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Comments on the Health Net Health Plan of Oregon Proposal for Individual Health Rates Effective January 2015

Filing # HNOR-129547091

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

Health Net's individual members will see an increase of 8.3% on average, ranging as high as 10% for some customers, if the premium rate hike proposed by the insurer is approved.

The main reasons given for this increase include the insurer's projection that medical and prescription drug costs will increase by 7% in the upcoming year and that the worsening health status of its customers will drive up costs by 4.6%.

After analysis of Health Net's filing and supplemental information provided by Health Net and the Oregon Department of Consumer and Business Services (DCBS), we conclude that the insurer has not provided sufficient information to justify their proposed rate increase.

Key Findings:

- **Health Net did not adjust its cost projections to reflect a reduction in "bad debt" from the Affordable Care Act's expansion of coverage.** With over 400,000 Oregonians newly signed up for coverage in 2014, rates of uncompensated care are beginning to decline. This benefit should be passed along to consumers in the form of lower rates.

- **Health Net's projection of a 7% trend for medical and prescription drug costs is high and has not been supported by sufficient data.** Health Net's projection is higher than many of their competitors, and higher than widely-cited independent projections of marketwide trends.

- **Health Net's projection of a 4.6% increase due to the worsening health status of their customers is insufficiently supported.** Next year, it is widely expected that the mix of customers enrolling in health coverage will be younger and healthier than those who signed up for 2014, which may bring down costs. Especially in a context in which some insurers are projecting decreases in costs due to this factor, Health Net does not provide enough evidence to support their projection.

- **Health Net includes a 4.6% increase to its calculations for a "Market Risk Adjustment."** However, adequate justification for this value was not provided.

- **When it comes to reducing costs and improving the quality of care, it is not clear that Health Net is doing all it can**. New health care quality, cost and utilization metrics submitted for informational purposes show that Health Net has high utilization and costs for emergency room visits, as well as high specialty care costs, in comparison to most of their competitors. Health Net also failed to supply data for one key metric required in the filing process, developmental screening. Further inquiry should be made into the causes of these metrics to ensure Health Net is doing everything possible to cut waste and improve quality of care.

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

Key Features & Insurer Information

Key features of the rate proposal	
State tracking # for this filing	HNOR-129547091
Name of health insurance company	Health Net Health Plan of Oregon
Type of insurance	Individual

Proposed Rates*	Rate	Increase from 2014
Standard Bronze	$200	6.4%
Standard Silver	$233	9.4%
Standard Gold	$266	8.1%
% premium to be spent on medical costs		78.90%
% premium to be spent on administrative costs		19.60%
% premium to be spent on profits		1.50%

Basis for rate - Key factors	
Medical cost trend	7.00%
Rx cost trend	7.00%
Cost due to health status of new customers	4.60%

Insurer's history of rate increases	**Requested**	**Approved**
2009	22.80%	22.80%
2010	10.60%	8.00%
2011	6.30%	5.10%
2012	8.90%	7.10%
2013	N/A**	N/A**

Enrollment	
Year	**Members**
2009	5,510
2010	4,763
2011	4,015
2012	2,421
2013	900
2014	2,369

Insurer information

Basic Information	
For profit or non-profit:	For Profit
State domiciled in:	California
Parent Company:	Health Net, Inc.

Insurer's financial position	
Year	2013
Surplus	$66,700,000
Investment earnings	$3,182,154

Surplus History	
Year	**Amount in Surplus**
2007	$67,400,000
2008	$57,400,000
2009	$73,600,000
2010	$63,300,000
2011	$70,000,000
2012	$70,800,000

*"Proposed rates" are for a benchmark population--a 40-year old nonsmoker in the Portland area
A Bronze plan will pay about 60% of the average policyholder's medical costs in a year; a Silver plan will pay about 70%, and a Gold plan will pay about 80%. For more information about the Oregon Standard plans, see http://www.oregonhealthrates.org/files/plan_summary.pdf
**Due to new consumer protections and coverage standards in the ACA, it is not possible to make an apples-to-apples comparison between the rates filed in 2013 and the rates filed in previous years.

