

Oregon Medical Insurance Pool
January 16, 2007
Health Net of Oregon
Tigard, Oregon

Board Members Present

Maribeth Healey, Public Representative (via phone)
Stephen Lynch, Health Net of Oregon (via phone)
C.J. McLeod, ODS (via phone)
Dr. Bart McMullan, Regence BlueCross BlueShield of Oregon (via phone)
Gary Morgan, Kaiser Permanente (via phone)
Dr. John Santa, Health Care Provider Representative (via phone)
Cory Streisinger, Dept. of Consumer & Business Services
Sue Sumpter, Public Representative (via phone)

Board Members Absent

Ken Provencher, PacificSource

OMIP Staff

Rocky King, Administrator
Tom Jovick, Program Manager
Barry Burke, Compliance Specialist
Becky Frederick, Fiscal Manager
Claudia Grimm, Program Development Specialist
Linnea Saris, Program Development Specialist
Marcy Tip sword, Administrative Assistant

Others Present

David Ball, Oregon Insurance Division
Missy Dolan, Oregon Prescription Drug Program
Ted Falk, Dept. of Justice
Gary Helmer, DCBS Information Mgmt
David Houck, Public Representative Emeritus (via phone)
Ronni Rachele, DCBS Information Mgmt
Sarah Roth, DCBS
Jason Strandquist, Regence BCBSO (via phone)
Sophary Sturdevant, Regence BCBSO (via phone)
Nathan Warren, OPHP Fiscal Analyst

Because Mr. Lynch had to leave at 2:22, he assigned Mr. McLeod to serve as vice chair in his absence.

Summary of Board Decisions

Assessment #32, January 2007

1. The Board agreed to direct the \$2.375 million in federal grant funds to cover losses incurred from July through December 2006.
2. The Board passed a motion to approve a five-month assessment in the amount of \$27,571,648 for Assessment #32 or \$3.18 per insured per month (\$16.04483 per insured for the period through May 2007). This is the amount of the assessment after applying the amount of the federal grant.
3. The Board agreed to not implement changes to the premium at this time.
4. At the April Board meeting, the Board will:
 - a. Review the projections for a seven-month assessment and make a decision about the magnitude of that assessment. OMIP staff will work with actuaries from several carriers and the Insurance Division to review the projections and any updates to the projection model.
 - b. Review options for premium changes effective July 2007. OMIP staff will work with actuaries from several carriers and the Insurance Division to discuss changes to the premiums targeted at a July effective date. One of the approaches involves redistributing the impact of surcharge changes across the age bands so that those in the 60+ bands not bear the bulk of the change.
5. OMIP staff will provide the Board updates of monthly expenditures in relation to projected expenditures.

Request for Proposals (RFP)

1. The Board passed a motion to release an RFP that accepts proposals for both a statewide network and a regional integrated network, with the understanding that the Board reserves the right to decide to contract only with a vendor that has a statewide network.
2. The Board agreed to include pharmacy services in the contract(s) with the understanding that the Board could decide whether to unbundle them during the course of the contract. This decision would be based on information about whether the utilization controls, costs and operational provisions of the Oregon Pharmacy Discount Program's new contract with ODS would indicate that unbundling these services would be beneficial to OMIP. Note: This decision does not prevent a company that submits a proposal from subcontracting its pharmacy services to a separate Pharmacy Benefit Management Company or other organization that provides pharmacy services.
3. The review of proposals will include a consideration of the extent to which different provider networks would result in a significant involuntary disruption of the continuity of care that would impact the enrollees under the different vendors.

Discussion

Assessment #32 January 2007

Mr. King reviewed the magnitude and source of the losses for the January assessment.

- The magnitude of the projected loss is \$35,116,718 (\$3.41 per covered life per month) before the application of federal grant funds received in December, and it is a function of a significant underestimation of the losses that OMIP would incur between July and December 2006, plus the estimation of losses for January through

- June 2007. The actual claims experience for July through December 2006 resulted in losses of \$9.3 million (\$0.90 per covered life per month) above projections. These losses are a function of both claims experience and a decrease in net revenues for the period.
- The projected assessment for January through June 2007 is \$25.8 million (\$2.50 per covered life per month), which excludes experience through December 2006; in October, we had projected the losses for this period to be \$24.5 million using a premium surcharge of 11%. Projections for Assessment #33 in July 2007 are estimated at losses of \$31.2 million (\$3.03 per covered life per month, subject to change from the total number of covered lives that will be reported for March 2007).

