

Oregon Medical Insurance Pool  
April 14, 2006  
Health Net of Oregon  
Tualatin, Oregon

**Board Members Present**

Maribeth Healey, Public Representative  
C.J. McLeod, ODS Health Plans  
Gary Morgan, Kaiser Permanente  
Ken Provencher, PacificSource  
Dr. John Santa, Health Care Provider Representative  
Cory Streisinger, Dept. of Consumer & Business Services  
Sue Sumpter, Public Representative

**OMIP Staff**

Rocky King, Administrator  
Tom Jovick, Program Manager  
Gayle Wong, Program Development Specialist  
Barry Burke, Compliance Specialist  
Kristin Persson, Program Development Specialist  
Marcy Meink, Administrative Assistant

**Others Present**

David Ball, Oregon Insurance Division  
Carol Burks, Regence BlueCross BlueShield of Oregon  
Janet Camelio, Health Net  
Dave Houck, Public Representative Emeritus  
Cheryl Hughes, Regence BlueCross BlueShield of Oregon  
Nancy Nevins, Lifewise  
John Powell, Regence BlueCross BlueShield of Oregon  
Susan Rasmussen, Kaiser Permanente  
David Rosenfeld, Oregon Health Forum  
Kim Wirtz, Regence BlueCross BlueShield of Oregon

**Call to Order**

The meeting was called to order at 10:05 a.m.

**Minutes**

The minutes from the January 2006 meeting were approved with the modification of adding Ms. Streisinger to the attendees list.

**Stat Pack**

Mr. King discussed the stat pack and accompanying summary sheet.

- Enrollment increased by 190 keeping the final membership numbers at approximately 15,000.

- Terminations in January more than doubled following premium increases that averaged 16.5%.
- The loss ratio dropped to 151% for fiscal year 2006. This may be a function of the fact that OMIP's premiums were set higher than they needed to be and reflect the high market rates that resulted in significant net income for the major commercial carriers. One major carrier is proposing a premium decrease between 9% and 20% in its new rate filings.
- Mr. Morgan asked why a drop occurred in the per member per month (PMPM) cost. Mr. King said it was due to rapid growth in enrollment, a considerable percentage of which were individuals with a 6 month pre-existing condition waiting period.
- Mr. Barnett asked if the Incurred But Not Received (IBNR) claims were included in the cost figures. Mr. King stated that the PMPM cost doesn't contain the IBNR. Mr. Jovick stated that this fiscal year figure is on a claims paid basis, which included run-out claims from the prior year.
- Mr. King stated that the demographics did not change significantly.
- The data also indicate that more people than usual had changed to a lower cost plan.

### **Termination Report**

Mr. Jovick discussed the new termination report. He indicated that OMIP sends out surveys monthly to enrollees that terminated from the plan. He also stated that Plan 500 showed a decrease in enrollment, likely because of the premium expense. Quite a few people switched to Plan 1500, which would have reduced their premium costs.

- The net enrollment decreased 1% in January; 16% of the terminations were Medicare enrollees.
- A number of FHIAP enrollees terminated because they lost their eligibility for the subsidy.
- 5.3% non-Medicare enrollees terminated in January 2006.
- 28% of terminations had no claims paid. Dr. Santa asked if this was normal business or if OMIP is pricing itself out by sending the healthier enrollees out of the program. Mr. Jovick stated that the terminated members PMPM for 2005 was \$609; for all members, the cost was \$546 PMPM. Mr. King stated that OMIP could have people with conditions that don't need treatment frequently but they have conditions that could be costly.
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### **Medicare Enrollee Update**

Mr. Jovick discussed the numbers from the handout.

- 93 enrolled in various Regence Medicare plans
- 24 enrolled in plans from other commercial carriers
- 4 termed earlier in the year due to non payment or because other options became available
- 4 enrolled in Medicare individual plans through CMS
- 3 moved out of the state
- Regence left messages for 18, who did not return calls, could not contact 9, and is providing additional follow up for 2

To the best of OMIP's knowledge, all of these people got covered in a Part D plan somewhere. Ms. Sumpter asked if the people who were put in a Regence plan were given a choice of plans

elsewhere. Ms. Rasmussen responded that yes, they were given all of their options. Mr. McLeod asked if the 18 people who received phone messages were still in the pool. Mr. Jovick said no. Mr. Houck asked what the consensus was from the people that Ms. Rasmussen spoke to. She stated that people were upset with Medicare, not OMIP.