Introduction and Background

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

When health insurers in Oregon wish to increase their rates on small businesses or people purchasing coverage on their own, they must submit a detailed proposal to DCBS laying out the justification for a rate hike. DCBS then determines whether the proposal is reasonable and approves, disapproves or cuts back the proposed rate.
In 2011, DCBS created a formal process for a consumer organization to analyze and comment on rate filings from a consumer perspective, supported by a grant of federal funds. OSPIRG Foundation has been the contracted organization under that program since November of 2011.

As part of this ongoing project, OSPIRG Foundation worked with the actuarial firm AIS Risk Consultants to analyze Health Net's rate filing. We examined the insurance company's justification for the proposed rates, the financial position of the insurer, and how the proposed rates would impact Oregonians if approved. Our staff and consulting actuary also reviewed additional information made available by Health Net and DCBS.[1]

Health care in Oregon is undergoing major changes. For the first time this year, insurers are no longer allowed to deny coverage to people with pre-existing conditions, and many Oregonians have qualified for new financial assistance to help pay for coverage. Also starting this year, many Americans will be required to have health coverage or pay a penalty. These changes make it more urgent than ever to ensure that premium rates are justified, and that consumers receive good value for their premium dollar.

At the same time, studies consistently show that as much as a third of every dollar spent on health care is wasted on something that does not improve health.[2] With rising costs making health care unaffordable for many Oregonians, Oregon needs all insurance companies to redouble their efforts to contain costs by cutting waste and focusing on prevention and other proven strategies that keep patients healthier.

While health insurance rate review cannot solve the myriad problems facing our health care system on its own, rate review does provide an opportunity to strengthen accountability for insurance companies—to ensure that rates do not go up for consumers unless increases are fully justified, and unless insurers are putting in a meaningful effort to keep down costs and improve quality.

Discussion of rate filing

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

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

[1] As part of this process, OSPIRG Foundation submitted questions to the insurer on July 7. Health Net provided responses on July 10.
[2] Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America (2012), available at http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx

Examining the justification for the proposed premium rates

Impact of federal health reform

Health Net did not adjust its cost projections to reflect a reduction in "bad debt" from the Affordable Care Act's expansion of coverage. The savings associated with these reductions could be substantial, and should be passed along to consumers in the form of lower rates.

Among the outcomes of this expansion has been a reduction in uncompensated hospital care for uninsured individuals. Since the uninsured often cannot pay for their own care out of pocket, the cost of providing needed care in emergency situations is frequently shifted onto the rest of us and is reflected in the reimbursement rates insurers pay hospitals and doctors for various services. This is the so-called "bad debt" factor, and the anticipated reduction in bad debt should exert substantial downward pressure on hospital rates.

Health Net provided the following explanations for their decision:

> In the initial filing: "We have not seen material movement in our provider negotiations that can be explicitly assigned as a reduction in bad debt. We recognize that a reduction in bad debt due to ACA is a valid argument, however, we note that other environmental factors due to ACA like sequestration cuts increase trend. How much ACA improves trend on a net basis is difficult or impossible to assess without experience data as these factors are not explicitly addressed in our provider negotiations. Our normal provider negotiation process stresses the need for providers to include all known environmental factors. We are confident that the best intelligence is built into our trend numbers."
>
> In response to OSPIRG Foundation questions: "Furthermore, the reduction of bad debt itself does not result in a one-to-one cost savings to the Commercial health care plan. Safety-net hospitals rely on disproportionate-share hospital (DSH) payments to help cover uncompensated care costs and underpayments by Medicaid (known as Medicaid shortfalls). Most Oregon hospitals receive DSH payments. The Affordable Care Act (ACA) anticipates that insurance expansion will increase safety-net hospitals' revenues by reducing bad debt/uncompensated care and will reduce DSH payments accordingly. Especially in states with enrollment difficulties like Oregon, decreases in uncompensated care costs resulting from the ACA insurance expansion may not match the act's DSH reductions because of the high number of people who will remain uninsured, low Medicaid reimbursement rates (with expanding enrollment), and medical cost inflation. The articles that OSPIRG cited cautioned that a reduction in bad debt does not mean improved revenue for the hospital which the health care carrier can leverage in provider negotiations. We quote from the second article cited (http://www.oregonlive.com/health/index.ssf/2014/06/oregon_health_science_universi_28.html)

> 'Though the increase in paying patients improves OHSU's revenue in one area, the gain is offset by a cut in Medicare payments also made under the new federal health reform law.'