Review of Experience During Assessment Period #31 (July through December 2006)

In July 2006, the Board approved an assessment for \$14,760,619, equivalent to a per covered life per month rate of \$1.42 after adjusting for the assessment reduction credit for Regence BCBSO. Assessment #31 included \$895,000 to cover net losses for the Assessment #30 period that we had not been able to foresee. Our actual claims experience for July through December resulted in losses of \$9.3 million above our projections. Had we been able to predict these losses, Assessment #31 would have been \$24.1 million or about \$2.34 per covered life per month.

- In August, the review of the July payments showed that we were below our projected expenditure.
- In September, the review of August outlays, however, showed they were about \$3 million above the projection. Although the discrepancy was sizeable, we could not tell if it would be one that would be sustained throughout the rest of the year.
- In October, at the time of the final Board rate-setting meeting, the review of September expenditures showed they were nearly \$1 million below the projections.
- In November, the review of October expenditures showed they exceeded the projections by almost \$4 million.
- In December, the review of November expenditures showed they were about \$600,000 under projections.
- In January, the review of December outlays showed they were \$18,000 under projections.
- Revenues for the six-month period were realized at \$3.8 million less than projected, due to several factors. This decrease does not reflect the receipt of federal grant funds of \$2.4 million in December 2006.

Input of Actuaries to Changing the Projection Model

In the beginning of November, OMIP management and staff began conducting a review of the projection model to determine where improvements could be made. This review resulted in several improvements to the existing model including factors to account for the timing of claims, the mix of new enrollees, seasonal variations, and other issues. A test of the changes made to the model was conducted to check the accuracy of the factors.

In December and January, OMIP staff met with actuaries from the Insurance Division, Health Net, PacificSource and Regence to review the projection model and solicit recommendations for improving it. Each actuary provided helpful perspective and recommendations, and all of them

pointed out the difficulty of projecting enrollment, terminations, costs and revenues for a population of 15,000 chronically ill people. Although not all of the actuaries agreed on its priority, the one recommendation that was shared by all of them was to change the model from a paid basis to an incurred basis. In addition, there were recommendations to look further into the issue of mix by looking at lengths of stay, disease burden, deductible leveraging, large out of area claims, and utilization and cost trends. Also, in relation to plan design and analysis, recommendations were made to consider applying of age and other benefit plan factors in setting premiums, examining the true cost differences by plan to assess the equity of the premiums, and analyzing the impact of provider contracts on expenditure trends.

Mid-year Rate Increase Considered by the Board

The Board considered a mid year rate increase as a strategy that it could implement to reduce the second assessment for 2007. The Board has authority under statute to make rate adjustments mid year rate change. **The Board chose to reconsider this option at the April meeting. At that meeting they requested that staff return with options for rates at 20% and 25% surcharges, but distributed across the enrollees so that those in the older age bands do not take the brunt of an increase.**

They acknowledged that spreading an increase in this way means that the spread between the lowest and highest rates would be reduced. For the January rates, the Board approved a spread that reflects the difference that exists in the market between the highest and lowest rates.

Mr. Morgan clarified that, even with a 25% surcharge, the revenue is still a decrease from last year. Ms. Frederick agreed that the revenue per person from premium would still decrease from 2006 level.

Mr. Houck expressed concern that the per enrollee per month cost increase resulting from an increase in the surcharge to 20% or 25% would be far greater than the per member per month increase that individuals in the commercial market would experience as a result of

the assessment increase. He noted that those in the 60-64 age band would see about an \$80 per month increase in rates, but the increased cost to the commercial insureds would be \$0.34 per member per month. Mr. McLeod noted that this amount is \$0.39 increase over the projection from the July meeting and the total assessment is nearly double the projection at that time.

Ms. Sumpter commented that the \$80 dollar increase is so huge for 60-64 age band, and that insurers would never expect individual market enrollees to pay an increase this drastic. She expected that enrollees would drop their coverage because they are not affordable, and most will receive treatment in the emergency room, spreading the higher cost of their care in that setting to the commercial market anyway. Ms. Sumpter said that it isn't an equal market due to the inequality of incomes between OMIP population and commercial market so in terms of sharing the pain they aren't equal. Mr. McLeod stated that he appreciated where Ms. Sumpter is coming from and his goal is to get the stability of the premium and the assessment. He also recommended setting the rate increase in a way that moderated the impact on the older age bands. Ms. Healey indicated that she agreed with Mr. McLeod on the stability issue.

Dr. McMullan asked what the desirable loss ratio or loss ratio range should be. Mr. King generally thought loss ratio would be at 200% based upon the experience of other state risk pools. Historically, Oregon has had a relatively low cost until the last six months of 2006. Mr. Houck said that if most risk pools were at 175% they would be very happy. Mr. King it is an aberration to see any jump over 200% for a period of time. Most are between 140% and 180%. OMIP historically has targeted a loss ratio range from 150% to 175%. Dr. McMullan asked if as the year progresses, do we think our goal is to come back into that range. Mr. King said the objective is to move back toward 160%.

