Oregon Medical Insurance Pool
June 23, 2008
Clackamas Community College Training Center
Wilsonville, Oregon

**Board Members Present**
Maribeth Healey, Public Representative
C. J. McLeod, ODS Health Plans
Stephen Lynch, Health Net of Oregon
Bart McMullan, M.D., RBCBSO
Ken Provencher, PacificSource
Dennis Reese, Kaiser Permanente
Cory Streisinger, Dept. of Consumer & Business Services
Sue Sumpter, Public Representative

**OMIP Staff**
Barry Burke, Compliance Specialist
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
Nathan Warren, Fiscal Staff

**Others Present**
Judith Anderson, Department of Justice
Mary Ann Evans, Oregon Insurance Division
David Ball, Oregon Insurance Division
Erik Davis, Wells Fargo
Brandon Doeden, Workers Compensation
Missy Dolan, Oregon Prescription Drug Program
Scott Fitzpatrick, Oregon Insurance Division
Gary Helmer, Information Management Division
Dave Houck, Board Member Emeritus
Nanci Johnston, Workers Compensation
Paul Kelly, Garvey, Schubert & Barer
Jay Ritchie, HCC Life Insurance
Scott Loftin, ODS
Lynn Nishida, Regence
Susan Rasmussen, Kaiser Permanente
Robin Richardson, ODS
Helen Sherman, Regence
Jason Strandquist, Regence
Sophary Sturdevant, Regence
Gail Worden, Lifewise

**Minutes**
The minutes from the 3-14-08 meeting require edits to reflect that Mr. Lynch and Mr. McLeod were not in attendance. Mr. McMullan moved to approve the minutes with those edits, and Mr. Provencher seconded the motion. The motion passed unanimously.

**Administrator's Report**
Mr. King explained that Dr. Santa resigned from the Board because he accepted a position with Consumer's Union in New York.

*Health Care Tax Credit (HCTC) Program*
Mr. King provided additional information about potential Congressional changes to the Health Coverage Tax Credit program. He noted that the Board may want to review whether to continue to allow OMIP to be the state's health insurance option for HCTC eligibles, if Congress expands the program's eligibility criteria.

*FHIAP Disenrollment*
Effective June 1, OMIP disenrolled 2,145 enrollees that were receiving FHIAP subsidies and offered them the opportunity to move to coverage under the Oregon Health Plan (OHP) Standard Benefit Plan. Fifty-nine members chose to remain on OMIP coverage and self pay. About 80 people have not yet responded. Mr. King thanked FHIAP staff for the smooth transition.

*Stat Pack*
Total enrollment at the end of May was 18,168. As of June 1, it should drop down to 16,100.

In 2007, OMIP received an average of 700 to 800 applications per month. In the first 5 months of 2008, this has dropped to about 475 applications per month. Projections show flat enrollment for the next 6 months.

Mr. King pointed to a number of facts under the claims expenditures section on page 34 of the stat pack: spinal/brain injuries continue to be high; cancers are the number one claims cost; for every dollar on HIV/Aids, about 65% goes for prescription costs.

Page 35 in the stat pack displays the generic use rates by group. OMIP is currently at 72.6% generic rate.

Mr. Lynch requested an explanation for the inpatient hospital data reflected on pages 38 and 39: Inpatient Hospital costs per day decreased from $3,304 in 2006 to $3,198 in 2007, but average length of stay has increased from 4.1 in 2006 to 4.7 in 2007 and average days per thousand has increased from 676 in 2006 to 719 in 2007. In particular he asked if there was a reason why the length of stay and days per thousand increased. Regence staff agreed to review the data and report back to the Board.

**Enrollee/Agent Meetings**
OMIP staff traveled to 13 cities in April to make presentations to enrollees; in most of the same places, OMIP collaborated with the Education and Outreach Unit from the Office of Private Health Partnerships (OPHP) to provide producer training. OMIP staff compiled a list of issues that came up from both producers and enrollees. Mr. Lynch commented that he was surprised nobody brought up the premium cost. Mr. Jovick explained that he outlines the basis for the OMIP funding and the fact that individuals and companies that purchase commercial insurance subsidize 45% of the cost of the program. Mr. Jovick said that OMIP holds the meetings in

April because the new rates and benefits always take effect in January, giving enrollees the opportunity to respond to the changes.

