

Oregon Medical Insurance Pool
Board Meeting Minutes
February 13, 2013
Wilsonville Training Center of Clackamas Community College
29353 Town Center Loop East, Room 111
Wilsonville, OR

Board Members Present

Robin Richardson, Reinsurer Representative
Suzan Turley, Public Representative
Ken Provencher, Health Care Services Contractor Representative
Patrick Allen, Department of Consumer and Business Services
Don Antonucci, Regence
Dave Houck, Public Representative Emeritus
Sue Sumpter, General Public Representative
Kelly Ballas, Oregon Health Authority
Robert Gluckman, M.D., Non-designated Representative (via teleconference)
Chris Ellertson, Non-designated Representative (via teleconference)

Board Members Absent

Rocky King, Public Representative Emeritus
Andrew McCulloch, Health Maintenance Organization Representative

OMIP Staff Present

Don Myron, Administrator
Linnea Saris, Program Development Specialist
Cindy Lacey, Data Analyst & Policy Advisor
Napua Catriz, Program & Operations Specialist
Matt Smith, Budget Analyst OPHP

Others Present

Mike Bonetto, Governor's Health Policy Advisor
Barney Speight, OHA Policy Advisor
Steve Villanueva, Regence
Csaba Mera, M.D., Regence
Lynn Nishida, Regence
Randy McDaniel, Regence
Laurel Klaus, Regence
Mark Lazzo, Regence
Matt Worthy, Regence

Karin Swenson-Moore, Regence
Roseanne Combs, Regence
Carolyn Espinoza, Regence
Gloria Coronado, Kaiser Permanente
Linda Nilsen-Solares, Project Access NOW
Janet Hamilton, Project Access Now
Teresa Blanshine, Familias en Accion
Olga Gerberg, Familias en Accion
Laura Berrutti, Familias en Accion
Jaeme Klever, Familias en Accion
Blanca Fernandez, Familias en Accion
Tom Jovick, Cover Oregon
Jeremy Vandehey, OHA
Brian Nieburt, OHA
Judith Anderson, OHA
Cindy Bowman, OPHP
Mark Jungvirt, OPHP

Approval of Minutes

Ms. Turley motioned to approve the October 24, 2012 Board meeting minutes. Mr. Ballas seconded the motion and all approved.

Administrators Report

Future of OMIP/Legislative subcommittee

The subcommittee (Don Antonucci, Robin Richardson, Ken Provencher, Andrew McCulloch) met on November 20, 2012 to discuss LC 353 which sunset's legislation for OMIP. There were discussions regarding potential amendments to LC 353 on:

- 1) The possibility of allowing enrollees with medical hardship to remain on their plan beyond 2013 to coincide with Cover Oregon's open enrollment; and
- 2) Amending current language which allows distribution of surplus at the end of claims run-out in 2014 or 2015; to be re-distributed to insurers on a pro rata basis.

Benefits Subcommittee Report

On October 30TH the Benefits subcommittee (Mr. Gluckman, Ms. Sumpter, and Mr. Ellertson) discussed potential options for adding acupuncture and naturopathic benefits to the OMIP/FMIP 2013 medical and portability plans. Dr. Chandler from Providence Cancer Center also attended this meeting and discussed how these types of therapies might benefit patients undergoing chemotherapy treatments.

Based on Dr. Chandler's discussion, the subcommittee proposed the following benefit design and directed staff to determine whether Regence could administer this design and what the cost impact would be.

The subcommittee members reconvened on Monday December 17, 2012. After careful review and consideration the subcommittee members decided not to recommend adding this benefit. There would be a number of manual interventions necessary in administering this non-standard benefit. Given the administrative difficulty and increased cost, relative to the small number of enrollees who might access this benefit, the addition of this benefit is not feasible.

The protocols for implementing OMIP benefit changes begin with the benefit subcommittee meetings in August through September to discuss possible changes. The benefit subcommittee then presents benefit recommendations to the entire Board, at the October board meeting. This protocol provides the subcommittee, staff, and Regence sufficient time for thorough discussion, planning, and implementation of any recommended changes at the start of a new benefit year.