Mr. King added that, after OMIP increased its choices of deductibles from two to four, enrollees began to select the higher deductible plans, causing revenue to decrease, although claims liabilities stayed the same or increased.

In response to a question from Mr. Lynch, Mr. Jovick noted that 17% of the enrollees are 55-59 years old and 20.8% are 60-65 years old. Mr. Lynch said that any mid-year rate increase could be distributed among the age bands so that the older enrollees would not experience get the full brunt of the increase. Ms. Streisinger noted that the Board has not increased rates mid-year before, although it has approved considerable increases on an annual basis. She also noted that an increase in the surcharge would not solve or even come close to reducing the magnitude of the losses; she recommended that the Board first examine the assessment model without increasing the surcharge. Mr. King stated that OMIP could consult with the actuaries about premium strategies and pricing.

Mr. McLeod noted that not increasing OMIP rates would increase premiums for the commercially insured population. He added that the OMIP enrollees should share in the cost of the losses they generate. Mr. Lynch noted that where the increase goes is a serious matter. The board needs to be aware that the individual premiums are likely to increase in the commercial market as early as July. Mr. Houck agreed that OMIP would have to face this issue again for next year's rates. Mr. McLeod fears that in 2008 there will be a significant increase and he would like to minimize the magnitude by approving a mid-year increase.

Dr. Santa also expressed concern about delaying the decision for a mid-year rate-increase until April. As a result of not increasing the OMIP rates, a number of people in the individual market that won't be able to afford the increase that the insurers will pass on to them from the assessment. He recommended discussing an increase at the April meeting because he does not comfortable waiting until end of year.

Dr. Santa said the younger enrollees subsidized the older population for a number of years, but the Board eliminated that subsidy in January by making the distribution of the rates across the age bands more consistent with the commercial market. He advocated redistributing a rate increase so that the younger enrollees again subsidized the older ones to some degree.

Assessment Options Considered by the Board

Assessment options included:

1. Assess the full six-month amount.

2. Split the six-month assessment into two parts: one in January for \$22 million and one in April for \$11 million. This strategy provides a time to review the early experience in 2007 to try to determine if the projected losses would actually happen.
3. Assess an amount lower than the full projected assessment by restoring only half of the full reserve. The current reserve is approximately \$12 million, a combination of a \$2 million plus one month of projected claims payments.
4. Assess in January for only five months, which would equal a projected loss of \$27 million. During the five months, determine if the projections were correct and determine what a seven-month assessment through December would be.

Mr. King indicated that the total assessment is about \$35 million. It includes \$26 million for the next 6 months plus another \$9 million for the last 6 months to re-establish the reserve that OMIP depleted paying for the claims. He also said that the OMIP staff assumed that the Board would want to **apply the full amount of the federal grant to offset the size of the assessment. Mr. Lynch asked if there was anybody that would disagree with spending the grant money this way and there were no objections.**

Mr. King indicated that the assessment is \$32.7 million after taking into account the use of the grant funds. If the Board does not approve an assessment for the full amount, OMIP will still need it if the projections of revenues and expenditures are correct. Ms. Streisinger said is literally cashing out its 2006 reserve to pay the claims, and OMIP staff are arranging a loan from the State Treasury to cover cash flow shortfalls until the assessment dollars come in. Mr. King and Mr. Jovick said that there really were no large cost cases that could explain the magnitude of the losses in the last six months of 2006.

Mr. King said that a 5 month assessment of \$27.5 million could be done now, with a follow-up Board meeting in April to address the assessment for the following seven months. At that meeting, the Board would discuss the impact of a premium increase and examine changes in the projection model.

Ms. Healey move to adopt option 2. Mr. McLeod clarified that the difference between Options 2 and 4 is that Option 2 is recalibrated in April and 4 would recalibrate in May; in addition Option 2 gives 3 assessments and option 4 has 2 assessments. Mr. McLeod said he preferred Option 4.

Ms Healey amended the motion to adopt Option 4, which is the 5 month assessment for \$27.57 million, and to meet again in April to determine further steps. Mr. McLeod seconded the motion. The motion passed unanimously.

Mr. Lynch asked an update showing monthly experience be sent to the Board.

Request For Proposals

RFP Timeline

Mr. Jovick said the RFP must be released by February be out in January and the selection of the TPA must occur by August. He provided a timeline with other critical dates leading up to the Board decision in July.