> "The Commercial market subsidizes Medicare/Medicaid shortfalls, thus a health care carrier would not necessarily see lower rates due to bad debt if the hospital's total revenue stream remains the same."

While some of these points are valid, and it goes without saying that reductions in uncompensated care need to be considered in a broader context, it is not clear why Health Net does not explicitly address reductions in bad debt in its provider negotiations. The evidence is mounting that rates of uncompensated care are already declining, and other Oregon insurers have stated, either in their rate filings or in public hearings on rate increases, that this issue has been a focus of their reimbursement negotiation efforts.

If Health Net does not incorporate savings from reductions in bad debt into its negotiated rates with providers, and pass those savings along to consumers, it will represent a major missed opportunity. Uncompensated care cost Oregon hospitals over $1 billion in 2008 alone.[3] The primary driver of these costs in past years has been the health needs of Oregon's estimated 636,000 uninsured individuals.[4]

However, at least 400,000 Oregonians have signed up for the Oregon Health Plan or Cover Oregon Qualified Health Plans over the past year, including many previously-uninsured Oregonians. While precise state-level numbers are not yet available, recent studies have suggested that Oregon has been one of the most successful states in the nation in reducing its overall uninsured rate,[5] with some researchers projecting that uninsured rates may have been cut by almost 2/3.[6]

Thus, it is not surprising that rates of charity care in Oregon hospitals have reportedly declined by 40% in the first quarter of 2014, representing a reduction of over 2.6 percentage points as a percent of overall hospital revenue.[7] Oregon Health and Science University (OHSU) reports that the percentage of uninsured patients seeking care has dropped to less than 1% from 5% last year.[8]

The cost impact of reducing bad debt can be expected to become clearer—and to grow—over time. However, it is also clear that uncompensated care costs are already going down. Thus, it is reasonable to believe that some health care providers will accept lower fees because of the reduction in bad debt. This position is supported by Milliman, an actuarial firm cited by Health Net, which stated that "some providers may be willing to accept lower rates than in the past, perhaps due to a reduction in uncompensated care for the uninsured."[9]

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[3] See http://www.oregon.gov/oha/OHPR/RSCH/docs/uncompensated_care/uncompensatedcaretrends_08.pdf
[4] See http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf, page 14.
[5] http://www.statesmanjournal.com/story/news/health/2014/07/14/multiple-studies-show-people-health-insurance/12644779/
[6] http://wallethub.com/edu/rates-of-uninsured-by-state-before-after-obamacare/4800/
[7] See http://www.bizjournals.com/portland/blog/health-care-inc/2014/06/oregon-hospitals-spend-less-on-charity-care-in.html
[8] See http://www.oregonlive.com/health/index.ssf/2014/06/oregon_health_science_universi_28.
[9] See 2014 Milliman Medical Index, page 9, available at http://us.milliman.com/uploadedFiles/insight/Periodicals/mmi/pdfs/2014-mmi.pdf

The other environmental factors cited by Health Net do have an impact on hospitals' bottom lines, but there is little reason to believe that they will entirely offset savings from reductions in uncompensated care. Medicare reimbursement cuts due to the Budget Control Act are not large enough as a percentage of hospital revenue to offset the reductions in uncompensated care that have already been reported.[10] The impact of reductions in DSH payments remains theoretical, as the cuts have been delayed until late 2015,[11] and there is an active debate about whether they will be implemented at all.

If Health Net believes that cost-shifting from Medicaid may offset or undo the impact of these reductions, further evidence should be supplied to support this theory. While increased enrollment in Medicaid will certainly have an impact on the bottom lines of Oregon hospitals, it is far from clear that this impact will be negative. Oregon's Medicaid transformation efforts and the ongoing development of Coordinated Care Organizations (CCOs) may help offset the phenomenon of cost-shifting. CCOs have already shown some success in reducing emergency room utilization and other preventable drivers of increased health care costs, which could help reduce hospitals' need to shift costs to commercial insurers.[12]

Downward trends in uncompensated care are already clear, and will only accelerate in the coming year. If insurance rates are not adjusted to reflect this reality, consumers will be on the hook for unjustified costs. We urge DCBS to consider this issue carefully before making a decision on Health Net's rate proposal.

