

Oregon Medical Insurance Pool
October 1, 2007
Clackamas Community College Training Center
Wilsonville, Oregon

Board Members Present

Maribeth Healey, Public Representative
Stephen Lynch, Health Net of Oregon
C. J. McLeod, ODS Health Plans
Bart McMullen, M.D., Regence BCBSO
Gary Morgan, Kaiser Permanente
Ken Provencher, PacificSource
John Santa, M.D., Health Care Provider Representative
Cory Streisinger, Dept. of Consumer & Business Services
Susan. Sumpter, Public Representative

OMIP Staff

Rocky King, Administrator
Tom Jovick, Program Manager
Barry Burke, Compliance Specialist
Claudia Grimm, Program Development Specialist
Linnea Saris, Program Development Specialist
Marcy Tipsword, Administrative Assistant

Others Present

David Ball, Oregon Insurance Division
Scott Fitzgerald, Oregon Insurance Division
Mr. Houck, Board Member Emeritus
Paul Kelly, Garvey, Schubert & Barer
Nancy Nevins, Lifewise
Tim Stumm, Oregon Health Forum
Sophary Sturdevant, Regence BCBSO
Terry Olson, M.D., Regence BCBSO

Minutes

The minutes from the two previous Board meetings were approved unanimously with no changes.

Administrator's Presentation and Discussion

Mr. King said that the projected enrollment for OMIP is currently at 18,190 prior to terminations, or a net of about 17,900 for August. September enrollment is projected at 18,200.

The individuals who have been enrolled less than 6 months have a loss ratio of 55% compared to well over 100% for those enrolled longer. The low loss ratio likely is due to

the six month wait period for coverage of pre-existing conditions and the inability of the lower income enrollees to be able to afford out-of-pocket costs of the deductible.

Mr. McLeod asked if the projected loss ratio this factored in the 11% rate increase that occurred in July 2007. Mr. Jovick indicated that it did and that it also factored in another 11% increase for recommended for January 2008. Beginning in July, the Medical Plan rates were set at the maximum allowed amount under statute, i.e., a 25% surcharge above the market for comparable benefit plans. He also noted that the projections take into account a 7% to 8% increase in January for the portability plans.

Mr. King stated that the 168% loss ratio includes CAREAssist which doubled in enrollment. Mr. Provencher stated that the overall loss ratio is high than in the past because OMIP added 2000 new members. Ms. Sturdevant noted that there were 799 new applications in July, 860 in August and 620 in September. This is about 200 to 300 higher than last year's enrollment numbers. Net enrollment is starting to drop off.

Ms. Sumpter asked if there is a maximum enrollment that OMIP can sustain. Mr. King noted a few considerations: 1) there is a maximum enrollment from the political standpoint because the OMIP losses create real fiscal issues for the insurers that pay the assessment; 2) nothing in the statute puts a cap on enrollment; 3) the statute states that losses cannot exceed 1% of the sum of all premiums, subscriber contracts, and 110% of all self insured expenditures. This is a cost cap not an enrollment cap. Dr. Santa asked whether an estimate of that cap exists to tell the Board whether the current losses are close to the statutory limit. Mr. Jovick said it is difficult to determine the volume of self-insured expenditures, therefore limiting OMIP's ability to estimate what the maximum is. OMIP asked for an attorney general's interpretation of the statutory limit and will share that analysis when it is completed.

Dr. McMullen asked if OMIP closed enrollment in the past. Mr. King responded that OMIP closed enrollment in 1991 or 1992 because the budgeted funds were categorized as "limited funds"; the legislature changed the medical expenditures and agent fees to the "unlimited funds" category subsequently. The program has never closed enrollment since that time.

Ms. Sumpter asked whether it would help if OMIP closed the lowest deductible benefit plans to enrollment as a means of controlling the medical loss ratio. Mr. King said that this strategy would cost shift the difference of the deductible to the enrollees and result in a loss of premium from the more expensive low deductible plan.

Mr. King said that the SB 329 legislation that created the Oregon Health Fund Board (OHFB) will address the role of OMIP as part of a restructuring of the health insurance market. Mr. Barney Speight, the administrator of the OHFB, is on the agenda for the meeting today.

