



DAS General Services Building  
1225 Ferry St SE, Ste B, Salem, OR

**PUBLIC MEETING AGENDA**

Tues., July 20, 2010; 10:30 a.m. – 4:00 p.m.

- 1. **Welcome and Approval of Minutes** (info/action: Bdattachs.1/1A/1B/1C) ..... 10:30 – 10:45  
**Rich Peppers, Chair**  
The Board will review and approve the minutes from its June 8, 15, 23 and 29, 2010 Board meetings.

**Overview of Meeting and Updates** (info)

**Joan Kapowich, Administrator**

The Board will hear an overview of the meeting agenda topics and receive an update from the Administrator.

- 2. **Operation Subcommittee Update** (info/discussion: Bdattach.2) ..... 10:45 – 11:00  
**Paul McKenna**  
Mr. McKenna will provide an update on the Operations Subcommittee’s July 13, 2010 meeting.

- 3. **GASB Update** (info/discussion: Bdattach.3)..... 11:15 – 11:30  
**Sheree Swanson, Mercer**  
Mercer will share the final GASB report.

- 4. **Public Comment**..... 11:30 – 12:00  
During this time period, PEBB members and members of the public may address the Board with comments, suggestions, recommendations or concerns regarding PEBB benefits or other Board business. The Board may proceed with agenda items between public presentations.

**BREAK** ..... 12:00 – 12:30

- 5. **Samaritan Audit** (info/discussion: Bdattach.4)..... 12:30 – 1:00  
**Ralph Trieselmann, Mercer**  
The Board will review the draft Samaritan Audit.

- 6. **Essential Benefit Package** (info/discussion: Bdattachs.5/5A)..... 1:00 – 1:45  
**Jeanene Smith, MD**  
**Dareen Coffman, OHPR**  
Dr. Smith and Mr. Coffman will share information regarding the Oregon Health Fund Board Benefits Committee recommendation for an essential benefit package.



**Public Meeting Agenda**  
Tues., July 20, 2010

- 7. **Health Value Community®:**  
**Marion-Polk Counties Demonstration** (info/discussion: Bdattach.6) ..... 1:45 – 2:15  
**Steve Franey, Alan Shiffer**  
 Messrs. Franey and Shiffer will present information about a proposed chronic disease pilot project in Marion and Polk counties. Handouts will be available at the meeting.
  
- 8. **2012 Plan Design** (info/discussion: Bdattach.7)..... 2:15 – 4:00  
**Joan Kapowich, Administrator**  
 Cost drivers, medical trend and plan design. Handouts will be available at the meeting.
  
- ADJOURN** ..... 4:00



DAS General Services Building  
1225 Ferry St SE, Ste B, Salem

### Public Meeting Minutes

Tues., June 8, 2010; 11:00 – 11:30 a.m.

**DRAFT**

**NOTE:** Time codes for the video stream (xx:xx:xx) are provided at the beginning of each section. Please refer to the recorded video stream of this meeting for additional details. Topics may be heard out of agenda order.

<b>Board Members Present</b>	
Rich Peppers, Chair	Paul McKenna
Peter Callero	Fariborz Pakseresht
Rocky King	Jeanene Smith
Rep. Tina Kotek	Barney Speight
Diane Lovell	
<b>PEBB Staff Present</b>	
Bobbie Barott	Kathy Loretz
Chelsea Hollingsworth	Ingrid Norberg
Joan Kapowich	Chérie Taylor
<b>Guests Present</b>	
Jeff Akers, Kaiser	John C. Powell, J. Powell & Assoc. (Regence)
Diane Lund, The Lund Report	Dennis Thompson, Statesman Journal
Megan Myrick, Willamette Dental	Deborah Tremblay, OJD
Jean Poling, Kaiser	Denise Yunker, OUS
<b>Consultants Present</b>	
Mikel Gray, Mercer	Hans Leitzinger, Mercer
Kari Johnson, Mercer	
<b>Agenda</b>	
<b>Welcome and Call to Order</b>	
<b>Overview of Meeting</b>	
<b>Renewal Report/Proposed Rates</b>	
<b>Reserves/2011 Composite Rate/Plan Design Options</b>	

<b>VIDEO STREAM (00:00/29:29)</b>		
<b>1.</b>	<b>Welcome and Call to Order</b> Chair <b>Peppers</b> opened the meeting.	00:01
	<b>Overview of Meeting</b> Administrator <b>Joan Kapowich</b> reviewed the agenda.	00:16
<b>2.</b>	<b>Renewal Report/Proposed Rates</b> (info/ <u>action</u> : Bdattachs.1A/1B) <b>Kari Johnson</b> , Mercer, updated the Board on dental and vision vendor responses (Bdattach.1A) to the 2011 fourth renewal letters, including vendors' best and final rates. <b>Hans Leitzinger</b> , Mercer, updated the Board on medical vendor responses (Bdattach.1B), including best and final rates.  <b>Action:</b> The Board reserved taking action until its next regularly-scheduled meeting, June 15, 2010.	00:57 08:37
<b>3.</b>	<b>Reserves/2011 Composite Rate/Plan Design Options</b> (info/ <u>action</u> : Bdattach.2) <b>Mikel Gray</b> , Mercer, reviewed required self-insurance reserves, the 2011 composite rate and discussed various plan design options, including savings and member impact.  <b>Action:</b> The Board reserved taking action until its next regularly-scheduled meeting, June 15, 2010.	13:51
<b>4.</b>	<b>Public Comment</b> – No oral comments were offered, but written comments, submitted by Sharron Fuchs, were distributed to Board members.	29:09 29:19
	<b>Adjourn</b>	29:28



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### Public Meeting Minutes

Tues., June 15, 2010; 10:30 a.m. – 4:00 p.m.

**DRAFT**

**NOTE:** Time codes for the video stream (xx:xx:xx) are provided at the beginning of each section. Please refer to the recorded video stream of this meeting for additional details. Topics may be heard out of agenda order.

<b>Board Members Present</b>	
Rich Peppers, Chair	Paul McKenna
Peter Callero	Fariborz Pakseresht
Rocky King	Jeanene Smith (via telephone)
Rep. Tina Kotek	Barney Speight
Diane Lovell	
<b>PEBB Staff Present</b>	
Bobbie Barott	Kathy Loretz
Terry Daily-Zornado	Ingrid Norberg
Wendy Edwards	Margaret Smith-Isa
Chelsea Hollingsworth	Chérie Taylor
Joan Kapowich	
<b>Guests Present</b>	
Jeff Akers, Kaiser	Jean Poling, Kaiser
Claudia Black, Governor's Office	Ernie Pressman, UO
Thandi Clements, VSP	David Scearce, The Standard
Cash Singleton-Davis, Providence	Diane McMillan-Skutack, BHS
Gordon Hoberg, ODS	Dana Tierney, Regence
Shelia Jameson, Providence	Dennis Thompson, Statesman Journal
Laurel Klaus, Regence	Deborah Tremblay, OJD
Diane Lund, The Lund Report	Don Wiggins, The Standard
Julie Marshall, Cascade EAP	Denise Yunker, OUS
Megan Myrick, Willamette Dental	Andrea Zottola, Providence
Cynthia Platanov, ODS	
<b>Consultants Present</b>	
Mikel Gray, Mercer (via telephone)	Sheree Swanson, Mercer
<b>Agenda</b>	
<b>[VIDEO STREAM: Screen 1]</b> <b>Welcome and Approval of Minutes</b> <b>Overview of Meeting and Updates</b> <b>Administrative Rules</b> <b>Public Comment</b> <b>Request from DAS</b>	<b>[VIDEO STREAM: Screen 2]</b> <b>Stabilization Fund, RBC &amp; Plan Design</b>

<b>[VIDEO STREAM: Screen 1 (00:00/01:22:56)]</b>		
<b>1.</b>	<p><b>Welcome and Approval of Minutes</b> (info/<u>action</u>: Bdattach.1)  <b>Chair Peppers</b> opened the meeting and called for a motion approving the Board's May 18, 2010 meeting minutes.</p> <p><b>Action:</b> <b>Barney Speight</b> moved to approve the May 18, 2010 minutes. <b>Diane Lovell</b> carried the motion, which passed unanimously.</p>	00:04  00:44
	<p><b>Overview of Meeting and Updates</b>  Administrator <b>Joan Kapowich</b> reviewed the agenda and updated the Board on recent events and other topics of interest.</p>	00:47
<b>2.</b>	<p><b>Administrative Rules</b> (info/<u>action</u>: Bdattach.2)  <b>Wendy Edwards</b>, Director of Operations, summarized draft Oregon Administrative Rules (OARs) changes for the Board, which include new, amended, and repealed OARs to be filed July 1<sup>st</sup> for an effective date of Oct. 1, 2010.</p> <p><b>Action:</b> Vice-Chair <b>Barney Speight</b> moved to approve modifications to PEBB's OARs. Chair <b>Rich Peppers</b> seconded the motion, which the Board unanimously carried.</p>	05:50  23:03
<b>3.</b>	<p><b>Public Comment</b> – The Board heard public comment jointly from Virginia Key, Eastern Oregon University, and Denise Yunker, Oregon University System, and from Keith Breswick, PEBB member.</p>	24:32
<b>4.</b>	<p><b>Request from DAS</b> (info/<u>action</u>: Bdattach.3)  <b>Paul McKenna</b>, Board member, presented three requests for disbursement of funds to pay the General Fund portion of plan premiums above 10%.</p> <p><b>Action:</b> The Board reserved taking action on this item until its last item, Stabilization Funds, RBC &amp; Plan Design, could be heard.</p>	56:10  01:09:55
<b>[VIDEO STREAM: Screen 2 (00:00/02:49:37)]</b>		
<b>5.</b>	<p><b>Stabilization Fund, RBC &amp; Plan Design</b> (info/<u>action</u>: Bdattach.2)  <b>Wendy Edwards</b>, Director of Operations, and <b>Sheree Swanson</b> and <b>Mikel Gray</b>, Mercer, discussed Mercer's recommended levels of stabilization fund and risk-based capital reserves. A variety of plan design options, including potential members' savings and member impact were reviewed for the Board.</p> <p><b>Action:</b> <b>Diane Lovell</b> moved to authorize staff to draw from The Standard demutualization funds to pay claims and to maintain PEBB stabilization reserves at the low reserve balance. The motion, receiving no second, failed to carry.</p> <p><b>Action:</b> <b>Peter Callero</b> moved to invoke benefit modifications that would require \$100 flat co-payment amounts on sleep study and imaging benefits. <b>Paul McKenna</b> seconded the motion, which the Board passed unanimously.</p>	00:14  01:38:13  02:41:45
	<p><b>Adjourn</b></p>	02:49:34



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### Public Meeting Minutes

Tues., June 23, 2010; 8:00 – 10:30 a.m.

**DRAFT**

**NOTE:** Time codes for the video stream (xx:xx:xx) are provided at the beginning of each section. Please refer to the recorded video stream of this meeting for additional details. Topics may be heard out of agenda order.

<b>Board Members Present</b>	
Rich Peppers, Chair	Paul McKenna
Peter Callero	Fariborz Pakseresht
Rocky King	Jeanene Smith
Rep. Tina Kotek (via telephone)	Barney Speight
Diane Lovell	
<b>PEBB Staff Present</b>	
Bobbie Barott	Kathy Loretz
Wendy Edwards	Ingrid Norberg
Chelsea Hollingsworth	Chérie Taylor
Joan Kapowich	
<b>Guests Present</b>	
Cash Singleton-Davis, Providence	David Scearce, The Standard
Shelia Jameson, Providence	Diane McMillan-Skutack, BHS
Laurel Klaus, Regence	Marilyn Teleck, PEBB member/retiree
Gregg Loudermilk, AFLAC WWHQ	Dana Tierney, Regence
Diane Lund, The Lund Report	Deborah Tremblay, OJD
Paul Pfinister, AFLAC	Don Wiggins, The Standard
Cynthia Platanov, ODS	Peter Wong, Statesman Journal
Jean Poling, Kaiser	Denise Yunker, OUS
<b>Consultants Present</b>	
Mikel Gray, Mercer (via telephone)	
<b>Agenda</b>	
<b>Welcome and Call to Order</b> <b>Overview of Meeting and Updates</b> <b>Stabilization Fund, RBC &amp; Plan Design</b> <b>Public Comment</b>	

[VIDEO STREAM: 00:00:00/02:30:04]		
1.	<p><b>Welcome and Call to Order</b> (info)  <b>Chair Peppers</b> opened the meeting.</p>	00:02
	<p><b>Overview of Meeting and Updates</b>  Administrator <b>Joan Kapowich</b> reviewed the agenda, updating the Board on staff's follow-up tasks from the Board's June 16, 2010 meeting, as well as other topics of interest.</p>	00:08
2.	<p><b>Stabilization Fund, RBC &amp; Plan Design</b> (info/<b>action</b>: Bdattach.1)  <b>Wendy Edwards</b>, Director of Operations and <b>Mikel Gray</b>, Mercer, reviewed updated information for the Board, explaining changes arising from the application of new numbers entered to develop a composite rate, the effects of applying the collective bargaining agreement and plan design options.</p> <p><b>Action: Barney Speight</b> moved to:</p> <ol style="list-style-type: none"> <li>1. adopt changes to PEBB's State-wide Plan benefits, including: <ul style="list-style-type: none"> <li>• application of a \$500 member co-payment (similar to OEGB's recent action) for certain specialty shared services, including upper GI endoscopy, spine procedures for pain, hip or knee replacements and shoulder and knee arthroscopies;</li> <li>• introduction of a \$250 In-Network/\$500 Out-of-Network member Deductible, with four office visits not subject to Deductible, and;</li> <li>• increase member annual out-of-pocket maximums from \$1,000 to \$1,250.</li> </ul> </li> <li>2. separate retirees from the PEBB active pool, and;</li> <li>3. discontinue PEBB's \$20,000 life insurance benefit, effective Jan. 1, 2011, transferring remaining Standard demutualization Fund monies into PEBB's Stabilization Reserves.</li> </ol> <p><b>Rocky King</b> seconded the motion.</p> <p><b>Diane Lovell</b> moved to amend Mr. Speight's motion, eliminating moved benefit changes and instead aggressively reviewing the options, including opportunity for public comment and make a decision to be incorporated into the upcoming RFP or implement earlier than 2012. Consistent with the collective bargaining agreement, Ms. Lovell would have the Board utilize current reserves as needed to pay claims and on a monthly basis, transferring funds from The Standard demutualization funds to maintain a low reserve balance in the stabilization reserve. <b>Peter Callero</b> seconded Ms. Lovell's amended motion.</p> <p>The amended motion, in a roll-called vote, failed to carry, with four Board members voting for, and four members voting against, the motion.</p> <p>Because the amended motion failed for lack of a majority, Mr. Speight's original motion was voted on in a roll-called vote. It, too, failed to carry for lack of a majority with the Board again evenly divided for and against the motion.</p> <p><b>Rocky King</b> moved to adopt the benefit changes contained in Mr. Speight's motion. <b>Barney Speight</b> seconded the motion. After some discussion, <b>Diane Lovell</b> moved the motion, which <b>Barney Speight</b> also seconded. The motion to</p>	<p>03:45</p> <p>01:36:41</p> <p>01:39:37</p> <p>01:48:53</p> <p>01:50:28</p> <p>01:52:27</p> <p>01:53:39</p>

	move the motion passed unanimously. Mr. King's motion, on which the Board voted evenly for and against, failed to carry.	02:27:04 02:27:23
<b>3.</b>	Written <b>public comment</b> was submitted by Marilyn Teleck, PEBB retiree.	01:35:22
	<b>Adjourn</b>	02:30:00



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### Public Meeting Minutes

Tues., June 29, 2010; 8:00 – 10:30 a.m.

**DRAFT**

**NOTE:** Time codes for the video stream (xx:xx:xx) are provided at the beginning of each section. Please refer to the recorded video stream of this meeting for additional details. Topics may be heard out of agenda order.

<b>Board Members Present</b>	
Rich Peppers, Chair	Paul McKenna
Peter Callero	Fariborz Pakseresht
Rocky King	Jeanene Smith
Rep. Tina Kotek (via telephone)	Barney Speight
Diane Lovell	
<b>PEBB Staff Present</b>	
Bobbie Barott	Kathy Loretz
Wendy Edwards	Ingrid Norberg
Chelsea Hollingsworth	Chérie Taylor
Joan Kapowich	
<b>Guests Present</b>	
Don Antonucci, Regence	Marilyn Teleck, PEBB member/retiree
Shelia Jameson, Providence	Dennis Thompson, Statesman Journal
Megan Myrick, Willamette Dental	Dana Tierney, Regence
Cynthia Platonov, ODS	Deborah Tremblay, OJD
Jean Poling, Kaiser	Don Wiggins, The Standard
Diane McMillan-Skutack, BHS	Denise Yunker, OUS
<b>Consultants Present</b>	
Mikel Gray, Mercer (via telephone)	
<b>Agenda</b>	
<b>Welcome and Call to Order</b> <b>Overview of Meeting and Updates</b> <b>Stabilization Fund, RBC &amp; Plan Design</b> <b>Public Comment</b>	

[VIDEO STREAM: 00:00:00/01:18:13]		
1.	<p><b>Welcome and Call to Order</b> (info)  <b>Chair Peppers</b> opened the meeting.</p>	00:04
	<p><b>Overview of Meeting and Updates</b>  Administrator <b>Joan Kapowich</b> reviewed the agenda, updating the Board on retirees covered by PERS' insurance program and other items of interest.</p>	00:21
2.	<p><b>Stabilization Fund, RBC &amp; Plan Design</b> (info/<u>action</u>: Bdattach.1)  <b>Wendy Edwards</b>, Director of Operations and <b>Mikel Gray</b>, Mercer, discussed stabilization fund and risk-based capital (RBC) reserve levels. Various plan design options were reviewed, including savings and impact to members.</p> <p><b>Action: Barney Speight</b> moved to:</p> <ol style="list-style-type: none"> <li>1. discontinue PEBB's \$20,000 life insurance benefit for employees (effective Dec. 31, 2010);</li> <li>2. accept DAS/SEIU's joint petition for PEBB stabilization reserve funds to bridge 2010's five percent to 10 percent General Fund premium gap, and;</li> <li>3. transfer remaining balance of demutualization funds into PEBB's stabilization reserve after above-listed financial transactions complete.</li> </ol> <p><b>Diane Lovell</b> seconded Mr. Speight's motion.</p> <p>The motion, in a roll-called vote, carried, with six Board members voting for and one member voting against. <b>Chair Peppers</b> abstained from the vote.</p> <p>Following the roll-call vote, <b>Peter Callero</b> moved to accept the joint petition of DAS (Scott Harra) and SEIU (Leslie Frane) to use PEBB stabilization reserve funds to cover the General Fund premium deficit, estimated by PEBB consultants to be about \$14,760,413, by taking the funds from The Standard demutualization fund. <b>Barney Speight</b> seconded the motion, which carried by a roll-called vote of 4-3.</p> <p><b>Barney Speight</b> moved to propose a 'sense of the Board' for 2012, recognizing that the cost of insured and self-insured medical and dental benefits in Plan Year 2012 will be the sum of the following;</p> <ol style="list-style-type: none"> <li>1. projected cost increases for benefits for 2012 over those incurred in 2011;</li> <li>2. an estimated \$14.7M resulting in the acceptance by the Board of the joint petition, and;</li> <li>3. an amount as determined by consultants to the Board to keep the PEBB stabilization reserves at the mid-point range.</li> </ol> <p><b>Diane Lovell</b> seconded the motion.</p> <p>After discussion, <b>Barney Speight</b> moved to amend his standing motion: Delete point 3, leaving the costs to be the sum of 1 and 2. In addition, the Board will keep the reserves at the low range and will make every effort to continuously grow the reserve to the mid-point.</p> <p><b>Diane Lovell</b> seconded the amended motion.</p>	<p>03:45</p> <p>08:04</p> <p>08:42</p> <p>11:46</p> <p>12:12</p> <p>16:26</p> <p>16:59</p> <p>28:17</p> <p>28:44</p>

	<p>After further discussion, <b>Diane Lovell</b> called the question, the calling of which passed unanimously. <b>Chair Peppers</b> called for members to affirm or deny amending Mr. Speight's original motion which, in a roll-called vote, was carried, four for and three against.</p> <p><b>Chair Peppers</b> then asked for a roll-called vote on Mr. Speight's amended motion, which was also carried by the Board, four voting for and three voting against.</p>	<p>42:28 42:38 42:46</p> <p>43:33</p>
<p><b>3.</b></p>	<p>Written <b>public comment</b> was submitted by Marilyn Teleck, PEBB retiree, and shared with the Board electronically on June 29, 2010.</p>	
	<p><b>Adjourn</b></p>	<p>01:18:13</p>



DAS General Services Building  
1225 Ferry St SE, Ste B, Salem

**OPERATIONS SUBCOMMITTEE  
PUBLIC MEETING MINUTES**  
Tues., May 11, 2010; 8:30 – 10:00 a.m.

**DRAFT**

**Subcommittee Members Present**

Paul McKenna, Chair  
Rocky King  
Fariborz Pakseresht

**PEBB Staff Present**

Bobbie Barott	Kathy Loretz
Wendy Edwards	Ingrid Norberg
Chelsea Hollingsworth	

**Guests Present**

Gordon Hoberg, ODS	Jean Poling, Kaiser
Shelia Jameson, Providence	Deborah Tremblay, OJD
Megan Myrick, Willamette Dental	

**Consultants Present**

None.

