

Oregon Medical Insurance Pool  
Board Meeting  
September 5, 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  
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  
Ken Provencher, PacificSource

**OMIP Staff**

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

**Others Present**

Judith Anderson, Oregon Department of Justice  
Mary Ann Evans, Oregon Insurance Division, DCBS  
Chris Day, Information Management Division, DCBS  
Keith Dubanevich, Garvey, Schubert & Barer  
Lynn Nishida, Regence  
Terry Olson, M.D., Regence

Jay Ritchie, HCC Life Insurance  
Jason Strandquist, Regence  
Sophary Sturdevant, Regence  
Kim Wirtz, Regence  
Gail Worden, Lifewise

**Minutes**

Mr. McLeod asked about the reference to a Request for Proposals (RFP) for a continuation of the OPDP drug services comparison. Mr. King explained that state programs are required to use an RFP process for personal service contracts that exceed \$5,000, and OMIP expects that the scope of work will cost considerably more. Mr. Jovick said that DCBS had just assigned staff from the procurement office to work with OMIP on the development and release of the RFP. Mr. King said that PEBB is also in the process of comparing the OPDP's PBM services provided through ODS and MedImpact with the Regence program, and OMIP expects to work with them to see what, if any, additional questions may develop.

Ms. Sumpter moved to approve the minutes as written and Mr. McLeod seconded the motion. The motion passed unanimously.

### **Assessment of Combined Insurance Company of America (Combined)**

OMIP received notification from Combined of its intent to pay the full assessments owed to OMIP. They must submit payment by 9/15/08. Combined delinquent assessments have been covered by OMIP reserves, so this payment will take the pressure off of the reserves. Combined will continue to be assessed on their current number of lives. The January assessment will be the last one for these lives.

Ms. Sumpter asked why Combined finally agreed to pay the assessment. Mr. King said that he and Tom had several discussions with the company representatives. In addition, OMIP had sent a final demand letter explaining the potential consequences of not paying the assessment. Combined had given up the group of student health business, and the University System contracted with Aetna to provide the coverage. In addition, Aetna's rates already include OMIP assessment fees.

### **New Board Member**

Mr. Jovick said that Dr. Gluckman has agreed to replace Dr. Santa. He is out of town today. He has participated in some of the benefit discussions thus far, and his resume is in the Board packet.

### **Bonus Grant**

OMIP received notification from CMS of the grant award of \$1.73 million to cover operating losses and \$950,000 for the bonus grant. The original request was for \$3.5 million. Staff estimated that OMIP would receive \$1.8 million for the Operating Losses Grant and had built this amount into the assessment model as revenue it would receive before the end of the year. Mr. McLeod asked if this is a one time grant. Mr. Jovick explained that it is, although Congress may authorize additional grant funds in coming years. He noted that no risk pool grants were available in 2007. They were available in 2006, which is when OMIP received its initial grant.

### **Health Fund Board Draft Report**

In ten public sessions throughout the state, the Health Fund Board will solicit input about its draft report. Ms. Healey noted that several propositions in the report could affect the OMIP population and asked whether there is any action the Board should take. Mr. King noted that an earlier letter from the OMIP Board expressed concern that there is a reasonable transition plan if OMIP coverage ends under the Health Fund Board proposals.

Mr. Lynch recommended that Mr. King ask Barney Speight to appear before the Board at the October board meeting to discuss potential impacts of the Health Fund board proposals on OMIP. The Board agreed.

Mr. Lynch asked if any of the committees had specifically talked about OMIP. Mr. King replied that the Finance Committee had discussed the possibility of utilizing some of the OMIP assessment and the potential impact on rates if OMIP's chronically ill population is folded into the individual commercial market.

### **Stat Pack**

Enrollment peaked at about 18,600, but it now is slightly over 16,000. The bulk of the loss is due to the transfer of about 2,000 FHIAP/OMIP enrollees to OHP Standard coverage. We expect claims to continue to grow, even with the enrollment reduction, due to the continued receipt of claims for services provided to these FHIAP enrollees before the transfer.