By using the rate review process to ensure that premium rates accurately reflect reductions in uncompensated care across the board, DCBS can push the market to respond. If no health insurer in Oregon is able to raise rates without incorporating savings from reductions in uncompensated care, no providers or provider networks in the state can continue to expect reimbursement rates that fail to reflect the changes underway in health care in Oregon.

Medical and prescription drug cost trends

Health Net's projection of a 7% trend for medical and prescription drug costs is higher than many of their competitors, and higher than widely-cited independent projections of marketwide trends.[13]

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[10] Most Medicare reimbursements are subject to a 2% cut under the Budget Control Act. (See http://www.medicarenewsgroup.com/news/medicare-faqs/individual-faq?faqId=2ec7b6bb-c68b-433e-830e-035b9d930e4d) Even hospitals that rely on Medicare for a high percentage of their revenue will not see reductions sufficient to offset the 2.6% reduction in uncompensated care we have already seen, which can be expected to increase.

[11] See http://www.beckershospitalreview.com/finance/president-obama-signs-2014-budget-bill-what-it-means-for-hospitals.html

[12] See a summary of the latest CCO data at http://www.oregon.gov/oha/Metrics/Documents/2013%20Performance%20Report%20Executive%20Summary.pdf

[13] Most nationwide studies suggest that prescription drug cost growth remains slow. *National trends in prescription drug expenditures and projections for 2014* gave a range for "a projected 3–5% increase in total drug expenditures across all settings." (www.ashpmedia.org/AJHP/DrugExpenditures-2014.pdf) *According to CMS, "Projected prescription drug spending growth for 2014 is 5.2 percent" and "For 2015 through 2022 […] 6.5 percent per year." (National Health Expenditure Projections 2012-2022)*

Especially in light of the fact that Health Net's loss projections in last year's filing were higher than the actual losses reported this year,[14] these trend projections merit close scrutiny.

Health Net's Actuarial Memorandum states that medical costs trends are based in part on estimates made by "reviewing current and anticipated future provider reimbursement arrangements," without providing further detail. In a context in which one of Health Net's competitors discovered a major error in the way their rate filing incorporated changes to provider reimbursement arrangements, more detail should be provided to ensure that premium rates are based on the most accurate information available.

Morbidity

Health Net's projection of a 4.6% increase due to the worsening health status of their customers is insufficiently supported.

As of this year, insurers can no longer deny coverage due to pre-existing health conditions. While it is too early to determine the precise impact of this historic change on the costs facing insurers, it is likely that many Oregonians who were previously unable to obtain coverage for this reason are now beginning to sign up, some of whom may have health conditions that are expensive to manage and treat.

However, next year, it is likely that the mix of customers enrolling in health coverage will be younger and healthier than those who signed up for 2014. This expected difference in the health status between the early enrollees in 2014 compared to later enrollees is a generally recognized actuarial concept, as expressed by the American Academy of Actuaries: "In general, higher-cost individuals are more likely to enroll early during the open enrollment period and in the first year of the program. Lower-cost individuals are more likely to enroll later during the open enrollment period and perhaps in later years as the individual mandate penalty increases."[15]

In response to OSPIRG Foundation questions about the development of their projection, Health Net stated the following:

> "Oregon is a Transitional Policy state and some non-grandfathered plan populations will be retained in the Grandmothered market and not a part of the single risk pool in 2015. We have concluded that a 4.6% adjustment to morbidity (related to transitional policies and selection risk) in the individual market is necessary."

This is a reference to the fact that Oregon is allowing insurers to continue offering non-ACA compliant plans, which are considered separately from the plans in this filing for rating purposes. Health Net appears to be projecting that the population that stays in those plans will be healthier and less expensive to cover than the population covered under ACA-compliant plans, but does not provide any specific evidence. If true, the impact of these costs would be felt by Health Net's competitors as well. Especially in a context in which some of Health Net's competitors are projecting a decrease in costs due to decreasing population morbidity,[16] Health Net does not provide sufficient justification to support their projection of a 4.6% increase. We urge DCBS to scrutinize this projection closely.

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[14] See Page 2 of the Filing Description; 77.3% actual versus 82.0% projected.

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

[16] LifeWise, for example, is projecting a cost decrease of 11.7% due to lower morbidity.

