

Oregon Medical Insurance Pool  
March 14, 2008  
Clackamas Community College Training Center  
Wilsonville, Oregon

**Board Members Present**

Maribeth Healey, Public Representative  
C. J. McLeod, ODS Health Plans  
Bart McMullan, M.D., RCBBSO  
Dennis Reese, Kaiser Permanente  
Ken Provencher, PacificSource  
John Santa, M.D., Health Care Provider Representative  
Cory Streisinger, Dept. of Consumer & Business Services  
Sue Sumpter, Public Representative

**OMIP Staff**

Rocky King, Administrator  
Tom Jovick, Program Manager  
Becky Frederick, Fiscal Manager  
Kelly Harms, Legislative Coordinator  
Barry Burke, Compliance Specialist  
Linnea Saris, Program Development Specialist  
Marcy Tipsword, Administrative Assistant

**Others Present**

Judith Anderson, Legal Counsel Department of Justice  
David Ball, Oregon Insurance Division  
Scott Fitzpatrick, Oregon Insurance Division  
Dave Houck, Board Member Emeritus  
Nancy Nevins, Lifewise  
Sophary Sturdevant, RCBBSO  
Lynn Nishida, RCBBSO  
Jason Strandquist, RCBBSO  
Susan Rasmussen, Kaiser Permanente  
Paul Kelly, Garvey, Schubert & Barer  
Gary Holliday, Oregon Insurance Division

**Officer Elections**

Mr. Lynch introduced Dennis Reese as the Kaiser Permanente representative replacing Gary Morgan.

Mr. McMullan made a motion to nominate Mr. Lynch for the chair position. Ms. Sumpter seconded the motion and it was approved unanimously.

Mr. McMullan made a motion to nominate Mr. Provencher as the vice chair. Ms. Sumpter seconded the motion and it was approved unanimously.

### **Minutes**

Mr. McMullan motioned to approve the minutes as written. Ms. Streisinger seconded and they were approved unanimously.

### **Executive Session**

The Board was then sequestered into Executive Session in order to discuss an appeal on an OMIP member. Mr. Provencher asked Ms. Healey to report on the findings of the appeals committee. Mr. Jovick described the materials he distributed for the appeal. Ms. Healey restated what the Appeals Subcommittee had discussed. She said that there was legitimate confusion with the claim payment as well as medical necessity issues. The Subcommittee recommended that bills be paid at the preferred provider rate. Ms. Sumpter asked if the recommendation set a precedent. Mr. Jovick and Ms. Anderson indicated that it did not, but Mr. Jovick added that OMIP staff would develop criteria for these kinds of cases to guide future deliberations. He also indicated that staff had completed a contract endorsement containing clearer language on the issue. This clarification information will be sent within the next month to all enrollees and added to the web site.

Mr. Provencher said judgments in these kinds of cases must be made on a case-by-case basis. Dr. McMullan said the primary driver to have lower cost network is ability to be clear so normally don't make exceptions because there is concern of precedent setting. The enrollee read a prepared statement to the Board. Ms. Healey thanked the enrollee for coming and making their appeal in person. Mr. Provencher adjourned the executive session.

### **Appeals Subcommittee Recommendation**

Ms. Healey moved that the Board affirm the recommendation of the Appeals Subcommittee to pay the enrollee claim as an in-network benefit. Ms. Sumpter provided the 2<sup>nd</sup>. The motion was approved with Dr. McMullan abstaining.

Mr. Provencher stated that the Appeals Subcommittee was set up to make recommendation but didn't give them authority to make decision. Mr. King wanted to affirm decisions that were made many years ago that delegated authority to the Administrator to make decisions regarding appeals that do not set precedents. If there were life-changing decisions to be made or critical issues that may set a precedent, then the Administrator would refer those cases to the Appeals Subcommittee.

Mr. King said the creation of the third party review by an Independent Review Organization (IRO) took the Appeals Subcommittee out of the process. The IROs review appeals dealing with medical necessity, continuity of care or investigational/experimental treatment. Several years ago, the Board agreed to accept whatever decision the IRO made in these cases.

Mr. King requested that the Board affirm continuation of this process and granting the Appeals Subcommittee the authority to make final determinations on cases that come

before it. Mr. King said Enrollees always have the opportunity to present their case to the appeals subcommittee in person.