Ms. Healey said that the concept around a health insurance exchange is part of SB 329 and asked if that would impact OMIP? Mr. King said there is a provision in the

legislation to form a health insurance exchange, but it is an operational approach to delivering health insurance products to the market rather than a resolution to funding and scope of coverage policy issues. Most likely, the OHFB will focus on individual mandates and the small and individual group markets. Ms. Healey, Mr. Provencher, Mr. McLeod and Mr. McMullen will serve on some of the committees of the OHFB

Mr. McLeod asked if there are any populations that OMIP currently covers that it is not required to cover. Mr. King said that technically CAREAssist is one of these populations. It is a small population but a huge cost to the program. Mr. Lynch asked if the CAREAssist population had other options. Mr. King noted that they do not have other insurance options and, without OMIP, the limited program funds would have to pay for care directly at retail rates. Dr. Santa said that changes along these specific population coverage lines should be submitted to legislature. Mr. McLeod indicated such a discussion may be appropriate for a planning meeting later as part of a discussion about options for sustainability of program.

Mr. Lynch asked what percentage of Medicare the Regence fee schedule is. Mr. King said that staff do not have that analysis but will work with Regence to obtain a range. Dr. McMullen stated that any consideration of a mandatory fee schedule, including requirements on providers to accept it without balance billing the patients, would require legislative changes.

Ms. Sumpter asked if other pools are facing the same problem as OMIP is. Mr. King and Mr. Jovick both responded that they are. The other pools are experiencing rising enrollment and higher costs, and they are exploring a variety of options to deal with the expense. None have a solution. New Mexico is considering merging a variety of pools. None of the program changes do anything to change the cost trend that the pool faces.

Ms. Sumpter noted that the Rates and Benefits Subcommittee discussed ways to help reduce costs such as mandating generic use. One of the recommendations from the Subcommittee is a higher co-pay for non-preferred brand drugs. It will help, but it is not sufficient to cause a significant shift in the overall cost trend.

Benefits

Mr. Jovick said that there were a number of issues remaining at the end of the Rates and Benefits Subcommittee meeting, and he included them in the chart about the benefit changes. The Subcommittee addressed three categories of benefits: Legislative mandates; new benefits that enrollees requested; and other benefits that were added on 1/1/07. Mr. Provencher wanted to make sure the spirit of the Subcommittee's recommendation is interpreted correctly. OMIP must implement the mandates, but the Subcommittee agreed it did not make sense to add any other benefits that would increase costs.

Legislative Mandates

HB 2918

This Bill relates to coverage of pervasive developmental disorders. OMIP could not determine what the fiscal impact of the mandate would be because there are unknown issues about what particular treatments and diagnoses must be covered. Ms. Sumpter said these services could get very expensive, but we are unable to put a price tag on them. Information from a recent New Jersey court decision to require coverage of behavioral therapy for treating autism indicates the treatment is very expensive, and OMIP does not currently cover it. We expect that this is something that will be tested through grievances and appeals. Dr. Olson, the Regence BCBSO Medical Director, will be involved in any such grievances. Dr. Olson noted that the state mandate requires treatment of conditions in addition to autism. The Oregon mandate also says that insurers are to treat autistic patients as they do any other member. The evidence indicates that there are no effective treatments for autism.

Mr. Provencher stated that he fears that the Insurance division has made a decision not to write regulations for this mandate, which will force the issues it generates to get interpreted through resolution of grievances and appeals. From OMIP's standpoint, this may end up being a "black box" expense that could impact costs significantly. Ms. Sumpter gave an example of children with cancer that developed brain injuries requiring cognitive treatment. Because the mandate applies to both group and individual benefit plans, the impact of the mandate should be reflected throughout the market over the next year. Commercial carriers cannot estimate the impact either for the same reason that OMIP cannot estimate it. Dr. Santa said that the impact on the private market may be a larger issue, particularly in its impact on dependent and family rates. Dr. McMullen stated that it is disconcerting that the legislature did not take the potential impact of this mandate into account at the time it passed the statute.

HB 2007

This Bill mandates same sex domestic partner coverage. The recommendation from Subcommittee was to cover domestic partners regardless of whether the partners are of the same sex.

Co-pay for Non-preferred Brand Drugs

The Subcommittee discussed the option to incentivize more generic use by increasing the coinsurance amount for the non-preferred drugs. Ms. Nishida reviewed OMIP claims data and indicated that, among non-preferred brand drugs that members use, 95% have a generic or a preferred brand available. She added that 30% have exact generic equivalents available. For the 5% of the non-preferred brand drugs that did not have a generic or preferred brand alternative, they were removed from the market or the science is still uncertain about their effectiveness.

To assist enrollees in transitioning from non preferred drugs, Regence has several programs in place as well as a physician education program. Regence already has implemented targeted interventions or mailings for the most utilized or most expensive

medications, such as Lipitor. Physicians are made aware of the alternatives, but it is a gradual process to change prescribing behaviors.