### **Regence Subrogation Presentation**

Ms. Hughes from Regence BCBSO claims staff made a presentation on the subrogation process that Regence uses on their claims. This process involves identifying the diagnoses and the claim amounts. If the claim diagnoses trigger questions, Regence BCBSO sends an information request to the patient, and, based on the response it receives back, the department makes the decision on whether to approve or deny the claim. Ms. Hughes stated that either the enrollee or an attorney usually notifies Regence BCBSO if the claims should not be paid.

Mr. King asked if Regence BCBSO pays the claim if the doctor makes a medical error. Ms. Hughes said that it does usually pay, but that it also recovers a portion of the expenditures after a settlement is complete. Dr. Santa commented that doctors who make errors should be required to notify the TPA. Ms. Hughes indicated that doing so would be an alternate way for the TPA to deal with the issue.

Ms. Hughes said that there is a coding system that hospitals can use to report errors, but they do not always do so. Dr. Santa asked to what degree do hospitals use this system and if they do not, OMIP should require them to do so. Ms. Hughes said that Regence BCBSO reviews all diagnosis codes. Ms. Sumpter asked how this would be policed. Dr. Santa said that one of the issues is that practioners consider mistakes an exception instead of being proactive to avoid them.

Ms. Streisinger said that medical error reporting has received considerable recent attention. The Patient Safety Committee just recently received reports about medical errors. Voluntary and confidential reporting has been the biggest push. She agreed that insurers, including OMIP, should not pay doctors for errors they make because it rewards for bad behavior. Ms. Sumpter said if it is voluntary, they aren't going to do it and get "punished" for reporting. Dr. Santa said that there are people doing this the right way but is it time to go to some places and tell them they need to voluntarily report and not be paid.

Mr. Barnett said that there are 3 different categories:

- Category 1 Serious gross mistakes such as removing the wrong leg or administering the wrong medicines
- Category 2 Tort claims
- Category 3 Preventable outcomes

Dr. Santa stated that he was referring to Category 1 items and added that medication errors are the largest and grayest area of errors. Mr. Barnett said what is really happening with these is that there is a quick payout. He thinks that in most cases, malpractice insurance ends up paying the member what originally was paid to the provider. He agreed that disclosure is crucial.

Dr. Santa stated that he does not want to be on the Board of an organization that pays for medical mistakes. He would like assurances that this is not happening.

Mr. Provencher said that OMIP cannot assume that a lot of errors end up in litigation. He questioned whether OMIP has the authority to mandate reporting of errors in the Regence provider contracts and how could any such requirement be enforced. Mr. Provencher added that the hospitals would take a position that the errors are not theirs but rather are caused by the physician either directly or indirectly. Dr. Santa responded that the hospitals are responsible for the behavior of the doctors that use their facilities.

Mr. Barnett stated that a disclosure process would be critical. Ms. Sumpter agreed and added that the OMIP position should be that the hospitals must disclose their errors. If they do not disclose them and OMIP discovers that they occurred, then OMIP should not pay them.

Dr. Santa mentioned that recently a company admitted having problems with an eye contact solution it sold and wanted to recall the product in order to correct the error. The company admitted the problem, but in healthcare it seems to be an acceptable practice not to admit to an error. Mr. Barnett stated that the Regence BCBSO provider contract specifies that the company will not pay claims in instances where there is a provider negligent act. The Regence BCBSO subrogation unit actively gets involved in selling instances where there are mistakes, as do other carriers. He questioned whether they could really do anything else. Mr. Provencher noted that no carrier tries to push cases to litigation or advise patients to pursue litigation.

Dr. Santa stated that it is the large number of claims that are not litigated, but rather get paid and not caught. Ms. Sumpter said that she does not believe that patient medical charts reflect if an error was made. In hospitals, errors, if recorded, appear in a separate document. Mr. Barnett asked to hear from the other carriers in the room on this issue. Mr. Provencher said that he thinks their contract is the same as that for Regence BCBSO, but he acknowledged that the subrogation process does not settle all instances of medical gross medical errors.

