

**OREGON HEALTH FUND BOARD – Federal Laws Committee**

March 13, 2008  
9:00 – 12:30 pm (Digitally Recorded)

Oregon State Library, Room 102-103  
250 Winter St. NE, Salem, OR

**MEMBERS PRESENT:** Frank Baumeister, M.D., Chair  
Ellen Gradison, Vice Chair  
Mike Bonetto  
Chris Bouneff (by phone)  
Michael Huntington, M.D.  
Julie James (by phone)  
Mallen Kear, R.N.  
Sharon Morris  
Larry Mullins (by phone)  
Nicola Pinson  
Thomas Reardon, M.D.

**MEMBERS EXCUSED:** Cheryle Kennedy

**STAFF PRESENT:** Susan Otter, Policy Analyst  
Barney Speight, Executive Director, OHFB  
Erin Fair, University of Oregon Law Student, OHFB Intern  
Judy Morrow, Assistant

**ABSENT STAFF:**

**ISSUES HEARD:**

- Call to Order
- Approval of Agenda and February 28 Meeting Minutes
- Medicare Panel: Medicare Advantage HMO and PPO Plans
- Medicare Panel: Medicare Advantage Special Needs Plan
- Presentation by Oregon Insurance Administrator
- Committee Discussion
- Public Testimony

---

(Digitally Recorded)

**Chair Baumeister I. Call to Order**  
• There is a quorum.

**Chair Baumeister II. Approval of Agenda and February 28 Meeting Minutes**  
**Motion to approve** the minutes as written is seconded. **Motion passed unanimously.**

**Chair Baumeister III. Medicare Panel: Medicare Advantage HMO and PPO Plans**  
**Presentation by Kevin Keck, MD, Chief Medical Officer, Providence Health Plans (HMO). (See presentation)**  
• Presented on the strengths of the Medicare Advantage Model as a strategy to mitigate the problems of the traditional fee-for-service Medicare.  
• Universal Health Care will not solve the problem of rising costs.  
• Value based payment is step in correct direction but it is not enough.  
• Imaging is the highest rising cost of the health care dollar.

- Minimal interaction with MDs leads to patients not understanding and not following instructions.
- Providence uses a “systems of care” approach. Manage chronic, high cost conditions to prevent high costs. Actively promoting generic drugs
- Discussion of Medicare Part D: treatment panels are working and can be enhanced. CMS requires medication treatment management which helps us identify members who could benefit from care management.
- Creating access by paying 1.17 times the traditional Medicare rate to physicians. On commercial side, using a “pay-for-performance” including increased pay if providers accept Medicare Advantage members.
- Provider network is stable – very few providers dropped Medicare Advantage participation, many more quit traditional Medicare.

### **Discussion**

- Question on customer satisfaction and prior authorizations on radiology.
  - Use American College of Radiology guidelines. High satisfaction even given prior authorizations for some drugs, radiology and spinal surgery.
- Question on cost quality strategy – investing in aggressive primary care management.
  - Four opportunities: (1) Reduce unnecessary healthcare; (2) American healthcare getting it right; (3) prevent avoidable admissions (4) manage sickest proportion of patients.
- What led to development of Providence systems of care approach?
  - Providence is mid-sized and could move quickly, Medicare Advantage pushed us to control costs because we’re taking on the risk, carved out mental health.
- Dr. Keck responded to a question on what are the current limitations within Medicare Advantage and how could these be fixed?
  - CMS could add requirements for managing care of sickest members or for tracking radiology trends.
  - Difficult to identify the 1% of members who cause 30% of costs – we have some tricks and software to find them.
  - We pay providers to send us performance information and then feed it back to them. Have found performance goes up.
- Question about barriers to cooperation between insurance companies and avoiding adverse selection under Health Insurance Exchange.
  - Think cooperation is possible.
- Administration costs are about 10%. 2,000 physicians are contracted with Providence, of those 140 are employed by Providence. Providence contracts with most of its physicians and is not a Kaiser-like program.
- Question on whether members are dis-enrolling.
  - Very few dis-enroll. Seniors tend to stick with a plan.