**Video Stream Navigation of Minutes:** Time links to the PEBB Operations Subcommittee Meeting video stream are provided to the right of each agenda item. Example: 00:04/01:17:18, where 00:04 is the time on the video stream where discussion was initiated, or an action was taken, by the Subcommittee.

- |                                 |                     |
|---------------------------------|---------------------|
| • Welcome/Call to Order         | • Operations Report |
| • OAR Review                    | • Public Comment    |
| • Projected v. Actual Cash Flow |                     |

1. **Welcome/Call to Order** (info/action: Opsattach.1)  
**Paul McKenna, Chair**  
**Chair McKenna** called the meeting to order and asked for a motion to approve minutes from the Subcommittee's last meeting. 00:04/01:17:18  
  
Action: **Rocky King** moved to approve the April 13, 2010 meeting minutes. **Paul McKenna** seconded the motion, which passed unanimously. 00:14/01:17:18
  
2. **Oregon Administrative Rules Review** (info: Opsattach.2)  
**Wendy Edwards, Director of Operations**  
**Bobbie Barott, Plan Design Manager**  
**Bobbie Barott** reviewed changes to PEBB's administrative and eligibility OARs, to be filed for an October, 2010 effective date. 00:33/01:17:18
  
3. **Projected v. Actual Cash Flow** (info/discuss: Opsattach.3)  
**Wendy Edwards, Director of Operations**  
**Wendy Edwards** updated the Committee on PEBB's projected cash flow compared to actual cash flow. 18:44/01:17:18
  
4. **Operations Report** (info/discuss: Opsattach.4)  
**Wendy Edwards, Director of Operations**  
**Wendy Edwards** reviewed PEBB's Operations Report through April 2010. 45:31/01:17:18
  
5. **Public Comment** 01:17:08/01:17:18  
 None.
  
6. **Adjourn** 01:17:18/01:17:18



## Projected v. Actual Cash Flow

July 13, 2010  
Wendy Edwards  
Director of Operations

Opsattach.2

### Executive Summary

PEBB staff and Mercer monitor projected versus actual cash flow reports for our self-insured carriers: ODS, Providence (Choice and PEBB Statewide Plan) and VSP. The projections are based on updated enrollment, and the claims are logged on an incurred basis. The projections for claims and fixed costs include incurred but not reported (IBNR) claims. This report provides data through May 2010. ODS remains in an overall negative position. Providence Choice, the PEBB Statewide Plan and VSP remain overall positive; all plans with the exception of Providence Choice Part-time plan and VSP ran a deficit for the month of May.

### Analysis

Staff compiles information from Mercer's monthly cash-flow reports and provides information on the following plans:

- ODS dental
- Providence Choice
- PEBB Statewide Plan
- VSP

To assist the Board in analysis of this information, each plan includes highlights for the month and notations that help explain trends and patterns. Represented data elements include projections of premiums and claims based on actual enrollment, as well as actual claims. The data are shown in both table and graphical formats to give representation of the monthly claims and cumulative impacts throughout the year.

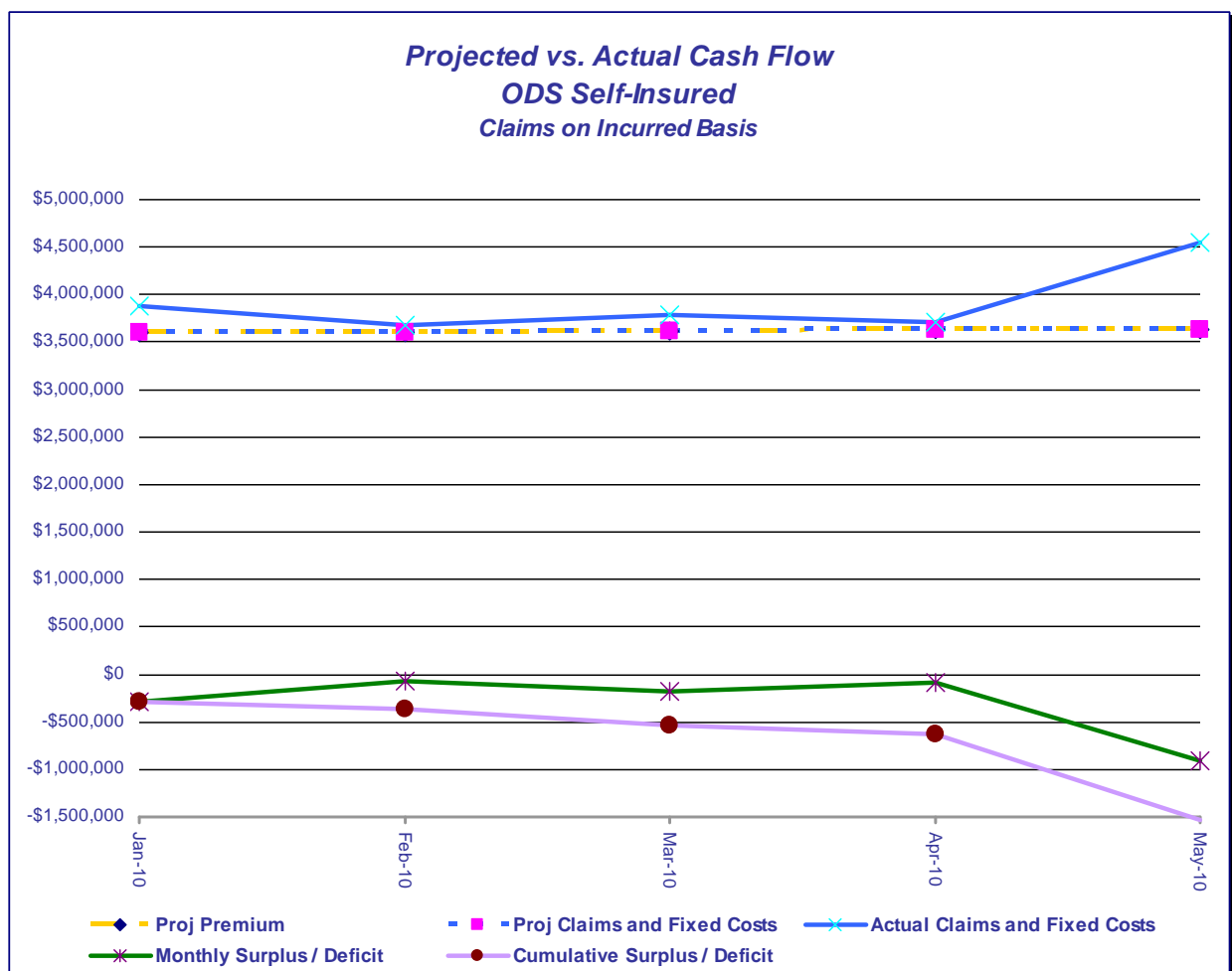
## ODS Cash Flow

Highlights for May include:

- Paid claims continue to grow, with almost \$4.2M paid in May
- On a PEPM basis, the 2010 YTD claims are 4.4% higher than 2009 YTD
- The deficit grew by \$912,000, with the year-to-date total deficit at \$1.5M
- All three plans ran at a deficit for the month with the Traditional plan deficit growing by \$548,000 to \$1.0M and the Preferred plan deficit growing by \$358,000 to \$564,000

Note: Numbers represent full- and part-time employees

Month	Proj Premium	Proj Claims and Fixed Costs	Actual Claims and Fixed Costs	Monthly Variance (Surplus / Deficit)	Cumulative Variance (Surplus / Deficit)
Jan 2010	\$ 3,596,545	\$ 3,596,545	\$ 3,882,256	\$ - 285,711	\$ - 285,711
Feb 2010	\$ 3,601,900	\$ 3,601,900	\$ 3,676,536	\$ - 74,636	\$ - 360,347
Mar 2010	\$ 3,610,301	\$ 3,610,301	\$ 3,786,827	\$ - 176,527	\$ - 536,873
Apr 2010	\$ 3,628,221	\$ 3,628,221	\$ 3,714,564	\$ - 86,342	\$ - 623,215
May 2010	\$ 3,633,512	\$ 3,633,512	\$ 4,546,096	\$ - 912,584	\$ - 1,535,799



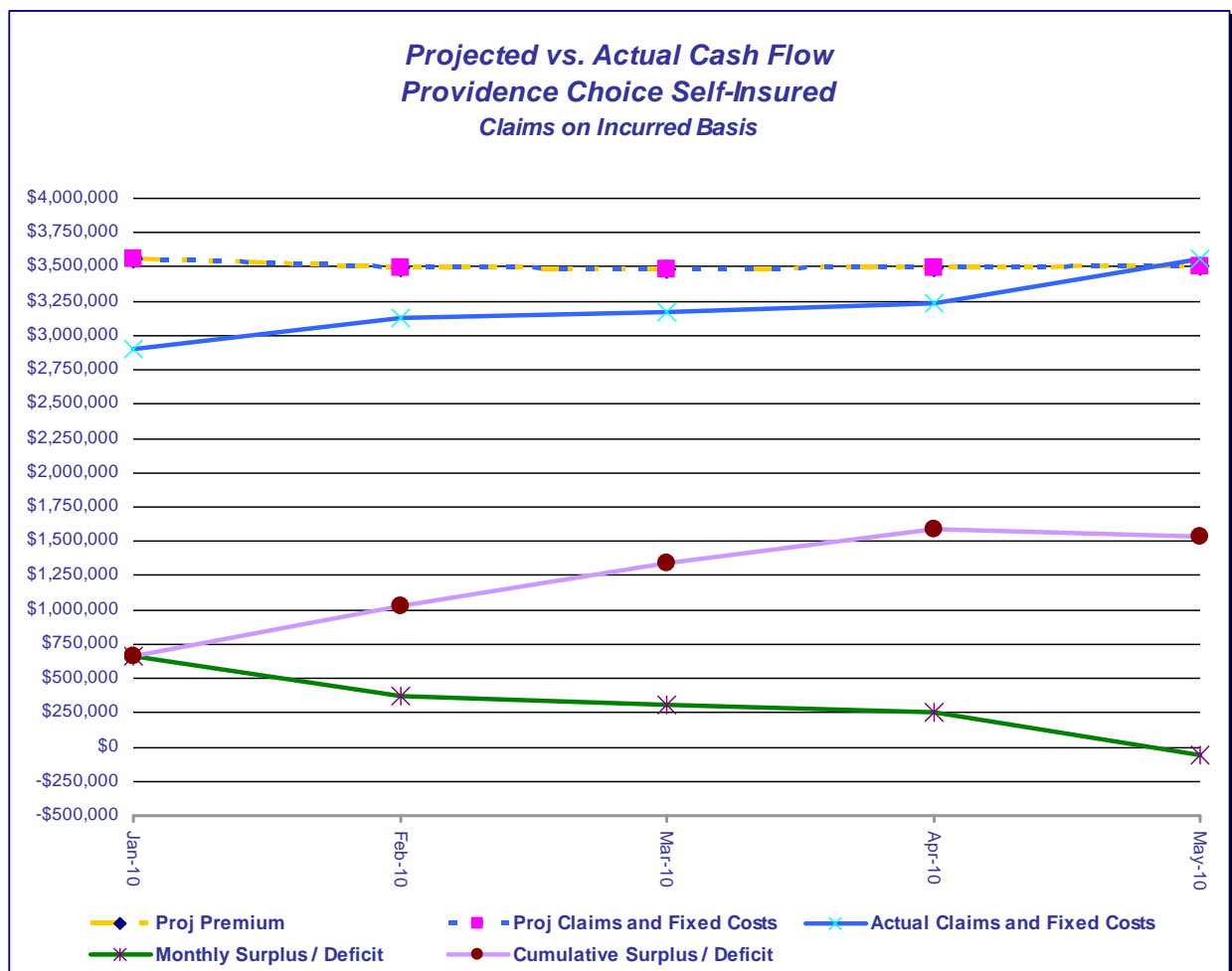
## Providence Choice Cash Flow

Highlights for May include:

- Paid claims grew in May to \$3.0M, with \$2.7M in medical and \$0.3M in Rx
- The plan ran at a slight deficit for May; for the year, the plan has a surplus of \$1.5M
- In May, the Full-Time plan had an \$82,000 deficit while the Part-Time plan ran a \$26,000 surplus

Note: Numbers represent full- and part-time employees

Month	Proj Premium	Proj Claims and Fixed Costs	Actual Claims and Fixed Costs	Monthly Variance (Surplus / Deficit)	Cumulative Variance (Surplus / Deficit)
Jan 2010	\$ 3,563,843	\$ 3,563,843	\$ 2,903,344	\$ 660,499	\$ 660,499
Feb 2010	\$ 3,496,066	\$ 3,496,066	\$ 3,128,930	\$ 367,136	\$ 1,027,636
Mar 2010	\$ 3,480,215	\$ 3,480,215	\$ 3,170,531	\$ 309,684	\$ 1,337,320
Apr 2010	\$ 3,494,212	\$ 3,494,212	\$ 3,238,648	\$ 255,564	\$ 1,592,884
May 2010	\$ 3,500,110	\$ 3,500,110	\$ 3,556,532	\$ - 56,422	\$ 1,536,462



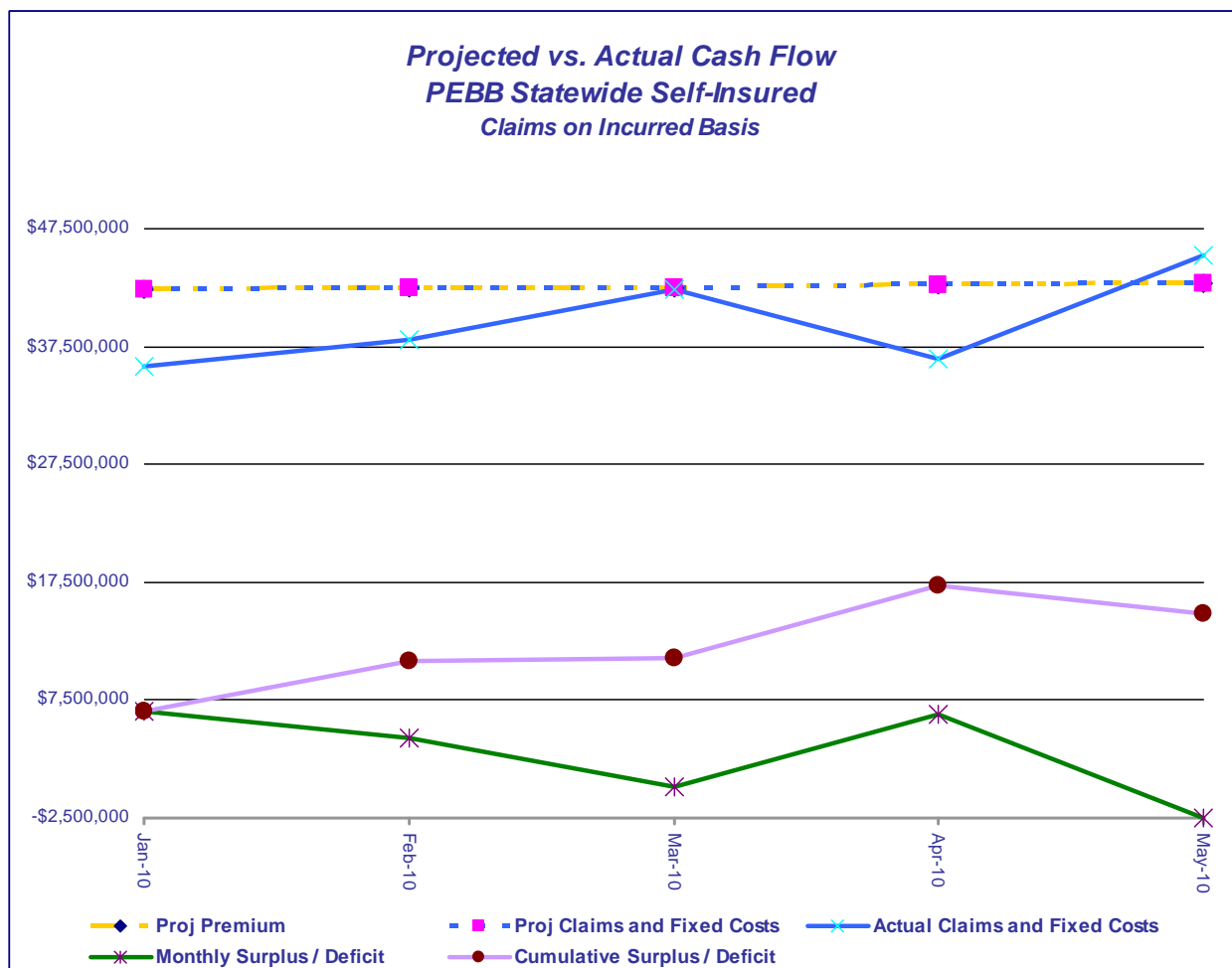
## Statewide Plan Cash Flow

Highlights for May include:

- Enrollment continues to grow in the Statewide plan with May at 39,543
- Paid claims increased significantly in May to almost \$42 million
- All of the increased claims were for medical services; prescription drug claims dropped to under \$5 million
- The plan ran at a deficit for May with expenses \$2.5M higher than the projected premiums; year-to-date, the surplus is at \$14.8M
- Both the Full-Time and Part-Time plans ran at a deficit for the month

Note: Numbers represent full- and part-time employees

Month	Proj Premium	Proj Claims and Fixed Costs	Actual Claims and Fixed Costs	Monthly Variance (Surplus / Deficit)	Cumulative Variance (Surplus / Deficit)
Jan 2010	\$ 42,382,999	\$ 42,382,999	\$ 35,850,365	\$ 6,532,635	\$ 6,532,635
Feb 2010	\$ 42,436,715	\$ 42,436,715	\$ 38,100,838	\$ 4,335,878	\$ 10,868,512
Mar 2010	\$ 42,511,675	\$ 42,511,675	\$ 42,342,705	\$ 168,971	\$ 11,037,483
Apr 2010	\$ 42,725,443	\$ 42,725,443	\$ 36,487,830	\$ 6,237,613	\$ 17,275,096
May 2010	\$ 42,789,440	\$ 42,789,440	\$ 45,276,685	\$ - 2,487,244	\$ 14,787,851

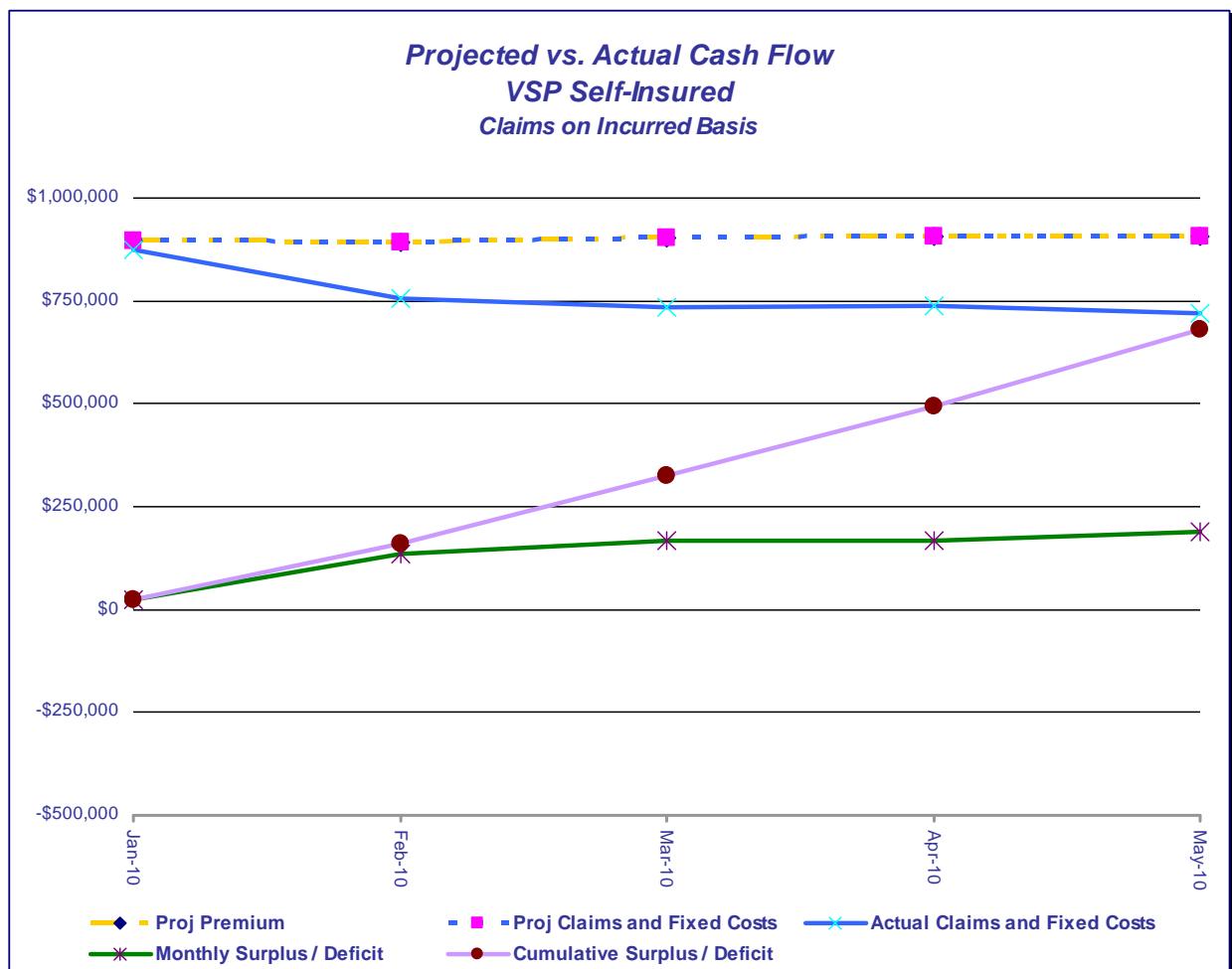


**VSP**

Highlights for May include:

- Paid claims for May were steady at \$666,000
- The surplus grew by \$188,000 in the month to \$682,000 YTD
- The plan is likely to run at a significant surplus for 2010 which is reflected in the decreased funding rate for 2011

Month	Proj Premium	Proj Claims and Fixed Costs	Actual Claims and Fixed Costs	Monthly Variance (Surplus / Deficit)	Cumulative Variance (Surplus / Deficit)
Jan 2010	\$ 896,820	\$ 896,820	\$ 872,694	\$ 24,126	\$ 24,126
Feb 2010	\$ 892,577	\$ 892,577	\$ 756,778	\$ 135,799	\$ 159,924
Mar 2010	\$ 901,615	\$ 901,615	\$ 735,410	\$ 166,205	\$ 326,130
Apr 2010	\$ 906,521	\$ 906,521	\$ 739,294	\$ 167,226	\$ 493,356
May 2010	\$ 908,355	\$ 908,355	\$ 720,008	\$ 188,347	\$ 681,703

**Board Action**

No Board action is required. This material is for informational purposes only.