Declaration of potential conflict of interest Mr. King said there is a memo in packet. A verbal declaration needs to be made by anyone that may have a potential conflict of interest. Mr. King indicated that OMIP Board members needed to verbally state if they have a potential conflict of interest before the Board enters discussion about the RFP.

- Ms. Sumpter stated that a family member works in the IT department for the current TPA.
- Mr. Morgan has potential conflict because he works for an integrated HMO in Oregon that may submit a proposal.
- Mr. McLeod has a potential conflict because ODS may submit a proposal.
- Dr. McMullan has a potential conflict because he is employed by the current statewide TPA.

Options for Contracting: Statewide Carrier (Option 1) and Regional Integrated system (Option 2)

The critical issue before the Board was whether it wanted the RFP to include an opportunity for proposals submitted by regional integrated delivery systems (Option 2) or limit proposals to statewide delivery systems (Option 1). Ms. Streisinger stated that if the Board releases an RFP that allows for either Option, it is not under any obligation to contract with a regional integrated delivery system. Ms. Sumpter agreed that having both options would give the Board more choices. The OMIP staff has not made a recommendation. Contracting with both a statewide system and a regional integrated system would increase the complexity of the administration of the benefit plan options.

Ms. Sumpter proposed that the Board approve release of an RFP that allows for proposals on either option. Ms. Healey seconded the motion. Roll call vote: Dr. McMullan abstained; all others voted in favor.

Provider Panel Considerations

Ms. Sumpter asked whether the review of the proposals would take into account access to providers so that patients are not forced to travel long distances to get care they need. She added a concern that forcing enrollees to switch providers would create stress for a number of chronically ill people and, potentially, adversely affect their continuity of care. Mr. King said the proposal analysis intends to examine access to providers and continuity of care based on provider location and what potential disruption of care could occur by changing to a considerably modified panel in different parts of the state. He also noted that there are always going to be areas that do not have ideal provider access, and that certain carriers in different parts of the state have broader provider representation than others. Dr. McMullan said that tension with providers will occur with all carriers. Ms. Sumpter mentioned the contracting issues that Regence had with physicians in the Bend area.

Ms. Streisinger wants to make sure the Board agrees with carriers taking a firm stance in provider negotiations.

Administrative Cost Scoring

Mr. King said that the intent is to use scoring methodology used by DCBS and developed with Sarah Roth from DCBS and Ted Falk with the Dept. of Justice. He noted that it was the intent of the OMIP staff to move forward with this scoring unless Board members had problems with it.

Dr. Santa stated that his recollection is that one of the difficulties is qualitative and quantitative. Administrative costs should not have a large weight assigned to it. What is more important are the provider costs and the utilization controls the proposers have in place. The formula to calculate the scores for administrative costs could result in very close scores, potentially having a disproportionate influence on the final score. Dr. Santa wanted to be sure that the formula-driven aspects of the review do not negate the value of critical qualitative differences among the proposals.

Mr. Jovick indicated that the staff would reduce the influence of the formula-driven score for administrative costs and increase the weight given to provider and pharmacy pricing and utilization management.

Carving Out Specific Services

Mr. McLeod asked if the board already had decided not to carve out the pharmacy benefit management services. Dr. McMullan noted that the contract would allow OMIP to carve out the pharmacy benefit management from the rest of the contract should the Oregon Pharmacy Discount Program (OPDP) prove to be cost effective in managing drug use and controlling costs. He commented that it would be a mistake to carve out pharmacy benefit management services from the TPA contract because the advantages to integrating it with the other services are huge. Mr. King says that board would make decision only if it made cost and quality of care sense. He noted that the governor requested that state agencies and programs reserve the opportunity to analyze the potential benefits of the OPDP. OPDP recently signed a contract with ODS to administer its pharmacy benefit management services.

Mr. McLeod indicated that he did not recall a board discussion and direction to OMIP staff to not carve out pharmacy benefit management services. Mr. Jovick said that, at a meeting in April to discuss just the RFP, the Board directed staff to present an RFP and contractual arrangement that allowed for a regional integrated delivery system. However, there was little interest in carving out any of the services that OMIP staff presented as options to the Board, such as disease management and intensive case management. However, there was interest in OMIP staff contacting OPDP about their new contractual arrangements once they were finalized. Mr. McLeod asked if Item c on page 3 meant that OPDP could bid on this proposal. Ms. Streisinger said that there would not be any option to submit a proposal for pharmacy services only nor to submit a proposal that excluded these services. The new contract, however, just gives the board the option to carve them out later.

Other Items

Mr. King said that this was a difficult meeting for all over the phone. Ms. Sumpter will be gone in the middle of April so Ms. Tipsword will attempt to schedule the next meeting accordingly.

Mr. McLeod adjourned the meeting at 2:51