

Oregon Medical Insurance Pool
January 8, 2008
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

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 Fitzpatrick, Oregon Insurance Division
Dave Houck, Board Member Emeritus
Nancy Nevins, Lifewise
Sophary Sturdevant, Regence BCBSO
Lynn Nishida, Regence BCBSO
Jason Strandquist, Regence BCBSO
Richard Goodwin, Combined Insurance
Elizabeth Dickenson, Oregon University System
Robin Richardson, ODS
Missy Dolan, ODS
Denise Honzel, OHFB Subcommittee
Kerry Barnett, OHFB Subcommittee & Regence BCBSO

Minutes

There was one correction to the minutes from October, 2007. Scott Fitzpatrick's name needed to be corrected from Fitzgerald. Mr. Provencher motioned to approve the minutes and Mr. McLeod 2nd the motion. The minutes were approved unanimously.

Stat Pack

- Mr. King reported that enrollment is at 18,600, and he expects it to approach 19,000 before decreasing. He noted that the FHIAP program is closed to new applications, and a change in the federal match rate constraints may require disenrollments mid-year, which likely would impact FHIAP enrollment in OMIP.
- 36% of the enrollment is above the age of 55, and the median age is 49.
- Pages 20 and 21 depicts the claims paid amount as a percent of premium earned. Mr. King explained that one page includes administration and one does not; both reflect payments rather than incurred claims amounts.
- Mr. Burke agreed that the language on page 21 needs rewording to clarify that the calculation is claims amount divided by premium amount.
- Mr. King described the per member per month cost by population on page 33.
- Mr. Lynch stated that the unit cost per medical service drives a considerable portion of the medical claims costs depicted on page 33. Dr. McMullan indicated that Medicare average per member per month costs are about \$700, compared to OMIP's at \$741 in 2007.. Mr. Lynch added that the Board needs to find a way to control the unit costs and their annual increases. Mr. McMullan noted if OMIP had a mandated fee schedule, as Mr. Lynch has advocated in the past, it would reduce costs at the point it is implemented, but the same trend would continue. Controlling the rate of increase in unit costs is the major long-term problem.
- Mr. King noted that the HIV/Aids drugs represent about 35% of the percent of drug payments. This figure excludes rebates from the 340b program. Through 2007, OMIP received about \$950,000 in 340B rebates from the CAREAssist program; this amount will increase in 2008 next year because it will be the first full year in which OMIP receives 100% of the rebates. (Note. OMIP pays CAREAssist about 28,000 per year to administer the rebates.)
- The generic use rate is 68%, based on the number of prescriptions. Mr. Lynch congratulated Regence for this generic utilization rate being high.
- Dr. Santa said that in 2007 Enbrel is an immune system drug used to treat Rheumatoid Arthritis; research indicates that it poses significant risks for patients. He noted that there are good generics available as alternatives. Enbrel is a preferred drug that requires prior authorization.
- Dr. Santa also stated that some of the HIV drugs are either now generic or approaching generic. He also shared Mr. Lynch's comment that it is impressive that there has been a drop in non-preferred and an increase in generic prescription use.
- Mr. McMullan said from 1993 to 1997 commercial premiums were flat because of the HMO plans, etc. Mr. King reported that, for the last 5 or 6 years, there has been a migration to higher deductibles, and OMIP lost the HMO option.
- Mr. Burke noted that the figure on page 16 t showing the state agency costs is an error that he will correct.

Dr. Santa noted that OMIP has a significant volume of HIV patients. He thought that HIV drugs have not been subject to the kind of drug review scrutiny that has been directed at other drugs, and that it would be worth consulting with Regence Pharmacy Services and the Office of Health Policy Analysis and Research to consider an

investigation of the effectiveness of them. Ms. Streisinger said OMIP should determine who the players would be and whether or not this should be a legislative directive. Mr. Dr. Santa wondered if it was appropriate that so few generics are being used here.

Staff assignment: Mr. Lynch clarified that OMIP staff will follow up on this topic for future discussions.

Mr. King directed the Board to other materials in the Board packet depicting what happened to OMIP's premium rates over the last 4 changes. Following the increase in July OMIP staff received complaints about receiving a 30% increase. Enrollees were comparing what their rates were in January 2007 to January 2008, but the period included a mid-year rate increase. However, most enrollees received a significant rate decrease in January 2007, so that the January 2008 rates were approximately where they were in 2006. Enrollees whose coverage became effective during 2007 did not see what the rates were like in 2006.

