

Oregon Medical Insurance Pool
Board Meeting
October 7, 2008
Clackamas Community College Training Center
Wilsonville, Oregon

Board Members Present

Maribeth Healey, Public Representative
Dave Houck, Public Representative Emeritus
Stephen Lynch, Health Net of Oregon
C. J. McLeod, ODS Health Plans
Ken Provencher, PacificSource
Dennis Reese, Kaiser Permanente
Cory Streisinger, Dept. of Consumer & Business Services
Sue Sumpter, Public Representative

Board Members Absent

Robert Gluckman, M.D., Providence
Bart McMullan, M.D., Regence

OMIP Staff

Barry Burke, Data & Policy Analyst
Becky Frederick, Fiscal Manager
Kelly Harms, Legislative Coordinator
Tom Jovick, Program Manager
Rocky King, Administrator
Don Myron, Program Development Specialist
Linnea Saris, Program Development Specialist
Marcy Tipsword, Administrative Assistant

Others Present

David Ball, Oregon Insurance Division
Scott Fitzpatrick, Oregon Insurance Division
Gary Helmer, Information Management Division
Nancy Nevins, Lifewise
Terry Olson, M.D., Regence
Ralph Prows, M.D., Regence
Susan Rasmussen, Kaiser Permanente
Kennedy Smith, Oregon Health News
Barney Speight, Oregon Health Fund Board
Jason Strandquist, Regence
Sophary Sturdevant, Regence

Minutes

The minutes of the September 5th OMIP Board meeting were approved unanimously after a motion from Ms. Sumpter and a 2nd from Mr. Reese.

Administrator's Report

Mr. King indicated that Dr. Gluckman is not in attendance due to jury duty. However, he has reviewed the materials and requested that his comments be expressed for the benefit changes discussion. Mr. King also noted that Dr. Prows from Regence and Barney Speight would be making presentations later in the meeting.

Questions from September 2008 meeting

Which FHIAP enrollees transferred to the OHP standard plan?

Mr. King distributed a chart showing costs of FHIAP members, and that those who transferred were people with incomes below 85% of the Federal Poverty Level, thus having less disposable income compared to other FHIAP enrollees.

Why did the CAREAssist inpatient hospital costs per day increase?

Mr. Jovick noted that the utilization costs for inpatient stays show an increase in length of stay as well as an increase in the number of CAREAssist enrollees receiving inpatient chemical dependency services.

Mr. Lynch asked if the costs were just the difference between residential and acute care. Mr. Jovick said that the increased use of mental health services reflects what CAREAssist management recently told OMIP staff about its experience with the general CAREAssist clients over the past year. Mr. Lynch asked if eligibility criteria had changed for CAREAssist; the answer was no. About 40% (865 individuals) of the entire CAREAssist caseload is enrolled in OMIP. Mr. McLeod asked when OMIP started experiencing the increase in CAREAssist enrollment. Mr. King said the increase started in early 2000s due to the cutback in enrollment in the OHP (Medicaid) standard benefit plan. The CAREAssist program reports the same type of influx occurred in its general caseload when the OHP standard benefit plan ceased enrollment.

Increase in FHIAP inpatient days

Mr. Lynch noticed in the stat pack that FHIAP inpatient days increased from 2007 to 2008, and he expressed a concern that it would remain at that level. Mr. King reminded the board that: 1) FHIAP ceased accepting new application in November 2007; and 2) when FHIAP lost federal funding, OMIP disenrolled 2000 FHIAP/OMIP enrollees and provided them the option to continue healthcare through OHP Standard.

Prior reports to the board indicate that the FHIAP enrollees have low costs in the first six month of enrollment for a number of reasons: 1) most are subject to a pre-existing condition waiting period because FHIAP eligibility requires that they have had no insurance coverage for at least six months; 2) all FHIAP enrollees have incomes below 185% of the federal poverty level, and most of them have incomes considerably below that. After six months of enrollment, the FHIAP expenses increase to the point that their claims experience resembles that of the general medical enrollee population. The change from 2007 to 2008, at this time, primarily reflects the decrease in new FHIAP enrollment and the subsequent increase in the percentage of the FHIAP enrollees whose tenure with OMIP exceeds six months. Ms. Sumpter reiterated that our data shows 55% of the people earn less than \$45,000 a year and 26% earn less than \$15,000 a year.