# MERCER

Consulting. Outsourcing. Investments.



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

July 13, 2010

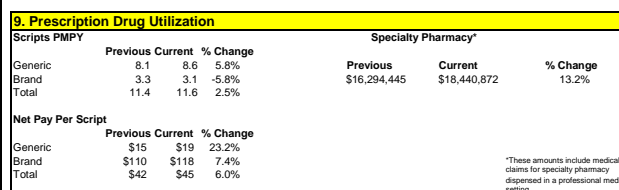
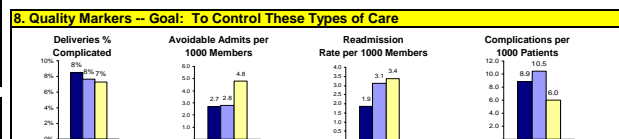
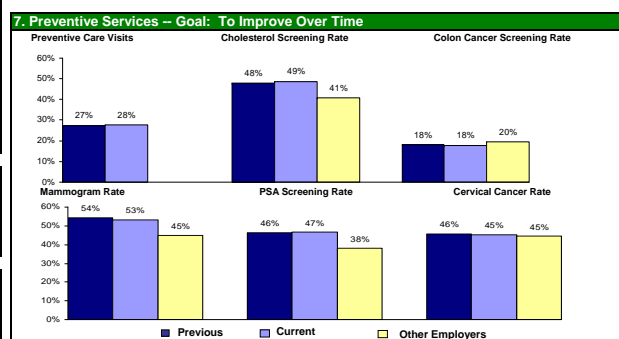
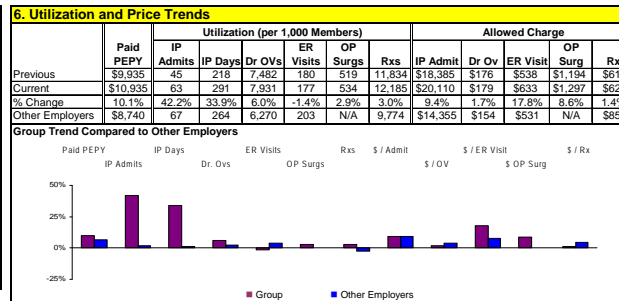
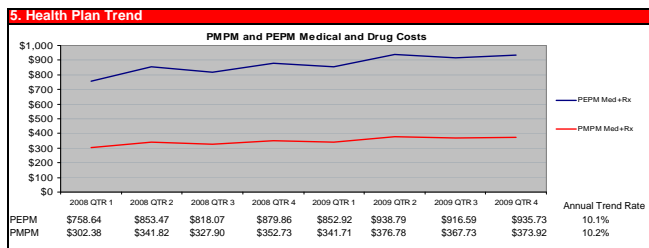
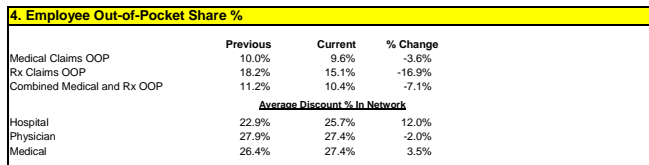
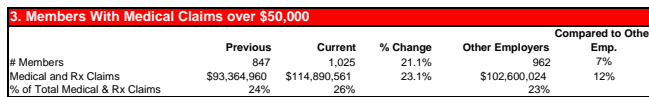
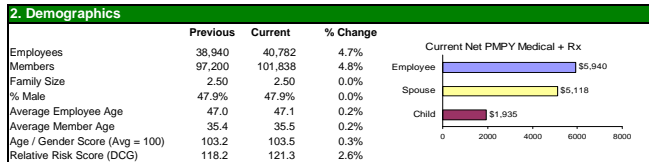
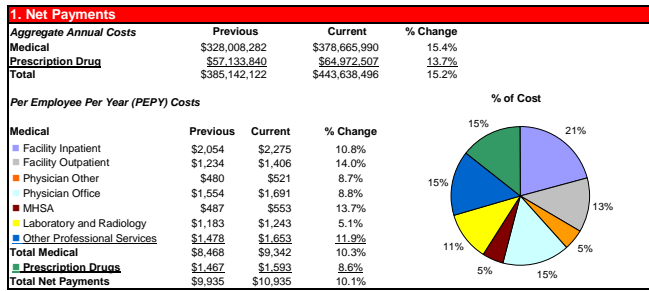
# Oregon Public Employees' Benefit Board Statewide PPO Plan Dashboard December 31, 2009 Quarterly Report

## Dashboard

# Comparison of December 2009 Quarterly Report to Previous Reports

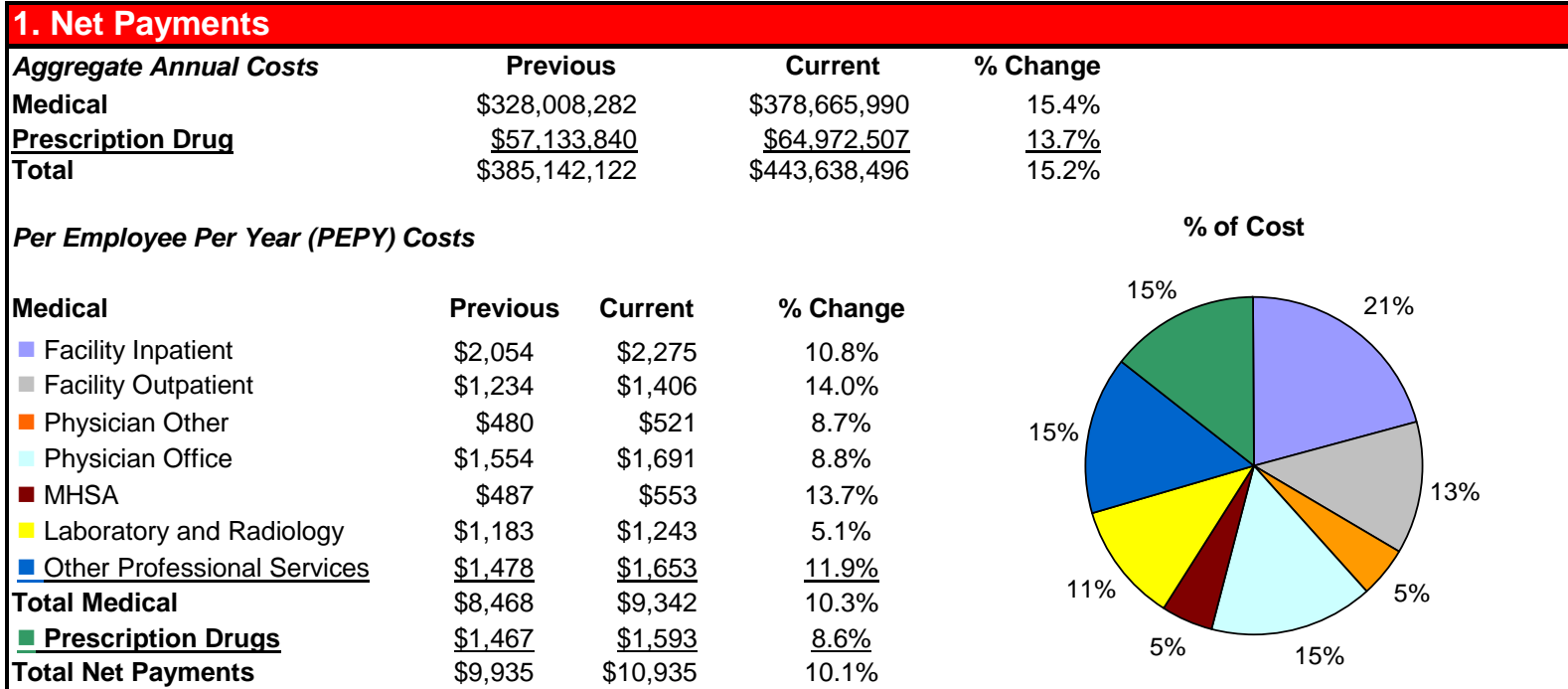
- High level changes from previous quarterly reports:
  - Medical/Rx PEPY trend currently 10.1%
    - September 2009 reported 12.0%
    - June 2009 was 12.6%
  - Medical only PEPY trend currently 10.3%
    - September 2009 reported 12.4%
    - June 2009 was 13.1%
  - Rx only PEPY trend now 8.6%
    - September 2009 reported 9.6%
    - June 2009 was 9.8%
  - 1,025 members with over \$50,000 in claims
    - September 2009 reported 1,000 members
    - June 2009 had 925 members

# Dashboard Overview



- This dashboard is a snapshot of statewide PPO experience, generated quarterly for PEBB's information - no Board action is required.
- Includes year-over-year comparisons of current 12 months over prior 12 months (current period is 1/1/09 – 12/31/09), and comparisons to other employer experience from Health Online database
- Each section highlighted red, yellow, or green.
  - Red – area of most concern
  - Yellow – area to watch
  - Green – no problems
- Each section is reviewed in more detail in the following pages.

# Dashboard Detail



- Total Net Payments increased 15.2% on an aggregate basis, and 10.1% per employee per year (PEPY) for the time period January 2009 through December 2009, versus January 2008 through December 2008
  - The 10.1% experience trend compares to a 10% trend assumption that was used for the statewide PPO plan for 2010 rates, which means rates are very slightly insufficient.
  - Facility Outpatient had the largest increase at 14.0%, reflecting significant increases in allowed charges for facilities.
  - Inpatient, MHSA, and Other Professional also had significant increases.

# Dashboard Detail

## 2. Demographics

	Previous	Current	% Change									
Employees	38,940	40,782	4.7%	<p>Current Net PMPY Medical + Rx</p> <table border="1"> <caption>Current Net PMPY Medical + Rx</caption> <thead> <tr> <th>Category</th> <th>Value</th> </tr> </thead> <tbody> <tr> <td>Employee</td> <td>\$5,940</td> </tr> <tr> <td>Spouse</td> <td>\$5,118</td> </tr> <tr> <td>Child</td> <td>\$1,935</td> </tr> </tbody> </table>	Category	Value	Employee	\$5,940	Spouse	\$5,118	Child	\$1,935
Category	Value											
Employee	\$5,940											
Spouse	\$5,118											
Child	\$1,935											
Members	97,200	101,838	4.8%									
Family Size	2.50	2.50	0.0%									
% Male	47.9%	47.9%	0.0%									
Average Employee Age	47.0	47.1	0.2%									
Average Member Age	35.4	35.5	0.2%									
Age / Gender Score (Avg = 100)	103.2	103.5	0.3%									
Relative Risk Score (DCG)	118.2	121.3	2.6%									

- The number of employees increased by 4.7%, with the family size staying constant
  - The increase in enrollment is partially due to former Samaritan enrollees joining the statewide PPO plan
- The age/gender score is slightly higher while the DCG risk score increased by 2.6%, indicating a worsening health status.
- Employees are 16% more expensive than spouses. This may be partly due to many spouses being covered as secondary.

## Dashboard Detail

### 3. Members With Medical Claims over \$50,000

	Previous	Current	% Change	Other Employers	Compared to Other Emp.
# Members	847	1,025	21.1%	962	7%
Medical and Rx Claims	\$93,364,960	\$114,890,561	23.1%	\$102,600,024	12%
% of Total Medical & Rx Claims	24%	26%		23%	

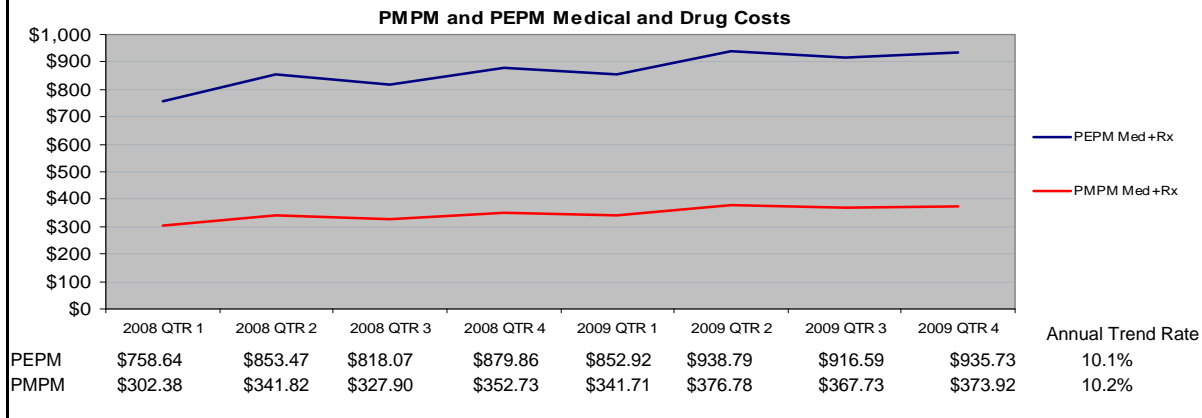
### 4. Employee Out-of-Pocket Share %

	Previous	Current	% Change
Medical Claims OOP	10.0%	9.6%	-3.6%
Rx Claims OOP	18.2%	15.1%	-16.9%
Combined Medical and Rx OOP	11.2%	10.4%	-7.1%
<b><u>Average Discount % In Network</u></b>			
Hospital	22.9%	25.7%	12.0%
Physician	27.9%	27.4%	-2.0%
Medical	26.4%	27.4%	3.5%

- The incidence of claims over \$50,000 has increased by 21.1%, and is still above the experience of other employers
- Employees are paying a smaller percentage out-of-pocket than last year, especially for prescription drugs
  - With increasing costs and fixed dollar copayments on some plan design provisions, the out-of-pocket costs as a percentage of allowed will decrease due to leveraging
  - Barrier free coverage helped reduce employee cost sharing
- Provider network discounts have improved for hospitals, but are unchanged for physicians and slightly improved for other medical services

# Dashboard Detail

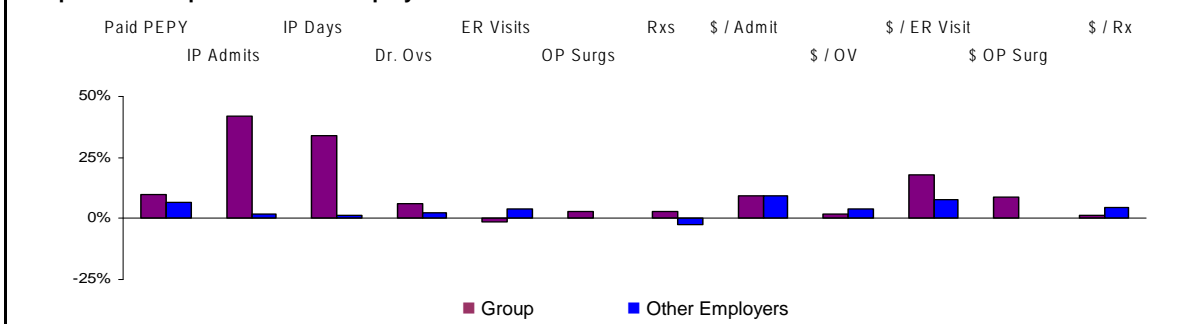
## 5. Health Plan Trend



## 6. Utilization and Price Trends

	Paid PEPY	Utilization (per 1,000 Members)						Allowed Charge				
		IP Admits	IP Days	Dr OV's	ER Visits	OP Surgs	Rxs	IP Admit	Dr Ov	ER Visit	OP Surg	Rx
Previous	\$9,935	45	218	7,482	180	519	11,834	\$18,385	\$176	\$538	\$1,194	\$61
Current	\$10,935	63	291	7,931	177	534	12,185	\$20,110	\$179	\$633	\$1,297	\$62
% Change	10.1%	42.2%	33.9%	6.0%	-1.4%	2.9%	3.0%	9.4%	1.7%	17.8%	8.6%	1.4%
Other Employers	\$8,740	67	264	6,270	203	N/A	9,774	\$14,355	\$154	\$531	N/A	\$85

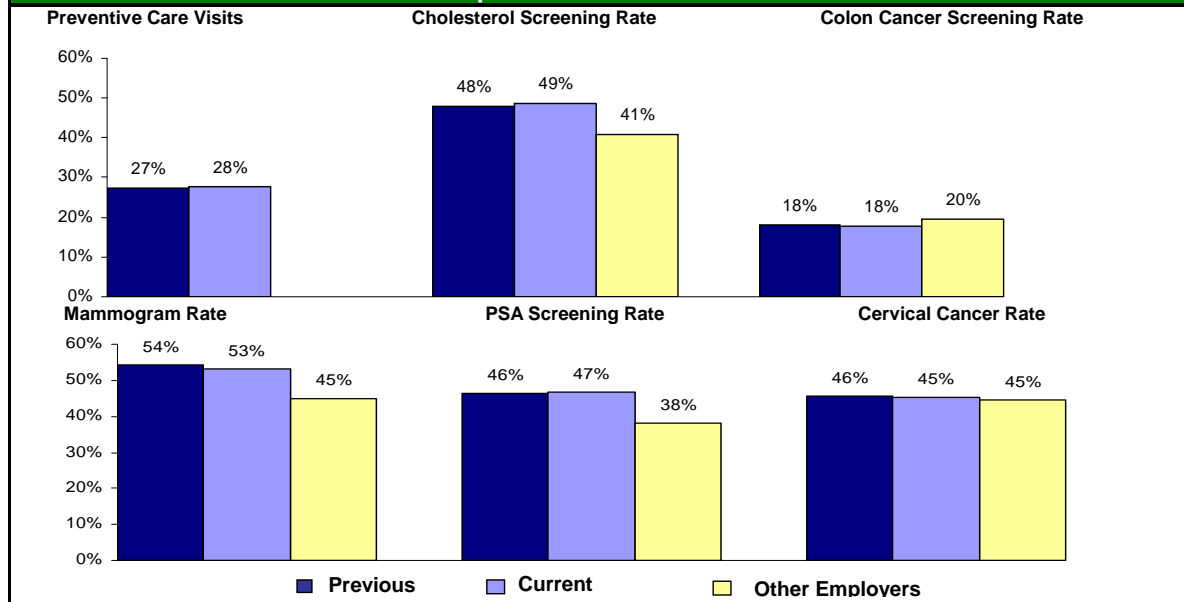
### Group Trend Compared to Other Employers



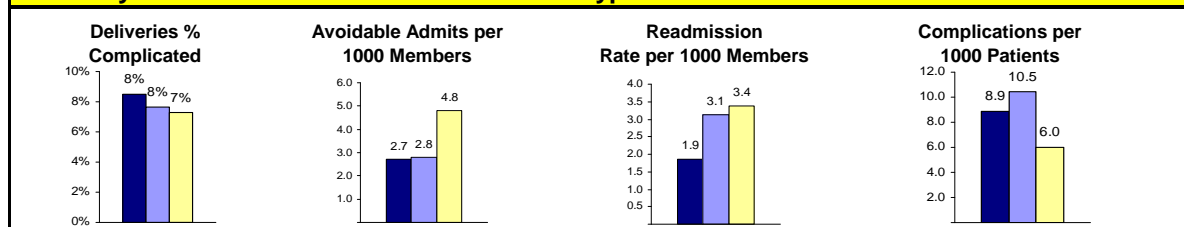
- Annual trend rate is 10.1% PEPY and 10.2% PMPM when comparing current 12 month period to prior 12 month period
- Average costs can vary from quarter to quarter due to seasonality, but in general have increased over the last 2 years
- Utilization is up in all categories except Emergency Room Visits
- IP Days, Office Visits and Rx are the categories with utilization higher than for other employers
- Allowed charges for IP Admits are 40% higher than for other employers
- The allowed cost per Emergency Room visit is 19% higher than for other employers

# Dashboard Detail

## 7. Preventive Services -- Goal: To Improve Over Time



## 8. Quality Markers -- Goal: To Control These Types of Care



- Colon Cancer Screening Rate remains the only Preventive Services category that is lower than for other employers.
- Complications per 1000 Patients and % of Deliveries that are Complicated are above the experience of other employers.
  - Complications per 1000 patients were 10.5 for the most recent 12 months, up from 10.2 reported during last quarter's report
  - Complications per 1000 members are increasing with the prior year at 8.9

## Dashboard Detail

### 9. Prescription Drug Utilization

Scripts PMPY				Specialty Pharmacy*		
	Previous	Current	% Change	Previous	Current	% Change
Generic	8.1	8.6	5.8%			
Brand	3.3	3.1	-5.8%	\$16,294,445	\$18,440,872	13.2%
Total	11.4	11.6	2.5%			
Net Pay Per Script						
	Previous	Current	% Change			
Generic	\$15	\$19	23.2%			
Brand	\$110	\$118	7.4%			
Total	\$42	\$45	6.0%			

\*These amounts include medical claims for specialty pharmacy dispensed in a professional medical setting.

