filing was based on information made available by DCBS after the rate request was filed.[5]

In response to DCBS questions regarding the filing, Providence made the following statements:

- "The combined impact of the two adjustments [to the submarket merger factor and the risk adjustment factor] would be a reduction of approximately 17% from Providence's original filing dated April 24, 2013."
- "Providence is prepared to revise the proposed rate filing using an assumed $6.62 PMPM [per member per month] reduction in projected claims costs. [Based on projected savings associated with Providence's Cost Containment and Quality Improvement programs.] This is estimated to translate to an approximate 2.1 percent reduction in the filed rates."
- "Given the uncertainty and opportunity to amortize certain ACA development costs, Providence is prepared to propose a reduction in the rate period administrative expense charge as reflected in Exhibit 3 and as the basis of the rate derivation of $18.00 PMPM. This would reduce the rate period expense from $74.41 PMPM to $56.41 PMPM with a resultant reduction in submitted rates equivalent to 5.7%."

The combined impact of these changes is a reduction from the originally proposed rates of about 23%.[6] In response to questions from OSPIRG Foundation, Providence later increased its estimate of the possible reduction due to savings from cost containment programs to 3.4%, which would result in a reduction of 24.6%.[7]

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[5] Specifically, information recently released regarding the methodology used to compile a report from Wakely Consulting entitled "Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon" released by DCBS last year. http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf

[6] 23% = [(1 – 0.17) X (1 - .021) X (1 - .057) – 1] X 100%

[7] The reduction could be even greater than this, since Providence has agreed to implement a larger reduction for Provider Networks (see DCBS 6/13/13 objection letter, item 4). Providence has also agreed that it could use a lower profit margin than the 1.5% included in its original filing. (See 5/8/2013 Note to Reviewer Sent by Dave Nessler-Cass, Providence Health Plan)

Providence's customers would benefit from lower premiums. However, Providence's admission that their initially requested rates were unjustified and based on a long list of errors, as well as other post-filing reductions that Providence has suggested, raises serious concerns that we urge DCBS to explore and resolve before making a decision on the rate.

If a large reduction from the originally proposed rates is justified due to errors Providence made in the initial filing, those errors and the source of those errors should be clearly identified, and Providence should explain what steps it will take to avoid proposing unjustifiably high rates in the future. Providence should also explain why it is now choosing to revisit cost factors—such as the impact of its cost containment programs and expense deferrals —that could have been addressed in the initial filing.

Just as critically, the fact that Providence's initially requested rates appear to have been unjustified increases the urgency of scrutinizing other factors used in calculating Providence's rates—and those of other insurers—to make sure that rates are decreased appropriately and only a fully justified rate is approved.

Providence's projection of a 6.6% trend for medical and prescription drug costs has not been justified by the documentation provided.

The trend data for the past year cited in Providence's filing are variable, but average out to about 1.9%[8] —well below the trend projection used for developing the proposed premium rates for the coming year.

Providence's projection that cost growth trends will be more than three times higher in the coming year merits scrutiny, since many experts expect that health care cost growth will remain low in the medium term.[9] A number of major national studies have demonstrated a substantial slowdown in health care cost growth in recent years; from 2009 to 2011, health care spending per capita rose about 3% per year.[10] According to a more recent study, health care prices have increased only 1.1% over the past year, with total expenditures—including both price and utilization—increasing 4.2%.[11]

In response to questions about the development of their trend projections, Providence stated:

> "At the time of the filing preparation, estimates were required to be made to project CY 2012 unit costs, the filing base period, forward two years to CY 2014. The basis of such projection relied on the status of contract negotiations either in process or yet to be undertaken."

[8] Average of rolling 12-month trends, March 2012 – February 2013, per Attachment F: Providence Health Plans Individual Book of Business Analysis of Historical Trends.
[9] Alexander J. Ryu, Teresa B. Gibson, M. Richard McKellar, and Michael E. Chernew. "The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist." Health Affairs, May 2013. http://content.healthaffairs.org/content/32/5/835.abstract
[10] CMS. National health expenditure accounts: historical national health expenditures by type of service and source of funds, CY 1960–2011 http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/
[11] Altarum Institute, Center for Sustainable Health Spending. June 2013 Health Sector Economic Indicators. Available at http://www.altarum.org/research-initiatives-health-systems-health-care/altarum-center-for-studying-health-spending/health-indicator-reports

It is legitimate for Providence to wish to avoid disclosing details of ongoing negotiations, but more information is required to evaluate the insurer's claims about accelerating cost growth in the year ahead.

