

DIVISION 5

PROCUREMENT AND CONTRACTING FOR BENEFIT PLANS AND SERVICES

111-005-0010

Policy

The policy of the Oregon Educators Benefit Board (OEBB) is to select Contractors and Consultants in an expeditious, fair, and efficient manner that is consistent with the goal of delivering high-quality benefits and other services at a cost that is affordable to the Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible , and meets the requirements of ORS 243.866. The Board may enter into more than one Contract for each type of Benefit Plan or other service sought.

111-005-0015

Renewal, Screening and Selection for Benefits, Vendor and Personal Services Contracts

(1) The Board is charged with the obligation of obtaining Benefit Plans for Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees. Oregon Administrative Rules (OARs) 111-005-0040 through 111-005-0080 set forth the screening, selection, and renewal processes to be used for all such Benefit Plans. The Board has sole authority to procure all Benefit Plans and services contemplated by ORS 243.860 through ORS 243.886.

(2) Except as provided in OARs 111-005-0040 through 111-005-0080, the Board adopts the DOJ model public contract rules in OAR 137, division 46 (General Provisions Related to Public Contracting) and division 47 (Public Procurements for Goods or Services) as the contracting rules that shall apply to its Contracts.

111-005-0020

Definitions

For the purposes of OARs 111-005-0010 through 111-005-0080 the following definitions will apply:

(1) "Apparent successful proposer" or "ASP" means the organization selected as a result of a competitive and completed Procurement process.

(2) "Bid" means a competitive document, binding on the Proposer and submitted in response to an Invitation to Bid.

(3) "Bidder" means a Person submitting a proposal in response to an ITB.

(4) "Competitive Range" means the group of Proposers or Bidders responding to a Procurement that has Proposals or Bids that score higher based on the Procurement's evaluation criteria than the remaining Proposers or Bidders in some meaningful way. Proposers or Bidders who are determined to be in a Competitive Range may also be referred to as finalists.

(5) "Consultant" means brokers or other advisory personnel hired by the Board to:

(a) Assist in acquiring adequate Benefit Plan coverage for Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees. ;

(b) Assist in the study of all matters connected with the provision of adequate Benefit Plan coverage for Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees;

- (c) Assist in the development and implementation of decision-making processes;
- (d) Design and implement additional programs to review, monitor and assist in health improvement for Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees; ; and
- (e) Provide other services as required by the Board.
- (6) "Contractor" means an individual or firm who provides services to the Board under a public contract.
- (7) "Emergency" means circumstances that:
 - (a) Could not have been reasonably foreseen;
 - (b) Create a substantial risk of loss, damage or interruption of Benefit Plans or other services or a substantial threat to property, public health, welfare or safety; and
 - (c) Require prompt execution of a contract to remedy the condition.
- (8) "Extensive Procurement" means the process of soliciting Proposals and Bids and selecting a Contractor for services amounting to \$150,000 and over.
- (9) "Intermediate Procurement" means the process of soliciting Proposals and Bids and selecting a Contractor for services amounting to under \$150,000 but over \$10,000.
- (10) "Invitation to Bid" or "ITB" means all documents, whether attached or incorporated by reference, used for soliciting bids.
- (11) "OEBB" or "the Board" refers to the Board or other Persons or groups the Board delegates authority to for all or part of the Solicitation process.
- (12) "ORPIN" means the Oregon Procurement Information Network, an online service operated by the Department of Administrative Services that displays Procurements and contracts issued by the state of Oregon's agencies.
- (13) "Person" means a natural person capable of being legally bound, a sole proprietorship, a corporation, a partnership, a limited liability company or partnership, a limited partnership, a for-profit or nonprofit unincorporated association, a business trust, two or more persons having a joint or common economic interest, any other person with legal capacity to contract or a public body.
- (14) "Procurement" means the action of obtaining goods or services under a public contract.
- (15) "Proposal" means a competitive document, binding on the Proposer and submitted in response to a RFP.
- (16) "Proposer" means a Person submitting a proposal in response to a RFP.
- (17) "Renewal Contractor" means a contractor or consultant who provided the same or similar employee benefit plan or other services under a contract with the Board in the plan year immediately prior.
- (18) "Request for Proposal" or "RFP" means all documents, whether attached or incorporated by reference, used for soliciting proposals.
- (19) "Responsible Proposer" means a Person who meets the standards of responsibility described in OAR 111-005-0055.