Dr. Santa cited an example of a patient who experiences an anesthesiology accident prior to surgery and is sent home without surgery with instructions to return the following week for the procedure. The patient receives two 2 bills. Although the first bill was for the services at the time of the accident in the facility, the patient was not responsible for the accident but the hospital billed for it as an office visit anyway. Mr. Barnett reiterated that the Patient Safety Committee is conducting surveys for this information but it is confidential so it can't be used.

Ms. Streisinger stated again that it is currently voluntary and confidential. Dr. Santa said that he thinks it should be that if something happens in any of a number of areas, the provider should not get paid. Mr. Provencher asked why anyone would expect providers to report errors knowing that they would not receive payment. He wondered how such a reporting system really could work given that hospitals and physicians do not usually admit mistakes. It seems to be an acceptable norm in the health care service delivery systems to hide mistakes.

Mr. King said that this topic is broader than just subrogation, but covers an entire process of best practices. Dr. Santa said that he would be happy to be involved in discussions among the hospitals to tell them about OMIP's concerns about paying for medical errors.

Mr. Houck commented that the more appropriate approach is for the insurance companies to approach the legislature about the issue because it is a larger issue that affects more than OMIP. Dr. Santa indicated that any legislation would not reach the floor for a vote because the issue has a number of political aspects and no legislator would want to speak in favor of paying for errors. Ms. Sumpter said that she doesn't think anything will happen unless the reporting is mandatory.

The Board agreed that it is interested in information from three sources:

1. Mr. King said that he would contact Jim Dameron from the Patient Safety Commission to provide a description of what the Committee is doing in this regard. The Commission receives data that is voluntary and confidential, which it, apparently, it uses in examining best practices.
2. Ms. Streisinger suggested having Andy Davidson or another representative from the Hospital Association provide information. Mr. Barnett stated that the OMIP Board needs to understand what happens within the hospitals when errors occur.
3. She also suggested that a presentation by someone representing the Leapfrog project may be worthwhile. Leapfrog is intended to reduce preventable medical mistakes and improve quality and affordability of health care.

### **Policy & Legislative Subcommittee**

Mr. King stated that this committee met on 2/9/06. The minutes were included in the handouts. Staff recommended delaying decisions on some of the items in the minutes.

- Small group OMIP eligibility - Mr. Provencher stated that OMIP needs to be careful to not create incentives for small groups to take advantage of a system that would allow micro-groups into the pool. Mr. Barnett indicated that he had some updated information for Mr. King about micro-groups.
- Assessment Reduction Program Modification – staff need direction from the Board.
  - Should carriers be eligible for a reduction in assessment if their rejection rate is at a low level? The raw number of rejections is not accurate due to agent declinations in the past.
  - There are only 2 or 3 carriers that currently report rejection rates, and Regence is the only one that gets the reduction. A concept would be to look at rejection rates compared to all other carriers. Mr. Barnett noted that the Insurance Division now requires companies to report rejection rates quarterly. He said that availability of the information could influence the behavior of agents to increase applications, particularly for sick individuals with medical conditions, to companies with low rejection rates. Mr. Barnett said that Regence is currently at 16% or 17% rejection rate, but there are companies out that have 50% rejection rates. Those with tight underwriting guidelines would artificially show low rejection rates solely because agents stop sending them applications for individuals with medical conditions. Mr. King said that he thinks most companies have rejection rates

between 25% and 50%. He also indicated that the normal rejection rate was 10% five years ago.

Ms. Streisinger stated that she was not sure if the Insurance Division's new report covered the entire market. The Board agreed that it wanted to pursue the rejection rate information further and develop a comparative methodology for the Assessment Reduction Program. Mr. McLeod asked if OMIP had the authority to do this, and Mr. King responded that the Board did not need Legislative approval to revise the Assessment Reduction Program. Ms. Sumpter asked how a revised program would benefit the members. Mr. King said that it would allow more people to get individual policies instead of coming to OMIP. Mr. Provencher asked if there was any positive or negative for carriers because it would only be individual. Ms. Streisinger asked if these factors get spread evenly over the different groups.