Providence's initial projection of a 46.4% increase in claims costs due to the health status of the insurer's new customers under health reform is very high and has not been justified.

As mentioned above, Providence's initial filing included not only a 20% increase due to the health status of the newly insured—it also included an additional 22% factor to account for the merging of Oregon's existing high risk pools and the Portability market into the Individual market. Together, these two projections would indicate a 46.4% increase.

Providence has since admitted that the market merger calculation was in error and double-counted the impact of health status, and has submitted a revised calculation. However, the insurer has not revised their projection of a 20% increase due to covering the uninsured. [12]

Experts differ in their estimates of the health status of the current uninsured and the impact this may have on the costs insurers will face when, starting in 2014, many more Americans will be able to purchase health coverage.

While some projections have estimated even higher cost impacts than Providence's projection in the current filing, many—including many of Providence's competitors in the current rate filing period—have made much lower projections. Some experts have predicted that covering the currently uninsured will prove to reduce costs, since many uninsured individuals are young and healthy, and incur few medical costs.

A study commissioned by CMS suggests that the majority—about 69%—of the currently uninsured have better-than-average health status.[13] A key consideration in determining the cost impact of expanding coverage to the uninsured is estimating how many of these healthy individuals and families will enroll, which will depend in large part on the success of the large-scale outreach, public education and enrollment efforts that the state and federal governments will undertake over the coming year. The extent of the success of these endeavors is difficult to predict, but consumers should not be made to pay extra for insurance on the assumption that coverage expansion efforts will fail.

The exact cost impact of expanding coverage remains unclear, but Providence's projection is high and should be scrutinized closely. Providence did not supply sufficient information in its initial filing to enable independent evaluation of the basis for this projection. In response to questions, Providence referenced some of the independent sources they consulted in putting together their projection but did not provide additional supporting data.

It is unclear whether Providence has adequately adjusted its cost projections to reflect a reduction in "bad debt" due to the expansion of coverage as the Affordable Care Act (ACA) comes fully into effect.

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[12] Providence's responses regarding these issues have been unclear. Providence has stated "the impact of the guaranteed issue requirement [is] (1.15). (See Providence response to OSPIRG RFI 3) DCBS has requested additional information from Providence on these issues (see DCBS 6/13/13 objection letter, item 2)

[13] http://marketplace.cms.gov/ExploreResearch/social-marketing-research-for-the-health-insurance-marketplace.pdf, see page 8.

Hundreds of thousands of Oregonians are expected to gain access to health coverage over the coming year as Cover Oregon comes online, enabling access to tax credits to pay for coverage, and as the state expands its Medicaid program.

Among the many benefits of this expansion will be a significant reduction in uncompensated hospital care for uninsured and underinsured individuals. Since the uninsured are rarely in a position to pay for their own care out of pocket, and underinsured individuals are frequently unable to cover all of the out-of-pocket costs associated with their plans, the cost of providing needed care is often shifted onto the rest of us and is reflected in the reimbursement rates insurers pay hospitals and doctors for various services.

This is the so-called "bad debt" factor, and the anticipated reduction in bad debt should exert substantial downward pressure on hospital rates. Providence's filing does not directly discuss the impact of this downward pressure in the development of its cost projections.[14]

While the cost impact of reducing bad debt can be expected to become clearer—and to grow—over time, there is good reason to believe that uncompensated care will go down substantially even in the first year of the coverage expansion.

According to the Office for Oregon Health Policy and Research, uncompensated care cost Oregon hospitals over $1 billion in 2008 alone.[15] The primary driver of these costs is the health needs of Oregon's estimated 636,000 uninsured individuals.[16] Oregon's Medicaid expansion is expected to cover at least 222,000 currently uninsured individuals,[17] and according to a conservative estimate, at least 60,000 currently uninsured individuals will receive coverage in Oregon's individual market in 2014.[18]

With nearly half of currently uninsured Oregonians expected to gain coverage in 2014, uncompensated care is sure to decline—most likely by hundreds of millions of dollars statewide—and this benefit should be passed along to consumers in the form of lower rates. Providence's filing includes allowances for a number of areas where ACA provisions may increase costs, but does not include this key area where reform will lead to lower costs.

Comparison of rates between Providence products

In addition to the Oregon Standard plans at the Gold, Silver and Bronze level, Providence is offering a range of non-standard plans. These plans have a number of differences from the Standard plans, including both network differences and different out-of-pocket cost arrangements, and Providence's filing proposes different premium costs for them.

