

Oregon Medical Insurance Pool
Board Meeting Minutes
July 11, 2012
Wilsonville Training Center of Clackamas Community College
29353 Town Center Loop East, Room 111
Wilsonville, OR

Board Members Present

Patrick Allen, Department of Consumer and Business Services
Dave Houck, Public Representative Emeritus
Chris Ellertson, Non-designated Representative
Suzan Turley, Public Representative
Kelly Ballas, Oregon Health Authority
Rocky King, Public Representative Emeritus
Robin Richardson, Reinsurer Representative
Ken Provencher, Health Care Services Contractor Representative
Jared Short, Domestic Insurance Representative
Robert Gluckman, M.D., Non-designated Representative

Board Members Absent

Andrew McCulloch, Health Maintenance Organization Representative
Sue Sumpter, General Public Representative

OMIP Staff Present

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

Others Present

Steve Villanueva, Regence
Lynn Nishida, Regence
Summer Kramer, Regence
Brian Niebert, OHA
Jonathan Eames, Fresenius
Judith Anderson, OMIP Legal Counsel

Mark Jungvirt, Manager OPHP
Cindy Bowman, Operations and Policy Analyst OPHP
Don Antonucci, Regence
Dana Tearney, Regence
Laural Klause, Regence
Dr. Csaba Mera, Regence
Karin Swenson-Moore, Regence (via teleconference)

Approval of Minutes

Mr. Allen motioned to approve the April 4, 2012, Board meeting minutes. Mr. Short seconded the motion and all approved.

Administrators Report

Mr. Jovick explained that Dr. Mera and Ms. Nishida of Regence would present on cost and utilization which contained information consistent with the stat packs. Therefore, Mr. Jovick would not review stat packs. Enrollment for OMIP is 11,765 and over 1,300 for FMIP which Mr. King confirmed are lives not contracts.

During the April Board meeting, the OMIP Board of Directors approved contracting with Familias En Accion to provide navigator services to OMIP's Latino population. This contract was signed and effective June 1, 2012 in the amount of \$909,000. Familias En Accion began their work with Latino enrollees receiving dialysis services and will continue to train and develop new navigators; enabling an increase in the quantity of Latino enrollees they work with. Regence case managers have worked closely with Familias en Accion's navigators to integrate work. Navigators will begin in July and have HIPAA forms signed by all engaged enrollees prior to beginning services. Marie Dahlstrom of Familias En Accion will provide an update of progress to Board members at the October Board meeting.

Alison Goldwater is the director of provider contracting at Regence. Mr. Jovick worked with Ms. Goldwater and reached rate agreements effective June 1, 2012 with dialysis providers DaVita and Fresenius. The out-of-network providers' benefit had been set to equal Medicare rates per dialysis treatment session, which is not adjusted with any risk associated with individuals. In turn this was a motivation for dialysis providers to contract with OMIP. There is an estimated savings of approximately \$18 million per year which is a cost reduction of \$10.7 million June through December. This figure will not be utilized in estimating the reduction for assessment purposes. Despite the negotiated rates and out-of-network provider benefit change, OMIP staff is concerned

that there may be increased rates in the commercial market. OMIP rates are based on commercial market average which will be affected if dialysis providers do this. Diabetes expanded education was also approved during the April Board meeting. Regence had estimated approximately 50 program participants. The actual program participants identified as of now is 61. Regence case managers are following up with these participants by preparing to mail letters and by telephone contact. The entire program cost is \$10,000.

Beginning October, Don Antonucci of Regence will replace Jared Short on the OMIP Board. Mr. Short's involvement with the OMIP Board will continue but not as a Board member. Mr. Antonucci has been attending OMIP Board meetings for a couple of years and understands his role.

Designated State Health Programs (DSHP) is a five year arrangement which is part of a new waiver, \$1.9 billion in federal matching funds that the Oregon Health Authority (OHA) just received from the federal Centers for Medicare and Medicaid Services (CMS). This differs from the traditional method where OHA would spend general dollars which the government would then match. OHA would locate programs throughout the state related to healthcare and in connection to Medicaid which included such programs as OMIP, the Oregon University system, and Smaller Dollars. OMIP will certify to the OHA that funds have been paid in claims which will then be matched at 60% by federal funds. These funds will be allocated to support the Coordinated Care Organization's (CCO's) in the healthcare transformation. \$620 million will be spent in the first two years then the amount will lessen. Those matched federal funds exclude programs such as Family Health Insurance Assistance Program (FHIAP) because its premiums are paid with federal funds; this leaves approximately \$170 million per year. The OMIP program is one of the largest basis for receiving the DSHP funds in the first two years. Without OMIP there would be major cuts in the CCO's healthcare transformation.

