

Oregon Medical Insurance Pool  
May 9, 2007  
Health Net of Oregon  
Tigard, Oregon

**Board Members Present**

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

**OMIP Staff**

Rocky King, Administrator  
Tom Jovick, Program Manager  
Barry Burke, Compliance Specialist  
Becky Frederick, Fiscal Manager  
Claudia Grimm, Program Development Specialist  
Don Myron, OPHP Marketing  
Linnea Saris, Program Development Specialist  
Marcy Tipsword, Administrative Assistant  
Nathan Warren, OPHP Fiscal Analyst

**Others Present**

David Ball, Oregon Insurance Division  
Scott Fitzgerald, Oregon Insurance Division  
Jason Strandquist, Regence BCBSO  
Sophary Sturdevant, Regence BCBSO  
Cynthia Johnson, Public Presenter

**Minutes**

The minutes of the January 16, 2007 meeting were approved unanimously.

**The Hydraulics of OMIP**

Mr. King presented an analysis of the OMIP growth and costs entitled “The Hydraulics of OMIP”. He noted that preparation of the analysis involved actuarial assistance from Jason Strandquist from Regence BCBSO, earlier discussion with actuaries from other domestic insurance companies and staff input. His general message was that the primary major impacts on the fluctuation and growth in the assessments were related to new individuals enrolling in the

pool and the level of the premiums. The Board packet included a copy of Mr. King's presentation.

Some of the major points in the presentation appear below:

#### Enrollment growth

This last enrollment period experienced average enrollment for an assessment period. March enrollment is over 16,000.

#### FHIAP monthly enrollment changes

FHIAP enrollees enrolled less than six months tend to cost less than the premium OMIP receives; those enrolled seven months or longer consistently cost more than their premium.

#### Commercial Coverage Rejections and OMIP Growth

Mr. King reported that the volume of commercial rejections of individuals for coverage has grown from about 17,000 in 2004 to over 22,000 in 2006. For the same period, the OMIP new enrollments grew from about 3,800 to about 6,000. Some people are coming in without getting a rejection. Mr. Becker noted that each carrier has its own underwriting guidelines, which get adjusted every so often. There are a number of different factors that affect the rejection rate and no particular reason for the increase.

Applications received in the last 5 months increased from about 500 to 1000 each month. About one-third comes from FHIAP enrollees.

#### New FHIAP Enrollees

The significant characteristic about these new FHIAP enrollees is that they have no credits on pre-existing conditions because one of the eligibility criteria is that they have had no coverage for the prior six months, unless they come from Medicaid. As a result, the vast majority have a six month waiting period on pre-existing conditions. In addition, they are poor; because their income can be no more than 185% of the federal poverty level, which is an annual income of about \$19,000 for a single person and \$38,000 for a family of four. Their income status makes it difficult for them to meet the \$500 deductible out-of-pocket costs.

The projected enrollment indicates that FHIAP enrollment will peak in October 2007; the 2008 projections show a decrease in new enrollees. Mr. King indicated that this change was related to availability of funding for the program.

The projected total OMIP enrollment anticipates 17,835 enrollees in July 2007. It should decrease somewhat in 2008 because FHIAP will cease accepting new applications near the end of 2007.

#### Premium History

In 2006 premiums increased about 15% but OMIP revenue increased only 9%. In the past ten years, OMIP has decreased premiums only twice: the decrease in 2005 was a function of moving all benefit plan choices to PPO plans; the decrease in January 2007, reflected weighted average market rates.

### Prediction of the Assessment Magnitude

A simulation to demonstrate the chances of error in predicting the assessments based on random fluctuations for a group the size of OMIP indicates that there is a 25% chance of actual expenditures exceeding the projected claims costs by 5%. Based on the relationship between expenditures and assessments, if the claims projections are 5% lower than the actuals, then the assessment ends up being 11% higher than projected.

### Revised Assessment Model

Based on analyses over the past six months, OMIP has updated its assessment model:

- Projections are made for four OMIP sub-populations—CAREAssist, FHIAP enrollees enrolled six or fewer months, FHIAP enrollees enrolled more than six months, and all other enrollees.
- There is an adjustment to take into account the relationship between incurred and paid dates of service.
- Medical costs which are trended monthly increase at an annual rate of 11%.
- The premium increase for January 2008 is set at 10%.
- It includes the increased revenue from the federal grant funds associated with the reduction in the generic copayment.

### **Assessment #33**

#### Projection Options

Assessment #33 is a seven-month assessment.

1. With no mid-year premium increase, the assessment would be \$48.1 million.
2. With a 13% premium increase July 1, 2007, the assessment would be \$42.6 million. This option sets the medical premium rates at the maximum 25% surcharge. The portability rates already are at the maximum they can be.

Two carriers now qualify for a 10% discount under the assessment reduction program – Regence BCBSO and Health Net.

Mr. King also presented projections for assessments #34 and #35 in 2008. Mr. Warren explained that assessment #34 shows a decrease from assessment #33 due to the reduction in new FHIAP enrollees starting at the end of 2007. In addition, assessment #34 is a six-month assessment and assessment #33 is a seven-month assessment.

#### Staff Recommendation

OMIP staff recommended increasing premiums 13% in July with an adjustment in the rate bands so that the highest rate is about three times the lowest rate, in order to minimize the impact on the higher age levels. The recommendation includes allowing enrollees to switch to a higher deductible plan, which is consistent with former Board policy. The resulting seven-month assessment of \$42.6 million includes \$7 million in unanticipated losses from assessment period #32, which was January through May.