### **Daelene Schwartz, Medicare Product Line Director, Kaiser Foundation Health Plan of the Northwest (HMO)**

- Provided background on Medicare Advantage funding and history.
- 1997 BBA included capping high rate counties and creating floor counties with guaranteed rate increases to gradually move to more equitable national payment.

- Medicare Modernization Act (MMA) enacted 2003, implemented in 2006.
  - Changed payment methodology to a more complex system.
  - Related how payment is calculated: Medicare Advantage plan calculates a 'benchmark' of what it thinks CMS will pay using county floor and risk adjustment based on disease burden and geographic elements. Plans calculate 'bid' – projected costs to care for the population (almost always below the benchmark). MA Plans get rebate of 75% of difference between bid and benchmark (if bid is below benchmark) which must go to enhancing benefits.
- Oregon MA plans pay approximately 133% of traditional Medicare fee-for-service rates (average between HMOs and PPOs). Policy debate around whether Medicare should only pay for core benefits.
- Committee debated that extra 33% does not reflect a true difference in payment, since it includes additional items.
- Issues and barriers of MA plans discussed.
  - Model has positive points – quality of care
  - Payment system needs revising to be equitable and address costs of care, allow for coordination of care, and be stable and consistent
  - Regulatory complexity – example of Part D which is very complicated and includes lots of reporting, hundreds of issuances from CMS, and is very complicated for beneficiaries.
  - Recommendation of simplicity of plan design.

**Pat Gibford, CEO, Clear Choice Health Plans (HMO), (See presentation).**

- Clear Choice is a small group, "*Niche player*" 12,000 lives covered. Serve rural counties. First provider sponsored organization to get Medicare Advantage contract.
- Western Montana physicians see MA as preferable to traditional fee-for-service Medicare because of systems of care approach and higher reimbursement.
- Policy discussion about limiting Medicare Advantage payment to traditional Medicare levels would be a problem considering that traditional Medicare rates vary by service areas. We'd love to get Miami, FL traditional Medicare rates.
- Current issues for MA plans:
  - Lack of understanding of contribution/value of plans (e.g., systems of care).
  - Reimbursement for floor counties
  - Access to primary care providers is limited for Medicare beneficiaries even with a Medicare supplement plan. Can often get access under Medicare Advantage.
  - Provider reimbursement and self-referral for ancillary services. Nine MRI scanners in Bend are difficult to manage.
  - Increasing costs and utilization and higher MLRs.
- Federal Policy issues:
  - Oregon MA plans lack clout in Washington DC, MedPac doesn't reflect localities and doesn't acknowledge the access problem.
  - Private Fee-For-Service Medicare Advantage plans (PFFS) and Prescription Drug Plans (PDPs) lack CMS controls. Confusion of initial implementation of Part D – many retroactively disenrolled.
  - CMS often makes changes without first testing.

- System is unsustainable.
  - Ethics of limits on treatments.
- Question on whether multiple insurance plans could coordinate under Health Insurance Exchange. Pat Gibford responded that the cost would make this prohibitive.

**Bart McMullan, MD, President of Regence Blue Cross Blue Shield of Oregon (PPO)**

- Have moved HMO models to PPO.
  - Regulated essentially the same way as HMO but PPO offers greater flexibility for members who can get some coverage out of network.
  - Parts of country HMO model does not work because there aren't many providers available.
- Regence pays more than Medicare.
- Access to providers is easier for PPO members than under traditional Medicare. Regence has no physicians in its network refusing new MA members.
- Question on whether multiple insurance plans could coordinate under Health Insurance Exchange. Responded that coordination could happen on quality measures but would still compete for the dollars.