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[14] Despite Providence claiming "contractual savings from the reduction of 'bad debt' due to ACA coverage expansion" was considered (Providence marked "Yes" in the applicable section of the DCBS GENERAL REQUIREMENTS FOR ALL SMALL GROUP AND INDIVIDUAL HBP RATE FILINGS), bad debt was not explicitly discussedin the Providence filing.

[15] See http://www.oregon.gov/oha/OHPR/RSCH/docs/uncompensated_care/uncompensatedcaretrends_08.pdf

[16] See http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf, page 14.

[17] See http://www.oregon.gov/oha/Documents/MedicaidExpansion-EstimatedFinancialEffects.pdf, page 4.

[18] See http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf, page 29

While non-standard plans designs may offer innovative benefits that are important for some consumers, the rationale for offering additional plans at a different price point than the standard plan should be crystal clear, and the rationale is not clearly spelled out in Providence's filing.

Clarifying the basis for these cost differences is important to ensure that consumers can rely on the premium prices of these plans as accurate signals of the value of the coverage they are purchasing, and not a reflection of an expectation that a plan will have a sicker and more costly membership base. Insurers offering non-standard plans should be doing so in order to offer unique benefits to consumers, not in order to find new ways to direct unhealthy individuals elsewhere, or to charge sick individuals higher prices for coverage.

In response to OSPIRG Foundation questions, Providence explained that they are offering non-standard plans in order to provide a range of cost-sharing options that would be appealing to their customers, and that "availability of varied provider networks was desired to be offered in the interest of affordability." [19]

The insurer also clarified that they do not anticipate any systematic differences in age or health status between the customer bases for the Standard and non-standard plans, and correctly pointed out that federal regulations prohibit using selection differences in pricing.[20] Providence stated that the price differences between their plans reflect differences in utilization due to the impact of different cost-sharing arrangements on consumer behavior, but that their estimates of these utilization effects were based on calculations holding age and health status constant. This could be an appropriate methodology, but we would encourage DCBS to take steps to ensure that Providence's calculation of these utilization effects is fair and not discriminatory.

Providing a choice of plans and networks at each metal level may benefit consumers with unique needs, but we urge DCBS to scrutinize the proposed costs of these plans to ensure that the price differences proposed by Providence are appropriate and justified.

Cost 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 for Providence's plans as proposed in the original filing would be substantial. Providence has proposed reducing the premium costs proposed in its initial filing, but a cost impact analysis of the rates as originally proposed is still a critical element of the review process.

Federal tax credits will help eligible individuals and families cover some of the cost of premiums and out-of-pocket expenses,[21] but the cost of the proposed rates should be considered on its own merits. The

[19] Providence response to OSPIRG RFI 32
[20] Providence response to OSPIRG RFI 34
[21] For information about eligibility for these federal tax credits, see www.coveroregon.com, the website for Oregon's Health Insurance Exchange. 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 have not yet been approved, it is impossible to project the impact of financial assistance precisely at this time.

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.

Policyholders	**Plan**	**Annual premium**	**Out-of pocket max (deductible + coinsurance + co-pays)**	**Total potential cost**
Sam, 32	Oregon Standard Bronze	$2,512	$6,350	$8,862
Sarah and George, 50	Oregon Standard Silver	$11,061	$12,700	$23,761
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$14,239	$12,700	$26,939

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.

Policyholders	**Plan**	**Annual premium**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Sam, 32	Oregon Standard Bronze	$2,512	$5,000 + $1,350	$8,862
Sarah and George, 50	Oregon Standard Silver	$11,061	$5,000 + $1,500	$17,561
Eric and Cynthia, 45, and their two children	Oregon Standard Gold	$14,239	$2,600 + $740	$17,579

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[22] plan reduce out-of-pocket exposure to financial risk in the case of medical need, but total costs remain high and will be burdensome on Oregon families and federal budgets.

The out-of-pocket maximums above were established by the ACA 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.

[22] 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%).

Comparison with current rates

It is impossible to make apples-to-apples comparisons between the proposed rates and the rates Providence offers today, due to new coverage requirements and other consumer protections that will be going into effect next year.

However, the $290 benchmark rate proposed in the initial filing represents a significant increase from the rate for the closest comparable plan Providence offers today. Providence's "Value 5000" plan, which offers the closest equivalent to the benefits and out-of-pocket costs in the Oregon Standard Bronze plan, costs $239 today.[23] This means that current Providence customers in that plan wanting to purchase similar coverage would face an increase of about 21% for 2014.

In the filing, Providence estimates that the average increase their customers will experience will be 53.2%. However, it appears that this higher estimate is largely due to the expectation that policyholders currently purchasing plans that do not meet the ACA's coverage standards will switch coverage to the more generous plans that the ACA requires.