Assessments

Children's reinsurance assessment

The Children's reinsurance assessment is administered by OMIP; therefore, viewed and discussed but not voted on by the OMIP Board of Director's. January was the first assessment and there were 523 Children ceded to the pool. We assessed \$592,000 which equaled 6 ½ cents per covered life per month. For assessment two we have accumulated additional lives with reported premiums and claims which equal approximately a \$2.9 million dollar assessment. Based on the current count of lives this equals 32 cents per covered life per month, we will re-calculate this figure if there is a change in covered lives.

Mr. King directed conversation to the insurance carriers with regards to their current process for ceding children. “Do we still receive and decide on a health statement or are the claims within the first 105 days still reviewed.” The answer is that the carriers may do both.

OMIP assessment

The January 2012 assessment was \$46 million and we projected the July 2012 assessment to be approximately \$50 million conservatively. The 2011 claims experience had fallen behind due to Regence’s recent system change, which in turn resulted in a reporting lag and lack of confidence in our ability to provide an accurate projection on the assessment so we over projected to be conservative. The actual assessment figure is \$43 million dollars. We could use the estimated \$10.7 million savings through the end of calendar year 2012 from dialysis rates to reduce the \$43 million assessment further. However, to remain conservative, we only reduced the assessment by about \$6 million from \$43 million to \$37 million because we do not have claims experience associated with the dialysis rate reductions at this time.

The Board of Directors would vote on the assessment followed by a discussion with regard to possibly decreasing rates that enrollees pay beginning in January or sooner on August 1st. There will still be a need to pay claims run-out in 2014 for services provided in 2013 and a decision of the Board members in regard to the assessment and the impact of dialysis rates. OMIP’s current reserve is \$2 million and one month of premium claims which amounts to \$12 to \$16 million, along with any unspent assessment and premiums.

Mr. King explained that there is a report being developed by Wakely which shows the impact going forward with the Affordable Care Act (ACA). Included in the draft of this report is the impact of OMIP ending and the reinsurance impact. The missing information is the run-out for OMIP during 2014. This amount needs to either be in OMIP’s reserve or included in Wakely’s report to show the true impact.

Data from the insurance division on the count of covered lives had been received but some of the instructions changed from the previous count which raised concern. The amount has decreased by 92,000 lives since this time last year. Our best estimate is \$4.38 per covered life, but the covered lives count needs to be confirmed with the insurance division. OMIP staff requested Board of Director approval for the projected assessment of \$37 million and allows staff to research the insurance division’s data and assess on the actual amount. The objective for OMIP’s reserve is to establish the actual

amount of funds that will be needed for claims run-out in 2014 when premiums are no longer being received and to be sure there will not be a need for assessment.

Mr. Ellertson motioned to approve the \$37 million assessment but to charge at \$5.09 per covered life; the difference between the \$37 million and the resulting amount at \$5.09 per covered life would be set aside and applied to reserve, for claims run-out in 2014. Ms. Turley seconded and all were in favor of the motion.

The benefit committee will convene in regards to 2013 rates and benefits. Once the actual count is determined, OMIP staff will notify Board members via email. Current rates are based on a 6% surcharge which had been a 3% rate increase from 2012.

Grant Fund Proposals

There is federal legislation that allows congress to appropriate funds exclusively to high risk pools. Funds are distributed based on a formula which is awarded on a federal fiscal year basis; OMIP receives these funds at the end of a calendar year. This funding can be used to offset assessment and/or for a benefit enrollment program. In the past, OMIP has utilized this operational loss grant only to offset the assessment. Last year the OMIP Board decided to utilize the operational loss grant to fund proposals. The operational loss grant will be utilized to offset assessment and to fund Familias en Accion.

The remaining grant funds of \$950,000 will be utilized to fund another proposed program. There are two grant proposals for consideration. There is a proposal from Dr. Mera to fund congestive heart failure (CHF) and diabetes which was presented during the April Board meeting. The other proposal is to fund a program called Project Access Now which is similar to the already funded program Familias en Accion. Project Access Now differs by outcome based payment and it serves the remaining populations.

Telemonitoring Proposal

Dr. Mera completed his follow up presentation from the first proposal. The primary populations being targeted are those with CHF and Diabetes. Participants will be OMIP members identified through our predictive modeling risk stratification tool. The objective is to have participants monitored from home with a tele-monitoring tool that can be communicated to centralized nursing through a telephone line; the tool consists of a scale and blood pressure cup. OMIP would be the grant manager and Regence would be the patient manager. Cardiocom is the company that will carry out this service once Regence establishes an RFP.