- Generic usage continues to increase while utilization of brand named drugs dropped; overall, utilization increased slightly
- Net paid per script increased across the board although the shift from brand to generics muted the increase; some of the increase in net paid per script is due to a reduction in cost sharing
- Specialty pharmacy increased 13.2%; the increase is lower than the 14.4% observed last quarter

# Financial Clinical Dashboard Glossary

## Glossary Definitions, Part 1

**Acute Phase Therapy** is the number of patients diagnosed with a new episode of depression and treated with an antidepressant medication, aged 18 years and older, who remained on that medication during the entire 84-day acute treatment phase, expressed as a percentage of the total number of patients, aged 18 years and older, who were diagnosed with a new episode of depression and treated with an antidepressant medication. This excludes patients who had an acute mental health or substance abuse inpatient stay within 245 days of the beginning of the episode. This measure requires 24 months of data.

**Age Gender Score** is a relative score reflecting a groups age/gender mix relative to the overall population. The Average score equals 100.

**Allowed Amount** is the amount of submitted charges eligible for payment for all claims. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.

**Allowed Amt Med + Rx Cost Per Patient** represents the average amount of submitted charges eligible for payment for services provided under medical coverage as well as prescriptions filled that are included in condition specific episodes of care, per condition specific episode of care patient with appropriate coverage. It is the amount eligible after applying pricing guidelines, but before deducting third party, copayment, coinsurance, or deductible amounts.

**Asthma Pharmacy** is the number of patients with asthma episodes of care having filled prescriptions for asthma. This measure requires 24 months of data.

**Avoidable Admissions Per 1000** is the average number of acute admissions for conditions that generally would not result in inpatient admission if appropriate prior treatment occurred, per 1000 members with medical coverage per year.

**Beta Blocker Therapy** is the percent of patients hospitalized and discharged, aged 18 years and older, who were prescribed beta blocker therapy for 6 months. This measure requires 12 months of data.

**Cervical Cancer Screening Rate** identifies tests used to screen for cervical cancer that were performed on females, age 21 through 64.

**Cholesterol Screening Rate** Identifies the cholesterol tests used to evaluate cholesterol levels as part of an adult (age 18 and older) cardiovascular assessment. Cholesterol tests are defined as lipid panels, serum cholesterol tests and blood lipoprotein tests, including VLDL, HDL, IDL, and LDL.

**Colon Cancer Screening Rate** identifies the tests or procedures used to screen for colorectal cancer that were performed on adults, age 51-80.

**Complications Per 1000 Patients** is the average number of patients who received services provided under medical coverage that were reported on a claim with a principal or secondary diagnosis denoting a complication of care resulting from a healthcare intervention, per 1000 unique members with medical coverage.

**Deliveries % Complicated** is the number of deliveries where the patient was identified as having a delivery complication, expressed as a percentage of the total number of deliveries.

**Emergency Room Visits Per 1000 (ER Visits)** is the average number of emergency room facility visits per 1000 members with medical coverage per year.

**HbA1c Test** is the percentage of patients, aged 18 to 75 years, who had a diabetes mellitus episode of care who had a hemoglobin A1c test. This measure requires 24 months of data.

**Inpatient Admits Per 1000 (IP Admits)** is the average number of acute admissions per 1000 members with medical coverage per year.

**Inpatient Days Per 1000 (IP Days)** is the average number of days from acute admissions per 1000 members with medical coverage per year.

**Mammogram Screening Rate** identifies the mammography procedures used to screen for breast cancer that were performed on females, age 40 and older.

**Member** includes employees, spouses and children.

**Net Payment** is the amount the plan paid. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted.

**Out of Pocket** is the amount paid out-of-pocket by the member for facility, professional, and prescription drug services. This generally includes coinsurance, copayment, and deductible amounts. It excludes expenses not covered by the plan and contributions required for plan enrollment.

**Outpatient Surgeries Per 1000 (OP Surgs)** is the average number of outpatient surgeries per 1000 members with medical coverage per year.

**Oxygen Therapy** is the number of patients who received oxygen therapy equipment in a Chronic Obstructive Pulmonary Disease or Emphysema episode of care, expressed as a percentage of the total number of patients who had a Chronic Obstructive Pulmonary Disease or Emphysema episode of care.

# Financial Clinical Dashboard Glossary

## Glossary Definitions, Part 2

**Patients Low Back w/o Imaging Studies** is the percentage of patients, aged 18 to 50 years, who had an ambulatory encounter for low back pain, had no low back pain encounter within the previous 6 months, who had no low back imaging study done within 28 days of the encounter. Patients with a diagnosis of cancer at any time, or a diagnosis of trauma, IV drug abuse, or neurologic impairment within the previous or following year are excluded from the results since these are diagnoses for which an imaging study for low back pain is clinically indicated. Patients with multiple ambulatory encounters for low back disorder are classified as being without imaging if any one of those encounters was not followed by imaging within 28 days.

**PEPM/PEPY:** Per Employee Per Month and Per Employee Per Year. Paid PEPM/PEPY medical rates are calculated assuming a 2 month enrollment lag. Paid PEPM/PEPY prescription drug rates are calculating assuming no lag in enrollment.

**PMPM/PMPY:** Per Member Per Month and Per Member Per Year. Paid PMPM/PMPY medical rates are calculated assuming a 2 month enrollment lag. Paid PMPM/PMPY prescription drug rates are calculating assuming no lag in enrollment.

**Physician Office Visits Per 1000 (Dr. OVs)** is the average number of professional office visits, per 1000 members with medical coverage per year.

**Preventive Screening Rates** (Colon Cancer, PSA, Mammogram, Cholesterol, Cervical Cancer) are the number of patients who received facility or professional preventive screening services, expressed as a percentage of the average number of members for whom this test is appropriate.

**Preventive Care Visits** is the Percentage of unique members who had a preventive visit and defined by service subcategory \*24.

**Primary Care Visits CHF** is the number of outpatient evaluation and management visits included in Congestive Heart Failure episodes of care, per the average number of patients who had congestive heart failure episodes of care.

**PSA Screening Rate** identifies the Prostate Specific Antigen (PSA) tests used to screen for prostate cancer that were performed on males, age 50 and older.

**Readmission Rate Per 1000** is the average number of acute admissions that occurred within 15 days of a previous acute care admission for the same patient, regardless of the diagnosis, per 1000 members with medical coverage per year.

**Relative Risk Score** provides the expected health risk of a group relative to a mean score of 100. The risk score reflects the underlying illness burden of a group based on age, sex and diagnosis data for group members. Scores were developed using the Diagnostic Cost Group (DCG) method developed by Verisk HealthCare, Inc. A score greater than 100 indicates that a group has a higher than average burden of illness; a score less than 100 indicates a more favorable level of health risk compared to MarketScan.

**Scripts Per 1000 Rx** is the average number of prescriptions filled per 1000 members with prescription drug coverage per year.

**Top Conditions** summarize the net medical and pharmacy payments for the top episode groups of care. An individual episode of care reflects the medical and pharmacy claims associated with a member level episode of treatment; the Top Conditions report reflects the aggregation of individual episodes into episode groups for summary purposes.

# MERCER



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN



## **PEBB Operations Summary**

Wendy Edwards  
Director of Operations  
July 13, 2010

**Opsattach.4**

### **Executive Summary**

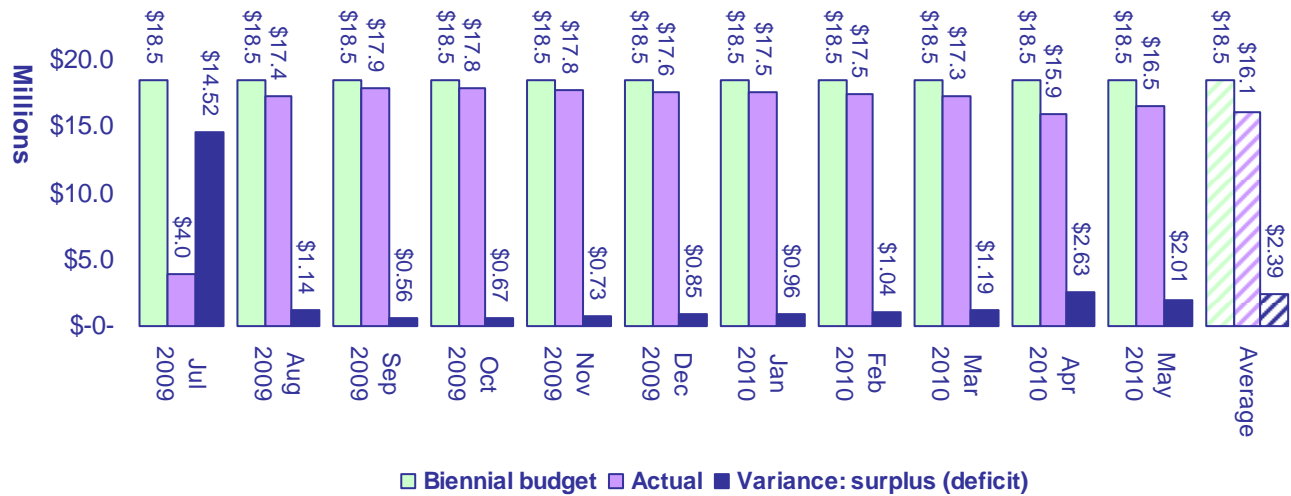
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This summary updates the Board on PEBB operations through June, 2010. Notable items include the following:

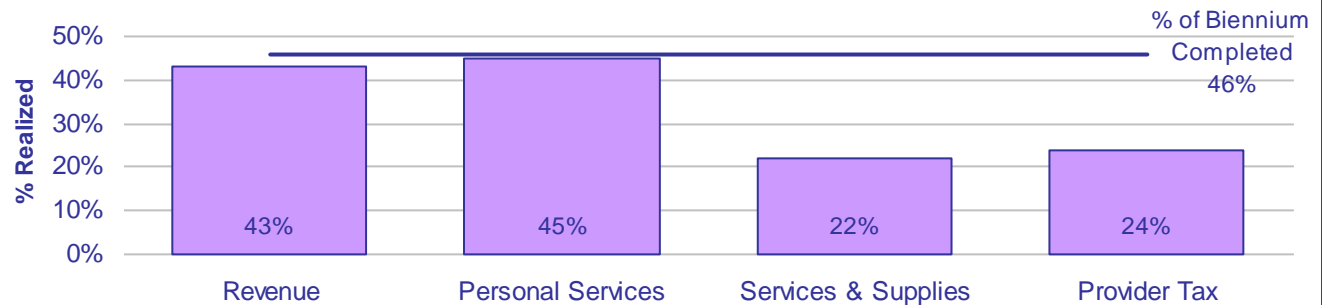
- PEBB operational budget remains unchanged and in line with biennial percentages.
- All PEBB self-insured plans maintain a positive budget variance for month-end June, 2010, despite variances in their cash flow.
- All plans are fully compliant with report requirements for June 2010.
- The number of lives covered in medical plans is at the highest point in the past year.
- Services and systems staff continues to handle a large volume of emails and phone calls.

## Finance

### Limited Expenditures Budget Variance



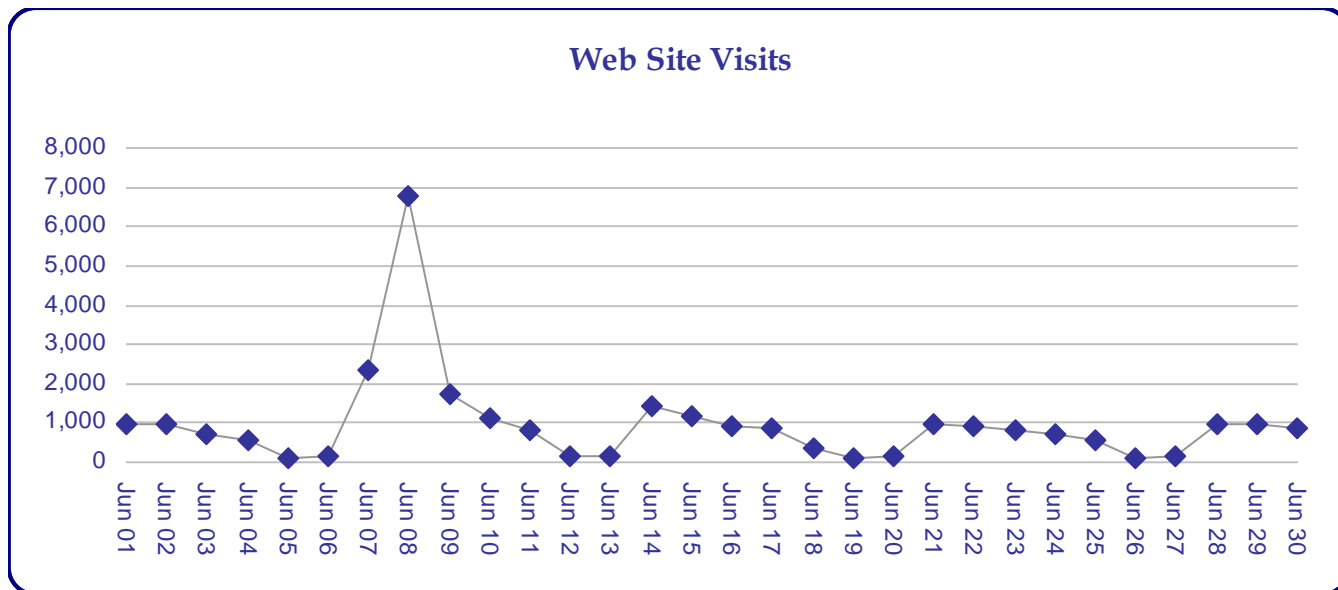
### Budget Status as of 5/31/2010



### Self insurance 2010 YTD (claims paid through June 30, 2010)

	ODS	Providence Choice	Providence Statewide	VSP
Premiums received	\$ 21,537,131	\$ 20,297,869	\$ 249,630,895	\$ 5,374,355
Claims paid	\$ 19,614,241	\$ 14,144,447	\$ 187,017,838	\$ 3,804,128
Fees paid *	\$ 1,288,016	\$ 2,423,995	\$ 14,709,365	\$ 431,200
Variance	\$ 634,874	\$ 3,729,426	\$ 47,903,691	\$ 1,139,027

## Communications



Most-Viewed Pages	
Page	Number of Times Viewed
PEBB Home Page	13,973
June Newsletter	12,102
Forms	3,297
2010 Core Benefits	3,109
May Newsletter PDF	2,119

- ◆ PEBB was the 95th most searched term on Oregon.gov in June 2010

## Contractor Compliance

2009 Contract Reporting Requirements						
Plan Name	1/1/2010	2/1/2010	3/1/2010	4/1/2010	5/1/2010	6/1/2010
ASI Flex						
BHS						
Kaiser Dental						
Kaiser Medical						
ODS						
Providence						
Regence						
Willamette						
	= Not fully compliant -- late reports					

- ◆ No further 2009 reporting is required for dental plans.
- ◆ Remaining 2009 reports for other plan types are monthly only.

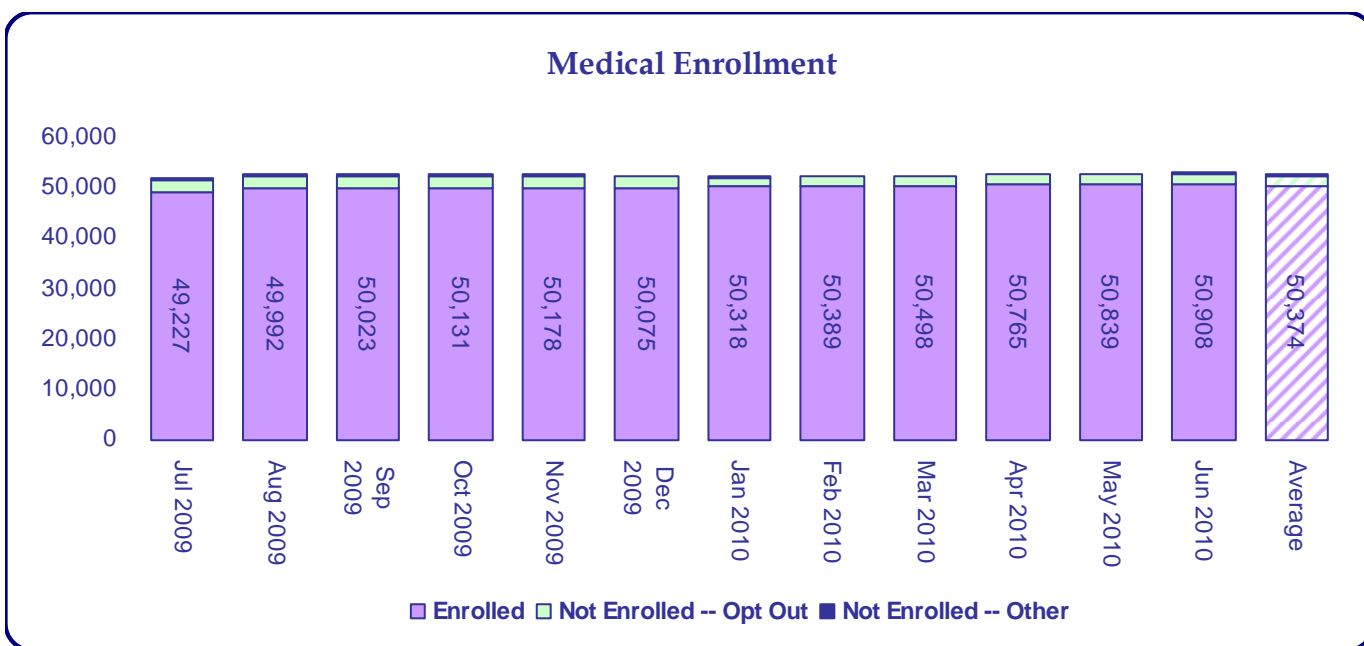
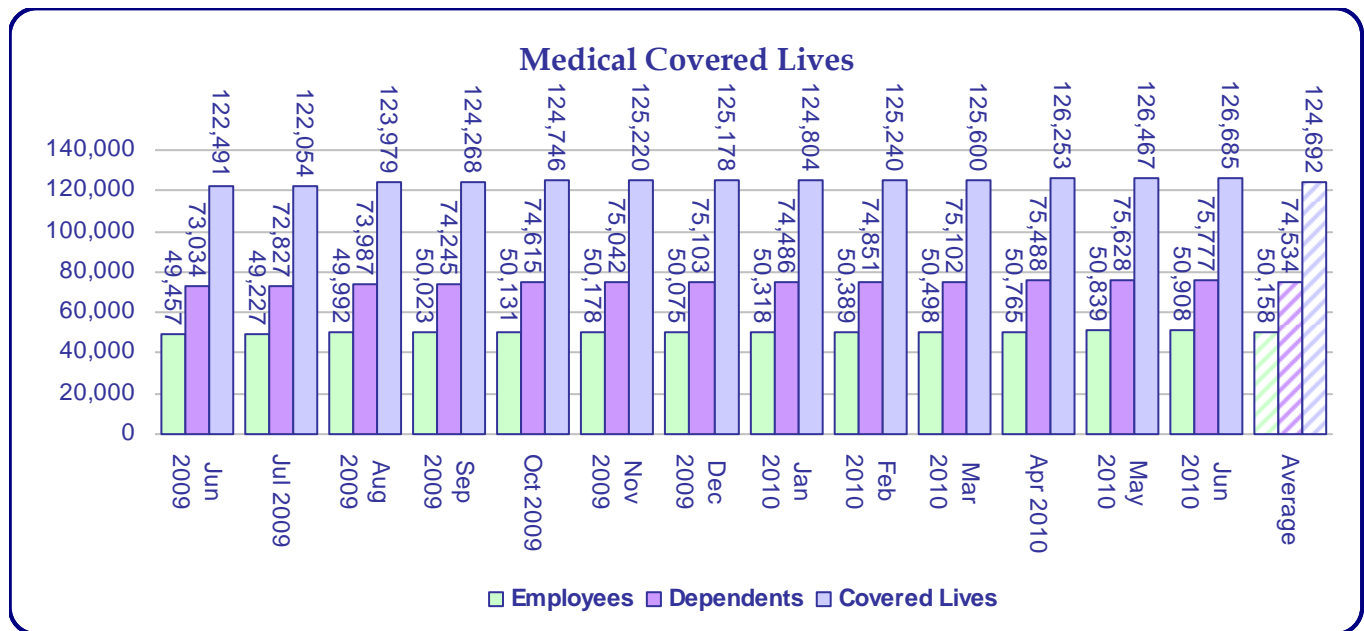
2010 Contract Reporting Requirements