Ms. Streisinger asked if the Appeals Committee could not make a unanimous decision would it come back to the Board and Mr. King said yes. Mr. King said this shouldn't happen often because it is based on precedents that have been previously set. Mr. Provencher asked if it showed the intermediate process in our grievance and appeal process and Mr. King said no because that was delegated by the Board.

Dr. McMullan said that Mr. King addressed the administrative types of appeals and today's appeal was rare. He doesn't have a problem letting committee make final determination. Ms. Healey wonders if they would have had to come to today's meeting if they had the authority and the answer is yes because the committee would have made the decision.

Mr. Reese commented on how long the process was and Mr. King clarified that the entire process takes time. Mr. Provencher noted that the OMIP grievance and appeals process uses the same timelines as the commercial market.

Ms. Healey moved to give the committee decision making authority unless they can't reach a unanimous decision at which point it will come back to the full Board for determination. Mr. McMullan seconded the motion and it passed unanimously.

### **Administrator's Report**

The flyer for the OMIP enrollee meetings was distributed and Mr. King discussed that staff will visit 13 cities. In 12 of these, staff has teamed up with the OPHP Education, Information and Outreach staff to provide training about OMIP to producers. We have 200 reservations from agents and expect more. Mr. King said that sometimes we have a big turnout of enrollees and other times not as good of a turnout. We deliberately set the meetings to occur after rate increases and benefit changes each year because that is when enrollees typically have questions.

January enrollment is at 18,400, which is a net loss of 254 from December. February is estimated at 18,325. The loss ratio on an incurred basis for 2007 will be around 191%. Generic Rx use continues to improve and is now at 68% of all prescriptions. The FHIAP enrollees have an 88% generic rate, likely due to the affordability of drugs and their low income levels. The high concentration of non-generic drugs for HIV/Aids enrollees is one of the largest components of the brand drug costs.

Mr. King distributed the memo for Assessment #34 (January through June, 2008). It is actuals vs. projections. February projected 18,465 and ended up at 18,325. Mr. King indicated that the numbers seem to be working out where we projected.

Mr. King said a letter written to the Joint Ways and Means Committee for the special session discussed FHIAP funding issues. The Centers for Medicare and Medicaid (CMS)

decreased the amount of the Federal match allowed for adults in FHIAP, decreasing it from approximately 70% to 60%, and it required that the program disenroll about 3,800 enrollees from FHIAP, about 2,100 of whom are OMIP enrollees.

The program will identify individuals from among those whose annual incomes are under 90% of the Federal poverty level, and offer them the opportunity to enroll automatically in the OHP Standard coverage. They will have three options – continue their current coverage on a self-pay basis; move to OHP standard or drop coverage completely. Those who may move to OHP Standard may bring their children with them, however, kids can remain on FHIAP. We have Identified 2,800 OMIP enrollees below 100% that are single adults. The FHIAP subsidy will end June 1. Mr. King said they will receive a 60-day notice.

Every individual will be contacted by phone; if they have an insurance agent, the agent will be notified. Each carrier has indicated it will have a phone number available for these people to call. The staffs from FHIAP and OMIP have worked with DHS for a smooth transition.

For OMIP, the transition would cause an immediate loss in revenue for June, but the payments for prior incurred claims would continue for the transferred individuals for about three months. Ms. Healey still didn't understand how the assessment would go down. Mr. Provencher explained how the assessment works.

### **Federal Grant**

OMIP received an extension of the \$1.5 million Federal Grant which was used to assist in paying for the reduced generic drug co-payments, allowing OMIP to reduce the copayment from \$20 to \$10. Staff currently is preparing a new grant request for funds that Congress just recently approved for risk pools.

### **Counting of Insured Lives**

This year OMIP will begin using the Insurance Division's Quarterly Enrollment report for the counts of covered lives. We anticipate that OMIP staff will need to send its own survey for a few specific data elements until the Insurance Division can incorporate all of the OMIP data needs into its survey, such as counts of special districts, federal employees and Tricare.

**Legislative Concepts**

Paul Kelly, Garvey, Schubert & Barer Mark Sektean, AIG, David Fry, Symetra, Tony Mistretta, HM Insurance (Highmark), Horace Garfield, Aegon Companies and Jay Ritchie, HCC Life all participated, either in person or via conference call, in a discussion of legislative proposals to reduce stop-loss carrier assessments and add authority to assess Third Party Administrators (TPAs). This group indicated that it represents about \$2 billion in stop loss premiums nationwide and about 10% of the assessment population in Oregon.