Mr. Jovick said that, when enrollees call, OMIP tries to educate them that their premiums cover 55% of program costs and the rest comes from the carriers. It is still an emotional issue because the enrollees constitute a lower income population. Mr. King stated that the affordability issue is the biggest complaint OMIP hears. This is also true of the regular market.

Mr. Lynch asked if OMIP staff should create educational material on the web or in a mailing with some explanation of this information how the program funding works.

Staff Assignment: Mr. Lynch requested that OMIP staff to prepare such educational material and distribute and determine how best to distribute it to the enrollees.

Patient Safety Commission - Mr. Dameron

Mr. Dameron, Administrator of the Patient Safety Commission, made a presentation about the activities of the Commission.

Mr. Dameron discussed "never" events.

The Patient Safety Commission tries to reduce the risk of adverse events and encourage a culture of patient safety and reducing medical errors. The board has 17 directors representing a variety of stakeholders. Mr. Dameron noted that the Commission meetings are public.

Areas of focus

The commission is building a voluntary unique reporting program that include quality improvement efforts and consensus development among hospitals. They started in May of 2006 and have had 5 alerts and a series of patient safety tips.

Mr. McMullan asked if there were any requirements that hospitals report. Mr. Dameron said that hospitals which sign a contract agree to report voluntarily. In return, the Commission guarantees confidentiality. The commission works with hospitals to clarify issues and publish information about safety alerts to all other hospitals. Alerts are public and appear on the Commission's web site.

They also produce an annual report that is public but does not disclose information about particular hospitals. Information obtained by the commission is confidential and cannot be subpoenaed.

Current quality improvement efforts

- * Colored wrist bands projects
- * "Retained" objects
- * Root cause analysis training huge variation and ability of hospitals to investigate
- * Oregon 5 million lives network interventions in hospitals
 - Dr. Santa asked how many hospitals are in this network and Mr. Dameron thought 40 out of 57.
- * Translating NSQUIP Data- National Surgical Quality Improvement Project, which creates a unique surgical data set identify kinds of complications that arise during surgery.

Consensus-building efforts

- * Written notification tool kit, that particular hospitals are testing for use in notifying patients in a timely way that something adverse has happened.
- * Reporting of healthcare-acquired infections.
- * Transitional care project to track patient safety issues involved in moving patients between hospitals, nursing homes and home health services.

Audacious patient safety vision - By the end of 2010 Oregon will have the best patient safety

Never Events

In 2002, the National Quality Forum developed 27 serious reportable events that believes should never occur. The Patient Safety Commission wants hospitals to report these events.

HealthPartners, in Minnesota stopped paying for never events in 2005. Now there aren't many events. Leapfrog developed its never event policy in 2006. In 2007, CMS identified eight never events: falls, mediastinitis after coronary artery bypass, catheter-related urinary tract infections, catheter-related vascular infections, pressure ulcers, retained objects after surgery, air embolisms and blood incompatibility. Dr. Santa thought it was interesting that they didn't include wrong-side surgery.

The Commission will be considering adding wrong-side surgery, ventilator pneumonia, staph infection and deep vein thrombosis/pulmonary embolism to its list.

Dr. Santa asked if reporting included whether or not never event was billed. Mr. Dameron indicated that they don't currently collect this information. Dr. McMullan indicated he would be surprised if hospitals did not bill for never events. The Patient Safety Commission is funded by each of 6 organizations and a big part of that are hospitals. These are mandatory fees so they aren't voluntary.

Dr. Santa said that it is important strategy to address cultural characteristics within hospitals that create fear or punishment about reporting events that are harmful to

patients. Dr. Santa noted a statistic reported a recent conference indicates that 1% of harmful patient events is all that is being reported.

Mr. Dameron said that voluntary system does not get the Commission all the events that occur, but the point is that they are trying to use the information they do get to improve the system. The Commission is a small piece of the system. Dr. Santa suggested that conversations with hospital CEOs would be a significant additional piece.

