

DRAFT
Joint Meeting
Health Insurance Reform Advisory Committee &
Insurance Pool Governing Board
Meeting Minutes
May 23, 2002

HIRAC Members Present:

Mary Neidig, DCBS Director
Rocky King, OMIP
Nancy Nevins, LifeWise
Lisa Trussell, Associated Oregon Industries
Ruth Rogers Bauman, The Regence Group
Ed Nieubuurt, Providence Health Plan
Vicki Brister, Brister Insurance Services
Barney Speight, Kaiser Foundation Health Plan of the Northwest

IPGB Members Present:

Glen Knickerbocker
Mark Jungvirt
Ellen Lowe
Steve Doty
Craig Kuhn
Mike Bonetto

Staff Present:

Joel Ario, Insurance Administrator
Lori Long, Senior Policy Advisor
Maxi McKibben, Rates & Forms Assistant Manager
Marcy Meink, Administrative Specialist

Others Present:

Muriel Dittlen, ODS	Kathy Barrie, OMIP
Sarah Reeder, ODS	Marjorie Taylor, Committee Services
Susan Cole, Regence	Jim Gravette, PacificSource
Darlene LeTellier, PacificSource	Doug Barber, OAHU
Chondra Wahrgren, ODS	Karen Kelly, Regence
Peggy Anet, HIAA	Jim Austin, Lifewise
Todd Yorke, Agent	Tom Eiden, Agent
John Powell, Regence	Waltrant Lehmann, Premera Blue Cross
Representative Mary Nolan	

10/02/02

Welcome and Agenda Review

Glen K. called the meeting to order at 9:10 a.m. and everyone went around the room for introductions.

IPGB Administrator's Report/E-Board

Rocky K. gave overview of how the E-Board gave permission to bump the budget back up for the work on the FHIAP project. They are also working with carriers to try and raise funds to help market this project. The E-Board accepted, with some minor modifications, the recommendation to expand FHIAP waiver.

HB 3126

Objectives are to see where we are, look at rating factors and where to take the three proposed draft plans next. HIRAC objectives are to provide input and decide what to do with the basic benefit plan in the marketplace.

Mark J. Gave an overview of HB 3126 and where it started as well as where it is today. Originally it was 2 bills SB 8 and HB 3574 that were combined into HB 3126.

There are 3 different plans. Plan 1, a limited coverage plan, plan 2 qualifies as a health benefit plan to fund a MSA and plan 3 is an up-front benefit plan. All of the plans are guaranteed issue. Employers have not provided group health insurance for their employees in the past 12 months.

IPBG put together focus groups that talked to agents and employers. At the end of each of these focus groups, IPGB handed out a survey that asked agents to pick their favorite plan, create their own plan and pick a rate for the plans. They also had to answer if they would be willing to market these plans. The focus groups narrowed it down to these 3 choices.

IPGB sent a packet around to 8 domestic carriers on 4/29/02 to be returned with comments and rating factors by 5/20/02. They received responses from 6 out of the 8 carriers.

The next steps are to choose a final plan, choose final rating factors and then meet with the carriers to see if these plans will work. Then IPGB will come up with an RFP.

Comments on the plans:

How did they arrive at the rates? The carriers were asked to give ballpark averages. These are midpoint using an average slice of the pie which covers all genders and ages. Basically these are guesses that will have to be narrowed down. These rates are comparable to other rates out there for some existing plans but not subject to the rate bands of SEHI.

Affordability for employer and employee is an issue. Was any profile used for income level of small employer? In Representative Derfler's bill last year, \$243 was the estimate used for the cost to employees for insurance.

The idea is to attract more young people into the market. One of the issues was the SEHI program. There are a series of reforms that may need to be made in the SEHI market.

10/02/02

It seems as if these plans will have definite winners and losers and that there is no overall benefit. The attractiveness of the plan is the low rate, not the plan benefit. It is difficult to come up with a plan that has both.

Representative Nolan commented that the plan shows promise but it isn't the answer. There are always going to be costs involved and somebody has to assume those costs. The intention is not to create a zero sum gain. The legislature wants to encourage younger people to get into the system which might end up changing the overall perspective in the marketplace.

Plan 2 is the only proposed plan that is unique as a qualified health plan to fund a MSA. A major factor is how consumers perceive the plans and these behaviors need to be addressed.