Dr. Gluckman expressed concern during the April Board meeting in regard to the past studies on Dr. Mera's proposed program. Dr. Mera and Dr. Gluckman conversed about the benefits in relation to evidence of the program outcomes. Dr. Gluckman encouraged the Board to base their decision on the benefits and not on the Return of Investment (ROI). Mr. Robinson commented that the Board is interested in seeing how the program funded will benefit the enrollee. Ms. Turley interjects with a suggestion to proceed with the CHF portion not the diabetic portion given the lack of improvement shown with the short term remaining in the OMIP program. Board members discussed strong points and short comings of this proposal and decided to hold on a decision until both proposals were made.

Project Access Now Proposal

Linda Nelson-Solaris, Janet Hamilton, and Troy Travis introduced themselves. Linda explained that Project Access Now is part of a larger health organization called the Community Health Collaborative. The proposal is to combine health with social work to connect people to their healthcare. A Pathways model is designed to shift their work to outcome by connecting people to services. Project Access Now focuses on at-risk people who are high risk and connect them to networks that will be helpful for them and measure the outcome. The example provided was on pregnancy because that is what this program's experience is with, not high risk pool data. They identify the enrollee and their barriers then pay their navigators with an incentive on the outcome. The result is payment based on value not volume. The intention is to save money now and to show change over time.

Beginning with an initial group of patients which turns out to be 95 people; the goal is to get to 200-300 people. Navigators will talk with patients to identify needs and if they will even accept the help. Once there is a relationship established they will connect patients where they have identified they will benefit most and pay their navigators for the outcome. They propose to save \$134,000 with compliance from one patient. The average caseload is 40:1 and their efforts will begin in the Portland tri-county and Lane county areas. The proposal is \$803,550 which will allow Project Access Now to launch this program.

Mr. Provencher began the discussion by explaining that he has difficulty with the idea of spending large amounts of funding on a program that will soon be ending. Board members discussed the context of what their intension is. Mr. Robinson raised the issue of struggling to get access to care.

Mr. Ellertson motioned not to proceed on the Project Access Now proposal and proceed with the telemedicine proposal limiting to just CHF patients. Dr. Gluckman had the opposite conclusion and motioned to endorse Project Access Now and cap funding at \$803,550. Mr. Short wanted the Board to make a decision on what this will do for OMIP and not what it will do for other companies in the future. Ms. Turley interjects that in the best interest of OMIP patients is what the decision needs to be based on, she seconds the motion. Majority are in favor, Mr. Ellertson is opposed. No motion was made to fund telemonitoring.

Regence TPA contract extension

OMIP is currently contracted with Regence for third party administration through January 31, 2013. This authorization came during a 2011 Board meeting and did not include further extension. Generally there are proposals received followed by a three year contract with the selected TPA. The legislative change for a two year contract was due to the uncertainty of the State and Federal transformation in the insurance market.

Mr. Jovick proposed establishing an OMIP Board committee to work with OMIP staff, and Regence in establishing rate and/or any provisions focused on data mining and data sleuthing. The goal is to target potential cost reduction and present at the September Board meeting. There were no volunteers; instead Mr. Provencher recommended that Board members authorize OMIP staff to proceed without forming a sub-committee and to utilize Board members when necessary for guidance then bring the recommendation back to the September Board meeting.

Annual OMIP Utilization and Cost Analysis

Dr. Mera of Regence reviewed key utilization metrics with the Board. The top diagnostic driver for medical is kidney disease and for portability it is musculoskeletal. Overall membership had increased in 2011 from 2010. Most of the cost is derived from outpatient facilities. 4% of the membership accounts for 65% of the cost which is skewed by the small quantity of high claimants in the population. Case managers reach out to members but sometimes need to work around them in an effort to reduce cost. In addition, educational material is mailed to members identified as non-compliant high claimants.

Ms. Nishida of Regence summarized statistics and highlighted some key drivers of prescription cost trends. In 2011, roughly over \$40 million in drug spend attributed to specialty medications for OMIP. There were variations due to enrollment across medical, portability, FHIAP, CareAssist and HCTC. There was roughly a 13% increase from the Oregon benchmark which is 3% of the nature of this population. Key drivers in

cost are specialty medications used for diseases such as rheumatoid arthritis not generic medications. Regence tries to assist patients in accessing cost saving programs such as specialty pharmacy. It is recommended to add generics Losartan (Cozaar), Losartan/HCTZ (Hyzaar) and Atorvastatin (Lipitor) to the \$0 dollar copay program with respect to grant funding on generic medications. Board members authorize OMIP staff to work directly with Regence on adding these medications to the \$0 copay program.

Sub-committees

Mr. Richardson had asked Mr. Jovick to assemble participants for committee assignments. These assignments are the Benefit, Medical Care Management, and Future of OMIP sub-committees. The entire industry will need to weigh in on the decision for the Future of OMIP and this will be taking place soon with Mr. King.

Public Testimony

No public testimony

Meeting adjourned at 4:15pm