The Board requested that OMIP staff contact the Insurance Division for the rejection rate data and model a revised Assessment Reduction Program that includes: categorization of companies into low, medium and high rejection rates; exclusion of the stop loss carriers and the special districts from eligibility for a reduction; a consideration of weighting based on the percent of the individual market that the carriers have; identification of which carriers the Insurance Division does not capture in its data request.

### **RFP Meeting**

There will be a meeting to discuss the RFP on April 28<sup>th</sup> from 9:30 to 12 in Salem. This process has to be complete by October in order to get all of the timelines met. OMIP has more flexibility now in how it structures the RFP and contracts for the TPA services. Discussions need to be conducted over how to frame the RFP. This will just be a discussion session. Mr. King indicated that the meeting would be the appropriate time to discuss case and disease management, and Mr. King responded that yes, now would be the time.

### **Provider Engagement**

Mr. King stated that he would like to have an informal meeting with providers to discuss how to manage costs better. He would also like to discuss how to engage the provider community into participating in OMIP. Mr. Lynch offered to take the lead on a provider meeting. Dr. Santa also will participate.

### **Medical Conditions List**

Mr. Jovick provided a memo that identified additional medical conditions that agents or enrollees have asked be added to the list. These conditions are:

1. Irritable Bowel Syndrome
2. Abnormal pap smear
3. High risk HPV (precancerous cells in uterus and/or a sexually transmitted disease)
4. Migraine headaches
5. Asthma
6. Compression fracture of L1 and L2
7. Trigger finger (Myotonic dystrophy- - a life-threatening disorder and different from "myotonia", which is on the current list)

8. Back injury
9. High Blood Pressure
10. Depression and perhaps some other specific kinds of mental health conditions.

Ms. Healey asked if the mental health parity bill would have any affect on these conditions. Mr. King said that it would not affect the conditions on the list, but that it would, however, impact benefits for 2007. Dr. Santa said that he wasn't sure of what other approach to take on these conditions. Mr. Barnett stated that IBS is general and often misdiagnosed. Dr. Santa stated that companies have turned a benign issue into a catastrophic one. Mr. Provencher commented that if these items get into OMIP's list, they could end up on carrier's lists as automatic rejections. Mr. Barnett stated that these items should not be on the list if they are not automatic rejections from carriers.

Mr. Provencher said that he liked Mr. Houck's idea of starting the clock for giving credits toward waiting periods for the first of the month following application to a commercial carrier. This would be the normal effective date of coverage had the carrier accepted the individual for coverage. This would avoid the problem for granting OMIP waiting period credits for individuals who must wait two or three months to receive a rejection from a commercial carrier.

The Board requested that OMIP staff work with Regence BCBSO to estimate the impact of applying such credits to the pre-existing condition wait period, including the logistics of implementing the policy and a projection of the number of enrollees it could affect.

#### **Look-Back Period for Assessments**

Mr. King stated that OMIP is proposing to go through the rules process to give carriers a 3 year period to bring to OMIP's attention for over or underpayment on their assessment. Most errors are for over-reporting. OMIP would apply overpayments to future assessments, unless the company has no lives to report covered in Oregon. Mr. Barnett asked if this appeal period applies only to carrier and not to OMIP. The Board agreed that there should be no restriction on the period for which OMIP can pursue recoveries on underpayments.

Mr. Morgan made a motion to accept this proposal and Ms. Sumpter seconded. All were in favor. Ms. Streisinger abstained from voting.

#### **Rates & Benefits Subcommittee**

This committee is comprised of David Ball, Rick Elliott, Ken Provencher, Sue Sumpter, Dave Houck and C.J. McLeod. A recommendation to the Board needs to be completed by August.

#### **Other Items**

Mr. Provencher asked about the size of the OMIP Public Forums. Mr. Jovick responded that Portland was the largest and Lincoln City was the smallest. Eugene also had a small turnout.

Ms. Healey requested that an email be sent to the Board with the newsletter when it is published. Also any other type of publication we sent out.

#### **Public Comment**

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No public comment

With no further discussion, the meeting adjourned at 12:45.