

Oregon Medical Insurance Pool
September 22, 2006
Regence BlueCross BlueShield of Oregon
Portland, Oregon

Board Members Present

Kerry Barnett, Regence BlueCross BlueShield of Oregon
Maribeth Healey, Public Representative
Stephen Lynch, Health Net of Oregon
C.J. McLeod, ODS
Dr. John Santa, Health Care Provider Representative
Sue Sumpter, Public Representative

OMIP Staff

Rocky King, Administrator
Tom Jovick, Program Manager
Barry Burke, Compliance Specialist
Claudia Grimm, Program Support
Marcy Meink, Administrative Assistant

Others Present

David Ball, Oregon Insurance Division
Diane Lund, Oregon Health News
Nancy Nevins, Lifewise
Susan Rasmussen, Kaiser Permanente
Sophary Sturdevant, Regence BCBSO
Jason Strandquist, Regence BCBSO (by phone)

Call to Order

The meeting was called to order at 10:13 a.m.

CAREAssist Emergency Room (ER) Use

Ms. Sturdevant discussed the high emergency room utilization among the CAREAssist population as a follow-up to a concern that Dr. Santa expressed in the September Board meeting. She noted that one individual accounted for a significant volume of the visits and was the only one of the CAREAssist enrollees who had inappropriate utilization. The individual started using the ER in August of 2004. In January, Regence had identified him as a problem utilizer and began trying to get him to comply with the Case Management nurses. The Case Management nurse had involved his physician and CAREAssist staff, but they had little success in changing his behavior. The Case Managers ultimately established a 100% medical necessity review of his emergency room visits prior to payment. Subsequently, his inappropriate utilization subsided.

Mr. King stated that he wants Regence BCBSO to make sure it identifies enrollees with similar utilization patterns early to get them into case management. He also noted that Regence BCBSO has added additional case management staff to support the increased workload that has accompanied the OMIP growth. Mr. King asked about the health statement that used to be mailed to members following their enrollment. Regence BCBSO ceased mailing it several years ago. However, Regence Disease Management and Case Management staffs review the self-reported information in the applications to determine who may be eligible for disease management or case management programs. In addition, OMIP staff plan to determine the feasibility of sending new enrollees surveys that are similar to health statements as a means of providing the Regence BCBSO disease management and case management staff better medical risk information about the enrollees soon after their OMIP effective date.

Minutes

The Board unanimously approved the minutes from the July 17, 2006 meeting with a motion from Ms. Sumpter and a 2nd from Dr. Santa.

Stat Pack

Mr. King discussed the Stat Pack and accompanying summary sheet.

- Enrollment has leveled off at 15,130, which includes the anticipated terminations. Leveling of enrollment is due primarily to the closure of the FHIAP program to new individual enrollments. Approximately 30% of the new OMIP enrollment was low-income individuals with FHIAP subsidies.
- The distribution among plan choices remains the same.
- The loss ratio continues to drop. OMIP has one of the lowest loss ratios of any of the state risk pools.
- There are 44 members eligible under the federal Health Care Tax Credit (HCTC) program for individuals who were displaced from their jobs by federal trade or who are covered under the Pension Benefit Guarantee Corporation (PBGC) as a result of their employer declaring bankruptcy. Mr. Jovick explained that the Employment Department certifies individuals in both categories as eligible for the 65% federal tax credit/subsidy for health insurance premiums paid to federally qualified health coverage. COBRA and OMIP are the only federally qualified health plans in Oregon the federal government has designated as “qualified” coverage. Originally there were 1500 identified as possible members but only 44 have applied. Ms. Healey asked why the 1500 identified didn’t come into the pool. Mr. Jovick said that it was due to having COBRA or other coverage available.
- Ms. Sumpter pointed out the low annual reported incomes of the OMIP enrollees, and she requested that the deliberation about new rates be sensitive to the percent of income that the OMIP rates, deductibles and coinsurances consume.
- Ms. Sumpter asked how long people in the pool had to wait before they could apply to another carrier. Mr. Jovick stated that they can apply to the commercial market anytime, but the commercial carriers can look back 5 years for diagnoses, treatment or consultations about medical conditions.