Plan Name	5/9/2010	5/16/2010	5/23/2010	5/30/2010	6/6/2010	6/13/2010	6/20/2010	6/27/2010
ASI Flex								
BHS								
Kaiser Dental								
Kaiser Medical								
ODS								
Providence Choice								
Providence State								
Willamette								

= Fully compliant -- all reports submitted timely

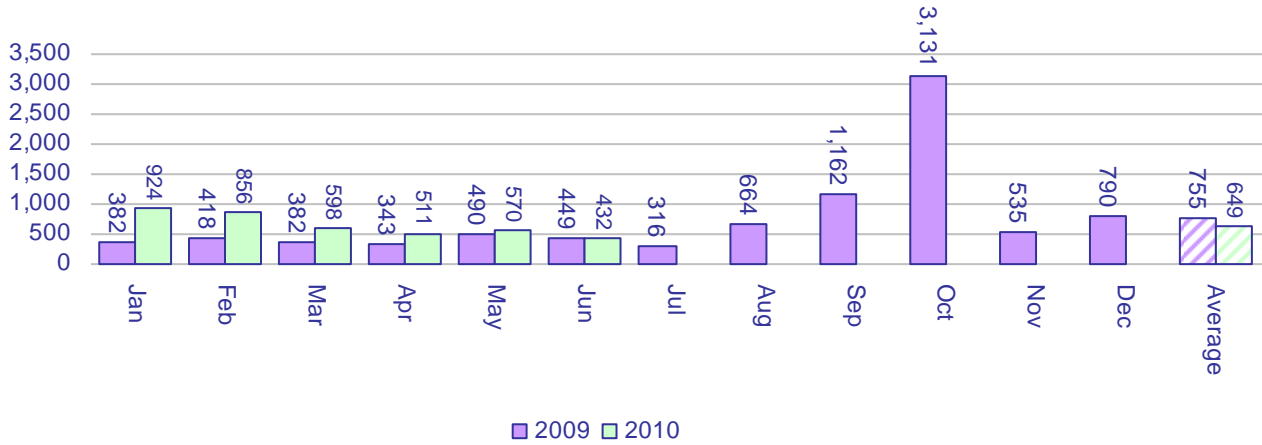
= Not fully compliant -- late reports

**Enrollment**



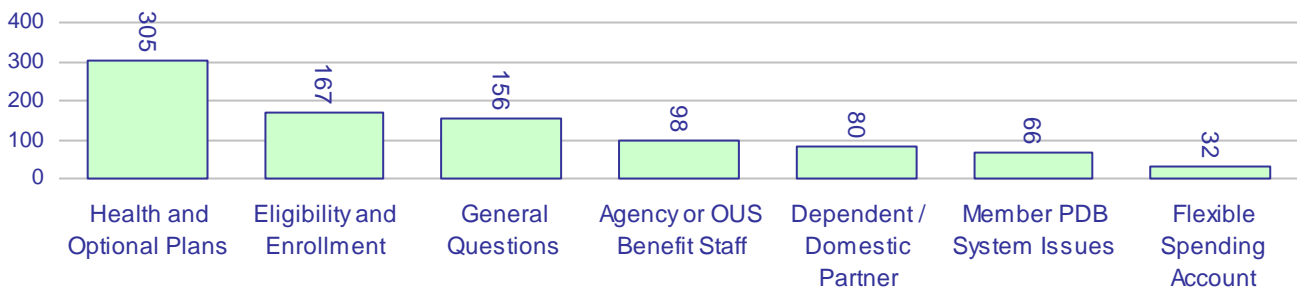
## Client Services

### PEBB Eligibility-Related e-Mails Received

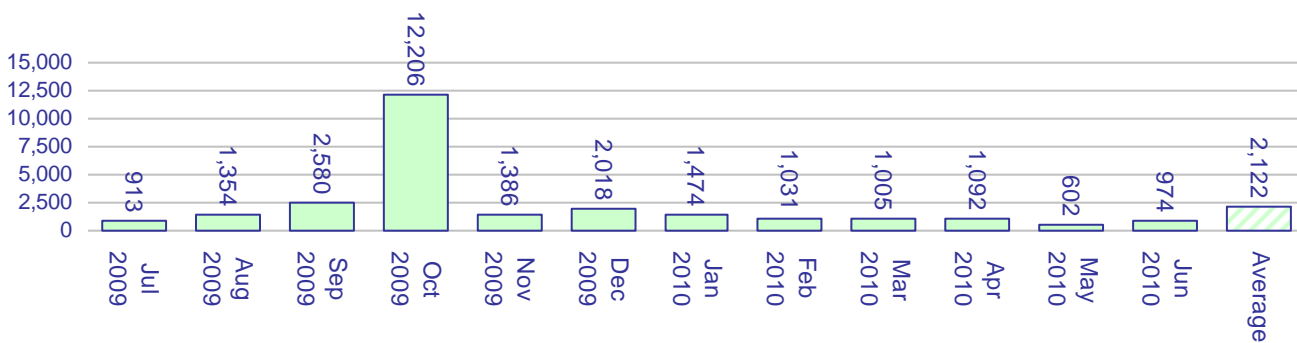


■ 2009 ■ 2010

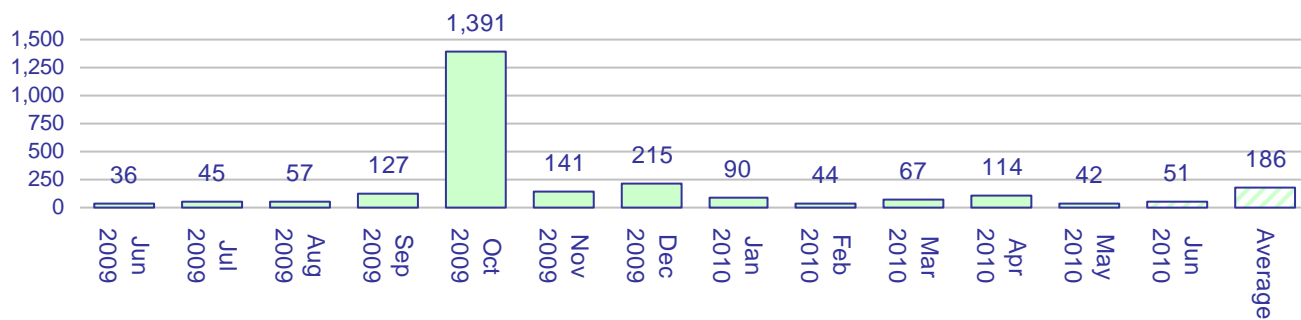
### Call Categories



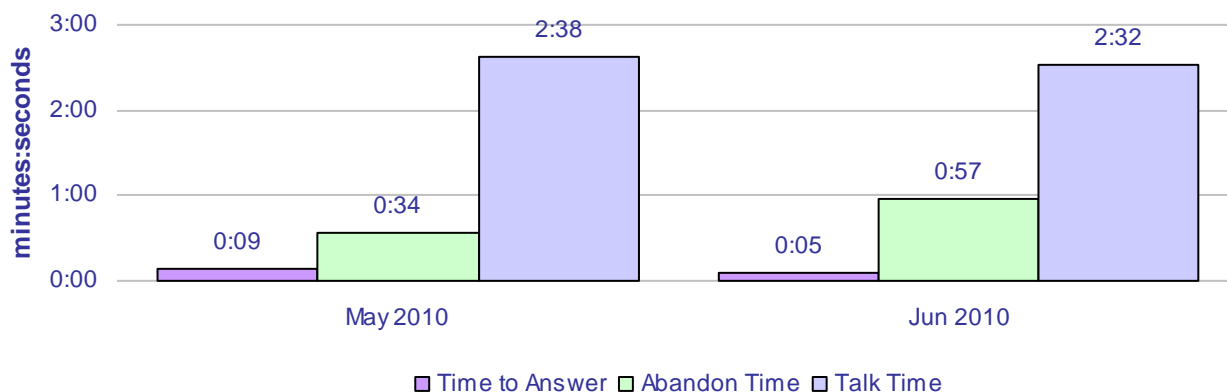
### Inbound Phone Calls: ACD + Non-ACD



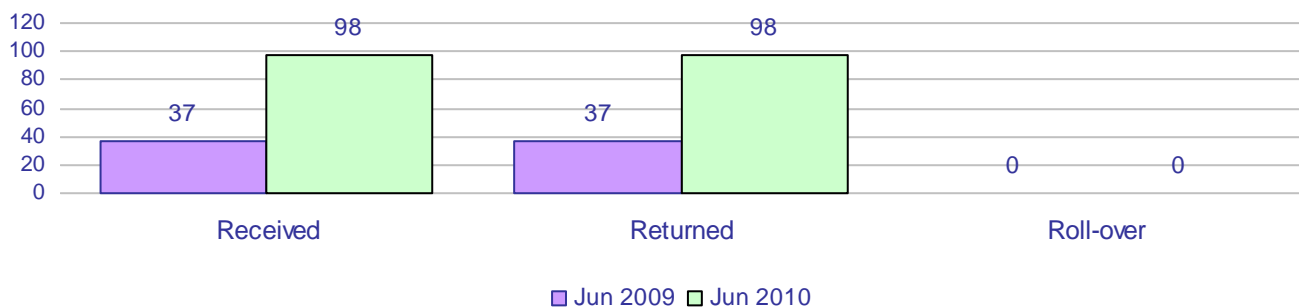
### Inbound Phone Calls: Abandoned / Rejected



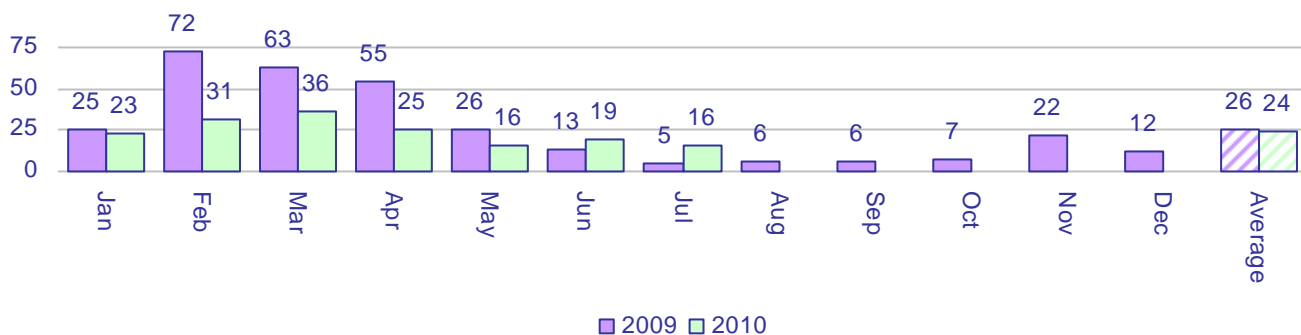
### Average Phone Queue Time



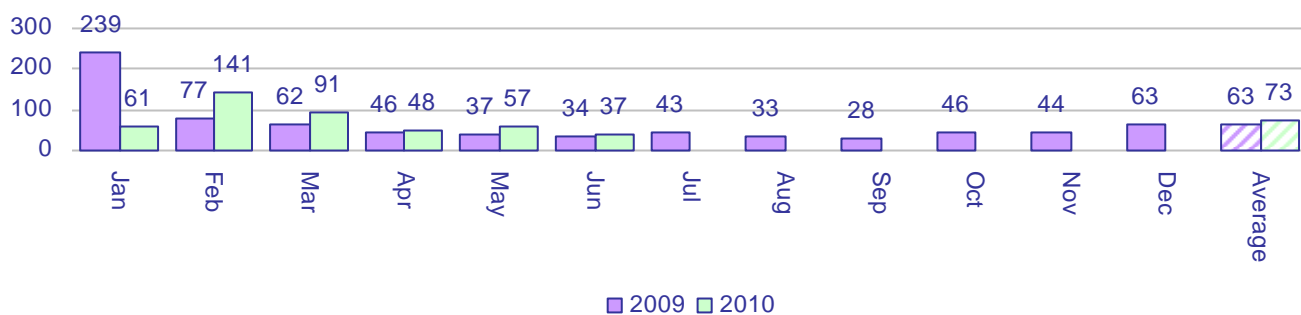
### Voice Mails



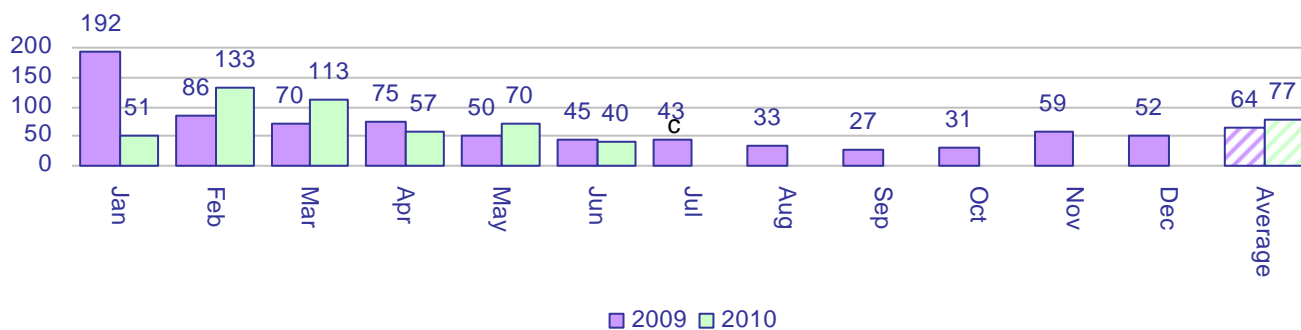
### Appeals: Carryover



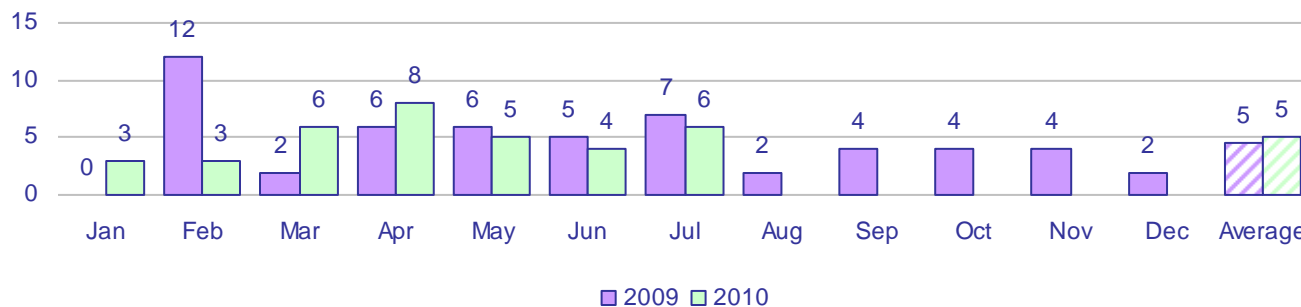
### Appeals: New



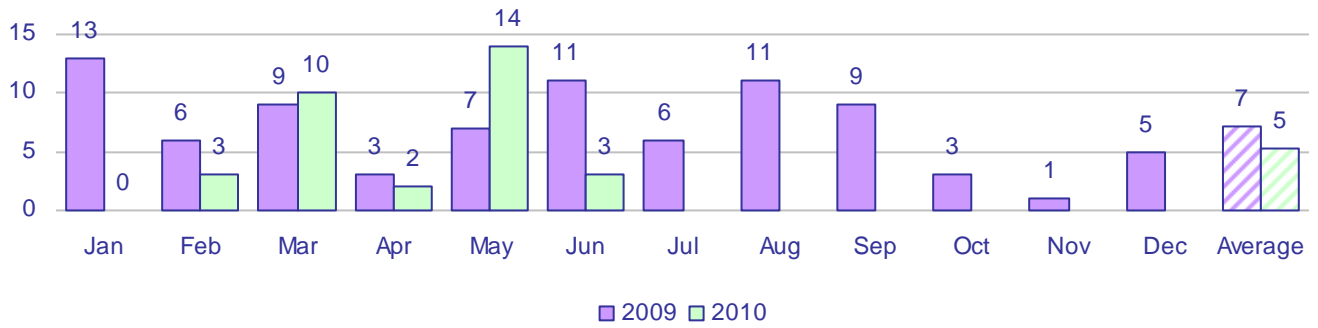
### Appeals: Closed



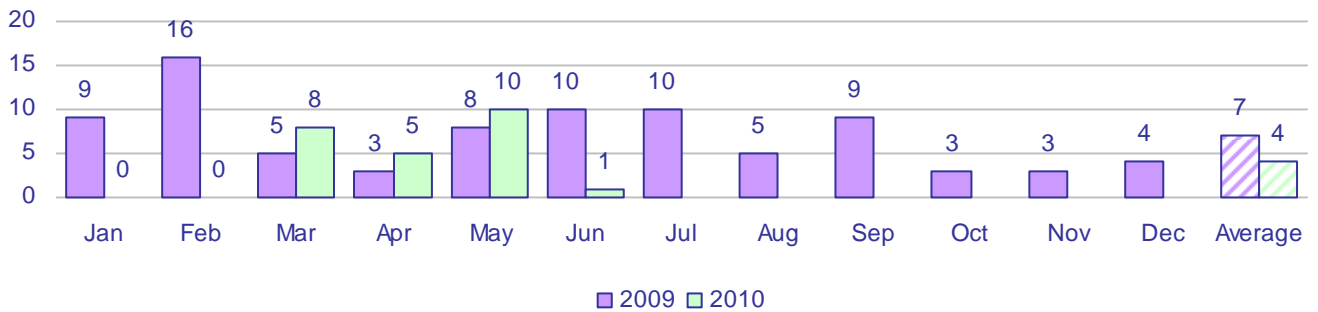
### Investigative Review: Carryover



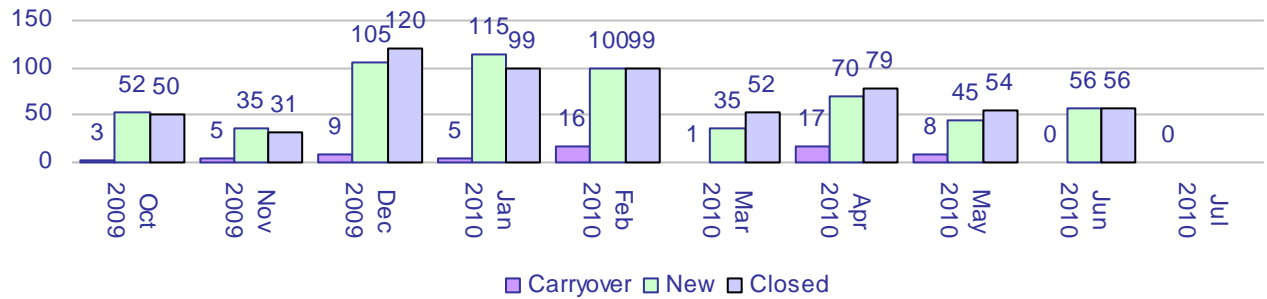
### Investigative Review: New



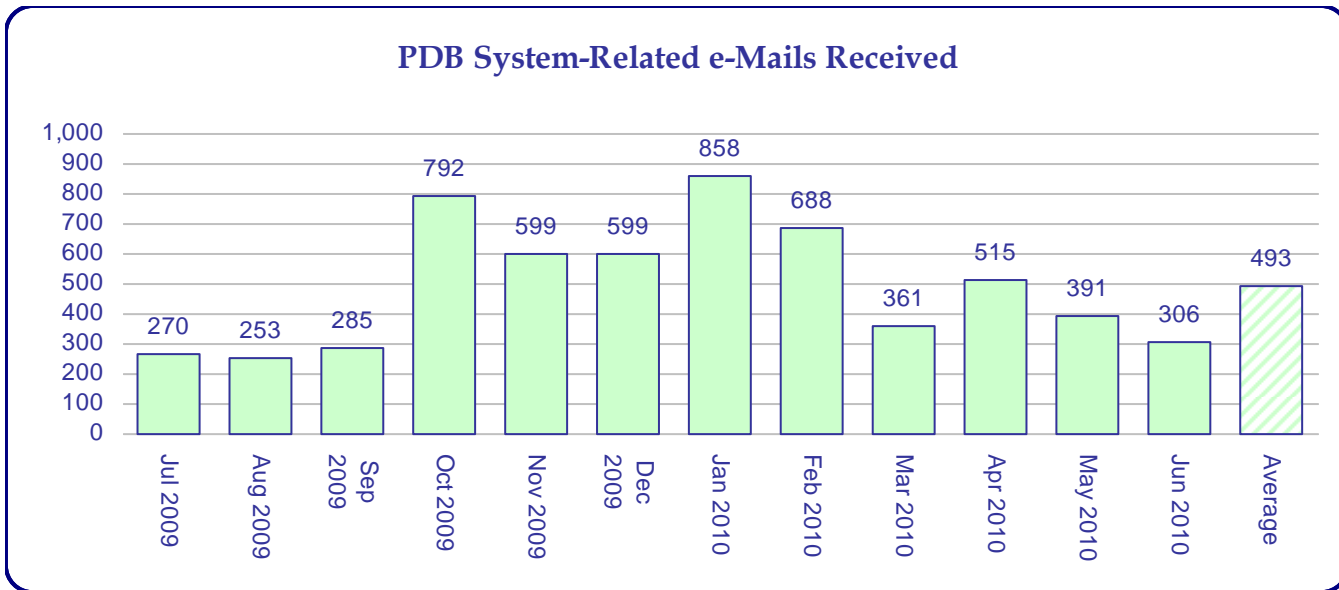
### Investigative Review: Closed



### New FSA Enrollments



PDB



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Version: Board20100720

Consulting. Outsourcing. Investments.