Regardless, while many customers will have access to premium assistance tax credits, and will have expanded options for finding coverage elsewhere through Cover Oregon, these increases are large and, if approved, the impact of these rates will be substantial.

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.

Reporting on efforts in this area as part of the rate filing is relatively new for insurers. From the consumer perspective, we are looking for a frank discussion of the insurer's approach to contain costs in ways that cut waste and improve quality.

In this analysis, OSPIRG Foundation tracks the insurer's reported efforts to implement six strategies understood to effectively reduce costs and improve quality, outlined through the chart below.

[23] For the same reference population: A 40-year-old single non-smoker in the Portland Metro area. See https://providence.connectedhealth.com/queries/160132/plans/106758/quote?rate=239 for coverage and rate information for the current "Value 5000" plan.

Insurer's Cost and Quality Initiatives

Initiative	Description	Insurer's current efforts	Projected Savings
Quality pricing, also known as "payment reform"	In contrast with the fee-for-service payment model, this model rewards providers that use best practices to help keep patients as healthy as possible.	Pay-for-performance/quality bonus program	Not specified
"Medical Home" initiatives	Coordinated patient-centered care that focuses on prevention and keeping patients healthy and out of the ER.	Providence Choice network as well as partnerships with OHA and the CMS Innovation Center to develop new care models	Not specified
Value based benefits	Plans with lower co-pays for treatment proven to be effective, and higher cost sharing for unnecessary procedures. Some insurers use this term to describe plans with higher cost sharing for specialty care or brand-name drugs.	None specified	Not specified
Chronic disease management	Case management and other tools to improve the health of patients with chronic disease. [24]	Case management and disease management programs	Not specified
Reducing hospital readmissions	Working with providers to ensure that discharged patients have adequate follow up care.	Discharge planning program	Not specified
Reducing errors, hospital-acquired infections and other adverse events.	This includes not reimbursing providers for "never events," and incentives to encourage provider safety practices.	Medication use management program	Not specified

In its filing, Providence reported taking a range of important steps to reduce health care cost in ways that improve quality for patients, including Medical Home initiatives; care management and health engagement programs; efforts to reduce fraud, waste and abuse; and efforts to pay providers on the basis of performance—sometimes known as "quality pricing."

In the filing, Providence also supplies some information about the aggregate health outcomes of its customers over time, as measured by hospitalization rates and other key indicators, and also supplies a chart of "Disease Management Event Rate Savings" for a range of common conditions such as asthma and diabetes. This additional information appears to indicate that Providence has achieved some success in reducing costs through successfully reorienting care toward prevention.

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

While it appears that Providence is more active in the area of cost containment and quality improvement than many of its competitors, it remains unclear whether the insurer is doing all it can because no specific measures or benchmarks for cost and quality have been outlined for its many programs. While measuring specific cost impacts can be challenging, it is also critical both for evaluating the adequacy of the insurer's overall strategy and for ensuring that savings are appropriately passed along to consumers.

In response to questions from DCBS and OSPIRG Foundation regarding how the savings from its cost containment programs are realized in Individual market premium rates, Providence has stated that the carrier did not include projected savings in the initial filing, but is "prepared to revise the proposed rate filing using an assumed $6.62 [per member per month] reduction in projected claims costs. This is estimated to translate to an approximate 2.1 percent reduction in the filed rates." As discussed above, Providence later supplied a 3.4% estimate for this reduction.

Providence's customers would clearly benefit from lower rates, and we commend the carrier for taking steps to ensure that their consumers reap the benefits of their cost containment programs. However, since the carrier has not supplied the basis for this proposal, it is hard to evaluate whether it represents a reduction that appropriately passes along the savings associated with the programs outlined in the filing.

We urge DCBS to encourage Providence and other carriers to seek and submit more detailed measures of the success of cost containment and quality improvement programs, and associated savings, as part of the rate review process.

Conclusion

Providence has not adequately justified its proposed rates, and its admission that the initially filed rates were in error raises questions about the reliability of the carrier's rate setting policies that should be addressed to ensure that such errors do not occur again.

OSPIRG Foundation is concerned that Providence has not provided enough data to support its projections of medical and prescription drug cost trends, as well as its projections of the cost of covering the insurer's new customers under health reform, and that the insurer has not done enough to pass along to consumers the cost savings associated with health reform.

We are also concerned that Providence has not provided information about its cost containment and quality improvement programs sufficient to enable independent evaluation of adequacy of the insurer's strategy in this key area.

We respectfully urge DCBS to closely examine these issues, as well as all the others raised through these comments, as it completes review of this rate proposal.