Ms. Streisinger noted the gradual shift in enrollment to the higher deductible plans. In 2005, a large majority of the enrollees was in the 500 plan. It was also noted that the recent spike in this deductible shift can be attributed to the loss of FHIAP members since they are primarily enrolled in the \$500 plan.

Ms. Sumpter noted that 77% of the enrollees earn less than \$55,000 a year. Mr. McLeod asked if subsidies are available for individuals who are not eligible for FHIAP, CAREAssist or HCTC. Mr. King indicated that no government program provides subsidies for them, although some may have access to support from an occasional foundation, family or friends. Ms. Sumpter pointed out that many foundations no longer have the funds available to subsidize health insurance.

Mr. King also noted that, among the FHIAP transfers, about 90% chose to keep their children in a commercial product, apparently because physicians have limited access for OHP patients relative to their commercial patients. Ms. Sumpter wondered if there was miscommunication at all about the transfer, but Mr. King indicated that FHIAP materials gave a wealth of information. A large number of those transferring originally came from OHP Standard coverage.

### **Rate Development for 2009**

Mr. King noted that this Board meeting constitutes the first discussion of rates. Staff was unable to obtain all the information needed to complete a thorough estimate of the market average. The estimates they provided the Board use trend figures from 2007; 12.4% for the medical plans and 11% for the portability plans. The staff also has been waiting for the final approval from the Insurance Division for a portability rate filing.

Preliminary estimates indicated the current medical rates to be 1.1% above the weighted market average. Tables presented to the Board also display preliminary estimates of what the medical rate increases would be at different surcharge levels. Ms. Sumpter commented that the addition of new benefits would increase rates as well. Ms. Streisinger said that, if the trend is actually higher than last year, it could significantly increase the estimate of the weighted average rates.

There is no expectation in the expenditure model that the FHIAP program will open for large volumes of enrollments.

### **Benefit Subcommittee Recommendations for 2009**

Mr. King noted that the Board needs to make decisions about whether to add benefits for 2009. Ms. Sumpter and Mr. Jovick reviewed the Benefit Subcommittee's recommendations.

#### **Benefit Proposals in the Bonus Grant**

OMIP proposed two generic drug benefit changes and one disease management project:

- a. Reduce generic co-payment to \$5. Projected cost is \$1.15 million. Fund with the combination of the bonus grant funds and an assumption that an increase of the generic use rate will cover the remainder of the cost. Each 1% increase in the generic use rate reduces costs by an estimated \$668,000.
- b. Reduce generic co-payment to zero, for specific evidence-based generic maintenance medications.
- c. Remote telemonitoring of individuals with chronic obstructive pulmonary disease (COPD), heart failure and diabetes.

The Subcommittee recommended implementing only "a".

#### *Discussion*

Mr. Jovick indicated the Regence Pharmacy Services staff had provided estimates in which reducing the generic co-payment to \$5 would shift about \$1.15 million in costs to the plan. Without another source of funding, it would require a rate increase to the average market rates of \$3.25 per member per month, which, then, would be subject to a surcharge for the medical plans. The Board agreed that the Subcommittee proposed a worthwhile alternative to a rate increase. The recommendation is to fund the change with a combination of the bonus grant funds, which would be \$950,000 in new grant funds plus about \$90,000 in left-over funds from the 2006 bonus grant (a total of \$1.04 million) plus an assumption that the generic rate will increase.

The change in the generic co-payment would require only a modest increase in the generic use rate to achieve a cost reduction of \$110,000. Ms. Nishida noted that there will be new generics available for migraines and antipsychotics in 2009.

Mr. Jovick explained that dropping the co-payment to \$5 affects the broadest number of people in OMIP, compared to the other Bonus Grant options. This was a significant reason for recommending the grant funds be used for this benefit change.

#### *Decision*

Mr. McLeod made a motion to accept the Subcommittee recommendation. Mr. Reese seconded the motion. The vote to approve was unanimous.