(20) "Responsive Proposal" means a Proposal that substantially complies with the RFP and all prescribed Procurement procedures and requirements.

(21) "Selection Committee" means the group of individuals appointed or approved by the Board to review, evaluate and score Proposals received as part of an Intermediate or Extensive Procurement.

(22) "Single Point of Contact" or "SPC" means the designated OEGB staff or designee that serves as the official point of contact between OEGB and interested Proposers, ASPs, or Contractors.

(23) "Small Procurement" means the process of securing Contractors or Consultants for services amounting to \$5,000 or less.

(24) "Sole Source" means the only Contractor or Consultant of a particular product or service reasonably available.

(25) "Solicitation" generally refers to the methods used to request goods or services through a competitive process, including Requests for Proposals, Invitations to Bid, and other methods used under Intermediate or Extensive Procurements.

111-005-0040

Extensive Procurement Process

The Board will use the following procedure for Extensive Procurements, except as provided for under OAR 111-005-0046 or 111-005-0048.

(1) Announcement. The Board will post Solicitation notices for Benefit Plans or services on ORPIN. The Board may also post Solicitation notices for Benefit Plans or services in trade periodicals or newspapers of general or specialized circulation. The Solicitation notice will include a description of the Benefit Plans or services sought, the scope of the services required, evaluation and selection criteria, and a description of any special requirements. The notice will invite qualified prospective Proposers to submit Proposals. The notice will specify when and where to obtain the RFP, where to return the Proposal, the method of submission, and the closing date.

(2) No remuneration will be offered to prospective Proposers for attendance, travel, document preparation, etc. unless otherwise specified in the RFP.

(3) Pre-proposal conference. Unless otherwise specified in the RFP, the pre-proposal conference will:

(a) Be voluntary; and

(b) Be held in Salem, Oregon.

(4) Protest of RFP specifications; request for change; request for clarification.

(a) Protest of RFP specifications.

(A) A Proposer may deliver a protest to the SPC not less than ten calendar days prior to closing, unless otherwise specified in the RFP.

(B) Protests must be in writing and must include:

(i) A detailed statement of the legal and factual grounds for the protest;

(ii) A description of the resulting prejudice to the Proposer; and

(iii) A statement of the desired changes to the RFP.

(C) OEGB will not consider a protest after the submission deadline.

(D) OEGB will provide notice to the protestor if it entirely rejects a protest. If OEGB agrees with the protest, in whole or in part, it will issue an addendum reflecting its determination under OAR 137-030-0055 and 137-047-0430 or cancel the solicitation under 137-030-0115.

(E) If OEGB receives a written protest that meets this rule's requirements, the closing may be extended if OEGB determines an extension is necessary to consider the protest and to issue any addendum to the RFP.

(b) Request for change.

(A) A Proposer may submit a written request to change the RFP specifications, unless otherwise specified in the RFP. If the RFP allows requests for change and does not specify otherwise, Proposer must deliver the written request for change to the SPC not less than ten calendar days prior to closing.

(B) A request for change must include a statement of the requested changes to the RFP specifications as well as the reason for the requested change.

(C) OEGB will not consider a request for change after the submission deadline.

(D) OEGB will provide notice to the requestor if it entirely rejects a change. If OEGB agrees with the request for change, in whole or in part, OEGB will issue an addendum reflecting its determination under OAR 137-030-0055 and 137-047-0430 or cancel the Solicitation under 137-030-0115.

(E) If OEGB receives a written request for change that meets this rule's requirements, closing may be extended if OEGB determines an extension is necessary to consider the request and to issue any addendum to the RFP.