**Discussion**

- Risk adjustment is a better model for MA plans – we're not penalized for doing a good job managing care
- Question on sustainability considering cost containment – Consumer Price Index + 1 is the Holy Grail of sustainability. We can't get there without cost containment strategies and a change in culture around ethical limits to treatment. Realign incentives for paying providers to keep patients out of hospitals – could take money saved on inpatient care and pay doctors for prevention and outcomes. 60% of Medicare payments are spent in the last 6 months of life.
- Question on hospital incentives for participating in Medicare Advantage – MA plans pay hospitals more than traditional Medicare. However, if systems of care work and can manage outpatient side then hospitals may end up with fewer inpatients. May need to redistribute some of the savings to hospitals. May be some advantage to hospitals: hospitals' margin is more on the surgical side than the medical side and Medicare Advantage members will tend to be hospitalized more for surgeries than for other medical reasons.
- Question about need to increase primary care work force – all agreed this was a huge issue and wouldn't happen under the current model, especially difficult in rural areas.
- Question on whether insurance companies can cooperate with each other in light of anti-trust laws. Oregon Quality Corporation is working on this – including Medicare, Medicaid, and commercial data.
- Discussion on rural area care and availability of Medicare Advantage plans in rural Oregon.
- Staff will put together data with penetration level for rural areas with distribution of HMO's and PPO's.

**Chair Baumeister IV. Medicare Panel: Medicare Special Needs Plans**

**Patrick Curran, Medicare Director, CareOregon (See presentation)**

- CareOregon SNP serves 5,300 dual eligibles (who have both Medicare and Medicaid) in 9 Oregon counties. Members access nearly all care

through CareOregon – carve out for dental and mental health care. Most states don't put dual eligibles in managed care.

- Benefits of integrated care discussed. Can easily sign up OHP enrollee in Medicare too, care coordination and community resources – can link to housing services, etc. Access: providers are open to new members.
- FFS reimbursement limits discussed.
- Discussed exceptional needs coordinators for OHP and Medicare members.

#### **Kelly Kaiser, CEO, Samaritan Health Plans (See presentation)**

- CMS is no longer accepting applications for new SNP plans and will not accept expansion of existing SNP plans starting Jan, 2009. Think this is due to unexpected influx of SNP plans.
- Samaritan offers a managed care SNP for dual eligibles, started in 2005. Discussion of start up process.
- Benefits of their SNP: Access to providers is contractually guaranteed, higher reimbursement rates for providers, community based plan, provider billing is simplified, mental health benefits are coordinated, one case manager or ENCC manages each member's care

#### **Discussion**

- Discussion on CMS restrictions on SNP plan expansions/applications: perhaps lots of SNP applications because costs can be managed and high cost population can be carved out which lowers Medicare Advantage bid.
- Now CMS requires SNPs send data separately from other Medicare Advantage plan data.
- Risk adjustment is based on diagnosis – heard about one chronic care SNP for high cholesterol – think CMS was overwhelmed.
- SNPs for duals offer true benefits to members and should expand.

#### **Chair Baumeister V.**

#### **Presentation by Scott Kipper, Oregon Insurance Administrator**

- Regulation of Medicare supplement products: National Association of Insurance Commissioners (NAIC) has authority to develop products. Products are approved at state level. Discussed loss ratios for individual and small group products.
- Medicare Advantage plans have very little oversight – state oversees solvency of carriers, licensure of insurance agents. No state oversight of product design, marketing practices by plans, etc. – these aspects are overseen by CMS.
  - Have seen documented marketing abuses mostly by agents, not carriers. In Louisiana, Scott Kipper saw abuses such as knocking on doors and refusing to leave until senior signs up, setting up tables at assisted living and senior centers to get seniors to sign up. Abuses mostly on PFFS side (not HMO/PPO)
  - Some interest in Washington DC in providing states with more oversight role. Think proposal will be to give states similar oversight to Medicare supplement oversight, which he would strongly support. State oversight allows states to get rid of marketing abuses and provide consumers with a local outlet for their concerns.

- Discussion of focused role of an Exchange and how rules would be enforced.

**Chair Baumeister VI. Medicare: Committee Discussion**

- Barney Speight inquired if the Committee had specific requests for information.
  - Unaccountability of payments and rebates of Medicare Advantage Plan. Staff will follow up on all plans and what kind of transparency exists now.
  - Research on what is possible within Medicare/Social Security Law for Health Fund Board recommendations.
  - Clarification/accuracy of the 133% payment difference to physicians
  - Question about Medicare Advantage open enrollment and being able to change plans, and formulary changes for Part D plans.
  - Concern that CMS doesn't have data to justify higher rates for Medicare Advantage plans.
- Recommendations on approach by committee.
- Need for relief on Medicare fronts.
- Implications of ERISA, e.g. individual mandate
- Oregon Quality Corporation, a 501(c) 3 program, discussed.