#### **Adult Preventive Visits**

OMIP currently does not provide any reimbursement for adult physical examinations including related diagnostic tests for adults age 19 or over. However all OMIP plans do provide the following benefits as preventive treatment, not subject to the calendar year deductible: Annual women's exams including mammography for women age 35 and older or if medically necessary; well child and well baby exams; colonoscopies for adults; and prostate cancer screening for men over the age of 50 or if medically necessary.

Based on average commercial population using \$500 deductible plans, the pricing of this preventative benefit is roughly as high as \$3.22 per member per month in the commercial market. . Regence actuarial staff expects that the actual costs incurred by OMIP would be about 67% higher.

The Subcommittee recommended that the Board not add this benefit due to its impact on increasing rates. They noted that enrollees tend to get the office visits they need and physicians will order the lab tests they need. Although visits and tests in these cases are not first dollar coverage, enrollees can get a portion of them covered if they have met their deductible

#### *Discussion*

Mr. King reviewed a relevant point from a presentation to OMIP staff by Ralph Prows M.D. and Terry Olson, M.D. comparing utilization and expenditures for the first six months of 2007 and 2008. He noted that one significant point they made was that preventive services do not show up among the top ten OMIP diagnostic categories, but it is 3<sup>rd</sup> highest in the Regence commercial market.

Ms. Sumpter reiterated that, due to the magnitude this benefit would have on rates, it did not seem reasonable to add the benefit. Her concern is that enrollees are dropping coverage because of the already high rates.

Mr. King noted that staff realized recently that there is really only one segment of the OMIP population that does not have access to a preventive annual exam now; it is males between the ages of 19 and 45. The rest of the population receives the benefit as first dollar coverage under one or more of the other preventive benefits.

Ms. Sumpter stated if that is true, then the estimation of the rate impact is too high because it assumes that no one has access to the preventive exams.

#### *Decision*

The Board agreed and requested that the Regence actuary provide a revised estimate of the rate impact for the males between 19 and 45. They added that it should be based on the typical commercial schedule for preventive exams for adults.

#### Immunizations for Adults (individuals 19 years and older)

Currently OMIP does not provide reimbursements for any immunizations or vaccines for adults, including flu vaccines. Until 2008, Regence had provided flu vaccines free of charge to all Regence enrollees, which included OMIP.

The impact of adult immunizations would be to increase the average commercial plan premiums as high as \$0.20 per member per month based on an average commercial population using a \$500 deductible plan. Regence actuarial staff expects the actual costs incurred by OMIP would be about 67% higher.

Ms. Nishida commented that the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC) recommends the following key immunizations for adults, in particular for high-risk individuals typical of a population like OMIP:

- Influenza vaccine (Flu shot)
- Pneumococcal vaccine (pneumonia)
- Tetanus/Diphtheria Toxoid (tetanus)
- Zostavax (Shingles)
- Varicella vaccine (prevent chicken pox)

The Subcommittee recommended that the Board add the benefit for the limited list of immunizations Ms. Nishida identified. The impact on rates is low. A medically compromised population like the chronically ill in OMIP would benefit from immunizations. The Subcommittee also recommended that the Board not expand coverage for Gardasil beyond the current coverage, which is through 19 years of age; because the latest research indicates it is not effective beyond 21 years of age.

#### *Discussion*

Mr. Jovick noted that one of the issues the Subcommittee did not discuss was whether or not to charge a different amount for the shingles vaccine. Dr. Gluckman favored charging a 50% co-pay because the cost is about \$200. It is used for people over 65 who have shingles. About 20% of the OMIP enrollees are between 60 and 65 years old, and about 1% are over 65. Anyone with significant co-morbidities or an immune deficiency is in a high risk group that should receive the immunization as well. The \$0.20 rate impact pricing assumes that Zostavax is covered along with the other immunizations.

Mr. Jovick explained that OMIP currently covers Gardasil for females between ages 11 and 19. Recent studies indicate that it is not effective beyond age 21.