Medical Management Report

Dr. Mera from Regence presented the medical management report, which replaced the OMIP/FMIP stat packs. Dr. Mera reviewed the first slide in great detail to provide a better understanding of the top diagnostic ranges by PMPM costs based on current, prior, and benchmarked range. The highest PMPM for the first three quarters of 2012 was outpatient care in the Medical subgroup (\$338.06) which is driven by ESRD care.

Mr. Provencher inquired about what is driving cost shares down for members given where benefits are going. Dr. Mera responded that the plan is paying more over all for high claimants. In relative terms it looks as though the member is paying less. Mr. Richardson added that in looking at the Portability slide the percentage of high claimants increased by 21% but the overall members cost share decreased due to the plan paying more. Ms. Nishida explained that pharmacy is driving some of this. The total spent is not increasing much, but the pharmacy trend with the cost attributable to pharmacy is increasing more than the total cost share in relative proportions. The plan pays for a majority of generic medications which lowers the members out of pocket percentage.

Ms. Sumpter requested that income demographics be included as they were in prior stat packs. Ms. Lacey advised that these are self-reported numbers and do not reflect true demographics, it was decided to have this information available at future meetings.

Navigator Program Updates

Roseanne Combs, Regence case manager, introduced herself as well as Teresa Blanshine, patient navigator/RN with Familias en Accion and Carolyn Espinoza, Regence case manager. Ms. Combs explained that they would be presenting on the co-management program between Regence Blue Cross Blue Shield of Oregon and Familias en Accion. She then explained the program objective, the member centric model and frame work for their work flow. Mr. Richardson explained that this was an update on Familias en Accion grant program.

Ms. Combs explained that one of their challenges has been identifying members to be referred to Familias en Accion. In order to meet the 200 referral milestone in the contract, they have expanded their identification criteria. Ms. Sumpter asked how they are successful with identifying Latino members, given they do not collect data on ethnicity? It was explained that the first review is based on surnames followed by data mining with case managers.

Ms. Espinoza showed Board members examples of clinical outcomes through collaboration efforts. 41 case interventions have been completed, 25 have been successful and 16 have barriers identified for medication reconciliation. Of these same cases 13 have gained access to care and 18 remain with barriers. In diabetic self-monitoring, 9 cases completed successful interventions whereas 8 cases continue to experience barriers. These interventions have been available to the Latino population for several years. However, there had been a lack of ability to engage this population and build a trusting relationship to break through these barriers.

Ms. Blanshine focused attention on the age of the population they are serving as a majority of the ESRD population is under the age of 40. ESRD is a devastating debilitating disease that will largely impact clients, their quality of life, and deplete on the health system with necessary costly treatments.

Ms. Sumpter expressed her concern for undocumented citizens and the new health care system. Those undocumented individuals will no longer have OMIP insurance available to them instead will continue to receive AKF; they are a vulnerable population to which Board members have a moral responsibility. Although they will have insurance available, outside of Cover Oregon, it will be at an expense beyond affordability for them and she fears that insurance coverage will become unattainable for this population. As a Board member she feels it is her responsibility to find out if these individuals can be identified in order to locate access to resources or support. According to Mr. Myron there have been discussions around undocumented individuals at the State level. In

addition these members may continue to receive their subsidies from the same places where they receive them now for example: AKF, local churches and family members.

Ms. Blanshine continued the presentation by presenting the outcomes of Pathways to the Board followed by two examples of successful clients. They closed with their future plans for further successful outcomes with patient navigation.

OMIP Legislation

Mike Benetto provided the OMIP Board with the Governors perspective on OMIP legislation. This is an interesting topic with the ACA implementation, the market impact and the role of OMIP in looking at this transition. The governor is interested in providing market stability and consumer protections going into 2014. The Wakely report provided insight in what rate impacts may be expected in the coming year and potential related mitigation strategies to be reviewed. Highlighted in the report is the impact on premiums and the effects of merging OMIP, FMIP, and portability members into the commercial market. In addition to the technical advisory group, the Governor's office has requested guidance and expertise of the OMIP Board.