Review of the Stat Pack

Rates and age of enrollee

Mr. Lynch noted that the OMIP premium rate structure assumes that the enrollees over 50 years of age should have the higher premiums because they have higher costs. However, page 33 of the stat pack shows that the high loss ratios are in the lower age bands. Relative to the premiums OMIP charges, the enrollees in the lower age bands have expenses considerably higher than their premiums. Mr. Lynch added that he brought this point up for the rate discussion. The higher age groups get hit harder with high rates, and maybe they should not be. Mr. King made two points: 1) there are fewer people in the lower age brackets, which tends to skew the loss ratio figures; 2) the rates have been set to mirror the rate distribution in the commercial market but modified to restrict the ratio of the highest and the lowest rate to 3:1, rather than the 5:1 ratio that currently exists in the individual commercial market.

Overview

Mr. King made the following observations:

- Enrollment has been pretty steady over last 3 months, and is currently at 16,100.
- The cost per policy per month has increased from \$740 to \$890 over the last year.
- Loss ratios have also trended up not down. On a cash basis, the loss ratio is at 204%, including administration, which is at the high end historically. Ms. Streisinger said that Mr. King had made the point that we were going to continue to pay claims over several months following the disenrollment of the 2000 FHIAP enrollees. Mr. Burke said he would expect the enrollment to continue to decrease due to the normal volume of terminations.
- We do not know if the March count of covered lives will increase or decrease; it will be used for the July 2009 and the January 2010 assessments. Given the condition of the state economy, there is a strong chance that it could be lower.
- We also don't know if the Governor's proposal for increasing enrollment in the OHP standard benefit plan will materialize in the legislature. If it did and the enrollments increased, it would reduce some of the pressure from increased OMIP enrollments. In addition, the fate of funding in the next biennium for new enrollments in FHIAP is unknown

Rates & Benefits

A chart was distributed showing historical surcharges and average premium changes for two different age brackets. It also described major benefit changes in each year.

Mr. King said that, prior to 1998, the maximum surcharge allowed in statute for medical plans was 150% of the standard commercial rate. In 1995, the statute changed to limit the maximum surcharge for these plans to 125% of the standard commercial rate. In addition, portability was established under the state's HIPAA alternative mechanism and the OMIP portability rates were limited to equal the standard commercial rate.

OMIP staff surveyed newly filed premium rates for individual plans with a \$500 deductible from five carriers having the largest individual plan enrollment. Actuarial adjustments were added to

make the benefits comparable to OMIP's \$500 deductible plan and to take into account the average market trend used in the filings. Staff calculated a weighted average premium for these plans, assuming all plans had the same enrollment as OMIP, and compared it to OMIP's premium. The percentage difference between the OMIP premium and the market average was the amount by which the medical premium would have to be increased to equal the market average. The Board then made the decision to set the surcharge at 15% above this market average rate. Finally, once the Board made a decision about the surcharge, the rates for the \$750, \$1,000 and \$1,500 deductible plans were calculated based on actuarial factors relative to the relationship of each to the OMIP \$500 deductible plan.

For portability rates, OMIP staff surveyed the newly filed rates for the Prevailing (\$750 deductible) plans and the Low Cost (\$1,500 deductible) plans, from the five carriers having the largest enrollment in portability plans. Actuarial adjustments were added to make the benefits comparable to OMIP's \$500 deductible plan and to take into account the average market trend used in the filings. Staff calculated weighted average premiums for the \$750 and the \$1,500 deductible plans, assuming all plans had the same enrollment as OMIP, and compared it to OMIP's premiums for the same plans. The percentage difference between the premiums was the amount by which the portability premium would have to be increased to equal the market average. These plans have no surcharge.

The analysis showed that the OMIP 2008 medical rates would need to decrease 0.6% to equal the 2009 market level. Because the OMIP medical rates are nearly at the market level already, any surcharge would approximately equal the size of the rate increase for 2009. The OMIP \$750 deductible portability would require a 19% increase to equal the 2009 market level, and the \$1,500 deductible portability plan would require a 23% increase. There can be no surcharge to increase the portability rates above the market.