Market Risk Adjustment

The Health Net rate calculation includes an increase of 4.6% for an "Average Market Risk Adjustment."[17] The basis for this increase was explained in the filing by citing two risk adjustment simulations performed by Wakely Consulting, which averaged out to a 4.6% increase in costs for the insurer. However, no data, documentation or calculations were shown in the filing to support this value.

OSPIRG Foundation asked for additional information regarding the derivation of this value, including the underlying data, calculations and analyses. In response, Health Net provided a spreadsheet containing some of the key numerical results and calculations from the study, but in the absence of additional explanation regarding the study's methodology, it is difficult to assess the validity of these figures.

In the absence of additional information, it is impossible to discount the possibility that insurance companies that can benefit from using Wakely's studies to determine market risk adjustment scores in the form of higher rates will rely on their projections in rate filings, while other insurance companies which have rates that should go down in accordance with study findings may not provide those results.[18]

We urge DCBS to carefully consider Health Net's market risk adjustment projection before making a decision on the rate filing.

Cost impact of proposed rates

Total cost of Health Net's plans

Taking into account premiums, deductibles, coinsurance and other forms of cost-sharing, the total cost of coverage for Health Net's plans as proposed in the filing would be substantial. The role of rate review is to ensure that the rate is appropriate for the benefits offered, so considering the impact of the total cost of coverage is critical.

The following case studies illustrate the total potential costs that Health Net policyholders may accrue in the event of serious illness or other medical need.[19]

[17] Health Net rate filing, Actuarial Memorandum, pg. 12 – shown as a factor of 1.046

[18] Since this factor is based upon a comparison to the overall market average, the factor across all companies (i.e., the market average) should be 1.00. Hence, there should be about as many insurance company policyholders with rates that are decreased from this factor as there are that are subject to increases.

[19] Each of the members in these case studies is a non-smoker in the Portland metro area.

Policyholders	**Plan**	**Annual premium (Increase since 2014)**	**Out-of pocket max (deductible + coinsurance + copays)**	**Total potential cost**
Sam, 21	Oregon Standard Bronze	$1,872 ($108)	$6,350	$8,222
Sarah and George, 40, and their two children	Oregon Standard Silver	$7,961 ($609)	$12,700	$20,661
Eric and Cynthia, 60	Oregon Standard Gold	$13,560 ($1,032)	$12,700	$26,260

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 (Increase since 2014)**	**Deductible + Coinsurance**	**Total cost after premium and $10,000 claim**
Sam, 21	Oregon Standard Bronze	$1,872 ($108)	$5,000 + $1,350	$8,222
Sarah and George, 40, and their two children	Oregon Standard Silver	$7,961 ($609)	$5,000 + $1,500	$14,461
Eric and Cynthia, 60	Oregon Standard Gold	$13,560 ($1,032)	$2,600 + $740	$16,900

As the chart above demonstrates, higher-value plans such as the Oregon Standard Gold[20] 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.

Oregon median household income, $49,161 in 2012,[21] the last year for which figures are available, has been stagnant for some time. The total costs for all of Health Net's plans would represent a large portion of this median sum. Although Health Net will not be participating in Cover Oregon, the state's health insurance marketplace, federal tax credits will help eligible individuals and families who sign up

[20] 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%).
[21] http://www.deptofnumbers.com/income/oregon/

via the marketplace to cover some of the cost of premiums and out-of-pocket expenses.[22] Regardless, these costs should be considered on their own merits.

The out-of-pocket maximums above were established by the ACA and cannot be changed in the rate review process, but we urge DCBS to take these costs into account when evaluating whether the coverage provided by Health Net's insurance products is worth the proposed premium cost.

The impact of this high rate of increase should also be considered when evaluating the impact of the rate. As detailed above, some families covered by Health Net could see an annual premium increase of over $1,000. To put this in perspective, an increase of $1,000 a year in health insurance premiums is significantly more than the total average annual premium paid in Oregon for either automobile insurance or home insurance.[23]

Insurer's efforts to reduce medical costs while improving quality

Rising medical and prescription drug costs are far and away the most significant driver of rising health insurance costs. Health insurance companies have a significant role to play to help lower these underlying costs – not by cutting access to needed care – but by cutting waste and working with providers in their networks to focus on prevention and other proven strategies that keep patients healthier.