(c) Request for clarification.

(A) A Proposer may submit a written request for clarification of the RFP specifications, unless otherwise specified in the RFP. If the RFP allows a request for clarification and does not specify otherwise, a Proposer must deliver the written request for clarification to the SPC not less than ten calendar days prior to closing.

(B) A Proposer may request that OEGB clarify any provision of the RFP.

(C) OEGB will not consider a request for clarification after the submission deadline. OEGB's clarification to a Proposer, whether orally or in writing, does not change the RFP and is not binding on OEGB unless the RFP is amended by addendum.

(5) Addenda to an RFP following a protest of RFP specifications, request for change, or request for clarification.

(a) Issuance; receipt. OEGB may change an RFP only by written addenda. A Proposer must provide written acknowledgement of receipt of all issued addenda with its Proposal, unless otherwise specified in the RFP.

(b) Notice and distribution. The RFP must specify how OEGB will provide notice of addenda and make the addenda available.

(c) Timelines; extensions. OEGB will issue addenda within a reasonable time to allow potential Proposers to consider the addenda in preparing their Proposals. OEGB may extend the closing if it determines potential Proposers need additional time to review and respond to addenda. OEGB will not issue addenda less than 72 hours before the closing unless an addendum also extends the closing, except to the extent required by public interest.

(d) Request for change or protest. A potential Proposer may submit a written request for change or protest to the addendum by the close of OEGB's next business day after issuance of the addendum, unless otherwise specified in the addendum.

(6) Submission. All Proposals must comply with the RFP's specifications.

(a) If portions of a Proposal are deemed unacceptable or non-responsive to the RFP's specifications, the Proposal will be deemed non-responsive and will not be given further evaluation or consideration, unless a clarification of portions of the Proposal is required to determine if it meets the RFP's specifications. If a Proposal is delivered late, it will be deemed non-responsive, will not be given further evaluation or consideration, and will be returned to the Proposer unopened.

(b) Submission of Proposals must be in written hard copy or electronic format and must be delivered according to the RFP's specifications. OEGB is not responsible for unreadable or incomplete electronic transmissions or for electronic transmissions that are not received by the SPC or designee as specified in the RFP by the closing date and time stated in the RFP.

(7) Evaluation. Proposals will be evaluated in accordance with the criteria set forth in the RFP and applicable law. OEGB staff, Consultants, or other persons designated by OEGB may provide recommendations to the Board on determining the Competitive Range and selecting the ASP(s).

(8) Rejection of Proposal. OEGB may reject any Proposal for good cause and deem it as non-responsive upon written finding that it is in the best interest of Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees to do so or acceptance of the Proposal may impair the integrity of the RFP process. OEGB will notify the Proposer of the rejection in writing and provide the good cause justification and finding. OEGB is not liable to any Proposer for any loss or expense caused by or resulting from any rejection, cancellation, delay or suspension. Without limiting the generality of the foregoing, OEGB may reject any Proposal upon finding that the Proposal:

(a) Is contingent upon OEGB's acceptance of terms and conditions (including the RFP Specifications and requirements) that differ from the RFP;

(b) Takes exception to terms and conditions set forth in the RFP;

(c) Attempts to prevent public disclosure of matters in contravention of the terms and conditions of the RFP or in contravention of applicable law;

(d) Offers services that fail to meet the RFP's specifications or requirements;

(e) Is late;

(f) Is not in substantial compliance with the RFP;

(g) Is not in substantial compliance with all prescribed Procurement procedures;

(h) Is from a Proposer that has been debarred as set forth in ORS 279B.130;

(i) Has failed to provide the certification of non-discrimination required under ORS 279A.110(4); or

(j) Is from a Proposer found non-responsive as described in OAR 111-005-0055.

(9) Intent to award, discuss, or negotiate. After the protest period provided in subsection (4)(a) expires or after OEBB has provided a final response to any protest, whichever date is later, OEBB may engage in discussions and negotiations with Proposers in the Competitive Range.