June 11, 2010

## **Samaritan Health Services Medical Claims Administration Review – Draft**

Ralph Trieselmann, CEBS, CLU

## Background

Effective January 1, 2009 Samaritan Health Services was not offered as a plan option to PEBB employees. During 2009 and early 2010 Samaritan Health Services continued to process PEBB claims incurred but not yet paid prior to January 1, 2009. Due to the volume of runout claims PEBB approved a work plan for Mercer to conduct an audit of SHS services. The audit objective was to provide an independent evaluation of the quality of SHS claim service, including verification of the financial accuracy of the amounts charged to PEBB for the period of January 1, 2008 through January 31, 2010.

## Process

Mercer obtained from SHS a data file for all claims processed for the audit period. The file showed a total of 42,886 claims with a total value of \$12,388,690. Mercer confirmed the data file was complete and consistent with the amounts charged to PEBB. Mercer selected a statistically reliable sample of 270 claims with a value of \$1,632,828 (13.1% of total).

All selected claims were then reviewed at the SHS office during the week of April 5, 2010 by a team of 3 experienced health plan auditors. There was some additional follow-up conversations. SHP personnel were very cooperative during the process.

Summary results of our review follows.

# Claim Review Results

The following results for Claims Processing, Financial Payment, and Payment Incidence Accuracy are based on extrapolating the errors found in the claim sample to the entire claim population for the audit period. The figures shown are our best statistical estimate of the impact of the errors detected in the claim sample for the entire claim population. Results for Turnaround Time are based on actual results as determined from the provided SHS claim file.

Measurement	Results	SHS Performance Guarantee	Common Industry Standards – Best Practices	Common Industry Standards - Minimum
Claims Processing Accuracy (claims processed without financial or non-financial error)	92.5%	98.0%	95.0%	94%
Financial Payment Accuracy (paid dollars processed correctly)	99.7%	99.0%	99.25%	99%
Payment Incidence Accuracy (claims processed without financial error)	98.5%	No measurement	98%	97%
Turnaround Time*				
within 14 calendar or 10 business days	72.2%	90%**	94%	90%
within 30 calendar or 21 business days	88.0%	No measurement	99%	98%

\* Calculated from date received to paid (check issued), most standards are based on processed date and do not include check production time. The SHS data file only included the check date but not the processing date so an accurate comparison cannot be made to the SHS performance guarantee.

\*\* Expressed as 90% of clean claims (no investigation) from contracted providers will be processed within 10 business days.

# Claim Review Results

The actual number and value of errors and the resulting extrapolation results are shown below:

	Error Results
Actual Financial Errors in Sample – Total	11
Overpaid	6
Underpaid	5
Extrapolated Financial Errors in Population – Total	645 (1.5%)
Overpaid (% of claim population)	587 (1.4%)
Underpaid (% of claim population)	58 (0.1%)
Actual Mispaid Dollars – Total	\$581
Overpaid	\$312
Underpaid	\$269
Extrapolated Mispaid Dollars– Total	\$34,733 (0.3%)
Overpaid (% of claim population)	\$31,521 (0.3%)
Underpaid (% of claim population)	\$ 3,212 (0.0% due to rounding)
Actual Administrative (non-financial) Errors	25
Extrapolated Administrative Errors	2,555 (6.0%)

## Claim Review Results

Considering the results of our review, the key areas are as follows:

- **Overall Results** – The overall results for Financial and Payment Accuracy are at or above common industry standards. Overall Claim Processing Accuracy was below standard primarily due to a large number of claims which were initially processed incorrectly but subsequently adjusted during the audit period.
- **Claim Processing Procedures** – We noted several claim processing procedures where SHS administered the plan based on their internal policies rather than the PEBB plan provisions, such as:
  - Waiving a copay for outpatient chemotherapy services or for colonoscopies due to a diagnosed illness
  - Not limiting the number of education hours for diabetic training
  - Incorrectly advising a member a preauthorization was not required for hospital and physician services rendered at an out-of-network provider. SHS' practice is to honor their misquote of the PEBB plan provisions

# Error Types

## Copayments

- 3 overpayments due to not applying copayments and 3 underpayments from applying excess copayments. Copayments were not applied for outpatient chemotherapy services even though the PEBB plan description provides for a \$10 copayment for all outpatient services. SHS applied multiple copayments for emergency room services when the services showed two days of service, even though it really was one emergency room visit. SHS disagrees with the errors on the basis of their interpretation of the PEBB plan.

# Error Types

## Provider Allowance

- 2 overpayments and 1 underpayment from incorrectly determining the provider allowance.

## Deductible/Out of Pocket Maximum

- 1 overpayment from incorrectly calculating the calendar year deductible and 1 underpayment from incorrectly calculating the individual out of pocket maximum.

## Administrative Errors

We noted 27 errors in the claim sample which did not result in an actual financial error. In most cases an incorrect payment was issued but the errors were adjusted during the audit period. The adjustments were primarily made to correct misapplication of copayments and provider reimbursements.

## Error Types

### Other Claim Processing Issues

**Plan Intent** – We noted several plan provisions which were administered by SHS which were not consistent with the PEBB benefit documents.

The PEBB plan does not require a copayment for preventive routine services including colonoscopies provided certain criteria are met. We noted 2 claims for colonoscopies where no copayment was applied which clearly were not part of a routine preventive type examination based on the patient's age and submitted diagnosis. SHS policy is to not apply a copayment for any colonoscopy.

The PEBB plan provides a limit of 3 hours for diabetes education services. SHS has a policy of not applying a limit for these services. We noted one claim where the 3 hour maximum was not applied and benefits were issued for additional hours.

## Error Types

**Misquote of Benefits** – For one claim handling the member received services from an out of network provider. SHS initially denied the claim as the services were not pre-authorized as required by the plan. However, SHS had previously advised the member a pre-authorization was not necessary for the services. Upon appeal by the member, SHS researched its records and issued benefits for the services. It is not possible to determine if the service provider had submitted a pre-authorization, if the service plan and PEBB liability would have been different.

## Observations

Based on the sample review results, we have the following observations:

**Observation #1 – Audit Results:** The projected accuracy rates for Financial Payment and Payment Incidence are above industry standards and quite good. Claims Processing accuracy is below industry standards primarily due to the number of adjustments performed during the audit period.

**Observation #2 – Plan Intent:** The differences between the PEBB plan provisions and SHS administrative policies should have been identified and discussed with PEBB. PEBB may have agreed to the policies and modified the summary descriptions; however, since this plan is self-funded, PEBB should be consulted on these issues.

**Observation #3 – Misquote of Benefits:** When SHS misquotes the benefits to a member, the matter should be discussed with PEBB prior to actually issuing benefits.

## Conclusions

Based on the claim sample review and extrapolation of audit results, Mercer concludes the amounts charged to PEBB for the audit period were correct. Overall Financial Payment and Payment Incidence accuracy was above standard while Claim Processing Accuracy was below standard.

# MERCER



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# **Oregon's Essential Benefits Package & Value-Based Services Overview and Next Steps**

**Office for Oregon Health Policy and Research  
July 2010**

# Typical Insurance Benefit Package Design

Portion a person pays (cost-sharing) is applied:

- By specific service or
- By the location where the service is provided
- May tier prescription drugs by generic versus brand name

<i>Service</i>	<i>HMO-type plan</i>	<i>PPO-type plan</i>
Hospital	\$50/day up to \$250/stay	15% coinsurance
Office Visit	\$5-\$20 copay	15% coinsurance
Ambulance	\$75 copay	15% coinsurance
Emergency Room	\$75 copay	15% coinsurance

# How is Value-Based Benefit Design Different?

## Definition

- The use of incentives (or disincentives) in a benefit plan to encourage enrollees to adopt healthier behaviors or use health services of higher value.

## Examples

- Pitney Bowes – Tiered drug copays and coinsurance for some selected chronic medical conditions
- PEBB: Eliminated copays for certain prescription drugs for a few common chronic diseases (e.g asthma, diabetes, etc)
- Health Leadership Council (HLC)
  - Three tiered value-based benefit plan

# Pitney Bowes' Results Over The First 3 Years

## Diabetes

- Increased use of diabetic meds from 9% to 22% of all employees
- Evidence that diabetics used their meds more regularly than before
- Increased use of test strips from 28% to 55% by employees with diabetes
- Decreased emergency room visits by 26% for employees with diabetes

## Asthma

- Decrease hospital admissions by 38% for employees with asthma

## Overall costs in the workplace

- Reduced short-term disability days for employees with diabetes by approximately 50%
- Decrease direct healthcare costs by 6% for employees with diabetes
- Total annual pharmacy costs per person showed a mild increase, but total pharmacy costs for employees with diabetes decreased by 7%

# Value-Based Benefit Design: Supports Oregon's Triple Aim for Health

- Improves lifelong health of all Oregonians
  - Incentivizes better chronic disease management
- Increases quality, reliability and availability of healthcare services
  - Reduces barriers to care needed to manage disease
  - Aims to get the right care at the right time and right place
  - Partner with payment reform to use effective care
- Lowers or contains cost of care so it is affordable
  - Lowers more expensive, emergency or delayed care costs

# Oregon Has Long History With Value-Based Benefit Design

- Prioritized List of Health Services – uses evidence for Oregon Health Plan benefits since 1994
    - Developed and maintained by the Health Services Commission (HSC)
    - Services are prioritized according to impact on individual and population health, based on best available evidence
    - Legislature determines funding level (3/4 of lines are covered)
    - Services ranked lowest on the List are those that:
      - Do not have evidence showing they are effective
- Or*
- No evidence they have a significant impact on health

## Health Fund Board's Benefits Committee: Essential Benefit Package

- Chartered by Fund Board to “develop recommendations for defining a set of essential health services that would be available to all Oregonians under a comprehensive reform plan.”
- Used the value-based benefit approach in developing the package’s framework and applying the cost sharing
- Underlying methodology based on Oregon’s Prioritized List

## The Essential Benefits Package (EBP)

- No cost share for:
  - Value-based services
  - Basic diagnostic services
  - Comfort care
- Tiered coinsurance/copays for other services
  - Four tiers based on evidence methodology of Prioritized List
  - Lower cost sharing for primary care outpatient services
- Use of an evidence-based drug formulary also suggested

# 20 Sets of Value-Based Services in the Essential Benefit Package

- Value-based services are medications, tests, or treatments that are highly effective, low cost, and have a lot of evidence supporting their use
- Most of these services should be provided via outpatient care – ideally in a patient-centered primary care home
- These services should be offered at NO cost to patients (no copays or coinsurance) in order to encourage use of these services given their high level of benefit

*Goal: Have these services used as much as possible*

# Remove Barriers to Care: Examples of the EBP's Value-Based Services

## Diabetes

- Meds (insulin or oral); blood test to check control; eye exam to check for changes

## Congestive Heart Failure (CHF)

- Meds: Generic versions of blood pressure meds (beta-blocker, ACE inhibitor, diuretic)
- Labs: Annual blood count (CBC), metabolic panel (CMP), cholesterol/lipid profile, urine test, and a thyroid test (TSH) once
- Tests: EKG, Diagnostic echocardiogram
- Other: Nurse case management

## Coronary Artery Disease (CAD)

- Meds: Generic versions of aspirin, cholesterol lowering (statin), and blood pressure medications (beta-blocker)
- Labs: Annual cholesterol/lipid profile
- Tests: EKG
- Other: Cardiac rehabilitation for post-heart attack

# EBP's Tiered Benefits for Other Services: Cost Sharing Applied Based On Best Evidence

## Tier I :

### Lower cost share

Highly effective care for severe chronic disease and life-threatening illness & injury

Examples:

- Emergent dental care
- Head injuries
- Appendicitis
- Heart attack
- Third degree burns
- Kidney failure
- Rheumatoid arthritis
- Low birth weight

## Tier II:

### Next level of cost share

Effective care of other chronic disease and life-threatening illness & injury

Examples:

- Breast cancer
- Bladder infections
- COPD/emphysema
- Multiple sclerosis
- Post-Traumatic Stress Disorder
- Attention Deficit Disorder
- Epilepsy
- Glaucoma

# EBP's Tiered Benefits: Cost Sharing Applied Based On Best Evidence

## Tier III:

### 3<sup>rd</sup> level of cost share

Effective care for non-life-threatening illness & injury

Examples:

- Broken arm
- Ear/sinus infections
- Dentures
- Kidney stones
- Herniated disk
- Reflux
- Migraines
- Fibroids
- Cataracts
- Obsessive-Compulsive Disorder

## Tier IV:

### Highest level of cost share

Less effective care and care for self-limited illness and minor illness & injury

Examples:

- Cold
- Chronic low back pain
- Sprained ankle
- Cracked rib
- Seasonal allergies
- Acne
- Viral sore throat
- Tension headache
- Dental implants
- Liver transplant for cancer

# Essential Benefits Package's Other Components

## Excluded conditions

- Non-emergent services that would have no coverage, similar to many commercial plans presently
- Examples: Cosmetic surgery, infertility services, experimental treatments

## Discretionary Services

- Non-emergent services that might have a separate benefit limit
- Examples: restorative dental services, glasses & other vision care supplies

# How The Essential Benefit Package Compares

	<b>Health Leadership Council's Design</b>	<b>Essential Benefit Package</b>
<b>Categories With No Cost Share</b>	<p><b>Tier 1</b></p> <ul style="list-style-type: none"> <li>• Tests and treatments for <u>six</u> chronic diseases (asthma, CAD, CHF, COPD, depression, diabetes)</li> <li>• Annual exam &amp; Preventive screenings</li> <li>• Immunizations</li> </ul>	<p><b>Value-Based Services</b></p> <ul style="list-style-type: none"> <li>• Same plus coverage for 14 additional conditions/chronic diseases (e.g., ETOH Tx, bipolar Dz, HTN, ↑ lipids, maternity/newborn)</li> <li>• Basic diagnostics &amp; Comfort care</li> </ul>
<b>Next Level (s) of Cost- sharing</b>	<p><b>Tier 2</b></p> <ul style="list-style-type: none"> <li>• Standard medical product design                             <ul style="list-style-type: none"> <li>– Portion of hospital services</li> <li>– Portion of outpatient services</li> <li>–Portion of Emergency Room cost</li> </ul> </li> </ul>	<p><b>Tiers I-III</b></p> <ul style="list-style-type: none"> <li>• Encourages care in primary care</li> <li>• Tiered cost sharing by condition/associated service based on evidence</li> </ul>
<b>Highest Cost Sharing or Not Covered</b>	<p><b>Tier 3</b></p> <p>Have higher cost sharing</p> <ul style="list-style-type: none"> <li>• Preference sensitive treatments</li> <li>• Complex outpatient imaging</li> </ul> <p><b>Excluded Services</b></p>	<p><b>Tier IV</b> less effective/self-limiting</p> <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• Excluded conditions (no coverage)</li> <li>• Discretionary Services (separate benefit limit)</li> </ul>

# Hypothetical Example—Maria's Story

Maria is single, earns \$40,000 per year as a teacher

- She receives coverage through her employer
- Her deductible is \$1,250; out-of-pocket max is \$3,000
- Plan design is a modified version of the EBP
- Coinsurance is tiered: 5%/15%/30%/50%
- RX coverage is \$5 for generic, \$15 for preferred, 30% for nonpreferred

## Maria's Story, continued

- Maria is in good overall health
  - Her GYN exam is covered with no cost sharing
  - She sees her family physician to talk about frequent nasal infections; no copay for an initial diagnostic visit
  - Sees a specialist who recommends repairing her deviated septum. Total Cost: \$8,000 for this Tier IV service.
    - Tier IV has 50% coinsurance. Maria thinks about whether she really needs the surgery.
    - If she proceeds, \$1,250 goes to deductible; Maria pays 50% of remaining charges until out-of-pocket is met; total out-of-pocket: \$3,000.

*Note:* In typical commercial plan design, Maria would pay a portion of her gyn visit *and* her diagnostic visit while her out of pocket for surgery would be only around \$2,250 (15% coinsurance) so might not pause as much before considering surgery

# What Has Been Happening with the EBP Since HB 2009 Passed?

## Health Services Commission

- Reviewed the latest evidence and detailed out the full list of 20 sets of Value-Based Services included in the Essential Benefit Package

## Also

- Initial review of federal reform regarding benefits and cost sharing
- Initial actuarial analysis of how the EBP could fit under federal reform parameters and its impacts by income level
- Cost Sharing Workgroup reviewed the EBP's cost sharing
  - Reviewed how could cost sharing look for each tier, based on work of Fund Board's past work, and under federal reform

# And...Federal Reform Passed: Sets Aspects of Benefit Design

## Individual Mandate:

- Secretary of HHS will establish Essential Health Benefit Package (EHBP) to qualify plans as minimum essential coverage

## Insurance Exchange:

- EHBP is the basis for cost sharing assistance and premium tax credits in the Exchange
- Sets fixed levels of coverage in the Exchange and fully-insured market based on actuarial value

## Value-Based Benefit Design:

- Secretary of HHS has oversight
  - “... may issue regulations for allowing value-based insurance design”

# Components of the Federal EHBP

<b>Ambulatory Patient Services</b>	<b>Emergency Services</b>	<b>Hospitalization</b>	<b>Maternity &amp; Newborn Care</b>	<b>Mental Health/ Substance Abuse</b>
<b>Prescription Drugs</b>	<b>Rehab and Habilitative Services/ Devices</b>	<b>Lab Services</b>	<b>Preventive, Wellness &amp; Chronic Disease Mgmt</b>	<b>Pediatric, Including Oral/Vision</b>

**Federal preventive care—No cost sharing allowed**

**Federal excluded services—Plans can cover but premium credits/cost sharing reductions to individuals cannot apply towards them**

## Still Lots To Learn About How Federal Reform Will Shape Benefits, Especially in the Exchange—

- Secretary directed to have the Dept. of Labor survey common products on the market to help define the specific details of the federal minimum package
- Uncertain how much/what kind of flexibility there will be around value-based benefit design
- Products offered in the exchange will have to fit inside set cost sharing limits to fit various federal requirements depending on income
- Awaiting the details on the exchange to see how much states can direct benefit designs offered

## Hypothetical Example—Robert's Story

Robert is single, earns \$20,000 per year

- He purchases insurance through an insurance exchange
- He will get tax credits to assist with his premium
- There will be federal limits to the amount of cost sharing based on his income
- Plan design is a modified version of the EBP
- Coinsurance is tiered: 10%/30%/50%/70%
- His deductible is \$300; out-of-pocket max is \$1,600 – amounts limited due to his income level
- Plan uses an evidence-based formulary for medications
  - \$10 for generic,
  - \$30 for preferred,
  - 50% for nonpreferred

## Robert's Story, continued

- He has Type 2 Diabetes
- His insulin, eye exams, and diabetic labs/supplies are covered with no cost sharing since all part of a value-based service for diabetes
- During his annual preventive visit, doctor finds a diabetic foot ulcer, and refers him to a surgeon and prescribes a generic antibiotic
  - No cost sharing for preventive service visit
  - For the antibiotic, Robert pays a \$10 copay based on an evidence-based formulary
- The surgeon treats the ulcer; cost: \$2,000
  - This Tier I service has 10% coinsurance
  - \$300 applies to deductible, and Robert pays 10% of the remaining \$1,700 for a total out-of-pocket cost of \$470

*Note:* Today, in a typical commercial plan out-of pocket costs would be \$810 plus exams, diabetic meds and supplies copays

## The Essential Benefit Package: Summary

- Furthers Oregon's Triple Aim by incenting the most effective services
- Could be considered by health care purchasers now
- Preliminary review shows that the EBP's cost sharing could be adjusted to fit federal reform limits and still provide incentives to use the most effective care.
- Further details on the federal minimum benefit to be eligible for subsidies in the Exchange are yet to be determined, but appears the EBP could certainly be a product in the Exchange