Mr. Jovick asked Mr. Dameron if he sees any ways that OMIP can be involved with the system. Mr. Dameron said he wasn't sure but they are looking into whether or not things can be done. Mr. King asked if it was as simple as asking the TPA to not pay for never events. Dr. Santa said that taking that kind of action is what he has proposed. Dr. McMullan said the big issue is reporting, because those that pay the claims rarely know about the adverse events. He added that a critical problem is in identifying harmful patient events through the hospital billing codes. He noted that hospital CFOs are smart people and will shift the costs elsewhere, which could be a reflection of the cultural problems within hospitals to never disclose such events.

The Board agreed that this is a legitimate to investigate further. Mr. Provencher asked Dr. McMullan if OMIP could enforce this policy. Mr. McMullan said a separate contract would have to be executed and asked if OMIP would be willing to deal with a restricted network if it worked out that way. Mr. Lynch says CMS is successful in exerting pressure on hospitals because has considerable leverage with them. Ms. Healey noted that these particular issues have not specifically been addressed in the Oregon Health Fund Board meetings.

Oregon Prescription Drug Program (OPDP) Presentation

Ms. Dolan and Mr. Richardson gave a presentation on the OPDP.

Northwest Prescription Drug Consortium went live last week with very few problems.

Why form pool?

- * Increase access to prescriptions to uninsured residents
- * Provide transparency
- * Reduce dollars spent on prescriptions by promoting evidence-based purchasing

Individual Discount Card

- * Average \$26 savings per prescription
- * Savings represent average 42% off of billed amount
- * Discounts on generics are as high as 65%
- * All drugs are covered
- * No cost to join
- * Only membership requirement is residency

Size of group does not matter in group program. Their Washington group is 200,000.

Dr. McMullan asked for clarification about whether the presentation by OPDP indicated that it is considering changing the TPA contact already signed with Regence. The Board agreed that it was not intending to change the contract, and that the presentation was for the Board's information. Mr. Jovick added that the TPA contract language indicates that the pharmacy Benefits Management services could change only if directed by the Governor or the Legislature.

Mr. Jovick stated that OMIP agreed to conduct a detailed price comparison between the OPDP prices and those of Regence. Near the end of November, OMIP shared with ODS six months of detailed pharmacy utilization data, excluding Regence allowed amounts, and has been awaiting receipt of a re-pricing data set for those prescriptions to compare to the Regence prices. The ODS Pharmacy Benefit Management Company (PBM), Med Impact is the entity that is repricing the claims. Mr. Jovick noted that the OPDP contracts with ODS for the actual pharmacy services; ODS contracts with MedImpact for the PBM services and Wellpartner for mail-order services. He also indicated that the agreement with ODS was to get a straightforward price comparison first. The results of that analysis would indicate whether to pursue comparison of the formularies and how rebates and their magnitude come in to play in their development, utilization review programs and cost control programs. He also noted that OMIP is pursuing a contract with an independent entity to assist in reviewing and comparing the data.

OMIP has received no data back yet nor an indication when it would be completed. Depending on this stage's outcome we will take a look at the rebate portion and clinical data as the next stage. Mr. Provencher asked when it will be done. Ms. Dolan indicated that the first portion is done but did not explain why they had not notified OMIP or sent the data. She also indicated that she wanted OMIP to provide rebate information. Mr. Jovick reiterated the arrangement and OPDP agreed to follow, in which the first review would be limited to price comparisons. He also noted that the issue of comparing rebates is more relevant to a comparison of formularies.

Mr. Lynch requested that the comparison examine the prices with and without HIV drugs included.

Dr. Santa asked what population would be eligible for 340b rebates. Mr. Richardson said it has to do with particular disease states and in which particular clinics the patients see providers and which providers they see. The eligible drugs include more than HIV drugs but it does not include all drugs. It is the point of care that gets the designation to qualify for the pricing. Mr. Jovick said OMIP would have to direct patients to those clinics, which are the Federally Qualified Health Centers, where many Medicaid patients and poor people without insurance receive their care. Mr. Richardson agreed. He also noted that it may require a large shift in the particular providers patients now use. He noted that Regence contracts with only some of these clinics.

Dr. Santa asked Ms. Dolan about the discounts she mentioned on generic drugs. Ms. Dolan stated that for generic discounts they use the MAC list and for non-MAC generics

they have competitive rate. MAC stands for Maximum Allowable Cost. Ms. Dolan said their pharmacies all have the same rates and use the same MAC list. OPDP holds the contract directly between all pharmacists. OPDP sets the maximum allowable rates in its pharmacy contract, and it does not negotiate rates with pharmacies.