Lisa T commented that the consumer problem is hospitalization isn't affordable. Individuals pay their premium but hope to never have to use the policy. They want to be able to use it when they need it without much cost. Plan 2 is not aimed at the younger population with a \$2000 deductible. Currently there are only individual qualified health plans to fund MSAs available in Oregon, one group.

Ed. N. Commented that his carrier did not comment on the 3 proposed plans because the benefit designs of these 3 plans are not administratively feasible at this time for Providence. The national experience in these type of plans has not garnered much interest.

The question was raised as to whether there are any areas nationwide that have any type of plan like this that has worked well. Arizona had something similar but then raised the cost substantially.

Historically, the bulk of IPGB folks bought more traditional plan designs. In the early years, most members bought up. Underwriting is not an option on any of these types of plans.

Nancy N. Stated that Lifewise people liked the middle of the road plans with low premium and decent benefits. Cost was the biggest factor.

Vicki questioned if there was any option for a tax credit. Consensus was that a tax credit would have to be too large for it to be attractive and that it wouldn't be refundable so would not work.

HIRAC applicability – common ground is more affordable plans. There are 3 HIRAC options: 1) Take it all wholesale if we think it's good, take it across the marketplace – this would be a legislative option. 2) Use some of these options which could be administrative and not subject to all of the restrictions. 3) Most likely option is to pilot test with IPGB to see if this works before applying to the rest of the market.

Mandating a new basic benefit plan in the small group market would be an easier thing to do.

Question was raised as to what kind of barriers are there for subsidy. How do any of these plans qualify against the benchmark plan? We need a plan that is not available now. One option would be to make the plan subsidizable.

Comments from HIRAC and IPGB representatives on the plans:

Ruth B. – For IPGB 3 plans are possible rating improvement. HIRAC is not sure of need. Need to see how they work before mandating.

Vicki B. – agrees with Ruth's comments

Ed N. – doesn't think they are good plans or that any of them could be applicable to the SEHI market.

Ellen L. – has some concerns on affordability for employers and employees. Questions if there will be a significant demand. Constricted by legislative issues. Needs additional profiles to test affordability.

Steve D. – encouraged by rates, they are the key. Partial to plan 3. Should try them out. Definitely need to meet with carriers to see why lack of participation. Concern over needing to pools. Possibility of merging 2 pools. HIRAC – would encourage to expand rate band and relax come rating restrictions. Thinks impact to older population is covered by employers and not as significant.

Barney S. – declines to participate. Doesn't think HIRAC should adopt. IPGB should call a party and see who comes. Needs consistency between rating factors. His sense is that HIPAA rules apply. These rating factors need more discussion because it is a zero sum game. Are there other demographics that lose, age, gender, income.

Lisa T. – likes the concepts. Need carrier interest to make successful. The problem is list of mandates to keep cost down. Liked the fact that you have a certain number of visits you can use at any type of doctor. Will rating factor alone change cost significantly?

Nancy N. – on rating issues – echoes concerns on erosion in SEHI market. Concerns regarding how other pools are affected. Age has dramatic impact.

Rocky K. – social policy with rate banding. Looks like we are encouraging employers to hire young workers due to rate factors – age banding. Wrong message no matter where you go with age banding. Equity is the issue. Concern is employers only hiring young people.

Next Steps

The next step is to meet with carriers to discuss issues and get all to participate. The issue of how IPGB moves forward on rating is something that HIRAC needs to be involved in. Subcommittee of both HIRAC and IPGB will continue meeting. Will meet within the next 6 months to discuss legislative input and carrier input.

10/02/02

HB 2519 FHIAP Expansion

Waiver will be submitted by 6/1/02. This is an expansion of 29,000 people. Want to implement by 10/1/02 with OMIP implementation by 12/1/02. Initial emphasis is on the group market. Want to get federal dollars into the program.

No applications will be mailed out until they know when they are getting federal approval. IPGB will be working with the carrier community on expansion. Would need 2400 people in group side per month for this to work. More marketing and targeting of employers should gather these people. It is ambitious but doable.

Question on federal timeline. It seems to be 60 days which will work with the outlined schedule.

Question on how marketing would take place. DHS will be used to target families getting assistance. IPGB has an interagency agreement due to federal funding. This enables a lot of cooperation in trying to make very user friendly for consumers to easily get the information.

The next HIRAC meeting will be at the end of June or early July.