**Wells Fargo Presentation by Erik Davis**
Mr. Davis conducted a preliminary comparison of the Oregon Prescription Drug Program (OPDP) and the Regence prescription prices. The study was an initial step that ODS proposed to OMIP staff to determine whether there was any major difference in raw prices. The original understanding between ODS and OMIP staff was that a preliminary comparison of drug prices would lead to a broader study comparing utilization management practices, rebates and formulary management services if the study showed that OPDP had considerably lower prices than Regence.

OPDP contracts directly with pharmacies in Oregon and Washington. OPDP also contracts with ODS Health Plans (ODS) to provide Prescription Benefit Management (PBM) services. ODS does not provide the PBM services itself, but instead, it subcontracts with a PBM from San Diego, California called MedImpact to provide claims processing, drug utilization management and formulary development services. ODS also subcontracts with a licensed pharmacy called Wellpartner to provide mail-order prescription benefits. Wellpartner also has been involved in developing relationships with Federally Qualified Health Centers (FQHCs) in order to develop access to special 340B discounts.

OMIP contracted with Mr. Davis, who works for Wells Fargo Insurance Services, to conduct a preliminary study comparing drug prices for OPDP and Regence. OMIP provided raw drug utilization data for a 6- month period to Mr. Davis and to ODS staff, who then sent it to MedImpact for repricing. The repriced data was sent back to Mr. Davis. Mr. Davis contacted representatives from the Regence Pharmacy Program and MedImpact to discuss claims processing details.

Mr. Davis reported that the analysis could not conclude that the OPDP pharmacy prices were considerably better than those for Regence. He recommended there be further study including an expanded analysis of all drug pricing rather than just those the OMIP enrollees used. He also recommended analysis of formulary development, rebates and their relationship to formulary development, the basis for categorizing brand drugs as preferred or nonpreferred, the identification of which drugs to include on the MAC list, the basis for developing the prices on the MAC list, the basis for updating Average Wholesale Prices (AWP) and the variety of drug utilization management programs.

Ms. Healey asked why the study is inconclusive. Mr. Davis replied that, out of the total expenditures of approximately $17 million, the Regence prices generated about $100,000 more in expenses than the OPDP prices would have. This equals a difference of about 0.6%, which is insignificant. These cost differences could easily be explained by factors that the study did not evaluate.

Ms. Healey asked what drug management programs are. Mr. Davis replied that they include programs such as step therapy to get patients to use less expensive drugs before more expensive drugs, clinical authorization for particular drugs, generic drug incentives, patient and physician

education programs, and an intensive process of reviewing the effectiveness of drugs on the formulary.

Mr. Provencher asked if OMIP staff know how many members receive care in 340 B settings. Mr. Provencher noted that he thought it is small. Mr. Burke said that OMIP received a list of qualified clinics and is starting to investigate whether he can identify clearly who receives services from these clinics. One problem for the analysis is that he does not have access to the unique provider Medicare ID numbers for the providers in the database.

The Board indicated it was interested in OMIP pursuing a further analysis. Mr. Jovick noted that it would require contracting for the study through a Request for Proposals process.

**Regence pharmacy management program presentation**
Helen Sherman, Assist Vice President of Pharmacy Services
Lynn Nishida, Director of Clinical Pharmacy Service

*Evidence- based*
Ms. Sherman stated the Regence approach to its entire pharmacy benefit program is grounded in evidence based medicine. The process includes: a thorough independent search of scientific literature; reference material from numerous credible data sources; consultation with original research staff; independent audits of research to establish its credibility.

Ms. Sumpter asked how they access information about drug failures, because such evidence is much more difficult to find. Ms. Sherman stated that they conduct their reviews as if they are private investigators and identify as many sources of research as they can. Their research staff will pursue information about studies that have not reported results or have reported them only partially.