Mr. King asked if OMIP current enrollees that have the 1500 plan with the \$1000 prescription deductible are already able to access the OPDP discounts to reduce out-of-pocket costs while meeting their drug deductible. Ms. Dolan responded that they do.

Ms. Streisinger asked if OPDP was aware of any generic HIV drugs with comparative data and Mr. Richards said not at this point.

Dr. Santa asked if patients must go to certain pharmacies in order for an organization to access the 340b discounts at the point of purchase. Mr. Richardson indicated that patients must receive their prescriptions from pharmacies affiliated with Federally Qualified Health Centers (FQHCs). He also indicated that this means that the providers in the FQHCs would have to be the ones who prescribe the medications eligible for 340B discounts. The implication is that patients would need to switch their providers to those in the FQHCs. Mr. Jovick said that the OMIP staff will be taking a closer look at the whole 340b process and the options available to OMIP.

Assessment of Student Health Insurance

Richard Goodwin, representing Combined Insurance, and Elizabeth, representing the Oregon University System (OUS), appeared before the Board to appeal the decision to assess student lives. In particular, they expressed concern about assessing those covered under the Basic Student plans, which comprise the bulk of the insured lives. These plans collect premiums of about \$12- \$15 per quarter. Mr. Goodwin provided handouts to the Board.

On the annual survey of covered lives for the 1st quarter of 2007, Combined Insurance reported over 27,000 lives. After receiving the assessment invoice, representatives of the company notified OMIP that approximately 24,700 lives were covered under student health insurance plans and should not be counted in the assessment. OMIP staff indicated that student lives are to be included in the assessment count and that the invoice was correct. Subsequent discussions with legal counsel in the Department of Justice confirmed that the definition of “medical insurance” in the OMIP statute and the instructions for the count of covered lives do not exclude student lives.

Mr. Goodwin indicated that he believed the statute gives OMIP the authority to grant an exception to assessing Combined’s Basic Student Health Plan lives on the basis that it creates an undue financial impact on their company. Mr. Goodwin stated that these plans were acquired from ACE in 2006. He also indicated that, if Combined is subject to this assessment, it likely will no longer write student health insurance business in Oregon. He added that he does not believe Combined can wait for the legislature to decide the matter.

Mr. King stated that the Insurance Division definition of health benefit plan is almost like OMIP's except they say dental, vision or credit insurance and it specifically excludes student health and OMIP's definition does not specifically exclude these items. The sense was it was intended to not exclude these items only to the degree that our definition was based on the NAIC model at the time. We could find no legislative history around that issue. On student health there are a few other companies that sell it and it is reported and assessed. ODS and Aetna include these lives. Mr. Goodwin says that they offer a higher plan with richer benefits that is similar to what they feel the other companies report.

Ms Dickenson indicated that her concern with this assessment is that roughly 24,000 students will push to have their mandatory insurance dropped altogether and go uninsured.

Mr. Jovick noted that OMIP does not know which particular plans carriers include in the count survey. The only reviews OMIP conducts are year-to-year basis comparisons and comparisons with the quarterly enrollment reports carriers provide to the Insurance Division.

Mr. King commented that staff also asked other state risk pools if they included student health in their assessment. Those pools report that they assume that carriers include student health insurance in the premium or the count of covered lives, depending upon the assessment methodology the pool uses.

Dr. McMullan said one thing that strikes him is that other states base on premium. The per-covered life methodology produces inequitable situations for plans like the Basic Student Insurance coverage because of its very low premium level. He recommended that the Board whether it should change the basis for distributing the assessments. He added that OMIP does not want to adopt a methodology that excludes a considerable volume of lives from the assessment. There are fundamental public policy choices around student health that would interest the legislature because of its impact on the university system.

Mr. Lynch asked if an assessment of \$42 a year is an affordable increase in premiums for the students. Mr. Goodwin and Ms. Dickenson believe it is not an affordable increase that can be passed along to them. Mr. Lynch asked when policy period ends, and Ms Dickenson reported it is in September ; however, she added that negotiations for the next benefit plan period occurs in April.

Mr. King said that the unpaid current assessment amount the Combined owes is \$600,000. Based on advice from legal counsel, OMIP will write Combined a letter indicating that the company owes the money. In addition, the company would owe another \$660,000 for the next assessment.