(10) Discussions and negotiations. If OEBB enters into discussions and negotiations with the Proposers in the Competitive Range, it will proceed as follows:

(a) Initiating discussions. OEBB must initiate oral or written discussions and negotiations with all of the Proposers in the Competitive Range.

(b) Conducting discussions. OEBB may conduct discussions and negotiations with each Proposer in the Competitive Range as necessary to fulfill the purposes of this section, but need not conduct the same amount of discussions or negotiations with each Proposer. OEBB may terminate discussions and negotiations with any Proposer in the Competitive Range at any time. In conducting discussions, OEBB and its designees:

(A) Will treat all Proposers fairly and will not favor any Proposer over another.

(B) Will not discuss Proposers' Proposals with any other Proposers.

(C) Will determine whether other factors such as Oregon residency of the primary business office and Proposer demonstration of services and products, will be used to determine the ASP, if a tie between Proposers occurs. OEBB may consider any factors that it deems are in the public interest.

(c) At any time during the period allowed for discussions and negotiations, OEBB may:

(A) Continue discussions and negotiations with a particular Proposer or Proposers; or

(B) Terminate discussions with a particular Proposer and continue discussions with other Proposers in the Competitive Range.

(d) OEBB may continue discussions and negotiations with Proposers until determining who will be awarded contracts.

(11) Notice of intent to award. OEBB will provide written notice to all Proposers of its intent to award the contract or contracts resulting from the RFP, unless otherwise specified in the RFP. OEBB's award will not be final until the later of the following:

(a) Seven calendar days after the date of the notice, unless the RFP provided a different period for protest; or

(b) OEBB's written response to all timely filed protests that denies the protests and affirms the award.

(12) Right to protest award. An adversely affected or aggrieved Proposer may submit a written protest of the intent to award to the SPC. The protest must be made within seven calendar days after issuance of the notice of intent to award the contract, unless otherwise specified in the RFP.

(a) The protest must be in writing and must specify the grounds upon which the protest is based.

(b) A Proposer is adversely affected or aggrieved only if the Proposer would be eligible to be awarded the contract in the event that the protest were successful, and the reason for the protest is that:

(A) All higher ranked Proposals are nonresponsive;

(B) OEBC has failed to conduct the evaluation of Proposals in accordance with the criteria or processes described in the RFP;

(C) OEBC has abused its discretion in rejecting the protestor's Proposal as nonresponsive; or

(D) OEBC's evaluation of Proposals or OEBC's subsequent determination of award is otherwise in violation of OEBC's rules or ORS 243.860 to 243.886.

(c) OEBC will not consider a protest submitted after the time period specified in this rule or after the time period specified in the RFP, if different than the time period specified in this rule.

(d) The Board, OEBC staff, or their designee has the authority to settle or resolve a written protest meeting the submission requirements of this rule.

(e) If a protest is not settled, the Board, OEBC staff, or their designee will promptly issue a written decision on the protest. Judicial review of this decision will be available only as provided by statute.

(13) Award of contracts. OEBC will approve the ASP(s), taking into consideration any recommendations made by OEBC staff, Consultant, or designees and the evaluation criteria included in OAR 111-002-0005(3) and the RFP. Selection criteria may include, but is not limited to, Contractor or Consultant availability; capability; experience; approach; compensation requirements; financial standing; previous litigation and remedy applied; customer service history with OEBC and the members and customers it serves; debarment status; and references.

(14) Contract. The ASP(s) must promptly execute the contract after the award is final and all contractual terms and conditions have been negotiated and agreed upon, consistent with any timeline(s) included in the RFP. OEBC will execute the contract only after it has obtained all applicable required documents and approvals. .

111-005-0042

Intermediate Procurement Process

Except as provided under OAR 111-005-0046 or 111-005-0048, OEBC will use the following procedure for an Intermediate Procurement:

(1) Selection procedure. OEBC will contact a minimum of three Proposers known to OEBC to be qualified to provide the work and services sought.

