Oregon Medical Insurance Pool
June 20, 2006
Salem, Oregon

Minutes

Special Board Conference Call Meeting:
Federal High Risk Pool Grant Options

Board Members On Call
Kerry Barnett, Regence BlueCross BlueShield of Oregon
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

OMIP Staff
Rocky King, Administrator
Tom Jovick, Program Manager
Marcy Meink, Administrative Assistant

Others Present
Rick Elliott, Information Management Division
Gayle Worden, Lifewise

Call to Order
The conference call was called to order at 2:35 p.m.

Grant Proposal
Mr. King discussed the background for the Federal grant for which OMIP is applying. Mr. King and Mr. Jovick learned at a NASCHIP meeting in Santa Fe that the grant applicants must specify how they would use the Bonus Grant monies. The federal requirements do not allow OMIP to propose a number of options and later identify which it specifically will implement. It must implement whatever programs it proposes. If the funding is insufficient, it must reduce the scope of each program, but still implement all of them. The news about the requirement for the Bonus Grant resulted in this emergency Board meeting conference call to decide how these monies should be allocated.

Mr. King discussed the following six options that are available for Bonus Grant money utilization.

1. Low income premium subsidies
    a. The FHIAP program already does this and receives federal matching funds.

2. Expand or broaden the pool of individuals eligible for coverage, such as through eliminating waiting lists, increasing enrollment caps or providing flexibility in enrollment
    a. OMIP has no waiting lists or enrollment caps.
    b. At the 2005 Board retreat, members of the Board cautioned against expanding the pool in ways that go beyond the mission of the pool.
    c. Expanding to new eligibility groups raises the question of sustainability once the grants are gone or in the event the grant amount is too small to support any worthwhile expansion.
    d. The federal staff do not define what "flexibility "means.
3. Reduce premium trends, actual premium or other cost-sharing requirements
   OMIP staff believes that there are two categories for potential use of the bonus funds under this option:
    a. Reduce premiums beginning January 1, 2007. The premiums for calendar year 2007 are projected to be $76,010,087.
        i. A 1% reduction is $760,101
        ii. A 2% reduction is $1,520,202
        iii. A 3% reduction is $2,280,303
    b. Reduce the copayments for generic drugs.
       NOTE: The estimates below are "quick and dirty" and they <u>assume there is no change in utilization patterns. Therefore, they represent a maximum financial impact. A significant copayment reduction should cause a shift in utilization of brand name drugs to generics and, therefore, would result in a lower increase in expenditures than are projected below.</u>

       For 2007, the projected total medical costs are $106,085,028.
        i. A $10 copay would increase costs 10% on drugs and about 2% of overall costs or about $2.1 million.
        ii. A $5 copay would increase costs for drugs 20% and about 4% of overall costs or about $4.2 million.
        iii. No copay would increase drug costs 28%.
4. Implement less stringent rules or additional waiver authority with respect to coverage of pre-existing conditions.
    a. OMIP staff does not recommend changing the pre-existing condition policy.
5. Increase benefits
    a. Changing the generic copay, as in 3-b above constitutes a benefit increase.
6. Establish a disease management program
   OMIP staff believes that implementing the Regence Advicare Disease Management Program as a significant enhancement of the current disease management program would satisfy this option. The cost of implementing the full scope of the program as PEBB has done would be $3.58 per enrollee per month or about $644,000 per year. Normally, disease management programs do not anticipate impacts until after two years, although the Advicare program has targeted intensive case management and aggressive phone contact components that could produce impacts sooner.

   The Advicare Program provides Enhanced Disease Management and High Risk Case Management with the following chronic medical conditions: diabetes, coronary heart

disease; COPD; asthma; chronic back pain; and oncology. In addition, the program would address selected specific high prevalence, high cost conditions such as fibromyalgia, to decrease outpatient physician and mental health visits; atrial fibrillation, to prevent stroke; acid-related stomach disorders, to decrease GI bleeding or H. Pylori infection; Hepatitis C, to decrease the potential for liver transplants; inflammatory bowel disease, to decrease surgery and outpatient visits; irritable bowel syndrome, to decrease workups and outpatient visits; osteoarthritis, to decrease joint replacements and GI bleeding; osteoporosis, to decrease fractures and prevent falls; and urinary incontinence, to decrease infections and outpatient visits. All of these diseases and conditions typically manifest co-morbidities with other diseases or conditions and represent significant opportunities to improve health quality and avoid unnecessary costs.

The program takes a more pro-active member health advocacy approach to managing diseases and conditions than typical disease management programs. RN's with advanced knowledge of chronic conditions directly call enrollees who participate in the program to provide education about managing their diseases, facilitate communication with their physicians and assist in setting and meeting goals for managing their diseases. In addition, they conduct health assessments and depression screenings; provide reminder calls about standards of care and hospital discharge calls.

The program aims to coordinate medical care across multiple diseases and co-morbidities, involving the TPA's case managers and customer service staff in the collaboration. It targets increases in patient self-reliance in managing their diseases, enhancing daily activities and fitness, and strengthened interdependence with family and friends. In addition, the program focuses on supporting physicians with treatment plan and medication compliance of their patients between office visits.

Discussion

Mr. King stated that Option 1 would not make sense because it would cost too much for the administrative structure needed for implementation. The benefit would be limited as well because the cost to implement such a program would be high.

Option 2 does not apply to OMIP because OMIP does not have a waiting list or caps. OMIP staff feels that the decision to expand its eligibility categories should be left to the legislature. Ms. Streisinger commented that the OMIP Board may not have the statutory authority to make this change anyway.

Staff do not recommend Option 4 because the current pre-existing condition waiting policy is working well.

OMIP staff recommends the Board select among the following options:

- Option 3a would reduce premiums and take effect 1/1/07. All income levels would benefit from this option.
- Option 3b would reduce generic drug copays.
- Option 6 would be the 3rd recommendation.

Mr. King stated that he believes OMIP will definitely get a share of this grant money, but there is no way to determine exactly how much that will be.

Ms. Streisinger had to leave the meeting so wanted to let everyone know that she preferred Options 3a and 3b with 3b being her first choice because it directly affects enrollees and is an issue about which most of the benefit complaints are. Ms. Healey agreed.

Mr. Jovick mentioned that Ms. Sumpter could not participate in thecall but she preferredoption 3b as her first choice because it provided the most benefit to the membership.

Mr. Barnett asked if there was anyway to target premium reductions to a specific income group of people. Mr. King stated that doing so would involve a high amount of administrative costs and OMIP could not assure that it could continue the reductions after the 2007 funding. The $75 million has been approved as a total budget for each of the next 3 years but the funds have only been appropriated for the first year.

Mr. Barnett stated that he was in favor of option 3b as well.

Mr. McLeod asked whether OMIP could adjust its proposal if the federal grant provided less money than the OMIP proposal required. Mr. King answered that the federal representatives indicated that OMIP would be able to adjust the scope of the program according to the amount of the award.

Board Decision
Dr. Santa made a motion to propose one program for the Bonus Grant and that the priorities for staff in completing the application are: include in the grant proposal option 3b reducing drug copays as the first choice, 3a. If there were problems with doing so, the second priority would be a premium reduction and adopting the enhanced disease management program would be the third priority. Mr. McLeod seconded the motion and the Board unanimously approved it.

The phone call meeting adjourned at 3:07 p.m.