Mr. McLeod indicated that ODS reports and is assessed on the students it insures. Mr. Provencher said PacificSource provides an insurance plan for graduate teaching fellows and they are included in the count.

Assessment

Mr. King said that the highlights of the assessment for January through July (Assessment #34) memo are asking Board approve \$36 million, \$3.46 per member/per month assessment. Health Net and Regence BlueCross BlueShield of Oregon received credit under the assessment reduction program. The 7 month assessment for May through December 2007 was \$42 million.

The assessment calculations include the current \$600,000 revenue shortfall for the money that Combined owes OMIP. Dr. McMullan asked, if Combined leaves the state, does it no longer owe the money. Ms. Streisinger said the company still owes what OMIP previously assessed.

She also stated that, unless something changes, OMIP must bill Combined for the assessment.

Assessment 35, for the period July through December, has a range of \$34 and \$50 million (a 20% variation). Mr. King part of the reason for the decrease is because of FHIAP and attrition. Mr. McLeod asked what staff has seen based on the rate increase are we going to keep growing. Mr. King we are where we projected and we usually get a 1% bump and it is too early to predict. Mr. Burke says right now it is a little higher because of the rate increase. Need another full month to see results.

Ms. Healey it seems there has been an increase in rejections and asked if it is because carriers are screening more. Ms. Streisinger indicated that underwriting has tightened up. Mr. Provencher countered that the individual market has grown substantially.

Mr. McMullan moved and Mr. McLeod 2nd approval of the assessment. The decision to approve was unanimous.

Subcommittee for Appeals

Mr. King noted that a member appealed a payment decision about the use of an out-of-network provider and the enrollee asked to appear before an Appeals Committee. Mr. McLeod, Ms. Healey, with Mr. McMullan as a guest when he can attend, volunteered. OMIP staff will schedule the Appeals Committee meeting.

Risk Pool Comparisons

Mr. Jovick explained the charts in the Board packet comparing the risk pools on assessments, benefit plan designs comparisons section and sources of pool funding. Mr. King said that Oregon's portability enrollment exceeds most other states because OMIP premiums are based on the weighted average of commercial group premiums. Mr.

McLeod commented that Oregon's medical plan premium level limit of 125% of standard commercial plans is on the low end compared to other pools at 125% maximum.

Mr. King said there are some pools that are having struggles mostly because of funding. Mr. Jovick is a member of a NASCHIP care management committee, which will develop surveys of all the pools about their case management, disease management and utilization control programs..

Oregon Health Fund Board Update

Denise Honzel, chair of the Health Fund Board (HFB) Exchange Subcommittee, and Kerry Barnett, chair of the HFB Finance Committee, reviewed the current progress of the Oregon Health Fund Board. They described the six committees: 1) Service Delivery; 2) Eligibility and Enrollment affordability; 3) Benefits plans design; 4) Federal Laws; 5) Equity and 6) Finance. Finance has to figure out how to fund the cost of care, subsidies and administration of the ultimate plan for coverage of Oregonians.

Ms. Honzel reviewed major assumptions. 1) There will be an individual mandate that all Oregonians have healthcare coverage and it will be enforceable. There are currently 600,000 uninsured. 2) The coverage will be guaranteed issue with no pre-existing wait period. 3) The base benefit plan will be affordable, some through the use of subsidies. 4) There will be an exchange that facilitates access to eligibility, enrollment and subsidies..

Ms. Honzel noted that the individual market would be one pool into which those in OMIP would be included, but there would be a risk adjustment for the sicker individuals. The assumption is that OMIP would fade away.

Mr. Barnett stated that there has been discussion about retaining OMIP as a separate entity for all of the high risk individuals, in order to prevent the premiums that others pay.

Ms. Honzel added that the Benefits Committee is looking at what coinsurance levels and affordability. Mr. Houck noted that the HFB must keep in mind that chronically ill individuals, like those in OMIP, need coverage that is both comprehensive and affordable.

Mr. Barnett stated that there is no question that the plan will take more dollars than are currently available. Revenue sources could include provider taxes and payroll taxes. Dr. McMullan noted that the tax base idea broadens the burden to everyone. Mr. Houck recalled a Business Week magazine article that showed that the U.S. health care spending at 16% of GDP is higher than it is in other countries.