Ms. Sumpter requested that there be a reasonable transition process for individuals who take antidepressants; she expressed a concern about removing patients from one drug and getting them on another. Ms. Nishida stated patients who take antidepressants do not start a transition to a new drug from “ground zero”, and most likely they would not need a long transition period.

Ms. Sumpter said that increasing the copay for non-preferred brand drugs seemed to be a reasonable way to help reduce costs and encourage enrollees to use generics. The enrollees would take financial responsibility for a higher out-of-pocket expense if they did not want to change.

Ms. Sumpter also requested that OMIP not penalize enrollees if a non-preferred drug is their only choice. Ms. Nishida indicated that this number of individuals would be very low. Mr. Lynch asked if the Subcommittee was recommending increasing the copay for non-preferred brand drugs unless there is a hardship. Mr. King said that implementing a hardship policy would require a process that could be challenging administratively, and he suggested adopting a stricter policy to not cover non-preferred brand drugs at all, unless exception is authorized. Ms. Nishida and Dr. McMullen recommended not using an exception process because it creates confusion for the physicians, pharmacies and enrollees.

Dr Olson said that getting enrollees to switch primarily involves physician education because the drive the utilization of particular drugs. Ms. Sumpter noted that Regence has processes in place to alert providers and also ways of contacting patients to let them know they can ask their provider about alternatives to non-preferred brand drugs.

Mr. Lynch asked if there were any generic HIV drugs coming to market for the CAREAssist enrollees. Ms. Nishida responded that there are no HIV generics in the pipeline. Mr. Jovick said the CAREAssist population takes expensive drugs but they also take other drugs: their generic use is 40%. HIV medications are preferred brand drugs which require \$40 copays.

Physical Exams

The subcommittee voted not to add coverage of physical exams because they would add considerable cost across the enrollee population, and the evidence doesn't support covering them. Dr. Olson said that, because the OMIP enrollees already have particular diagnoses, they can get regular office visits with their physicians for exams related to those conditions.

Adult Immunizations

The committee recommended not adding coverage of this benefit because it would add considerable cost across the enrollee population eligible to receive them. OMIP currently covers Gardasil for enrollees under 19 years of age under the well child benefit. The

Board also rejected covering Zostavax, an immunization for adults who are at risk of incurring shingles.

Smoking Cessation

The OMIP cost has been 20 cents per member per month for the 61 individuals who participated in the program, 21 of whom reported that they quit smoking. The Subcommittee considered a recommendation to drop the program because it adds cost but has not attracted very many people; however, the members of the Subcommittee wanted a full Board discussion of the topic. Mr. McLeod said it seems reasonable to continue the program with the OMIP population. Dr. Santa said getting rid of the program does not mean costs are going to decrease. He suggested that, if the Board wants to consider this type of strategy, perhaps it should target ceasing coverage of lumbar fusion surgery because it works only in half of the population that receives it. He recommended retaining the program because the cost is small and it may gain in popularity among the enrollees. In response to a question about a relatively new drug called Chantix, Ms. Nishida indicated that the evidence is questionable about its long term effects.

Decision About Benefits

Dr. Santa moved for approval of the Subcommittee recommendations, with the addition to retain the smoking cessation program. Ms. Sumpter provided a 2nd to the motion. The motion was approved unanimously.

Discussion

Ms. Healey asked why the Subcommittee did not recommend offering a 90-day mail-order drug service. Mr. Jovick responded that OMIP has such a high number of terminations each month that the program would risk adding costs without collecting the premiums to cover them. In addition, a Regence analysis distributed at an earlier Board meeting indicated that 90-day mail order programs increase costs due to the volume of wasted unused drugs that occurs.

Ms. Healey also asked if OMIP has done any analysis of the OPDP pharmacy discount program. Mr. Jovick indicated that Regence compared its discounts to those in the OPDP pharmacy contract, which is available to the public. The Regence review indicated that the OPDP prices are in the same range as its own. The Regence pharmacy program staff also reviewed the formulary that was available several months ago for OPDP and noted that it included more brand drugs than the Regence formulary. More brand drug availability tends to decrease generic drug use.

2008 Rates

Mr. Jovick discussed the premium rate handout. OMIP staff recommends an 11% rate increase for the medical plan rates effective January 1, 2008, which would bring OMIP's rates up to the maximum 25% surcharge allowed in the statute.