Ms. Sumpter stated that she favors including Zostavax and not charging a higher co-payment because the rate impact is so low. Mr. Lynch asked if OMIP should include coverage only for ages 65 and older. Dr. Olson advised against doing so because there will be some enrollees who may need it but would not meet the age requirement. He added that Zostavax is not a real immunization, so it most likely wouldn't be abused. Mr. Jovick asked Ms. Nishida if the cost was going to drop any time soon. She replied that it is not expected to drop.

#### *Decision*

Ms. Streisinger made a motion to approve coverage for the entire list of drugs indicated by Ms. Nishida; Mr. Reese seconded the motion. Approval was unanimous.

#### Transplants

Dr. Olson recommended to:

- Set the maximum transplant benefit at \$250,000 for any transplant.
- Combine the separate donor costs into global coverage for transplants. Current benefit limits donor costs to \$5,000, but they typically are \$20,000 to \$50,000.

OMIP experience is that costs for transplants are under \$250,000; more typical is that they are around \$100,000. Regence transplant team works with provider transplant units to manage costs.

The transplant cap would reduce premium an estimated \$0.70 per member per month based on an average commercial population.

The Subcommittee recommended placing the \$250,000 cap on the transplant benefit and combining the donor costs as part of the global benefit. Some concern remained about whether the cap would disadvantage enrollees who may need the rare more expensive transplant or a re-transplant. They also were not convinced that there would be a reduction in OMIP risk. There is a question whether the estimated \$0.70 per member per month reduction in commercial premium for this kind of change would apply to OMIP, and if it does, wouldn't the reduction be greater given that the risk among the OMIP population is greater than the commercial population. Mr. Jovick indicated that Dr. Gluckman and Mr. King express concern that the limit would prevent OMIP from meeting a need that would not be met elsewhere.

#### *Discussion*

Mr. King reported that OMIP has never had a transplant above \$250,000, using the contracted Regence rates. We do pay 100% of the cost if the transplant occurs in a contracted facility. Mr. King reviewed the 2007 and 2008 transplant cases. There isn't a big trend or change in transplants. He added that, historically, the Board decided to remove a \$100,000 limit on transplants quite awhile ago.

Ms. Sumpter expressed a concern that the limit establishes a lifetime benefit, which would jeopardize someone with a high cost transplant that needed another. Mr. Lynch asked for clarification about whether this imposed a lifetime benefit or was a per-transplant limit. He noted that, for the commercial market, it is a lifetime limit. He asked Dr. Olson if a person needed a 2<sup>nd</sup> transplant that cost \$50,000 more than the limit, what would the transplant case manager do. Dr. Olson replied that they manage the transplant service within the benefit, and the limit gives them leverage with the transplant facility to do so. When a transplant center knows what the benefit limit is, they find a way to keep the cost within the limit.

Ms. Streisinger asked whether OMIP covers all transplants. Mr. McLeod and Dr. Olson responded that OMIP covers only medically necessary transplants.

Ms. Healey asked if OMIP has not had any cases above \$250,000 and may not see any savings from imposing a limit, what is the benefit of doing this. Mr. McLeod explained that it gives OMIP leverage and does not create an incentive for people to enroll in OMIP because it has an unlimited transplant benefit. Mr. Lynch said he does not see the value of the change.

#### *Decision*

Mr. McLeod moved to approve the Subcommittee recommendation. Mr. Reese seconded the motion. Mr. Lynch and Ms. Healey opposed the motion, the others favored it. The motion failed because five votes are needed to pass a motion.

### Mail-Order 90-day Drug Supply

The 90-day mail-order coverage could increase plan costs. Several hundred enrollees leave the plan each month, and a hefty portion of them could leave with a 90-day supply, having paid only one month of premium. Wastage due to unused prescriptions could result in additional costs to OMIP, even if the 90-day supply were limited to generics or only to individuals who have been enrolled more than 6 months.

The Subcommittee recommended that the Board not add this benefit.

### *Decision*

Mr. Reese moved to approve the Subcommittee recommendation; Ms. Healey seconded the motion. Approval was unanimous to not add the benefit.