Mr. King's indicated that his interest is insuring there is an appropriate transition period for enrollees in OMIP and that an infrastructure remains so that, if the HFB plan does not work, the former OMIP enrollees have a place to go.

Mr. Provencher noted that the individual mandate in Massachusetts isn't as popular as many originally thought. He added that the biggest challenge to Massachusetts is affordability.

Ms. Honzel thinks that the HFB is trying to build on what state agencies already do. One example is having a central source for eligibility checking.

Ms. Honzel said that there are two key questions: 1) are we going to have the money; and 2) is there going to be a mandate?

Mr. Lynch asked what problems would occur if the OMIP Board developed legislative concepts in conflict with those of the HFB. Ms. Streisinger says that they would not be opposing concepts, but, rather, they would be additional alternatives if the pool were to continue.

Mr. Barnett said nobody will know until May or June of 2009 what is going to happen with the HFB proposal. Nothing will be implemented until the legislature decides what wants to pass. Ms. Streisinger said OMIP finalize its own 2009 legislative concepts by April this year. Ms. Streisinger proposed developing the legislative concepts in the event the HFB proposal does not get approved and that the OMIP Board send a letter to the HFB expressing its concerns about potential impacts the HFB proposal could have on the OMIP population.

Legislative Concepts

Mr. Lynch referred to the list of legislative concepts OMIP staff prepared for Board discussion. Mr. King said staff will prepare a more in-depth analysis of concepts the Board wants to pursue at the next Board meeting. Ms. Streisinger indicated that DCBS must submit the legislative concept package to legislative counsel at the beginning of April. No concepts can be submitted afterwards.

Assessing TPAs

Mr. McLeod supports TPA assessment concept, because it is the only way to indirectly assess large self-insured employers who do not purchase stop-loss coverage. Mr. Morgan agreed. Dr. McMullan asked if the only way to assess these particular self funded companies is through the TPAs. Ms. Streisinger noted that OMIP would encounter ERISA pre-emption issues if OMIP tried to directly assess the self-funded companies. Mr. King said the Board decided several years ago to not test the ERISA pre-emption.

Mr. Provencher suggested reviewing which types of companies and coverage OMIP assesses currently. Mr. Morgan asked if there existed a model whereby the pool could assess by covered life but allow a percentage of the normal assessment amount for insurance coverage that has very small premiums. Mr. Provencher said the "skinny" will become more common. Mr. Lynch added that it would be worth reviewing option of changing from a per life basis to a premium basis.

Ms. Streisinger noted that OMIP could assess through a stop loss carrier or a TPA but not both. The Board would have to decide which is the primary avenue for assessing self-insured companies.

Mr. Lynch asked if the Board believed that all insured lives in Oregon should be assessed. The consensus was that all lives under authority of DCBS should be included in the assessment, although some, perhaps, should be assessed at a lower level than others.

Mr. Lynch suggested using claims cost as a basis for the assessment rather than lives or premium.

He also indicated that every insured person in Oregon needs to be counted regardless of whether the companies that insure them are domiciled in Oregon. If there is a statutory barrier to doing so, then the legislative concept must address it. Ms. Streisinger said OMIP does have statutory authority and, together with the Insurance Division, it has the tools.

Fee schedule

Dr. McMullan said that establishing an OMIP fee schedule in statute is an interesting idea, but it is unclear who would agree to it. He said he isn't opposed to it, but it is another cost shift that eventually the commercial carriers pick up sooner or later. He added that, if we proposed it, the schedule should be mandated for specialists and hospitals only. He also noted that adoption of a reduced fee schedule would produce a one-time reduction in costs, but do nothing to reduce the medical trend. Dr. McMullan stated that a fee schedule set at 130% of Medicare would reduce OMIP expenditures \$6 to \$9 million one time.

Mr. McLeod and Mr. Morgan expressed support for exempting primary care providers from the fee schedule. Mr. Lynch said it has to be a volunteer concept. Mr. Provencher recommended getting Andy Davidson from the hospital association involved.

Ms. Streisinger asked whether the board should resurrect the idea of trying to negotiate additional discounts with the hospitals and, perhaps, specialists that receive the largest percentage of payments from OMIP. Mr. King indicated that staff can identify those providers.