Mr. Jovick also distributed a chart depicting what impact the proposed rate increases would have on the projected losses, and therefore, the projected assessments on insurers. The projections for the 2008 assessments (Assessments 34 and 35) assume the premiums

are set at the statutory maximums and there is an 11% rate increase January 2008. The chart shows how the assessments and the medical loss ratios increase if the surcharge on the rates decreases. Mr. Jovick indicated that, the 11% rate increase in January would take the rates to the maximum surcharge level allowed under the statute for the medical plans.

Mr. Jovick said the weighted average medical cost trend used was 12.4%. Mr. Lynch stated the issue driving the OMIP costs is the cost trend not premium. Dr. Santa commented that, whenever OMIP experiences a net decrease in individuals enrolled for six months or less, OMIP loses revenue that subsidizes the cost of those enrolled longer. He noted that OMIP has no source of revenue to replace that lost income other than the assessment. Mr. Provencher asked when the effective dates of the benchmark commercial rates are. Mr. Jovick said some are in July some in January; however, OMIP trends the commercial rates forward to January 2008.

Mr. McLeod noted that over 50% of the OMIP enrollment is over age 50. Ms. Sumpter commented that 29% of OMIP's members make less than \$25,000 a year.

The statute requires that OMIP set the portability rates no higher than the market, so the Board has flexibility only in increasing the rates for the medical plans. In July 2007, OMIP increased the medical plan rates from the 11% surcharge at which it was set for January to the maximum 25% surcharge. The handout also showed what the medical plan rates look like at market, 20% and 25% surcharge and what kind of dollar increase the enrollees face in each of the age bands.

Mr. King firmly believes surcharge should be as low as possible but the growth of the OMIP population is such that a lower surcharge is not sustainable. Mr. McMullen noted that a lower surcharge simply creates a larger gap between expenditures and revenue. Ms. Sumpter said the Board has to remember that many people cannot afford the coverage now; the proposed rate increase would make the coverage less affordable. Mr. Houck added that the proposed increase pushes an average of \$39 a month onto OMIP members, which is not a just action to take.

The level of reported annual declinations by carriers increased from 22,000 to 24,000 over the past few years. Mr. King noted that there is an indeterminable number of duplicate counts in the declination figures because people could be declined by more than one company. Mr. Houck stated that even if it is 12,000 or 13,000 being declined and OMIP takes in 2,400 people a year, the declinations by the commercial carriers leave a lot of people uninsured in the state.

Dr. Santa said one of the most significant aspects OMIP can influence is that 95% of the time people purchase brand drugs, they don't need to. OMIP cannot win at the existing health care game it is attempting to participate in; the only sound option is to play a different game, and the prescription benefit change is good because it is a different game. He challenged the insurers to get to a different game also.

Ms. Sumpter said that raising the rates \$39 a month will not change people's behavior. They need education and incentives to change their behaviors. The rate increase simply will result in more uninsured people. Dr. Santa agreed and said that it is one of the reasons that the "game" needs to change. Mr. Lynch stated that there is no practical solution.

Dr. Santa said that we are asking people to pay for a failed and corrupt system, and we aren't protesting it. OMIP may be a small program, but the biggest insurers in Oregon sit on its board. Mr. McMullen said that OMIP could damage the small group market by having the assessment get out of hand. Mr. Houck said he has seen no effort by the insurers to come together with anybody to resolve the broad system problems. Ms. Streisinger noted that this discussion is very well timed because SB 329 formed the Oregon Health Fund Board to develop a proposal to reform the system toward a universal health care model.

Dr. Santa said that Medicare is no longer paying for mistakes. This is a step that others need to take. Mr. King said that the Patient Safety Commission report to the PEBB Board revealed an amazing number of medical errors based on medical chart reviews, including many result in deaths in Oregon.

Decision on Rates

Mr. McLeod made a motion to set January 2008 rate at 125% surcharge and portability to be at market. Mr. Morgan provided the 2nd. Ms. Healey and Ms. Sumpter opposed the motion, all others voted in favor. The motion passed.

Discussion: Mr. McLeod one other example that hasn't been discussed is reinsurance market. An Oregon business with 14,000 members terminated its stop loss coverage with ODS to avoid the charge forth assessment. Mr. Houck said the people that are in OMIP are going to take this and go on because they can't go anywhere else.

Dr. Santa made a motion to keep age bands where they are, i.e. at a 3-to-1 ratio. Ms. Healey provided the 2nd to the motion. The motion passed unanimously.