In this analysis, OSPIRG Foundation looks at two data sources: newly required quantitative data reported by the insurer, and the insurer's qualitative description of its efforts to implement six strategies understood to be effective in reducing costs and improve quality.

In future years, we hope that both types of data are integrated, and presented in detail sufficient to evaluate the effectiveness of insurers' broader cost containment strategies. From the data available, it is not clear whether Health Net is doing all it can in this critical area.

New quantitative data on cost and quality

For the first time this year, every Oregon insurer submitted hard data on health care quality, cost and utilization as part of the rate filing process. These metrics represent a step forward for transparency and provide some helpful information to form a baseline to evaluate insurers' efforts to contain costs and improve quality of care.

These metrics show that Health Net has utilization and costs for emergency room visits (127 visits per 1,000 members per year and $1,721 per visit), as well as specialty care costs ($414 per visit) that are higher than most of their competitors.

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[22] For information about eligibility for these federal tax credits, see www.coveroregon.com, Oregon's health insurance marketplace. Since the amount of premium assistance available via tax credit is pegged to the second-cheapest Silver plan available in a state's Individual market, and Oregon premium rates for 2015 have not yet been approved, it is impossible to project the impact of financial assistance precisely at this time.

[23] National Association of Insurance Commissioners Reports: "Dwelling Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owners Insurance: Data for 2011" and "2010/2011 Auto Insurance Database"

Health Net also failed to supply data for one key metric required in the filing process, developmental screening, though they indicated in response to OSPIRG Foundation questions that they are instituting policies to enable reporting in this area next year.[24]

For this initial year, these metrics have been submitted for informational purposes only, and should be taken with a grain of salt, as the data is not current enough to reflect the changes underway with health reform. In future years, DCBS and the public will have the ability to compare multiple years of data to evaluate insurers' progress on these metrics and begin to hold insurers accountable for delivering results.

Considered as a baseline, this data raises some important questions for Health Net. More information is necessary to fully understand the insurer's performance, as well as what improvement efforts the insurer may be undertaking.

More context is necessary to fully understand Health Net's performance in these areas and what efforts the insurer may be undertaking to improve performance. For example, while Health Net's ER costs and utilization are higher than some of the competition, this may be due to a number of factors. It is possible that Health Net's customer base is unusually unhealthy or unlucky and required more emergency treatment[25], but it is also possible that Health Net is not doing enough to prevent unnecessary ER trips by providing proactive, coordinated, preventive care.

In response to OSPIRG Foundation questions, Health Net provided the following additional information to help evaluate this data in context:

> "The costs for Emergency Room Visits reflects Health Net's policy to pay 100% of billed charges if our member goes out of network. We instituted this benefit in 2013 when Providence Hospitals canceled their contracts with us. It assures financial protection to our members in emergency situations where they have little choice in providers. We do not expect to modify our ER benefits in the future thus our expected cost and utilization of ER is unlikely to decrease unless the market average cost of this benefit decreases. We note that our ER costs are in line with Kaiser so while it is higher than some carriers, it is not an extreme outlier.
>
> "The costs for Specialty Care are impacted by low volume. While average cost is $414, the PMPM cost is $0.79, less than 0.3% of total claims cost. We believe variations in this metric across carriers are due to differences in coding. What constitutes Specialty Care services is ambiguous and there is no industry standard. It can compass ancillary services such as lab and XRay depending on how the bill is bundled."

Health Net's admirable policy to protect members from financial ruin in the event of emergency situations provides helpful context for their ER costs. To fully evaluate HealthNet's efforts in this metric, it would be helpful to understand how much of HealthNet's ER utilization rates is specifically

[24] In its initial filing, Health Net also reported a 0% score on a diabetes screening measure. In response to OSPIRG Foundation questions, it was clarified that this was a typo, and the correct score was well above statewide benchmarks.

[25] Though it should be noted that Health Net states in the filing that "A second Wakely risk adjustment simulation … suggested Health Net would be a net payor into risk adjustment as we have lower than market average risk." See ACTUARIAL MEMORANDUM - Projection Factors - B. Morbidity for risk selection

attributable to this policy, so that HealthNet's other efforts to reduce ER utilization can be evaluated against the larger marketplace and best practices.