This legislative bill is technical in a statutory sense rather than policy, according to Barney Speight. Oregon is among one of the first states to review some of the market implications with the Wakely report. The technical advisory group attendees included major domestic carrier actuaries, Wakely under OID contractual agreement, and were led by Ms. Laura Cali of the Insurance Division. There is knowledge of the potential cost impact of moving the current OMIP, FMIP, Children's Reinsurance Program, portability and other uninsured into the "no longer medically underwritten market". We have been looking at the potential in utilizing the current OMIP assessment method to supplement the Federal reinsurance program. There is an estimated \$5.25 per member per month that will be imposed throughout the nation on all employers; this amount will decline over three years' time. Nationally this money will fund a reinsurance program for carriers serving the individual market throughout the country. It includes specified attachment points of what high cost claims the Federal program will reimburse; the unknown factor is if there will be enough assessment funds for the federal program claims.

As we approach 2014, parameters are being set in the legislative bill. Mr. Speight explained that this is a State program that will supplement the Federal program. The Federal program proposed information such as attachment points and co-insurance rates. This gives carriers within the exchange greater certainty. The purpose of the Oregon Supplemental Reinsurance Program is for those enrolled in OMIP, FMIP, CRP, or a carrier based portability plan, if they are enrolled on 12/31/13 Claims cost for these

groups are atypical from regular claims and this fund will allow the receiving carriers to cede a portion of this risk and further mitigate the expected increase in premium rates. The purpose of the OMIP Board will change during the three year period will add a business representative. There is a concern among carriers that there may be more assessed than what is needed. As a protection, the Board will be allowed to change attachment points on a pro rata basis ensuring there is a fair distribution. The lesser of \$4.00 per member per month or \$72 million dollars total will be set in statute for the allowable amount of assessment. The \$4.00 per member per month amount is less than current. In 2015, per member per month is reduced to \$3.50 or 87.5% of the 2014 levy; which translates to \$63 million dollars. This is reduced even more to an assessment lesser of \$2.20 per member per month or 55.56%; \$40 million during 2016. By the fourth year the assessment is estimated to be at zero and allow for claims run-out in 2017. Any funds in excess will be returned to the carriers.

There are several assessments in Oregon. There is a 1% premium tax that was levied in 2009 for the Healthy Kids Program The 1% premium tax will sunset and be replaced with the reinsurance mechanism. The Federal law is clear that assessments on self-insured through ACA is only legal at the Federal level; it does not extend the law to states for assessment.

OMIP Assessment #44

OMIP contracted with Kevin McCartin, a consultant for analytical support and guidance on the assessment forecast. This support and guidance is necessary due to complex changes resulting from anticipated closure of the program, implementation of the ACA in 2014, and other factors including the impact of dialysis rate savings and potential 'benefit packing.'

The Board discussed in recent meetings concerns regarding the issue of benefit packing, and we asked Mr. McCartin for his guidance on the matter. Staff implemented Mr. McCartin's recommendation, and the forecast has been adjusted to reflect a 7% surge in the last six months of the program.

The assessment options considered are to approve the assessment of health insurers, as authorized under ORS 735.614, and government entities, as defined in ORS 731.036(6) and authorized in ORS 731.036(6) (g) for:

- *Option 1 – Standard Six Month Assessment:* the amount of **\$40,951,210** or **\$4.80** per covered life, per month, for six months based on a covered lives count of **1,422,060**;

or

- *Option 2 – Extended Assessment through Program Close*: the amount of **\$85,610,958** or **\$5.02** per covered life, per month, for twelve months based on a covered lives count of **1,422,060**

Staff suggested that allowing for adjustments in the assessment at mid-year may be critical. Uncertainties regarding underlying patterns in recent claims expenditures combined with potential volatility in enrollee behavior as we get closer to program closure have the potential to be substantial, and Option 1 would provide an opportunity to make these adjustments. There was Board discussion based on the analysis of Mr. McCartin, recommendation of OMIP staff, and OMIP history by Mr. Jovick, the decision was unanimous to proceed with option 1, modified to \$5.09 pmpm.

CRP actuals (premiums – claims) for the last 6 month period for assessment #3 was calculated at \$0.6415 per insured per month. It was suggested that the assessment be doubled to build an end of program reserve & to reduce the final assessment. Following further discussion in relation to CRP with its 6 month lag, Board members came to a decision. Ms. Turley motioned to proceed with the \$1.28 assessment and to re-visit in July. The motion was seconded by Ms. Sumpter and all approved.

Public Testimony

No public testimony

Meeting adjourned at 5:00 p.m.