Mr. Provencher asked for a process check on Legislative Concepts. Mr. King said Mr. Jovick will give a high overview of what they are. We can come back and do what the Board wants. He said we should start with the overview and then listen to our guests on the phone give testimony and then have a Board discussion.

Mr. Jovick gave a Legislative Concepts overview. There is no guarantee that the Governor would support any of them at this point. Ms. Streisinger stated that the Legislature convenes in January, 2009, and there is a series of timelines that eventually ends up with Legislative Counsel drafting actual language in June and July. The Governor makes his decision in late fall.

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*Clarification of who should be assessed*

Legal counsel indicated that the OMIP definition of medical insurance is halfway between the Insurance Division's language that defines "limited benefit plans" and "health insurance". Mr. Jovick reported that the legislative concept would adopt the Insurance Division's language for "health insurance" as its definition of "medical insurance". In addition, it also would identify which types of insurance are specifically excluded from this definition for purposes of the assessment. The handout identified what types of coverage OMIP cannot assess as well as those for which the Board can choose to assess or not to assess. The document also provided recommendations on whether or not to include or exclude them in the assessment.

There is no statutory or administrative category of Basic Student Health Insurance Plans or Extended Student Health Insurance Plans that reflects the particular Oregon University System (OUS) mandatory student insurance plans that Combined Insurance Company of America (Combined) provides for particular OUS campuses. Mr. Jovick said the level of benefits and premiums in the Basic plans are lower than student insurance plans at other campuses. Ms. Dickenson, representing the OUS in the January board meeting, noted that absorbing the assessment in the premiums would double the cost for students from \$40 to \$80 per year.

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*Assessing TPAs*

If OMIP assessed TPAs, they would be assessed before stop-loss carriers would. Only if OMIP could not assess TPAs would the assessment be directed to the stop-loss carrier.

Mr. Ritchie, representing the stop-loss industry, noted:

- A TPA assessment has ERISA pre-emption issues because TPAs and the self-funded companies they serve tend to not be state-regulated entities. In Washington, DC, a committee is exploring ERISA issues and considering “battlegrounds” for the pre-emption. The Oregon bill to assess TPAs would be an appealing target for the committee members.
- Oregon-based TPAs could suffer some damage as a residual impact. DCBS could find that Oregon TPAs pay the price for those that are out-of-state or unregulated by the Department

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*Assessing stop-loss carriers*

Mr. Jovick said the assumption is that the stop-loss carriers would pass on the assessment to the self-insured companies for which they provide stop-loss coverage. He noted that some of the stop-loss carriers report that they do not pass the assessment to the self-funded companies. If the Board decides not to pursue assessing TPAs, there remains a question of whether it would want to assess stop-loss carriers at a reduced rate. The Washington risk pool assesses them at 10% of the level it assesses other companies.

Mr. Ritchie commented that Washington and Texas have a 10:1 assessment ratio for the stop-loss carriers. The industry would prefer that OMIP base its assessment on a premium rather than on covered lives. He indicated that typical stop-loss premiums are about 10% of fully insured premiums. Mr. Ritchie noted that the lower ratio would allow the stop-loss carriers to stay in Oregon. He provided an example of a self-funded group of 9000 Oregon lives that decided not to purchase stop-loss coverage because the charge for the assessment made the premiums unaffordable.

Mr. Provencher noted that, from a policy level, what makes him uncomfortable is building incentives in the system that would encourage companies to look into direction of self funding. Mr. Ritchie added that he does not believe that the assessment cost drives the decision by companies to purchase either a fully-insured product or become self-funded. Once a company decides to be self-funded, its decision about whether to purchase stop-loss coverage will be affected by the assessment. Some could decide to use an “off-shore” TPA in order to avoid the assessment charge.

Mr. Ritchie thanked the Board again for the opportunity. Mr. Ritchie noted that the industry supports broad-base funding approaches, and that everybody in Oregon should participate in funding OMIP. What they propose is that limited benefit plans, student health plans and stop-loss carriers be lumped into the same category of plans that get assessed a lower rate.

Mr. King noted about 2000 OMIP people are portability, and those people generally come from self-insured plans, most of which do not contribute to funding OMIP. There is a benefit in terms of self-funded companies having OMIP as an option.