Dr. Santa thought that adopting the \$2 million lifetime benefit was a big mistake. Ms. Healey asked is there anything around "never events" that the Board should consider. Mr. King and Diana Lovell will discuss the work of the Patient Protection Commission and whether PEBB is willing to develop a joint public statement of support with OMIP for the Commission's work

Ms. Streisinger the Board needs to keep in mind the low income levels of the enrollees if it wants to pursue changing maximum premium levels under the statute.

Housekeeping legislative issues

Majority voting

Mr. King noted that Board actions must always have five votes in favor to pass, regardless of how many Board members are in attendance at a meeting. The legislative concept would change that to a majority of voting directors in attendance.

Rulemaking authority

Mr. King said that legal counsel is investigating whether OMIP statutes should be reworded to grant broader rulemaking authority.

Enrollment Cap

Mr. King said we have in statute a very vague cap on losses that is difficult to calculate. Staff will confer with legal counsel to determine if it is worth changing the language in the statute.

Mr. Lynch asked if OMIP should try to manage expenditures to a budget. Mr. King indicated that the legislature said there shouldn't be a budget limit for its medical expenditures because of the unpredictable nature of eligibility and enrollment. Ms. Healey said OMIP is a place of last resort but only for people that can afford it, and placing constraints on OMIP will exacerbate problems in the market.

Letter to HFB

Ms. Healey recommended sending a letter to the HFB advocating the OMIP Board's position on the reform measures it may propose. Mr. McMullan said if whatever they do results in either mandated coverage or guaranteed issue doesn't it move everyone into it. Ms. Healey said it is the disruption of service and how the transition would occur that would be the issue. Mr. Provencher said there is a sequence issue that depends on what direction the HFB proposes to go.

Assessment reduction program

Mr. King got authority to make this optional and want to revisit to say it isn't the same world. Does the Board want to continue with it or not. Are there other ways to give incentives to carriers to accept more people? Rejection rates aren't indication of anything although it is nice to see carriers below 20%.

Mr. McLeod asked if staff has a recommendation. Mr. Jovick said we didn't have a recommendation. Mr. King recommended obtaining assistance from some of the commercial carrier actuaries to develop options. Ms. Streisinger said it is good policy for us to have an option for carriers to accept more people. Mr. Jovick said that the current assessment reduction program doesn't appear to be doing what it was intended to do.

Mr. Provencher asked if Regence and Health Net are cognizant of what they are doing to reduce rejection. Dr. McMullan said that the assessment reduction opportunity is not a driving factor in rejections. Mr. Provencher said he would like to know what members they are rejecting that the other companies are accepting. Ms. Streisinger said we have

people in the pool that have gone years without a claim and we should try to come up with incentives for companies to take them as well. Mr. King noted that, to the degree that a program extracts the healthy live from the pool, the assessment will increase. Mr. McMullan said when you have carriers that have rejection rates that are lower it is a pressure relief valve for the market as a whole. Mr. King says agents will say they will go to Regence and Health Net because they have a better chance to get people covered.

Executive Session: Assessment of Student Health Plans

Executive Session with Judith Anderson, OMIP legal counsel from the Attorney General's Office

Ms. Anderson's analysis covers indicates that, because student health insurance is not excluded in the OMIP definition of "medical insurance", OMIP must assess companies for the lives that they cover under student health insurance plans. She noted that, although student health insurance policies have low benefits and low premiums, they still are health insurance under the insurance code.

She also recommended that OMIP change its definition of "medical insurance" to be consistent with the Insurance Division definition of "health insurance", and specifically identify the types of coverage that would be excluded from that definition for purposes of the assessment. The use of the current definition of "medical insurance" in the statute is inconsistent with the Insurance definitions of both "medical insurance" and "health benefit plans".

Ms. Streisinger asked if Ms. Anderson could talk about the authority to defer assessments for companies. Ms. Anderson noted that ORS 735.614(7) is the only place that allows any type of deferral or abatement of the assessment. She noted that the research about the intent of the legislation indicates that the provision refers to abatement in the event of the potential impact of the assessment on the solvency of the insurer as a whole, not on the profitability of a particular line of business products. Mr. King said so if they say they are canceling their policy if we assess them does that mean they meet the criteria for this issue. Mr. King indicated that the Board may have invoked the provision with the eventually insolvent company, Greater Oregon Health Services from Medford in the early 1990s.

Mr. King stated that, at the March meeting, the Board can address whether to exclude student health plans in the assessment or assess them at a lower level.