2007 Rates

- Mr. King stated that OMIP Staff developed the rates with the assistance of a technical committee that included Regence and DCBS staff. He noted that Ms. Sherman from RBCBSO was attending the Board meeting to technical questions about the prescription coverage.
- Mr. Jovick said that OMIP staff begins the rate development process by surveying the new commercial rate filings. Staff identifies the companies that have the most enrollments in \$500 deductible plans that are most comparable to the OMIP Medical Plan 500, and they use them as a basis for developing the market average. Staff conducts a similar survey of the Portability Prevailing and Low Cost plans in the commercial market filings.
- Mr. McLeod asked what figure was loaded in as an adjustment to get the Medical plan benefits equal to the OMIP benefits. Mr. Jovick said that the commercial individual plans required adjustments between 7% and 15% to make the equivalent to the OMIP plan.
- Mr. Jovick said that staff also calculated a weighted average to adjust trend 8.1% for medical and 13% for portability.
- Mr. King stated that last year OMIP included Fortis in the average and this year they were replaced with Health Net because Health Net had considerably more enrollment in \$500 deductible plans.
- Mental Health Parity is a new group mandated benefit that takes effect January 1, 2007. The Regence BCBSO actuarial staff project it would increase expenditures 1.115%.
- Age band discrepancy: Last year, the Board acknowledged that the OMIP medical plan age bands were considerably different from the market. They limited the adjustments to no greater than 2% per age band; larger adjustments risked making the premiums unaffordable.
- Mr. Jovick reviewed the rate and benefit change handouts.
- Ms. Sumpter reminded everyone that the rates for 2006 were set too high and that the loss ratios did decrease considerably compared to prior years. She stated that she wants to make sure the Board does what is fair and affordable. Mr. Jovick highlighted the handout showing the premium and deductibles as a percent of household income for age 50 and above. Mr. Jovick stated that an assumption for the impact on household income is that the enrollee has paid the entire deductible. Mr. King mentioned that the FHIAP enrollees likely cannot afford the deductible, which partly may explain why their loss ratio is so low. Mr. McLeod noted that 30% of OMIP's population is subsidized by FHIAP.
- Mr. King reviewed five scenarios were for the impact of the 2007 rate change on the estimated assessments.
 - 5% increase in premiums
 - No increase in premiums

- 2007 market rates including mental health parity with no surcharge
- 2007 market rates including mental health parity with 11% surcharge
- 2007 market rates including mental health parity with 25% surcharge
- Mr. Jovick said that the OMIP trend based on historical experience is 8.9%.
- Mr. Lynch said that even though rates in the market decreased, the costs continue to increase.
- Mr. Barnett noted that the Board should make the benefit and rate decisions together, taking into account the impact on both the affordability for enrollees and the magnitude of the assessment.
- Mr. Lynch asked if the Board wanted to hold to an 11% surcharge or to change the surcharge, because there is a decrease in the OMIP rates to make them equivalent to the market average.

2007 Benefit Changes Adopted

Mr. Jovick reviewed the recommendations from the Benefit Subcommittee about 11 different benefit options.

Generic co payment

The Board agreed to change the generic copayment to \$10 for all generics. The consensus was to not implement a two-tier copayment structure for generics because it would be too confusing for the enrollees.

- The subcommittee recommended changing to a \$10 generic co pay. The federal grant request proposed a \$5 co pay but it could also be used to support \$10 if the amount provided in the grant is less than the amount requested to support a \$5 generic copayment.
- The Board discussed Dr. Santa's recommendation to establish a two-tier generic copayment structure. He noted that the new Walmart promotion of a \$4 price for a particular list of generics is similar to his proposal. Ms. Sumpter expressed concern about a two-tier copayment structure because it would mean that patients may have to pay more if their physicians write prescriptions for drugs that have the higher copayment.
- Ms. Sherman said that the goal of the two-tier structure is to provide incentives for a handful of medications that have evidence they work well in generic form.
- Ms. Sumpter asked how many members actually know what their option is.
- Dr. Santa reiterated that consumers need to be more involved in their healthcare.
- Mr. Lynch said that members would be confused by a differential co pay system.
- Mr. King reiterated that we wouldn't know about any Federal grant funds until 9/30/06.
- Mr. McLeod commented that the single tier generic copay of \$10 would incentivize people to use generic drugs because it is considerably lower than the preferred co pay of \$40.