# References

Oregon Health Services Commission

<http://www.oregon.gov/OHPPR/HSC/index.shtml>

Cost Sharing Work Group

<http://www.oregon.gov/OHPPR/HealthReform/CostSharing/CSW.shtml>

Health Fund Board Benefits Committee Final Report

<http://www.oregon.gov/OHPPR/HFB/Benefits/FinalRecommendation.pdf>

Health Leadership Council (formerly Health Leadership Task Force)

<http://www.healthleadershiptaskforce.com/>

Center for Value-Based Insurance Design

<http://www.sph.umich.edu/vbidcenter/>

# Questions?

## Value-Based Services

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### Proposed “Barrier-Free” services for use within a value-based benefit package

<b>Diagnosis</b>	<b>Medications</b>	<b>Labs</b>	<b>Imaging/Ancillary</b>	<b>Other</b>
<b>Alcohol &amp; Drug Treatment</b>	Buprenorphine for opioid dependence Acamprosate for alcohol dependence	None	None	Brief behavioral intervention to reduce hazardous drinking (SBIRT) Methadone maintenance treatment
<b>Asthma</b>	Medications according to NICE 2008 stepwise treatment protocol	None	Diagnostic spirometry	None
<b>Bipolar Disorder</b>	Lithium, valproate	Lithium – lithium level (q3 months); creatinine and TSH (q6 months) Valproate -LFTs and CBC (q6 months)	None	Medication management
<b>Cancer Screening</b>	None	Pap smears Fecal occult blood testing	Mammography Colonoscopy/Flexible sigmoidoscopy	Per USPSTF recommendations, “A” and “B” recommendations only
<b>Chronic Obstructive Pulmonary Disease(COPD)</b>	Short-acting inhaled bronchodilator	None	None	None
<b>Congestive Heart Failure (CHF)</b>	Beta-blockers, ACE inhibitors, diuretics	CBC, CMP, lipid profile, urinalysis (annually) TSH once	EKG, Diagnostic echocardiogram	Nurse case management
<b>Coronary Artery Disease (CAD)</b>	Aspirin, statins, beta blockers	Lipid profile (annually)	EKG	Cardiac rehabilitation for post-myocardial infarction (MI) patients

## Value-Based Services

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Diagnosis	Medications	Labs	Imaging/Ancillary	Other
<b>Dental Care, Preventive</b>	Fluoride supplements (age 6 months to age 16), if indicated  Professionally applied fluoride varnish (twice yearly in children aged 12 months to 16 years old who are at high risk), if indicated	None	Pit and fissure sealants in permanent molars of children and adolescents	None
<b>Depression, Major in Adults (Severe Only)</b>	SSRIs	None	None	Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (subject to limit, e.g. 10 per year) in conjunction with an antidepressant  Medication management
<b>Depression, Major in Children and Adolescents (Moderate to Severe)</b>	None	None	None	Psychotherapy (CBT, interpersonal, or shorter term family therapy)
<b>Diabetes – Type I</b>	Insulin (NPH and regular only), insulin supplies, ace inhibitors	HgA1c (annually)	None	Diabetic retinal exam for adults (annually)
<b>Diabetes – Type II</b>	Metformin, sulfonyureas, ACE inhibitors, insulin (NPH and regular only), insulin supplies	HgA1c, lipid profile (annually)	None	Diabetic retinal exam for adults (annually)

## Value-Based Services

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<b>Diagnosis</b>	<b>Medications</b>	<b>Labs</b>	<b>Imaging/Ancillary</b>	<b>Other</b>
<b>Hypertension</b>	Diuretics, ACE inhibitors, Calcium channel blockers, Beta blockers	Fasting glucose, fasting lipids (annually)	None	None
<b>Immunizations</b>	Routine childhood and adult vaccinations	None	None	Follow ACIP recommendations for non-travel vaccinations
<b>Maternity Care</b>	Folic acid, Rh immunoglobulin (when indicated)	Screening for hepatitis B, Rh status, syphilis, chlamydia, HIV, iron deficiency anemia, asymptomatic bacteriuria, rubella immunity, screening for genetic disorders	None	None
<b>Newborn Care</b>	Ophthalmologic gonococcal prophylaxis, Vitamin K prophylaxis	Sickle cell, congenital hypothyroidism, PKU (cost borne by the state)	None	None
<b>Reproductive Services</b>	Condoms, combined oral contraceptives, intrauterine devices, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization	See STI screening and maternity care	None	None
<b>Sexually Transmitted Infections</b>	Syphilis – Penicillin IM or doxycycline Chlamydia – azithromycin or doxycycline Gonorrhea – ceftriaxone IM or cefixime po	In certain populations: chlamydia, gonorrhea, HIV, syphilis	None	According to USPSTF guidelines for appropriate populations to screen (A and B recommendations only)

## Value-Based Services

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Diagnosis	Medications	Labs	Imaging/Ancillary	Other
<b>Tobacco Dependence</b>	Nicotine replacement therapy, nortryptiline, and bupropion	None	None	None
<b>Tuberculosis (TB)</b>	Per CDC guidelines – standard drug treatment for latent and active TB	Screening and diagnostic algorithm according to CDC guidelines	Chest x-ray per CDC guidelines	None

Guidelines based on empirical evidence (systematic reviews and health technology assessments), from trusted sources such as: ACIP, AHRQ, Cochrane Collaboration, CDC, OHSU Center for Evidence-Based Policy, NICE, NIH, Ontario, SIGN, USPSTF, WHO

General principles

For medications

- 1) Generics unless no equivalent available
- 2) Medications for ≤ \$4 per month are preferred to more expensive medications

Glossary

ACE: angiotension converting enzyme  
 ACIP: Advisory Committee on Immunization Practices  
 AHRQ: Agency for Healthcare Research and Quality  
 CBC: complete blood count  
 CDC: Centers for Disease Control and Prevention  
 CMP: complete metabolic panel  
 EKG: electrocardiogram  
 HgA1c: hemoglobin A1c  
 HIV: human immunodeficiency virus  
 IM: intramuscularly  
 LFTs: liver function tests

NICE: National Institute for Health and Clinical Excellence (England)  
 NIH: National Institutes of Health  
 OHSU: Oregon Health & Science University  
 PKU: phenoketonuria  
 SIGN: Scottish Intercollegiate Guidelines Network  
 SBIRT: screening, brief intervention, and referral to treatment  
 SSRIs: serotonin specific reuptake inhibitors  
 STI: sexually transmitted infection  
 TSH: thyroid stimulating hormone  
 USPSTF: US Preventive Services Taskforce  
 WHO: World Health Organization

# PUBLIC EMPLOYEES BENEFIT BOARD

## **Presentation of Marion-Polk Counties Demonstration Initiative**

July 20, 2010

# Goal

Create a sustainable forum in which leaders who know and are from the community can:

- Solidify a vision
- Create a roadmap
- Build commitment

to improve the health and healthcare delivery in Marion and Polk Counties.

# Problem

- The health care system is broken
- A single solution will not work
- There is tremendous clinical and outcome variation
- There is no community forum and roadmap

# Opportunity

Initiate channels of communication and a platform that creates the nucleus for advancement while developing something that works locally both today and in the future.

# Opportunity

## Why Marion & Polk Counties?

- Self-contained health area with dedicated provider community
- Key purchasers can immediately create critical mass
- Encouragement of Salem Health and key physicians
- Broad community receptivity, energy and readiness
- Many local activities, yet fragmented & piecemeal

# How

## Approach

- Bring all stakeholders to the table
- Build commitment for ongoing improvement through common activity, discussion & accountability for outcomes
- Address practice variability using an evidence-based approach
- Collaborate and don't reinvent the wheel

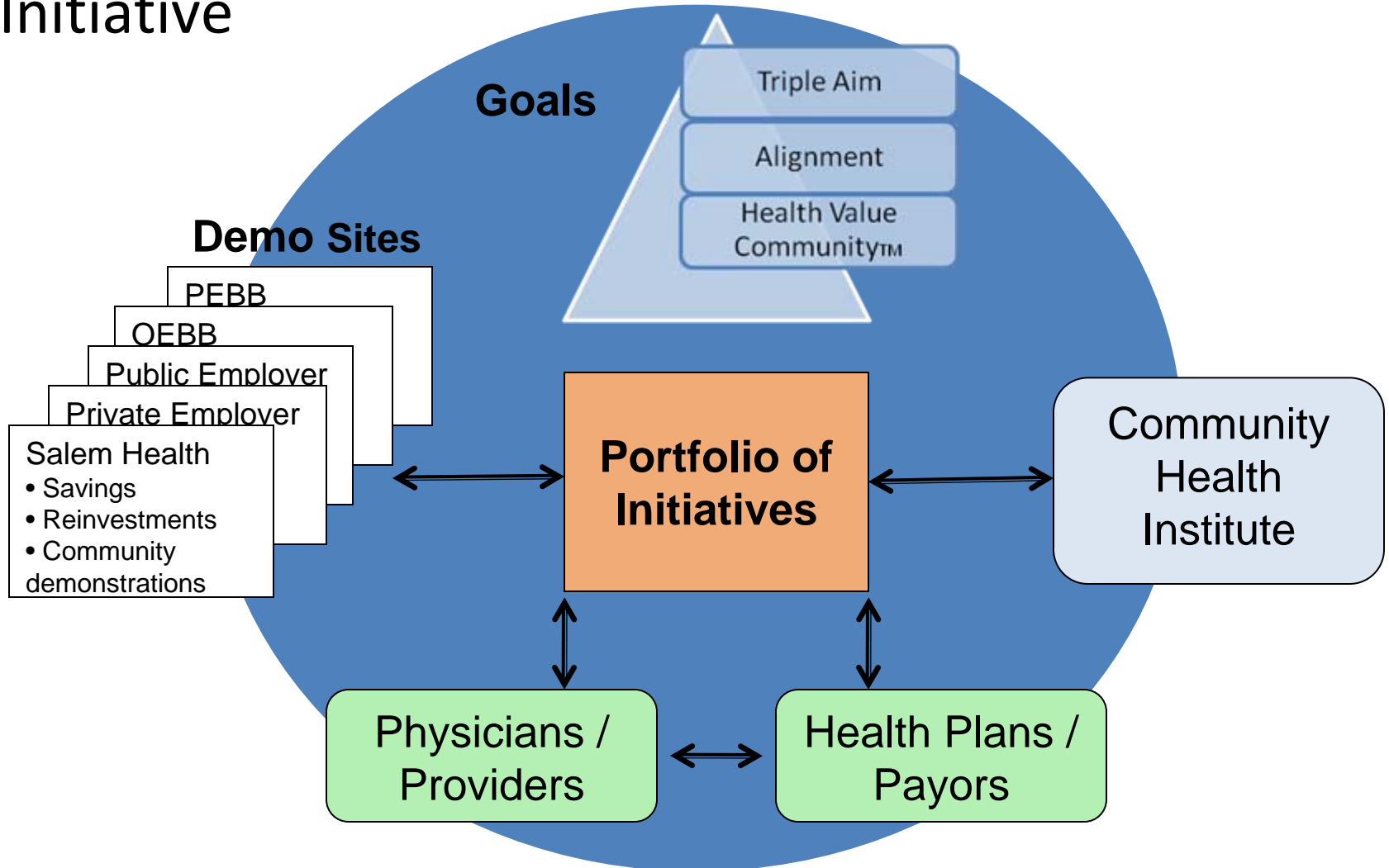
# How

## Expected Outcomes

- Implement targeted chronic disease initiatives to improve health and care
- Develop priorities for community-wide health behavior improvement initiatives
- Collaborate and secure projects from others that contribute to efforts in Marion & Polk Counties
- Establish a vehicle and structure for ongoing community health reform collaboration

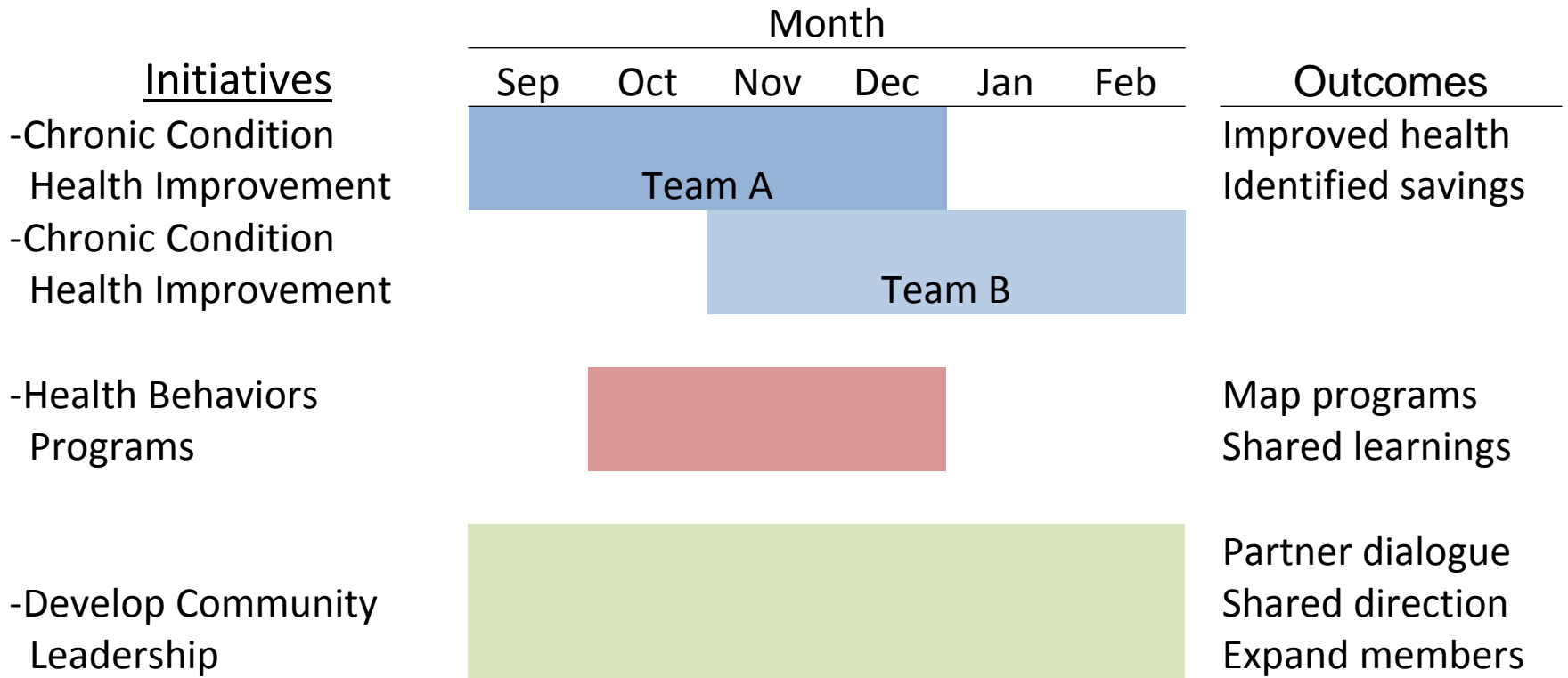
# How

## Initiative



Marion-Polk County Demonstration Initiative

# Demonstration Workplan



# Requested Support

- Operating Premise
  - Economically self-sustaining
  - Reinvest 25% of savings into improvements in health and healthcare delivery
- Phase I Costs--\$250,000
- Sources of Funding
  - Per Capita Assessment (\$.30 PMPM) for 6 months
  - Hospital participation
  - Infrastructure supporters and grants

# Value of Initiative for PEBB

- Brings physicians and hospitals to the table
- Leverages learning and critical mass across employers
- Creates public and private partnership
- Provides low cost/risk endeavor that offers significant upside potential



## PEBB Cost Reduction Methods

July 20, 2010

Joan Kapowich, Administrator

### **Executive Summary**

This report provides a variety of potential methods to reduce agency, member and PEBB benefit costs for the Board to discuss as we plan for 2012 benefit and the 2013 medical RFP. PEBB is frequently asked about cost containment options. In mid-2009, PEBB staff identified and analyzed a number of options to save agencies and members money with a minimal impact on benefit levels.

### **Analysis of Options**

#### **Option 1: State Employees with Double-PEBB Coverage**

Require PEBB members who are “double-covered” with their spouse or domestic partner on two PEBB plans to only have one person covered and the other receive an opt-out-of-coverage payment.

Impact:

Approximately 2,200 double-covered employees would no longer have the cost-sharing portion of the plan (i.e., deductibles and coinsurance) paid by PEBB, but half would receive a payment for opting out. On average, the opt-out payment the member receives will exceed the additional cost sharing they will pay by approximately \$1 million.

The self-funded rate effective January 1, 2010 would exclude the extra cost sharing for the double-covereds prior to developing total projected claims, but it would also exclude the additional double-covereds who will opt-out, which will result in a net increase to the average premium rate. The overall premium rates times new enrollment would be cost neutral, with the exception of the lower cost sharing for the double-covereds, which as mentioned in the above paragraph is more than offset by the opt-out payment.

The PEBB stabilization fund would experience a net increase of \$2,000,000 in opt-out reserve funding each year, and the agencies will have savings due to the funds they will still receive for opt-outs, but this will be offset by both the opt-out payments to employees and the increase in the self-funded premiums.

#### **Option 2: Change Eligibility for Member Spouse or Domestic Partner**

If employees' spouse or domestic partner is eligible to be covered by an employer, we could require the spouse or domestic partner to take the coverage offered by their employer. Or, the employee would be required to pay extra to provide coverage for the spouse or domestic partner. In this case, there would be two components to the savings - the addition contributions for the

spouse or domestic partner charge for employees who continue to cover their spouse or domestic partner and the reduction in claim cost for employees who eliminate coverage of their spouse or domestic partner through PEBB. The savings would depend upon the additional contribution charged and the percentage of employees who continue to choose coverage for their spouse or domestic partner.

**Impact:**

Estimated total savings range from \$9M to \$22M per year (assuming a \$35 per month surcharge for low end of the range and \$106 per month for the high end of the range). Of this estimated savings, \$3M to \$14M is due to the expected decrease in claim costs for spouses and domestic partners who would no longer be covered.

**Option 3: Change Eligibility for Coverage Upon Termination from Employment**

Terminate medical coverage on the last day of work. Currently, regular employees who work more than 80 hours in the month prior to terminating employment with the state have their employee benefits paid for the following month.

**Impact:**

The employee would lose one month of PEBB-funded health care coverage and might need to pay a COBRA premium to continue coverage. A one-time savings would be generated for PEBB and the agencies in the 2009-2011 biennium. If 1,000 employees left state government and were no longer eligible for an additional month of coverage after termination, that would save  $\$1,070.44 * 1,000 = \$1,070,440$ . This savings could be offset by employees anticipating their health care needs and seeking care prior to their termination date. The agency savings would depend upon the difference between the funding rate they would no longer receive and the actual premium payments they avoid depending upon which plan the terminated employees are enrolled in.

If those who were not eligible for the following month, and those who were had their benefits terminated on their last day assume 50% of  $\$1,070.44 = \$535.22 * 3,000 = \$1,605,660$ .

Total savings estimate is \$2,676,100 per year (excludes seasonal and limited duration positions).

- There were 4,450 separations (approx.) in 2007 and 2008. Most were full-time positions and would have been eligible for paid insurance for the month of their termination and for the next full month. For that reason, the \$2,676,100 figure could be a conservative estimate of savings for ending coverage on the last day of work.)

<b>Next Steps</b>
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With board consensus staff plans to update these figures based on 2011 premiums, gather additional information on potential savings from Mercer and explore any other feasibility issues.

# MERCER



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

Bdattach.7B  
Consulting. Outsourcing. Investments.