### Discussion

Mr. Lynch asked Ms. Sumpter how she would feel if OMIP closed or limited new enrollments. She indicated that she would be opposed to such a proposal. Mr. Lynch said that, if growth were a problem, there was a potential need to close new OMIP enrollments in order to minimize the impact on current members. Mr. McLeod noted that there was a period of time when enrollment was capped. Mr. King clarified that the closure occurred at time when the legislature allocated a limited expenditure authority for the program. In the early 1990s, the legislature granted OMIP unlimited spending authority, thereby removing a legislative spending constraint on enrollment.

Mr. Jovick described what the premiums for individuals would be under the 13% premium increase with a reduction in the spread between the highest and lowest rates. The change in the spread between the rates meets the Board request at the last Board meeting to redistribute the rate increase so it did not create an inordinate burden for a particular age group compared to the 2006 premium levels. For most enrollees, the premiums would reflect a rollback of the January 2007 rate decrease.

Dr. Santa asked how an increase in the deductible would be administered for individuals who changed plans mid-year. Mr. King explained that the amount the person has accumulated toward the deductible already would roll to a higher deductible if the member wanted to change.

Dr. Santa noted that when there is an increase in premiums people tend to disenroll, particularly their children and spouses. He wondered what the impact of the rate increase would be on terminations. Mr. Becker reported that a national study showed that a 1% increase in premiums results in 1000 people leaving the marketplace. Ms. Healey noted that the \$6 premium in the Oregon Health Plan (OHP) drove the termination rate high. Dr. Santa said that the OHP experience is an example of how a small amount can produce such a huge impact.

There is a 30 day notice requirement for the premium increase. Individuals who already paid in advance would get an adjustment bill. Maribeth asked if there is a reason to do a July increase. Mr. Morgan indicated that the magnitude of the January rate increase would be very large if the Board did not approve a July increase. Mr. Jovick said that the projection model with no July rate increase estimates there would be a 25% rate increase in January.

Mr. Lynch requested that the Board keep in mind that, when insurers get assessed, they pass it along to the market. Everybody pays one way or another.

Mr. Lynch said moving back to the 3:1 rate band ration puts the enrollees back where they were in 2006. Certain age groups might get a small increase over 2006 rates. Mr. Jovick noted that an age-band ration of 3.6:1 would produce a greater impact on the higher age bands. Ms. Streisinger noted that 3:1 ratio produces the least "sticker shock".

### Public Comment

Ms. Johnson is an OMIP enrollee who attended the Portland forum. She asked to appear before the Board to request that the premiums not be increased. She wanted to put a human face on the program and is very thankful for it.

She reported that she is self-employed and supports one child who is also on the program. When her prior insurer, Mutual of Omaha, left the state, she had to come into the pool. One year later she was diagnosed with breast cancer.

She noted that premium rate increases do not look like a lot on paper or to people who earn considerable incomes. However, for individuals who are diagnosed with a major illness, premiums can be a considerable financial burden to pay, in addition to the deductibles and coinsurance amounts. She and her son go without a lot of amenities in order to afford the premiums. The biggest thing she hears from people when she tells them about OMIP is they can't afford the program. Out of pocket costs are high if you have an illness to begin with. She would love to work with the program to figure out long range out of the box solutions to rate increases.

If premiums are too high, there are major impacts in other ways. People go without insurance or lose their homes. Self employed people have a hard time getting coverage. She noted that she opposed a policy that would place a limit on enrollment because there is no other option for individuals to obtain coverage if the commercial market rejects them.

She noted that the burden of a chronic illness is more than just the illness itself. For example, she described the need to be on the phone for hours this week trying to straighten out physician bills. She stated that the OMIP program is a Godsend.

Mr. King noted that a FHIAP/OMIP enrollee appeared before the legislature with a similar story. The Board members thanked her for taking the time. Mr. Lynch stated that the Board takes its charge seriously, and that it has been a real dilemma for the Board to make these decisions.

#### Board Vote on July Premium Increase

Mr. McLeod recommended that the Board adopt staff recommendation. Mr. Morgan seconded the motion. All voted in favor.

Mr. Lynch noted that communication is really important and that OMIP should give people as much notice as possible. He also requested that staff give some tolerance for late payments.

Mr. McLeod asked if most carriers have filed their rates for a 7/1 effective date. He requested that staff obtain those as soon as possible. Mr. Jovick indicated that staff had already began gathering filing information about rates and benefits that the Insurance Division has approved.

#### Board Vote on Assessment #33

Dr. Santa moved that assessment #33 be equal to \$42.6 million. Ms. Healey seconded the motion. All voted in favor. Mr. Lynch suggested OMIP send out a letter to major carriers to warn them of the high assessment.

#### **Request for Proposals for OMIP Third Party Administrator**

Rocky informed the Board that the RFP process has been closed. Staff will begin analysis of the proposals.

### **Living Well With Chronic Illness**

Mr. Jovick provided the Board with a memo to update the Board about the use of the program. He also showed flyers that OMIP is sending to members. He said that the program started in January but took awhile to get set up and get the word out to people. Ms. Sturdevant said that 13 people enrolled in living well and 11 in free and clear smoking cessation.

Dr. Santa said that are other issues that the Board should discuss. For example, a recent study about a type of mammogram determined to be a useless procedure but it is used a lot and is expensive. OMIP should address whether to pay for such procedures. Mr. King indicated that, if there are these types of evidence about procedures that would help us keep premiums down, we need to know about them and communicate with the TPA about not paying for them. He requested that Board members send these ideas to himself or Mr. Jovick.

10:40 AM adjourned.