### Add coverage for complimentary and alternative medicine: massage therapy, acupuncture, naturopathic and chiropractic.

OMIP has received several requests annually from members for coverage of complimentary and alternative medicine services, including chiropractic care, acupuncture, massage therapy and naturopathic treatments. A review of domestic group plans indicates that these benefits are sold typically in a separate rider and have limited benefit provisions.

The projected per member per month premium increase would be \$5.51 for an average \$500 deductible commercial benefit plan.

The Subcommittee recommended that the Board not add this benefit.

### *Decision*

Ms. Sumpter moved that the Board approve the Subcommittee recommendation. Mr. McLeod seconded the motion. Approval was unanimous to not add the benefit.

### Add an HSA plan

There continues to be an interest among producers for OMIP to add an HSA benefit plan. An HSA is a tax exempt account established exclusively for the purpose of paying qualified medical expenses for individuals covered under a qualified high deductible health plan (HDHP). About a third of other state risk pools offer these plans, but their enrollment is low. A study provided by America's Health Insurance Plans (AHIP) reflected less than 3% of total enrollment in private health insurance plans is in an HSA plan.

OMIP would not arrange for banking services needed to support the HSA plan. The additional administrative expense would fall mostly on customer service staff in explaining what the plan was and how it works.

Regence actuarial staff estimates that modifying the OMIP 1500 plan to meet HSA benefit requirements would increase the premium based on a comparable average commercial plan to 11.5%. A \$2,500 deductible plan structured to meet the requirements would have rates equivalent to the current Plan 1500 rates.

The Subcommittee provided no recommendation other than engaging the Board in discussing its merits.

### *Discussion*

Ms. Sumpter made the point that 11% of the OMIP enrollees report incomes over \$75,000 a year, and there are probably some people that would move into this product. Mr. Jovick reported that about 3% of Oregon's total enrollment in the private market is in HSA plans. Mr. King added that those enrolled do not necessarily establish a bank account to fund the savings account.

Mr. King noted the risk is that individuals will move to it simply because it provides a better drug benefit than the 1500 plan. The drug deductible would no longer be separate from the medical deductible under the HSA plan and there would be a maximum out-of-pocket expense for drugs, which does not exist for any of the other OMIP plans. The risk is that OMIP could incur more expenses that would be covered by the additional premium charged for the plans.

### *Decision*

Ms. Healey moved to not add the plans because they typically would not be used by a chronically ill population. Mr. McLeod seconded the motion. Approval was unanimous to not add the benefit.

### **Legislative Concepts**

The Board is dealing with three legislative concepts. The Board would need to decide whether to recommend that DCBS and the Governor's pursue these concepts. The governor's office will decide whether to adopt the recommendations.

### **Housekeeping**

Four statutory changes are included in a Housekeeping legislative concept:

1. It would clarify who is subject to assessments by replacing OMIP's definition of "medical insurance" with the Oregon Insurance Code's definition of "health insurance" and specifying the particular types of insurance that are not included in the definition for purposes of the assessment.
2. It would redefine the quorum necessary to enable the Board to act: "A quorum consists of a majority of voting board members. If a quorum is present, then an act of the Board only requires a majority vote of the members present at that meeting."
3. It would delete one word in statutory language in order to clarify that a public entity or health care providers cannot pay or reimburse OMIP premiums for any enrollee, even if a reduction of financial loss or obligation of the payer is not the sole purpose for paying the premiums. The provision also would authorize, but not require, the Board to identify exceptions in administrative rules.

4. It removes the language requiring that an individual be an Oregon resident for at least 180 consecutive days immediately prior to the termination of their prior coverage in order to be eligible for portability. This change puts the Oregon statutes in compliance with federal requirements for portability eligibility.

#### *Decision*

Mr. Reese moved for approval of the housekeeping legislative concepts. Mr. McLeod seconded the motion. Approval was recommended by all, with Ms. Streisinger abstaining.

