

Oregon Medical Insurance Pool
Board Meeting Minutes
July 6, 2011
Wilsonville Training Center
Wilsonville, OR

BOARD Members Present:

Ken Provencher, Health Care Services Contractor Representative
Andrew McColloch, Health Maintenance Organization Representative
Dave Houch, Public Representative Emeritus
Robin Richardson, Reinsurer Representative
Rocky King, Oregon Health Authority Representative
Sue Sumpter, General Public Representative
Teresa Miller, Dept. of Consumer & Business Services Representative
Robert Gluckman, M.D., Non-designated Representative
Chris Ellertson, Non-designated Representative

Board Members Absent:

Jared Short, Domestic Insurance Representative
Suzan Turley, Public Representative

OMIP Staff Present:

Tom Jovick, Administrator
Barry Burke, Data & Policy Analyst Manager
Cindy Bowman, Legislative Coordinator
Linnea Saris, Program Development Specialist
Erica Hedberg, Research Analyst
Paulos Sanna, Research Analyst
Margaret Moran, Administrative Assistant

Others Present:

Lynn Nishida, Regence
Dr. Mera, Regence
Alison Nicholson, Regence
Susan Rasmussen, Kaiser

Karin Swenson-Moore, Regence
Kim Wirtz, Regence
Eve Ford, Healthy KidsConnect
Diane Lund, The Lund Report

Chris Ellertson introduction as new board member – appointed by Bruce Goldberg

Introductions:

Mr. Provencher welcomed Chris Ellertson to the Board.

Regence Health Care Service Report (Dr. Mera and Lynn Nishida)

This report reviews major cost drivers in the program compared to the Regence commercial book of business. It provides financial data on an incurred basis, including three-month claims run-out, which captures well over 95% of the claims associated with those services.

The report compares OMIP and Regence plans for the entire calendar years of 2009 and 2010.

Rocky King noted that the medical per member per month (PMPM) cost for the CAREAssist enrollees is significantly lower than it is for the FHIAP and Medical/Portability enrollees; however, the medical utilization per 1000 is significantly higher for inpatient admits, inpatient stays and ER services. Mr. Burke indicated that it likely is because CAREAssist has significantly higher utilization of inpatient mental health stays, which are typically lower cost than medical stays.

Teresa Miller asked if the report breaks out the differences between the increases in utilization and the increases in costs. Dr. Mera stated that it does not. However, he added that the data often shows a flattening or a slight decrease in inpatient utilization accompanied by a unit cost increase of 8 -10%. He noted that the data also has shown significant increases in outpatient facility costs per unit with little or no change in utilization. He commented that it appears to be the intensity of services and use of new technologies that is driving the outpatient hospital costs.

Dr. Gluckman would like to know why musculoskeletal disease category shows an increase for the FHIAP population. Dr. Mera replied that the utilization for this population has increased and is consistently higher than the benchmark. He added that it's probably because this group starts coverage with a six-month pre-existing wait period and have not had previous coverage in the previous six months. Likely they have pent-up demand for services.

Dr. Mera referred to page 26, which outlines comments and recommendations. In addition, he noted that Regence is exploring ways to control dialysis costs and what options are. Mr. Jovick stated that the Benefits Subcommittee should discuss options for control of dialysis costs through benefit modifications.

Ms. Sumpter expressed a concern with the high utilization of emergency rooms and requested more focus be put into developing incentives for enrollees to keep them from only using the emergency rooms.

Mr. Gluckman asked if Regence identified patients with high frequency of ER use to identify if there are particular triggers that could be controlled to reduce utilization. Dr. Mera explained how Regence is currently reviewing ER cases to identify these types of events.

Mr. King asked why there aren't more than 243 enrollees in case management out of the fourteen thousand total in OMIP. Dr. Mera said it's often difficult to get individuals to comply and follow-up with case management. Mr. King suggested that staff contact PEBB to see what they are implementing, but agreed that it is difficult to manage get individuals to cooperate in case management services. Mr. Jovick says he doesn't see a problem with staff pursuing this issue more. He added that staff has begun to explore the feasibility of requiring the use of medical homes. Dr. Gluckman commented on medical home options for patients with hepatitis C.

Mr. McCulloch asked Dr. Mera for additional comments and recommendations related to what OMIP is not doing and what it might not be doing enough of today. Dr. Mera noted that the program needs to find a

way to address the extremely high cost of dialysis treatment and how to get more individuals into care coordination/case management.

Minutes:

The approval of the April 6, 2011 meeting minutes were accepted with no issues.

Nomination for Benefits Subcommittee:

Sue Sumpter, Robin Richardson, and Dr. Robert Gluckman volunteered to be members of the Benefits Subcommittee.

Assessment:

The estimation model indicated that the six month assessment through December 2011 needed to be \$38.77 million. Mr. Jovick noted that there had been a drop in the number of covered lives from the prior year, but the count has not been finalized due to problems in contacting a few large companies about their reported numbers.

Mr. Jovick said that, although the last assessment was approximately the same total dollar amount, the pmpm assessment increased from \$4.05 pmpm to an estimated \$4.32 due to the decrease in the count of covered lives. He also explained that Regence experienced claims processing delays due to its new system transition, which affected the analysts confidence in the estimates of future claims liabilities.

The Board voted unanimously to accept the staff's recommendation that the assessment for July through December 2011 be \$38.77 million.

Administrator's Report:

Mr. Jovick did not review the Stat Pack because of the detailed report from Dr. Mera and Lynn Nishida. Instead he confirmed the enrollment is about 12,800 for OMIP and 838 for FMIP.

Also he mentioned an issue for which Regence had identified a number of enrollees whose premiums have been paid by the American Kidney Fund (AKF). He noted that OMIP staff will explore with legal counsel the issue of whether AKF is eligible to pay premiums for OMIP enrollees. Tom's Report:

Mr. Jovick called attention to a national press release about premiums dropping significantly for the Federal pools in a number of states. He explained that the premium reduction applies just to the 21 states where the federal government is in charge of administering the federal pool. In those states, the federal estimates of market average premiums was determined to be considerably inaccurate in several states, so the federal agency in charge of the pools implemented a methodology change that reduced the market averages.

Mr. Jovick noted that OMIP has received notice of a new federal grant for approximately 2.22 million dollars; \$1.46 million of it is available to offset operational losses and the rest can be used to support the subsidized pharmacy copays and weight watchers memberships.