Ms. Sumpter asked how quickly clinical trial data can be incorporated into their analyses. Ms. Sherman stated that they review studies within 3 to 6 months of the release of all new medications.

Ms. Sumpter asked if they review off-label use of medications. Ms. Sherman replied that they will review it if information is available. She also noted that, if there is proof that a benefit exists for off-label use of a medication, then Regence approves it as long as the contract allows it. Ms. Sumpter said she was specifically thinking of cancer drugs. Ms. Sherman said that cancer drugs are particularly challenging, and they have a regional group that specifically addresses cancer drugs.

*Generic use*
OMIP shows a high use of generics, currently at 72.6%; it could decrease somewhat due to the exit of FHIAP enrollees. Every 1% increase in generic utilization reduces OMIP costs by an estimated $167,000 per quarter, or $668,000 per year. Ms. Streisinger asked how OMIP’s generic use rate compares to a general commercial population. Ms. Sherman said that OMIP is higher then most carriers. The insurance company representatives acknowledged that the generic

use rate that Regence has helped OMIP achieve is better than the commercial market and particularly impressive for a population like OMIP's. Mr. King noted that it is better than PEBB.

Ms. Nishida discussed specifics that are influencing generic utilization. These include targeted medications for diabetes, heartburn, cholesterol, antidepressants. She stated that, conservatively, the use of generics in these four conditions accounts for about $467,000 in annual savings.

- 84.2% generic rate in diabetes meds
- 77.1% generic rate for heartburn meds - Nexium
- 59.6% generic rate for cholesterol lowering – Lipitor/Crestor
- 72.9% generic rate for antidepressants

Ms. Streisinger stated that she thought this was low for cholesterol-lowering drugs. Dr. McMullan mentioned that there continues to be high usage of brand drugs because of the influence of advertising on enrollees and drug manufacturer representative influence on physician prescribing

Ms. Sumpter asked if Regence educates physicians as well as members about using generics. Ms. Nishida answered that they provide mailings and outreach to physicians about generics for these conditions in addition to blood pressure medications. To persuade physicians to promote generics, Regence staff talks to physicians individually or in groups, providing power-point presentations and documented science-based comparisons between generics and brand drugs. Dr. McMullan stated that they have to create a zone of safety for the patients and the physicians based on the evidence that exists. Ms. Sumpter said her concern is for the patients that may be paying more because their physicians insist on prescribing brand drugs.

Ms. Nishida presented the Regence timeline for targeting generic use promotions for particular medications.

Ms. Nishida discussed the 2007 – 2008 member and prescriber outreach. Mr. Lynch asked when prescriber outreach occurs. Ms. Nishida stated it happens by the pharmacist as one last check before dispensing at pharmacy.

Ms. Nishida also discussed Regence's Integrated Care Programs which incorporate behavioral health services as part of a holistic approach to managing chronic conditions.

Ms. Sherman noted that more generics should be available as alternatives for HIV drugs and antipsychotics. Board members expressed an interest in steps that Regence could take to provide tighter utilization control for these types of drugs. Ms. Sherman noted that Regence staff could pursue such a program, but it could create a negative reaction from the enrollees. Mr. King said that although it may not be popular to enrollees, it may be an important initiative to take.

*Expenditure drivers*
Ms. Sherman stated that Mr. Davis touched on what drives ultimate program costs: negotiated price per prescription, generic use rate, medication product mix in the formulary, utilization control programs and benefit plan design. Ms. Sherman noted that these are key to forecasting the opportunities for reducing expenditures.

Ms. Sumpter asked why spinal injuries were such high cost. Mr. Lynch clarified that it was a high number of members that had them, not necessarily cost per service. Ms. Sherman said they would do an analysis of spinal costs to see where they are showing up.

**Assessment 35**

Mr. King recommended that the Board approve the assessment of $43.45 million for 6 months from July through December 2008 (an estimated $4.03 per covered life). The preliminary count of covered lives shows a total of 1.86 million lives. Mr. Jovick said that OMIP staff is still finalizing the counts of covered lives and reconciling differences from the prior year and from the Insurance Division counts.