#### Assessment of Third Party Administrators (TPAs)

This legislative Bill that would allow OMIP to assess Third Party Administrators (TPAs) which the Insurance Division requires to be licensed or registered in Oregon. It would specify that TPAs are subject to the assessment as primary over stop-loss carriers. This means that, for instances where OMIP can identify counts of self-insured lives covered by stop-loss carriers and administered by TPAs, OMIP will assess only the TPAs for those lives. The effective date would be January 2011, to give these companies time to anticipate the timing of the assessment's impact on their business and that of their contractors. Mr. Jovick said that TPAs would add an estimated 297,000 lives. He noted that OMIP staff believes this is a conservative estimate. Staff does not know how many new entities would be assessed.

#### *Discussion*

Mr. Jovick noted there are three risk pools in the country that have statutory authority to assess TPAs. Mississippi, Tennessee and Wyoming are the three states that have the authority to assess TPAs. Although Wyoming has the authority they currently do not assess TPAs. The Mississippi and Tennessee risk pools do assess TPAs. Mississippi law places a limit of \$3 per member per month for the assessment; Tennessee is in the process of its first assessment, but representatives report no strong resistance.

Ms. Sumpter asked if OMIP would face legal challenges and would OMIP be responsible for the legal fees. Mr. King responded yes to both questions. Mr. Jovick added that there would not be a legal challenge until after the legislation passed through session.

Ms. Healey asked what would happen if there was both the OMIP legislation to assess TPAs and other legislation to assess TPAs to fund other health care programs? Ms. Streisinger mentioned this has received some discussion in a variety of venues. Mr. King noted that those kinds of possibilities would be identified and discussed among the legislators for a resolution. He added that the OMIP legislation would be part of the broader debate in the legislature about funding health care coverage.

Mr. Lynch thinks it would be good to have Barney Speight from the Health Fund Board come talk to the OMIP Board for this reason. He added that the potential for conflicting legislation should not preclude the OMIP Board from moving forward with its own legislation.

### *Decision*

Mr. Reese moved for approval of the TPA assessment concept. Ms. Sumpter seconded the motion. All voted approval, with Ms. Streisinger abstaining.

### Reduced Assessment for Stop-loss Carriers

This legislative concept would allow the Board to assess stop-loss carriers and extremely low benefit plans for university students at reduced rates. The effective date would be January 2010.

This legislation would change the current methodology for distributing the assessment burden. It would reduce the burden for stop-loss carriers, and, likewise, for any self-funded company to which they currently pass the assessment. The amount of the 60% reduction in assessment for the stop-loss carriers would be paid by the other assessed companies.

Representatives from the stop-loss carriers have recommended the percentage be set at 10% of the per covered life amount assessed to other carriers.

### *Discussion*

Mr. Jovick noted that the original draft of the proposal did specify a percentage at which the stop-loss carriers be assessed. Staff recommended 40%. Mr. McLeod commented that the other carriers would prefer it be a higher percentage than the 10% recommended by Mr. Ritchie.

Mr. King noted that, if legislation passes to assess TPAs as primary, then there would be very few stop-loss carriers that would be assessed because most self-insured companies contract with a TPA. Ms. Streisinger commented that if the Board believes each concept has value, then it is better to have them submitted as separate concepts.

Jay Ritchie from HCC noted that the current methodology will drive stop-loss carriers out of the market. He added that, if a business has less than 500 lives in Oregon, his company declines to provide stop-loss coverage because the arrangement would not provide sufficient premium to cover the assessment.

Ms. Sumpter stated that she thinks the Board should approve moving forward with the concept. None of the Board members had any recommendation for what percentage to use. Ms. Streisinger noted that the final percentage will be decided by legislature, but her inclination is to start with a higher percentage instead of a lower one. Board members agreed that the effective date should be moved to 1/1/2011 from 1/1/2010 to provide a better transition time for the carriers that would absorb the assessment that the stop-loss carriers would no longer pay.

### *Decision*

Ms. Sumpter moved to approve the legislative concept but have DCBS determine what percentage to use. Mr. Reese seconded the motion. All voted approval, with Ms. Streisinger abstaining.

### Public Comment

No public comment