Ms. Streisinger said that she appreciates the industry's participation in these discussions and acknowledges that they have recommended broad-based funding options. She added that she wanted to make sure they understand the political realities that OMIP faces as well. The state requires that there be a three-fifths approval vote in the legislature in order to pass measures with new fund-raising proposals. There is not anything in the industry's proposals that the Board necessarily disagrees with, but any proposals for funding must make sure they have a prospect of passing in the Legislature. Ms. Healey said the Oregon Health Fund Board intends to propose broader based funding for a number of health insurance reforms in the 2009 session, including some that impact OMIP, but the increased revenue requirements may be so onerous that the proposal fails early.

Mr. Jovick noted that staff estimated impacts only for a scenario of stop-loss carriers paying 10% of what other assessed entities pay because that is what two other states do. He added that the staff can estimate other scenarios. Mr. Ritchie said no other state risk pools have reduced rates for stop-loss carriers, but most of them assess based on premium, which results in stop-loss carriers paying less than others anyway. Mr. Ritchie said they felt 10:1 ratio is accurate across the country, but he would have to do more research on Oregon to see if any other number is more appropriate.

Mr. Jovick said that assessing stop-loss carriers at 10% of the assessment for other entities shifts about \$10.8 million to the other carriers. The consequence of not reducing the stop-loss carrier assessment is that companies will drop stop-loss coverage and OMIP will lose all of the assessment from those lives.

Ms. Streisinger said we do not assess self insured companies, we assess Stop loss carriers. Mr. King said that back in the mid 90's school districts went to the Legislature to get ability to self insure and the association of self insurers wanted to make sure they were subject to assessment even if self insured. Notwithstanding the ERISA issues, OMIP staff recommends moving forward with working with DOJ to analyze the proposal. Mr. King noted that, if it goes to litigation, then OMIP pays the legal fees. Ms. Streisinger said the legal cost would be insignificant by comparison and should not affect the Board's decision.

Mr. Reese thinks it is an important topic and should be advanced. Ms. Streisinger said we should take it to the next level of analysis. Mr. Provencher was concerned about feasibility of getting money. Mr. Fry from Symetra asked, if the preferable approach is to assess TPAs, does it make sense to still address stop loss reduction.

He also asked if there is anything that can be done in the interim to alleviate the assessment of the stop-loss carriers. Ms. Streisinger said unfortunately all of these options take legislative action. Mr. Ritchie stated that HCC has engaged Paul Kelly as its legal counsel, but wants to make sure OMIP is aware that they want to work together with OMIP.

Mr. King said there will be three or four more Board meetings prior to legislative session, allowing the board to continue to work with the carriers. The Board agreed that OMIP staff should continue working on legislative concepts for the assessment of TPAs, extremely low benefit student health plans, and stop-loss carrier, including scenarios for higher percentages than 10% at which stop loss carriers could be assessed. Mr. Reese said equity issue needs to be addressed as fairly as possible.

Mr. King said he appreciates Mr. Ritchie working with us and hopes that when we all come before legislature we do come together. He acknowledged that it is difficult but is hopeful. Mr. King added that staff will develop a legislative concept for the housekeeping issues.

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*OMIP fee schedule*

Mr. Jovick discussed a statutory provider fee schedule issue would specify that it is a specific percentage above what Medicare pays providers. It would apply to hospitals and specialists, and exclude primary care providers. Mr. Jovick noted that the hospitals and specialists could reject participating with OMIP because of the reduced fee schedule, impacting the enrollee access to care. Mr. King added that the result will be an increase in fees charged to the commercial insurers.

An alternative to creating a fee schedule is to pursue Mr. Lynch's recommendation of approaching some of the hospital systems that get most of the money from OMIP and negotiating a possible reduced rate. Dr. McMullan noted that hospitals do not really negotiate their rates.

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*Housekeeping concepts*

- Redefine what a quorum is so a passing Board vote would require a majority of the quorum rather than a majority of the full Board
- Define quorum necessary to enable the Board to act
- Remove the word "sole" from a current provision that disallows certain entities to pay premiums for the enrollees. Mr. King said the issue is a doctor can do heart surgery and pay premium for the person. Just removes the word sole from this language. This would allow Board to designate exceptions. Mr. King said Sacred Heart had a community wide program to help people pay premiums. Mr. Provencher said that community strategies to provide premium or out-of-pocket assistance should be allowed.

**Oregon Health Fund Board (OHFB)**

Mr. King distributed a draft a memo to the OHFB from the OMIP board. He requested feedback within a week.

**Public Comment**

No public comment