Ms. Sumpter pointed to the percentage of income that any rate increase means to the majority of the OMIP enrollees. She expressed the position that, in good conscious, OMIP should not raise its rates because people who desperately need the coverage will drop it due to its unaffordability. She proposed that the surcharge either not increase at all or increase minimally for the medical enrollees. She added that the coverage should be affordable so that individuals can utilize OMIP as their last resort for coverage.

Ms. Sumpter said that, given the current economic instability, it seems likely that more people would need the OMIP coverage if they lose their jobs, because they would not be able to get insurance anywhere else. Mr. King said that, if the larger companies with self insured plans stop providing coverage, smaller companies may go out of business and individual employees would pursue their portability options.

Ms. Streisinger said one of the lessons the Board learned recently is that the OMIP rates need to be consistent with the market over time. If OMIP does not stay consistent with market, it would face significantly higher increases in the near future.

Mr. Jovick said Dr. Gluckman voiced the same opinion as the one that Ms. Sumpter expressed. His philosophy is that this is the last chance for health insurance coverage for individuals,

outside of spending themselves into poverty to become eligible for OHP coverage, and it is unreasonable to make the coverage unaffordable. Mr. Jovick noted that Dr. Gluckman voiced the same argument Mr. Houck often advances - - that the dollar increase for enrollees is far more significant and has a greater personal impact than the dollar increase that insurance carriers face with the assessment. Dr. Gluckman said if there is an increase, it should not be more than a 5% surcharge.

Mr. Lynch commented that the higher the assessment is, the higher the increase in insurance premiums will be for the businesses and individuals that purchase health insurance in the commercial market. It could drive some businesses to drop insurance coverage, which would create more customers for OMIP, although the coverage would continue to be unaffordable for many. He asked whether the board should be conservative on the assessment at this point in time, because the medical trends are increasing. Portability rates are reflecting a 10.2% trend but the rate increases are about 20%, reflecting the premium increases in the group market.

Mr. Provencher added that what OMIP does not collect in premium, it must charge in assessments to cover the expenditures. The average per covered life amount increased about 22% between 2007 and 2008. That is the balance the board is trying to address, and the challenge it must consider is how to distribute the funding of the pool equitably.

Ms. Sumpter said that it seems that the insurance companies could absorb the increase easier than the members. Ms. Healey said the reason that the program exists is because insurance companies are allowed to deny coverage for individuals. If the coverage is not affordable, then what sense is the program; increasing the premium for chronically ill individuals who absolutely need the coverage will force them to terminate and become part of the uninsured population. She asked if it is better for carriers to spread an increase in the per covered life assessment amount, which is relatively small, to their covered lives rather than to increase premiums for some individuals by as much as \$100 per month.

Mr. Lynch noted that, the 2008 premiums are at the same average level they were in 2006, because of the significant rate decrease in January 2007; he added that the assessment did not decrease over the same period.

Mr. Lynch added that the reaction to coverage declinations seems to be an accusation of greed towards companies. However, the affordability of rates in the individual market is affected by the ability of insurers to reject people for coverage. If OMIP were to charge only the market rate for its medical plans, then an increasing portion of the pool costs would get passed to the people who pay commercial premiums.

Mr. King said that OMIP cannot set the surcharge at zero because OMIP rates are based on a commercial market average. Setting the rates at the average would make the OMIP plans competitive with plans offered in the commercial market. In addition, he noted that a small rate increase now could force the board to make a large increase next year to keep up with the market. He recommended that the board consider a surcharge between 115% and 120%.

Board motion and vote

Mr. McLeod made a motion to mirror the market rate increases by setting the surcharge for the medical plans at 115% and set the portability rates at the estimated portability market average. Mr. Provencher seconded the motion. The motion to set medical rates at a 115% surcharge and the portability rates at the market average was approved unanimously.