Mandatory generic requirement

The Board agreed to add a mandatory generic requirement with a Dispense As Written (DAW) provision.

- Dispense as Written (DAW) means that OMIP would not cover non-generic drugs unless the physician wrote a prescription for one and indicated that it should be dispensed as written. Ms. Sherman noted that this is the program that PEBB has implemented. Under this provision, the pharmacist has the responsibility to assure that the generic drug is equivalent to the one prescribed.
- Ms. Sherman indicated that Regence BCBSO requires mandatory generic use for statins, anti-depressants and cholesterol lowering drugs. She also noted that if the OHSU Evidence-Based Medicine program reviews a medication, then Regence also reviews it.

Smoking Cessation

The Board agreed that they would prefer to make this program available to the enrollees at no charge. They requested that Ms. Sturdevant report what the cost is for a person who completes it.

- The actuarial cost to implement this benefit would be 50 cents per member per month. However, the Board was reluctant to add this amount to the premium because it is so minimal, and they did not want to pay Regence BCBSO this amount as an added administrative cost because it equals \$90,000 a year for 15,000 enrollees.

Self-care Management Education Course

The Board agreed with the Benefit Subcommittee recommendation to make this educational program available to the enrollees at no charge by providing reimbursement to those who complete the training.

- This program teaches individuals how to self-manage their chronic illnesses. It consists of six 1.5 hour sessions over several weeks. Trainers are certified through Stanford University, which developed the curriculum, and they schedule classes throughout the state. Some classes are free; others range from \$25 to \$50.
- Mr. King stated that there would be reimbursement after course completion.
- Ms. Sumpter asked if case management from Regence BCBSO provides the same kind of education. Mr. King noted that the course is more broad-based than the services that case managers provide and is geared toward getting individuals to be responsible for a significant part of the management of their own diseases.

Mr. King indicated that OMIP staff would return to the October Board meeting with a report displaying rates that include the mental health parity benefit, \$10 generic copay and the mandatory generic requirement with DAW. The report also will display the rates, average premium change and assessment impacts for surcharges of 5% and 10% to 25%. Staff also expects to have the Federal grant information available.

Benefit Changes Rejected

90-day Mail Order

The Board agreed with the Subcommittee position that it would result in wasted medication and increased cost due to the high volume of OMIP terminations.

Kids Plan

The Board decided not to adopt a separate kids plan. The Board agreed that it could create controversy because the benefit for adults would not be as good, and the current percentage of kids in OMIP was only 7%.

HSA Plan

- In order to implement this type of plan OMIP would have to change its prescription drug benefit. Very few enrollees have requested that OMIP provide an HAS plan. This isn't an option that is requested much so it wouldn't be worthwhile to pursue.

Obesity Surgery

- The Board agreed that, because commercial carriers do not routinely cover obesity surgery, then OMIP should not cover it either.
- Mr. King noted that evidence exists to demonstrate that this surgery works for a certain small group of people.

Other Business

Mr. McLeod asked why the assessments are being driven up with lowering of rates. Mr. Jovick and Mr. King responded that there is still an increase in costs projected and there will be a decrease in premium coming in.

Mr. McLeod stated that most stop loss carriers already have their renewals set for January. This process doesn't give them any opportunity to make adjustments if needed. Mr. King said that there is a model that DCBS employees are working on that is looking at if there are different ways to do the assessment. Mr. King also stated that the terminations are due to some people getting jobs, Medicare, losing their FHIAP subsidy or death.

Public Comment

No public comment

With no further discussion, the meeting adjourned at 12:30 p.m.