July 20, 2010

## Oregon Public Employees' Benefit Board

Retiree Options  
for PY 2012 & the 2013 RFP

Wendy Edwards, PEBB  
Mikel Gray, Mercer

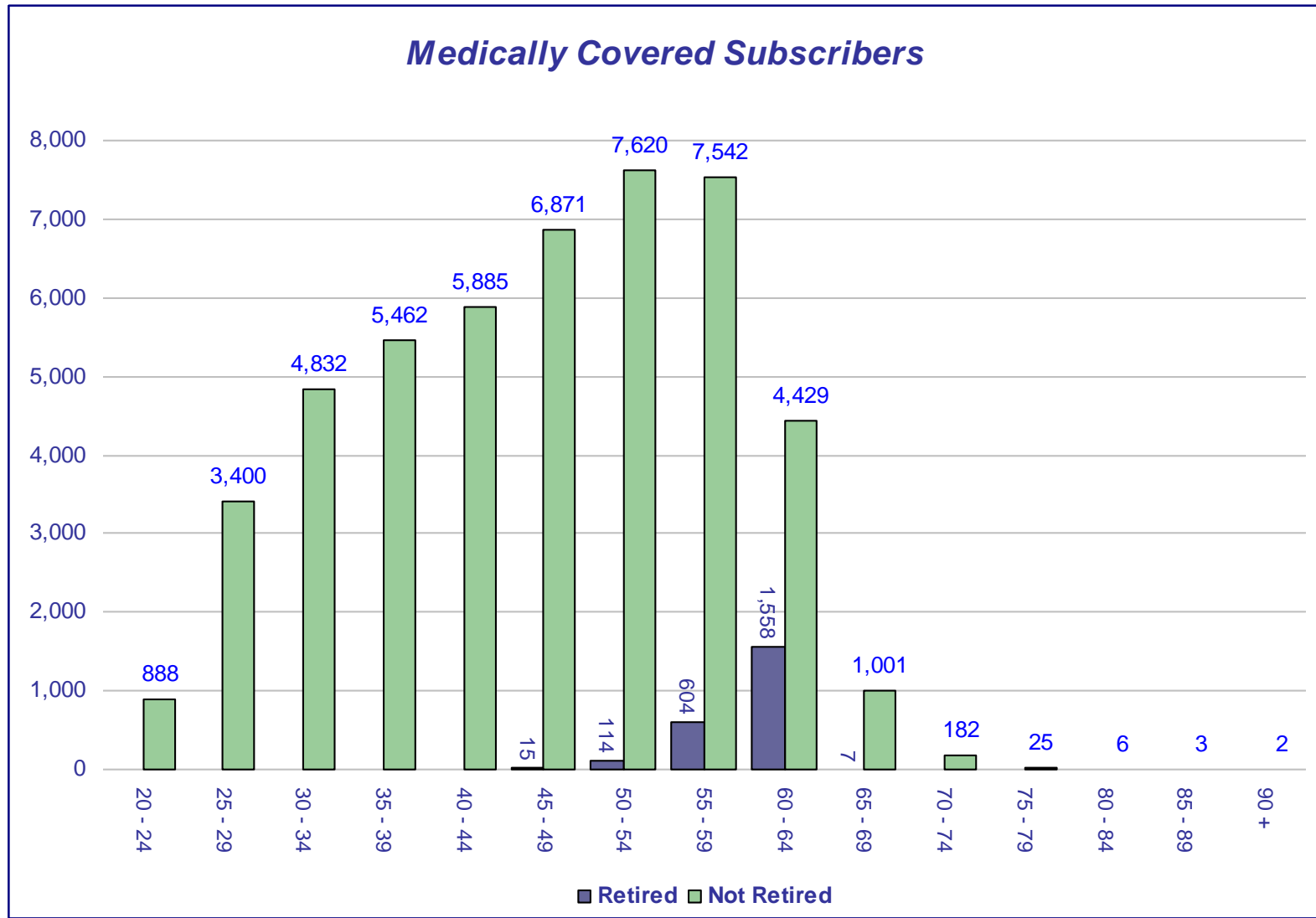
## PEBB Retiree Options for PY 2012 and 2013 RFP

- Retiree historical enrollment and demographics
- Retiree options
  - Option 1: Remove retirees from active PEBB pool
  - Option 2: Offer only retiree plan (no buy-up to full-time), keeping them in the active PEBB pool
  - Option 3: Offer only retiree plan (no buy-up to full-time), removing retirees from active PEBB pool
  - Option 4: Offer Only a High Deductible Health Plan (HDHP) for retirees
- Retiree Alternatives for PEBB retirees:
  - PERS
    - Comparison of PERS and PEBB plan options
  - COBRA
  - OMIP
- Next Steps

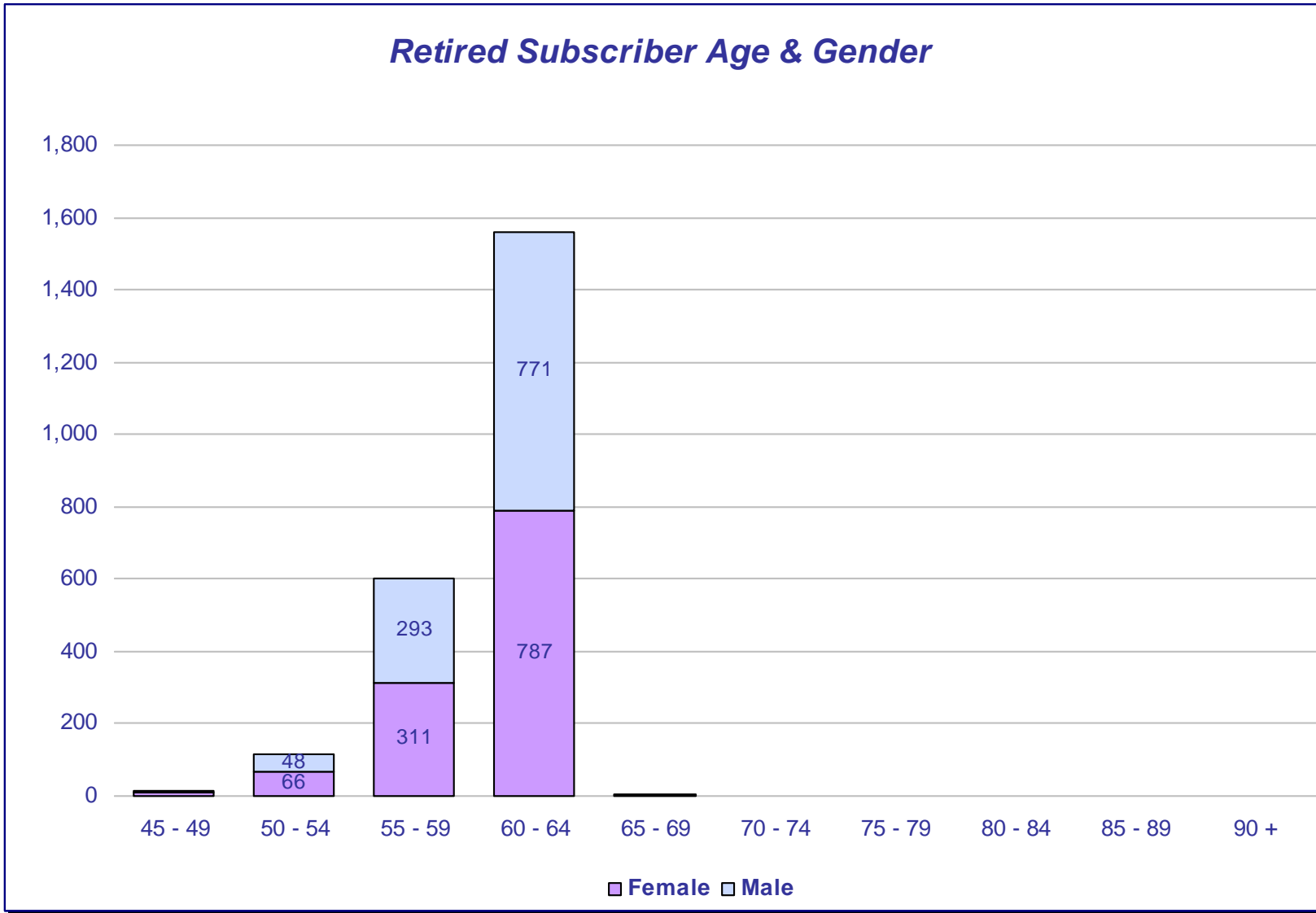
## PEBB Retirees 2008-2010

- For Plan Year 2008 PEBB had 2,913 retirees out of 44,598 employees, or 6.1%.
- For Plan Year 2009 PEBB had 2,619 retirees out of 49,294 employees, or 5.3%.
- For Plan Year 2010 PEBB has 2,330 retirees out of 50,478 employees, or 4.6%.

# PY 2010 PEBB Enrollees: Retired v. Non-Retired (Active, Semi-independent and Self-Pay)



# PY 2010 Retired Subscriber Age & Gender



## Option 1: Remove retirees from PEBB active pool for PY 2011 (From June 29, 2010 presentation), keeping same benefits

- Retirees pooled separately for medical and dental
- Retiree pool medical premiums increase 42% based on actual experience & unblended rates
- Retiree Pool, New Tiers, based on industry standard and projected claims experience to illustrate 2011 impact
- Rating retirees separately would save the PEBB \$10.5M, or 1.9%

Tier (Enrollment June 2010)	Statewide w/VSP			ODS Traditional		
	Current	Retiree Pool	Retiree Pool, New Tiers	Current	Retiree Pool	Retiree Pool, New Tiers
Retiree Only (1017)	\$997.71	\$1,412.06	\$1,049.03	\$81.58	\$81.83	\$60.22
Retiree & Spouse/DP (920)	\$1,336.78	\$1,891.94	\$2,098.02	\$109.32	\$109.66	\$120.43
Retiree & Children (71)	\$1,147.29	\$1,623.76	\$1,888.23	\$93.82	\$94.11	\$108.40
Retiree & Family (139)	\$1,366.71	\$1,934.29	\$3,147.03	\$111.77	\$112.12	\$180.66

## Option 2: Offer only retiree plan (no buy-up to full-time), keeping them in the active PEBB pool

- Retirees pooled with actives but have access only to the Part-Time plan
  - Tiers and contributions are unchanged
- PEBB claims would drop approximately \$1.5 million due to leaner plan design
- Contributions received would drop approximately \$2.4 million
- Net cost to PEBB is an increase of approximately \$900,000 (0.2% of statewide plan premium)
  - The difference in plan design is less than the difference in the plan rates
  - As retiree contributions would drop more than the claims paid by PEBB, the net result is an increase to PEBB

## Option 3: Offer only retiree plan (no buy-up to full-time), removing retirees from active PEBB pool

- Retirees pooled separately for medical and dental in the Part-Time Plan Only
- Retiree pool medical premiums increase 50% based on actual experience & unblended rates
- Retiree Pool, New Tiers, based on industry standard and projected claims experience to illustrate 2011 impact
- Rating retirees separately would save the PEBB \$10.5M, or 1.9%

Tier (Enrollment June 2010)	Statewide Part-Time		
	Current	Retiree Pool PT Plan Only	Retiree Pool, PT Plan Only, New Tiers
Retiree Only (1017)	\$798.52	\$1,201.60	\$893.51
Retiree & Spouse/DP (920)	\$1,069.91	\$1,609.95	\$1,786.96
Retiree & Children (71)	\$918.26	\$1,381.74	\$1,608.28
Retiree & Family (139)	\$1,093.89	\$1,646.05	\$2,680.47

## Option 4: Offer only a High-Deductible Health Plan (HDHP) option for retirees

- There are two models of high deductible health plans: a traditional catastrophic plan and an account based plan with a savings component (Health Savings Account (HSA))
- Traditional catastrophic plan: complete flexibility of plan design
- HSA: plan design is regulated, triple tax savings, employee & employer contributions are acceptable, portable, immediate ownership of contributions
- There is potential for adverse selection when high deductible plans are offered as a slice offering, e.g. those that are healthy may select the lower cost plan and those with higher risk select the more comprehensive benefit plan.
- Enrollment in traditional catastrophic plans is low, typically less than 10%. Overall enrollment in HSA is significantly lower than PPO and HMOS but growing rapidly every year.

## Option 4 (continued)

- Analyzed three plan design options with \$1,000; \$1,500 and \$2,000 deductible levels with increased out of pocket maximums.
- Success factors include: carefully designed plan of benefits to avoid barriers to appropriate care, risk segmentation, and comprehensive member communication and tools to support good healthcare decision making process.

Plan Design	Employee Rate	Two Party Rate
Statewide Full Time Plan	\$998	\$1,337
\$1,000 deductible	\$912 (9% savings)	\$1,217 (9% savings)
\$1,500 deductible	\$887 (11% savings)	\$1,183 (12% savings)
\$2,000 deductible	\$864 (13% savings)	\$1,153 (14% savings)

## Retiree alternatives for PEBB retirees: PERS

### **PERS Health Coverage Eligibility and Enrollment: (excerpted from the PERS 2010 Health Plan Handbook):**

- An “eligible person” includes an eligible retiree, an eligible spouse, an eligible dependent or an eligible surviving spouse or dependent.

**An eligible retiree:** a PERS member who is receiving allowance or benefit under PERS or who is on service or disability retirement or received an optional lump sum payment.

### **Enrollment Periods:**

- There are several enrollment periods for PERS Health coverage available for retirees.(e.g., new retirees, retirees that work past Medicare eligibility or are Medicare eligible) There is an allowable enrollment if the individual has been receiving continuous group coverage:

- **Continuous group coverage:**

- PERS retirees may enroll at any time if they have been covered under another group health plan for 24 consecutive months immediately preceding enrollment in a PERS health plan.

### **PEBB plans compared to PERS plans**

- Mercer valued PERS plans compared to 2010 PEBB plans
  - PERS Clear Choice
  - PERS ODS
  - PERS Kaiser
  - PERS Providence
- PERS plans are valued between 93% and 97% of PEBB full time plans based on plan design features
- See chart PEBB/PERS retiree Benefit Comparison July 2010-3.xls

## Retiree alternatives for PEBB retirees: COBRA & OMIP

- **Retiree COBRA Coverage Eligibility if the PEBB Retiree plan coverage terminates:**
  - PEBB could allow COBRA coverage only if the retiree is within the original allowable 18-month COBRA eligibility period.
- **Retiree COBRA Coverage Eligibility if the PEBB Retiree Plan Coverage premiums increase and the Retiree wants to move to COBRA:**
  - PEBB could allow COBRA coverage only if the Retiree is within the original allowable 18-month COBRA eligibility period.

### OMIP

- The Oregon Medical Insurance Pool (OMIP) provides medical insurance coverage for all Oregonians who are unable to obtain medical insurance because of health conditions. **OMIP also provides health benefit portability coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them.**

- Individuals may be eligible for coverage if they are an **Oregon resident** *and* meet any of the **portability requirements:** (medical requirements not included)

### OMIP Portability Requirements:

- **To be eligible under Portability criteria, the individual must apply to OMIP within 63 days of losing COBRA, losing Portability coverage from another insurer in Oregon, or losing group health benefits coverage because of a move from another state to Oregon. Coverage must be continuous from the termination of prior coverage and premium is due from the effective date of the OMIP coverage.**

## Next Steps

- Meeting scheduled for July 27, 2010
- Meeting scheduled for August 10, 2010

# MERCER



MARSH MERCER KROLL  
GUY CARPENTER OLIVER WYMAN

# Rural Subsidy Update



Board Meeting  
July 20, 2010

# Background

- Established in 2000 based on access and network assumptions
- Subsidizes member care in 20 “rural” counties in 2010, 18 in 2011
- 5,730 members and dependents in the current 18 counties
- Pays all providers at favored rate regardless of contract status

# Rural subsidy example

<b>Member Sees Out-of-Network Provider for Service X</b>	
<b>Lives in Rural Subsidy County</b>	<b>Lives Elsewhere</b>
Provider charge = \$100 Plan covers \$90 Plan pays 85% of \$90 = \$76.50 Member pays 15% of \$90 = \$13.50 Provider balance-bills member \$10	Provider charge = \$100 Plan covers \$90 Plan pays 70% of \$90 = \$63.00 Member Pays 30% of \$90 = \$27.00 Provider balance-bills member \$10
<b>Plan paid \$76.50</b> <b>Member paid \$23.50</b>	<b>Plan paid \$63.00</b> <b>Member paid \$37.00</b>

## History of Actions on Rural Subsidy

- 1999: Approve 11 counties for rural subsidy.
- 2001: Add nine counties; drop three counties for Plan Year 2002
- 2002: Add back Umatilla county for Plan Year 2003

## History of Actions on Rural Subsidy

- 2006: Extend rural subsidy to members residing in specific out-of-state zip codes
- 2007: No action on rural subsidies until the future state of PEBB is defined
- 2009: No action until RFP
- 2011: Remove Deschutes and Jackson counties

# Analysis by Year 2000-2011

Plan Year 2000	Plan Year 2001	Plan Year 2002	Plan Year 2003-2010	Plan Year 2011
Baker	Baker	Baker	Baker	Baker
Gilliam	Gilliam	Gilliam	Gilliam	Gilliam
Hood River	Hood River			
Klamath Falls	Klamath Falls	Klamath Falls	Klamath Falls	Klamath Falls
Morrow	Morrow	Morrow	Morrow	Morrow
Sherman	Sherman	Sherman	Sherman	Sherman
Union	Union	Union	Union	Union
Wallowa	Wallowa	Wallowa	Wallowa	Wallowa
Wasco	Wasco			
Malheur	Malheur	Malheur	Malheur	Malheur
Umatilla	Umatilla		Umatilla	Umatilla
	Lake	Lake	Lake	Lake
	Wheeler	Wheeler	Wheeler	Wheeler
		Crook	Crook	Crook
		Curry	Curry	Curry
		Deschutes	Deschutes	
		Grant	Grant	Grant
		Harney	Harney	Harney
		Jackson	Jackson	
		Jefferson	Jefferson	Jefferson
		Josephine	Josephine	Josephine
		Tillamook	Tillamook	Tillamook

# Changing Landscape for Rural Subsidy

Original question was HMO access in rural areas

- Issue impacts provider contracting
  - Acts as disincentive
  - OON providers not subject to contract requirements

# Availability of providers in 18 Rural Subsidy counties

County	# of PEBB	Providence Primary Care*	Total Available PCP in County per OMB**	# of PEBB Employees per Providence Primary Care
Baker	269	19	15	14
Crook	167	31	9	5
Curry	123	24	14	5
Gilliam	23	2	0	12
Grant	122	9	5	14
Harney	120	12	5	10
Jefferson	195	20	13	10
Josephine	461	87	70	5
Klamath	776	73	62	11
Lake	170	5	5	34
Malheur	507	61	25	8
Morrow	139	10	5	14
Sherman	18	1	1	18
Tillamook	294	19	22	15
Umatilla	1477	45	48	33
Union	759	29	27	26
Wallowa	83	13	8	6
Wheeler	27	1	1	27
TOTAL	5730	976	695	

\*Includes MD and DO with a practice address in the county, active licenses only, does not include NP, PA, midwifery, psychologist, social workers, physical therapy, etc

\*\*Primary Care includes Family Medicine/Practice, General Practice, Internal Medicine, OB/GYN

# Providence In-Network Providers in Contiguous States

Providence has an extended network through First Choice Health in Washington and Idaho and nationwide through MultiPlan.

# Providence In-Network Providers in Continuous States

	Hospitals	PCP*	Other Providers**	Total Providers
Boise	2	221	1048	1269
Walla Walla	2	107	415	522
Kennewick	1	112	507	619
Richland	1	106	389	495
Pasco	1	76	127	203
Sacramento	4			250***
Redding	3			212***

\*Includes family practice/medicine, general practice, internal medicine, OB/GYN

\*\*Includes all other providers

\*\*\*PCP plus all other providers

# Estimated Savings

The estimated 2012 savings if Rural Subsidy is eliminated in the remaining 18 counties is \$4 million.

People per  
Primary Care Provider by County  
(by # residents/total primary care provider)

Counties receiving Rural Subsidy in 2011 are highlighted in yellow

	Providence In Network Primary Care	Total # Primary Care per Oregon Medical Board*	County Population**	# County Resident / Providence Primary Care
Hood River	35	44	21625	618
Wheeler	1	3	1575	1575
Wasco	50	44	24170	483
Jackson	246	316	205305	835
Clackamas/Columbia	1482	2472	1661460	1121
Deschutes	260	247	167015	642
Baker	19	21	16455	866
Wallowa	12	9	7115	593
Malheur	70	36	31675	453
Union	23	28	25360	1103
Klamath	72	73	66180	919
Lane	277	381	345880	1249
Coos	68	69	63210	930
Tillamook	21	28	26060	1241
Gilliam	3	2	1885	628
Josephine	81	88	83290	1028
Douglas	78	111	105240	1349
Clatsop	53	39	37695	711
Lincoln	63	42	44715	710
Linn/Benton	221	181	196305	888
Marion/Polk	258	347	383100	1485
Yamhill	73	79	94325	1292
Morrow	11	10	12485	1135
Grant	9	6	7530	837
Lake	4	6	7585	1896
Harney	17	6	7705	453
Umatilla	49	56	72380	1477
Curry	29	16	21510	742
Jefferson	24	16	22450	935
Sherman	1	1	1845	1845
Crook	37	5	26845	726
Total	3647	4782	3789975	

\* Includes MD and DO primary care providers and PA. Some MD and DO primary care providers may be on an HMO panel and not available for contracting with Providence. Some PAs may not be primary care providers (e.g., those in specialty clinics). Does not include NP, midwifery, psychologist, social workers, PT, etc. Obtained from Oregon State Medical Board.

People per  
Primary Care Provider by County  
(by # residents/total primary care provider)

\*\* Oregon Blue Book 2009

People per  
 Primary Care Provider by County  
 (by # residents/total primary care provider)

# County Resident / Total Primary Care Provider in County
491
525
549
650
672
676
784
791
880
906
907
908
916
931
943
946
948
967
1065
1085
1104
1194
1249
1255
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People per  
Primary Care Provider by County  
(by # residents/total primary care provider)

People per  
Primary Care Provider by County  
(alphabetically)

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People per  
Primary Care Provider by County  
(alphabetically)

\*\* Oregon Blue Book 2009

People per  
Primary Care Provider by County  
(alphabetically)

# County Resident / Total Primary Care Provider in County
784
967
916
5369
1344
676
948
0
1255
1284
491
650
1403
946
907
1264
508
1065
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People per  
Primary Care Provider by County  
(alphabetically)