There is an issue relative to Combined Insurance Company of America (Combined), which has accumulated $1.1 million in unpaid assessments. For this particular assessment, the Board took the amount owed by Combined from the cash reserve rather than distributing it to other carriers. Mr. Lynch stated he agrees with this approach.

Mr. Provencher asked what the net impact of the FHIAP loss is. Mr. King reported that, by the end of December 2008, it is projected to be break even. Between May and August, the projections show a $1.8 million premium loss, but OMIP will continue to pay run-out claims for those whose coverage terminated on June 1.

Mr. Reese made a motion to accept the assessment recommendation. It was seconded by Mr. Provencher and approved unanimously.

**Legislative concepts**

OMIP staff will include an analysis and fiscal impact regarding the two legislative concepts: assessment on TPAs and the assessment reduction for certain entities at the September Board meeting. The Board can decide whether to promote any further legislative action at that time.

*Housekeeping*

There are four provisions in this legislative concept:

1. OMIP is changing its definition of "medical insurance" to be the same as the Insurance Division's definition of "health insurance".
2. It redefines quorum for the OMIP Board to be a majority of those attending the Board meeting.
3. In the premium payments portion, it removes the words "sole" from a provision that prohibits a public entity or health care provider from paying premiums for enrollees. The change means that "reducing financial loss or obligation of the payer" does not have to be the sole purpose for paying the premiums in these cases. Ms. Sumpter asked if it would impact the Leukemia Society program that helps patients pay premiums. Mr. King said it would not because the Society is not a public entity or a provider. Mr. Jovick said transplant centers want to do the same thing, but OMIP prohibits them from paying premiums for enrollees that need transplants because they would benefit financially.
4. A change to the portability language aligns the state statute with federal requirements.

Ms. Healey asked when the deadline is. Ms. Streisinger said they will be introduced by the governor in December. They are now in process of being drafted and the governor will make the final decision in late fall.

**Work plan**

Mr. King noted that work in developing benefit change considerations and the market average rates for 2009 begin at this time. He requested Board volunteers for the Benefits Subcommittee. Ms. Sumpter and Mr. Provencher volunteered. Mr. McLeod and Ms. Healey volunteered to be alternates.

**Public comment**

Jay Ritchie from HCC Life Insurance presented a number of comments:

- The legislative concept to assess TPAs may provide an incentive to some TPAs to not get licensed. He noted that not all states require TPAs to be licensed. The stop loss carriers have opposed assessments of TPAs because they do not believe it solves the problem. The solutions they have presented in the past are more broad-based, such as a the use of general funds to cover the assessment.
- HCC Life has the largest percent of stop-loss premium in Oregon. Changing the stop-loss assessment to 10% of what the other carriers pay would make OMIP consistent with what the pools do in Texas and Washington. Mr. Lynch asked how he arrived at the 10:1 ratio. Mr. Ritchie said he thinks it is a fair alternative based on information he has nationwide regarding the relationship of stop-loss premium compared to premium for fully insured plans. In response to another question from Mr. McLeod, Mr. Ritchie reported that the stop-loss administrative load would be 20% on the claims costs.

Mr. Ritchie provided the following example of a group HCC proposed to cover one-third of its employees in Oregon starting 1/1/08. Under the current assessment methodology, the group would have had to pay over $1 million in assessment costs; at a 10% assessment ratio, it would have dropped to just over $100,000. Mr. King noted that the remaining $900,000 in assessment not paid by HCC would shift to all of the other carriers that sold fully insured products.

Mr. King noted that these self-insured groups don’t want to pay the full assessment, but they benefit from the pool’s existence because it provides portability coverage for their employees that leave employment. He asked Mr. Ritchie how he reconciled this equitability issue. Mr. Ritchie said he understands that there is an equitability problem of self-funded insurers not paying the assessment and that the reduced stop-loss assessment would reduce the assessment liability for the self-funded insurers that purchase stop-loss coverage. He commented that the basis for funding the pool losses should change to a broader basis.

Mr. Lynch thanked Mr. Ritchie on behalf of the Board and for his spirit behind this proposal.