Mr. Lynch told the Board this surcharge results in a 37% increase on the assessment and a 14.4% average rate increase for the medical plans. Mr. Provencher said that the chances of needing a mid-year increase due to an unexpected increase in costs are less at these rates, but still possible. It would be preferable not to impose a mid-year increase, and 115% is a potential tipping point.

Ms. Sumpter asked Mr. King how the January rate increase typically impacts membership. Mr. King said that terminations increase about 1.5% during the first few months after an increase. This is consistent from year to year. Mr. King added that a more important issue from an assessment standpoint is who terminates coverage as opposed to how many. OMIP could experience an enrollment decrease, but the loss ratios would increase if only the most seriously ill remain on coverage. Ms. Streisinger said the termination data show a small spike each January. In July 2007, when OMIP increased rates mid year, there was another spike in terminations.. Ms. Sumpter thanked Mr. McLeod and Mr. Provencher for their perspectives in the discussion.

Mr. McLeod said the continual increases in rates and assessments are not sustainable, and that the board may have to make more difficult decisions in the future. He noted that the CAREAssist enrollees have the highest loss ratio. The OMIP program is not statutorily bound to allow CAREAssist to pay premiums for its clients. Mr. Jovick said this population account for 19% of the OMIP losses for 2008. In addition, 75% of their costs are for extremely expensive prescriptions. Mr. McLeod noted that the board may want to discuss options with the CAREAssist program management. Ms. Sumpter said if there isn't an alternative for them, the board cannot simply let them go without coverage.

Mr. Jovick said the CAREAssist management indicates that the priority is to enroll the clients in OHP, then Medicare under a disability status, and then OMIP as the last choice. CAREAssist pays 100% of premium up to 300% of the FPL. It requires cost sharing on deductibles and coinsurance depending upon the FPL status. The program management also reports that it is concerned that OMIP would not be an option for these people, because CAREAssist does not have the funds to pay for the drugs and other medical treatment these individuals need.

OMIP Benefit Changes

Mr. King discussed benefit recommendations from the Benefits Subcommittee. Repricing of physical exams and immunizations, based on a request at the September Board meeting, showed that adding these benefits would increase costs by \$0.24 per member per month for the \$1,500 deductible plan and \$0.27 per member per month for the other plans. Staff recommended adding these costs to premium for these two benefits. Adding routine adult physical exams impacts only males between 19 and 40 years old because children under 19 years old and adult women already have access to this benefit.

A benefit that the Board did not address at the September meeting is transplant donor costs. Staff recommended removing the current \$5,000 limit on donor costs. Transplant costs shown at the September meeting included donor costs. Mr. McLeod said that he could be supportive if there were an overall cap on the transplants, but such a proposal did not pass at the September meeting. Dr. Olson said the transplant providers bill globally for transplants, and those bills do not unbundle the donor costs; because of this and the nature of the global contracts that it has signed with transplant centers, Regence has administered the contract using the \$5,000 donor cost limit.

Ms. Sumpter moved that the Board approve adult preventive visits and to remove the \$5,000 donor cost limit from transplant benefit. Ms. Healey offered the 2nd to the motion. The motion was approved unanimously.

Regence Cost and Utilization Presentation – Dr. Ralph Prows, Medical Director for The Regence Group

Dr. Prows gave a presentation on cost and utilization experience comparing the prior period from 1-1-07 to 6-30-07 to the current period 1-1-08 to 6-30-08. The analysis was based upon paid claims history rather than incurred claims. Summary points include:

- Overall utilization increased in all areas.
- Disease of the musculoskeletal system was the top diagnostic category, with the exception of CAREAssist, for which the top category was infectious diseases.
- Cancers were the top diagnostic category for large claimants, followed by diseases of the kidney and urinary tract and diseases of the circulatory system.
- For pharmacy claims, there was a 0.5% decrease in overall plan paid amount, a 4% increase in enrollee cost sharing, and a 7% increase in the generic utilization rate. The overall generic utilization rate in the current period is 73%. The overall plan paid amount per-member-per-month increased 10.7% between the periods; for the medical and portability groups, it increased 4.4%; for FHIAP enrollees it increased 11%; for CAREAssist enrollees, it increased 14%. The Regence pharmacy program includes prior authorization requirements and quantity level limits, a half tablet program, a generic incentive program, a diabetes free meter program, a specialty pharmacy program for high cost biologics, Prilosec over-the-counter coverage, and pharmacy outreach and education for enrollees and physicians.
- Regence recommends 1) adding an adult immunization benefit for flu, pneumonia, tetanus/pertussis and varicella and 2) decreasing the generic copayment to \$5.
- About 0.4% of the claimants accounted for 20% of the paid claims in the prior period and 19% in the current period.
- Surgical inpatient paid amounts increased 39%, primarily due to orthopedic surgeries; this translates into a 45% increase in the inpatient surgery cost per case.
- Regence reviews all cases over \$45,000 and has recovered expenditures based on contractual appropriateness of billings, unbundling of services, up-coding and other questionable practices”.
- There were many cases of chronic renal failure needing dialysis; the individuals with End Stage Renal Disease must receive dialysis for 30 months while they wait to be eligible for Medicare coverage.

- Visits to physicians were 19% lower in the current period than the Regence commercial experience, likely representing the fact that OMIP has not covered adult preventive visits.
- Case management activity for the current period resulted in an estimated \$1.65 million in cost avoidance.
- About 7% of participants in the asthma, diabetes and cardiac disease management programs are high risk and 67% are moderate risk. Of enrollees identified for participation in these programs, 99% participate.
- The Special Beginnings program targets enrollees with high-risk pregnancies, and OMIP started offering it January 2008. Ms. Streisinger asked why the participation in special beginnings program wasn't higher. Dr. Prows said that normal participation in the first year of this program is low, and that Regence plans to step up promotion of it among the eligible enrollees. Outreach typically involves an initial mailing followed by up to three phone calls to try to get eligible individuals to participate.

Presentation by Barney Speight: Oregon Health Fund Board

The Oregon Health Fund Board worked through late August to develop its report. It conducted public input meetings between September 3rd and September 30th. The Board received over 1500 comments through comment cards and in person testimony. The Board will draft its final recommendations taking into account the public comment. It intends to meet in mid-November for a final decision about the report. The goal is to deliver the report to the Governor on or before November 24.

The charter of the board has been completed at this point. This has been a volunteer effort from the beginning and over 100 people have been involved. The final report will be delivered to the legislature; Mr. Speight indicated that he could not speculate on the legislative decisions. However, it should frame the health care debate for 2009. He noted that the public and private sector business communities are more interested in the issue than in the past because of the cost of coverage.

Mr. Speight commented that there is generally strong support for enhanced data collection and transparency. He added that there are some ideas that stakeholders do not like at all, such as price ceilings and the insurance exchange, which itself is seen by some as a new bureaucracy that adds nothing but cost. The Board has not emphasized the tort reform issues, but it recognizes that they need to be part of a longer-term solution.

Mr. Provencher asked how likely is it that some of the legislative discussion about provider tax and premium subsidies will get tied in with the OMIP assessment and TPAs. Mr. Speight said there is no financing plan that everybody likes, and that the most agreement was with the Massachusetts approach to a provider tax. The Board recommended taking a hard look at implementing a provider tax; the state has experience with it, albeit in a considerably different arrangement with the OHP. Mr. Speight added that a lot of concern was expressed about providers simply passing the tax on to everyone else.

The OHF Board is aware of the need for coverage for chronically ill people and the OMIP financing issue.

The Board supports an all-payer claims database to use as a basis for planning and policy development.

He added that, should there be an individual mandate and guaranteed issue of coverage, there would be a need for premium subsidies; FHIAP offers a model that could work.

He thinks there could be a way to make medical underwriting more universal among carriers. As long as the insurance market allows individual underwriting to reject individuals for coverage, the system will need OMIP. He added his opinion that OMIP is the best risk pool in the nation because of the civic support it has. Furthermore, he believes that the erosion of the group insurance market will stimulate interest in individual market coverage.

Real limitations of comprehensive reform at the state level are a big issue that is ongoing. Some of this is going to call for federal action. Mr. Speight commends work that OMIP has done over the years to make this program work.

Public comment: None