DCBS should investigate whether differences in coding are leading to different responses for metrics of specialty care costs and utilization, and make policy changes as needed to ensure apples-to-apples comparisons across carriers.

In evaluating Health Net's performance in these areas, comparing trend lines year-over-year will be critical. Some insurers may serve a less healthy customer base than others, and this may be reflected in their performance on some of these metrics, but if insurers implement adequate, comprehensive cost containment and quality improvement efforts, consumers should be able to expect continuous improvement on these metrics as insurers work to bend the cost curve for quality care.

Qualitative reporting on cost and quality initiatives

Insurer's Cost and Quality Initiatives

Initiative	Description	Insurer's current efforts	Projected Savings
Quality pricing, also known as "payment reform"	In contrast with the fee-for-service payment model, this model rewards providers that use best practices to help keep patients as healthy as possible.	Not specified	Not specified
"Medical Home" initiatives	Coordinated patient-centered care that focuses on prevention and keeping patients healthy and out of the ER.	Not specified.	Not specified
Value based benefits	Plans with lower co-pays for treatment proven to be effective, and higher cost sharing for unnecessary procedures. Some insurers use this term to describe plans with higher cost sharing for specialty care or brand-name drugs.	Health Net's Community Care plans include some value-based benefit design components, but these are not explored in detail in the filing or supplemental material.	Not specified
Chronic disease management	Case management and other tools to improve the health of patients with chronic disease. [26]	Case management and care coordination programs mentioned but not described in detail.	Not specified
Reducing hospital readmissions	Working with providers to ensure that discharged patients have adequate follow up care.	Discharge planning programs.	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.	"Never event" reduction program.	Not specified

In its initial filing, Health Net reported taking steps to reduce health care cost in ways that improve quality for patients in three of the six key areas we track. In response to OSPIRG Foundation questions, Health Net provided some additional information, including several initiatives not included in the original filing, but did not specify savings projections for specific programs, goals or benchmarks.

Health Net did provide an estimate that its suite of cost containment programs saved between $8.50 and $12.75 per member per month, but did not spell out how it arrived at this estimate, or what value in this range was reflected in the proposed rate. In response to OSPIRG Foundation questions about this issue, Health Net provided the following:

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

> "We are asked to quantify the degree of which they reduce claims – this is a difficult calculation as you're asking us to figure out what would have happened absent intervention.
>
> "However, we have conducted large studies of cohorts with and without intervention. Based on those studies, the average savings has been between 150% to 250% of investment. Note, that these figures are subject to diminishing returns so that simply increasing investment will not increase savings. Based on our expenditures, we would expect a savings of $8.50 to $12.75 PMPM. We cannot know an exact number unless cost containment and quality improvement measures were removed. "

The difficulty of measuring the impact of cost containment programs and the potential for diminishing returns are well taken, but without further information it is difficult to evaluate whether Health Net is doing all it can—i.e., whether its cost containment efforts have in fact reached the point of diminishing returns—and whether its overall strategy is adequate.

To determine this, it would be helpful to have a clearer picture of what the insurer is investing in specific strategies and what the rate of return appears to be, along with an analysis of whether increased investment in those strategies, or the adoption of new strategies, could lead to increased savings, and to integrate the qualitative evaluation of insurers' cost containment strategies with quantitative cost, utilization and quality metrics.

It is also difficult to assess how the insurer is passing these savings along to its customers without further information about how the $8.50-$12.75 PMPM range is incorporated into the rate.

We urge Health Net to redouble its efforts in this critical area, and urge DCBS to evaluate whether cost savings from the insurer's programs are being shared with its customers appropriately.

Conclusion

Before deciding to approve or deny any increase, we urge the Insurance Division to obtain all necessary documentation to justify any increase, scrutinize the details of this filing carefully, and consider the consequences of the rate for individuals and families in Oregon.

OSPIRG Foundation is concerned that Health Net is not taking steps to pass along the savings from reductions in uncompensated care, and in many areas has not provided enough information to justify its projections of increased costs.

We are also concerned that Health Net has not provided information about its cost containment and quality improvement programs sufficient to enable independent evaluation of adequacy of the insurer's strategy in this key area, raising the possibility that Health Net's customers are being asked to pay more than they should.

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