**Chair Baumeister VII. Public Testimony**

- **Debby Schwartz, Archimedes Member, person with disabilities on Medicare**, addressed a previous comment concerning people tending not to switch out of the Medicare Advantage plans: mentioned enrollees are locked in for one year. Provided testimony on personal experiences with Medicare.

**Chair Baumeister VIII. Adjournment**

Meeting adjourned by Chair Baumeister.

**Next meeting March 25, 2008.**

Submitted By:  
Paula Hird

Reviewed By:  
Susan Otter

**EXHIBIT MATERIALS**

1. Draft Agenda for March 13 meeting
2. Feb 28<sup>th</sup> draft minutes
3. Medicare themes presented to Committee
4. Medicare Advantage background:
  - a. Medicare Advantage background, including Special Needs Plans: MedPac Report to Congress, March 2008 (excerpt)
  - b. Medicare Advantage and SNP enrollment, payment data
  - c. "Medicare Advantage: Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries" GAO report 08-522T, Feb. 28, 2008.
  - d. "CMS to Investigate Use of Rebate Funds by Medicare Advantage Plans, Weems Says," National Health Law Program, Volume 13 Number 40, February 29, 2008
5. Medicare background
  - a. Current CMS demonstration and pilot programs
  - b. "Medicare: Starting Now on the Path to Higher Value," By Karen Davis and Stu Guterman, Commonwealth Fund, Feb. 28, 2008.
  - c. OMA Letter to Sen. Wyden, Oct. 24, 2007
6. Medicaid follow-up:
  - a. Report for US House Committee on Oversight and Government Reform, on the impacts on Oregon of CMS proposed rules, DHS Office of Federal Financial Policy, Feb. 15, 2008.
  - b. "The Proxy War — SCHIP and the Government's Role in Health Care Reform," Sara Rosenbaum, J.D., New England Journal of Medicine, Vol. 359 No. 9, pp. 869-872, Feb 28, 2008.
  - c. "New Medicaid Rules Would Limit Care For Children in Foster Care and People with

- Disabilities in Ways Congress Did Not Intend,” Judith Solomon, Center for Budget and Policy Priorities, Feb. 8, 2008.
- d. “Four States Ask Court to Overturn HHS Limits On Medicaid Payments for Case Management” National Health Law Program, Volume 13 Number 42, Friday, March 4, 2008
7. Other articles:
    - a. “The Cost-Coverage Trade-off: ‘It’s Health Care Costs, Stupid,’” Ezekiel J. Emanuel, MD, PhD, *JAMA* 2008; 299: 947-949, Feb 27, 2008.
    - b. “Who Really Pays for Health Care?: The Myth of ‘Shared Responsibility’” Ezekiel J. Emanuel and Victor R. Fuchs, *JAMA*. 2008; 299(9):1057-1059, March 5, 2008.
  8. Other Committee business:
    - a. February OHFB report to legislature, includes revised design principles and assumptions
- b. March OHFB newsletter
  - c. Affordability recommendations from the Eligibility and Enrollment Committee presented to the Oregon Health Fund Board on 2/19
  - d. Eligibility recommendations from the Health Equities Committee presented to the Oregon Health Fund Board on 2/19
9. Public comment:
    - a. Prof. Art LaFrance phone conversation notes

**PRESENTATIONS/HANDOUTS:**

1. Dr. Kevin Keck’s presentation, Providence Health Plans
2. Pat Gibford’s presentation, Clear Choice Health Plans
3. Patrick Curran’s presentation, CareOregon
4. Kelley Kaiser’s presentation, Samaritan Health Plans
5. Medicare Advantage enrollment in Oregon by region and plan type (HMO/PPO/PFFS)