Discussion: Mr. Jovick noted that moving the age band ratio from 3-to-1 to 5-to-1 and preserving the same revenue would result in a decrease in rates for lower ages and increases for higher ages. Doing this would result in an 11% across the board increase. Mr. Burke said if the Board adopted a 5-to-one ratio, the rate increase would be over \$100 a month in top three age bands. Ms. Sumpter said the people that are making \$25,000 a year are paying 15% of their income for health insurance. These people are likely to discontinue their insurance.

Oregon Health Fund Board

Mr. King introduced Mr. Speight, the Administrator of the Oregon Health Fund Board (OHFB), who was attending to provide information about the direction the OHFB is taking and to provide a perspective for the OMIP Board.

Mr. Speight said the OHFB is to develop a comprehensive plan in 366 days that would move Oregon forward on the 12 goals that are outlined in SB 329 focusing around

reforming the cost and inequities in the current health care insurance system. The OHFB will be conducting its initial work at a committee level. The committees are finance, delivery system, benefits, eligibility and enrollment and federal policy. By July 31, 2008, the federal policy committee has to deliver a report highlighting impediments caused by any federal policies. The other committees will be working together. The OHFB will use the recommendations of the Oregon Health Policy Commission and the Oregon Business Council to the Legislature as its starting point. The long term focus also includes cost containment strategies, health technology, evidence based medicine, primary care and chronic disease management.

The Finance committee will be looking at two areas. 1) A fundamental assumption is that Oregon should have an individual mandate. The OHFB needs some strategic revenue options. 2) It also must report to the February legislature about the use of an insurance exchange and what role it could play.

We know that there are nearly 75,000 people above the federal poverty line that do not have insurance. If these people were brought under a universal coverage pool, what would be the affect on the individual market and the way we subsidize it? We also need to consider how to cover those people who earn below 200% of the federal poverty level, including the use of the OHP standard and plus plans. In the middle of those two populations is the more difficult group of individuals with incomes above 250% of the federal poverty level.

Mr. Lynch said the fundamental concern that never gets addressed is cost per unit of service. The state can subsidize up to 300% of the federal poverty level, but if it continues to underpay providers on public programs it will do nothing to control costs. Mr. Speight agreed that the biggest issues are controlling the cost trend and developing a viable strategy for funding. One of the goals is to determine how to decrease the cost curve 5% to 10% each year. The difficulty is going to be in the candid conversations about sustainability of any program.

Mr. King said that sustainability of the OMIP program is a major issue for the OMIP Board. The OMIP Board wants to make sure it is on same track as the OHFB. There are still issues OMIP needs to address in the short term, but the Board should be able to work together with the OHFB through the 2009 legislative session. Assuming there will be legislation or a voter referendum in 2009, Mr. Speight expects that no implementation could occur until 2010 or 2011.

Mr. Lynch asked Mr. Speight if he has any early thoughts on where saw the ultimate roll of OMIP. Mr. Speight responded that there will be discussion about whether or not OMIP is necessary and how to sustain funding for the medical expenses that the pool enrollees incur. Linkage with OMIP is going to be extremely important, including what are the market consequences involved with this program.

Mr. Speight indicated that an individual mandate is where change should start. Other related significant issues include sustainable and equitable funding, primary care models for managing chronic conditions, involvement of the purchasing community in determining the acceptability of prices in the delivery system, health information technology and interoperability, and the availability of useful information for patients, providers and purchasers. Mr. Lynch asked if, as OMIP considers its strategy, the Board can utilize a person from Mr. Speight's group to come to OMIP Board meetings. Mr. Speight agreed and also noted that several of the OMIP Board members serve on OHFB committees.

Mr. Provencher noted that a major challenge is how government will influence change. Mr. Speight said that the OHFB has legislative authority to recommend governmental changes in healthcare, including implications for the Oregon Education Benefit Board (OEBB) and PEBB. He referred to a comment from Leonard Shaffer that the public purchasers, particularly state-level agencies, need to know what they want out of a delivery system and push for it. However, states also need to know when to get out of the way and how to reinforce what goes on in the private sector.

Dr. Santa said it is interesting that the emphasis has been on the delivery system and questioned whether the problems in the health care system can be solved unless the delivery system issues are addressed.

Next Meeting

Mr. King recommended delaying the full-day planning meeting originally scheduled for October until January in order to give the OHFB time to make some progress. Mr. Jovick distributed a list of proposed agenda items for that meeting. Ms. Healey said it might be helpful for board to discuss its vision for OMIP at the meeting. The Board agreed to hold the planning meeting as part of the regularly scheduled Board meeting in January.

Public Comment

No public comment.