(2) Submission. All Proposals must comply with the OEBC's specifications for the Intermediate Procurement. If portions of the Proposal are deemed unacceptable or non-responsive to the specifications, the Proposal may be deemed non-responsive. OEBC may give the Proposer an opportunity to submit a responsive Proposal. Submission of Proposals must meet the specifications for the Intermediate Procurement. . OEBC is not responsible for unreadable or incomplete electronic transmissions or for electronic transmissions that are not received by OEBC.

(3) Evaluation. OEBC will evaluate Proposals in accordance with criteria set forth in the Intermediate Procurement.

(4) Discussions and negotiations. If OEBC chooses to enter into discussions and negotiations with a Proposer under this Intermediate Procurement procedure, OEBC will do so consistent with 111-005-0010.

(5) Notice of intent to award. OEBC will provide written notice to all Proposers under an Intermediate Procurement of its intent to award the contract.

(6) Right to protest award. An adversely affected or aggrieved Proposer may submit to OEGB a written protest of OEGB's intent to award. The protest must be made within seven calendar days after issuance of the notice of intent to award the contract, unless otherwise specified by OEGB.

(a) The Proposer's protest must be in writing and must specify the grounds upon which the protest is based.

(b) A Proposer is adversely affected or aggrieved only if:

(A) The Proposer is eligible for award of the contract as a responsible Proposer; and

(B) OEGB committed a substantial violation of its Intermediate Procurement procedure or of an applicable procurement statute or administrative rule.

(c) OEGB will not consider a protest submitted after the time period specified in this section or a different period if provided in the specifications of the Intermediate Procurement.

(d) The Board, OEGB staff, or their designee, has the authority to settle or resolve a written protest meeting the submission requirements of this rule.

(e) If a protest is not settled, the Board, OEGB staff, or their designee, will promptly issue a written decision on the protest. Judicial review of this decision will be available if provided by statute.

(10) Contract. The successful Proposer must promptly execute the Contract after the award is final. The Board Chair, or designee, will execute the Contract only after it has obtained all applicable required documents and approvals.

111-005-0044

Small Procurement Process

For a Small Procurement, OEGB may procure Contractor services in any manner it deems practical, including by direct selection, negotiation and award.

(1) Award of Contracts. OEGB will base selections on evaluation criteria which may include, but is not limited to, contractor availability; capability; experience; approach; compensation requirements; previous litigation and remedy applied; customer service history with the OEGB, members and clients; debarment status; and references. Emphasis will be placed on quality customer service, creativity, affordability, and innovation and the improvement of employee health.

(2) Contract. The selected Contractor must promptly execute the Contract. OEGB will execute the Contract only after obtaining all applicable required documents and approvals.

111-005-0046

Sole Source Procurement Process

OEGB may award a Contract for Benefit Plans or services without competition when OEGB determines in writing that the Benefit Plans or services are available from only one source, or the Contractor is defined as a Qualified Rehabilitation Facility as defined in Oregon's Public Contracting Code.

(1) The determination of a Sole Source Procurement must be based on written findings that may include, but are not limited to, the following:

(a) That the efficient utilization of existing Benefit Plans or services requires the acquisition of compatible services;

(b) That the Benefit Plans or services required for the exchange of software or data with other public or private agencies are available from only one source;

(c) That the Benefit Plans or services are for use in a pilot or an experimental project; or

(d) Other findings that support the conclusion that the goods or services are available from only one source.

(2) To the extent reasonably practical, OEGB shall negotiate with the sole source organization or Person to obtain Contract terms advantageous to OEGB.

(3) Contract. The sole source organization or Person must promptly execute the Contract after the award is final. OEGB will execute the Contract only after it has obtained all applicable required documents and approvals.

111-005-0047

Renewal Process

Renewal process. OEGB may renew Contracts with Contractors for as many years as OEGB determines is in the best interest of the state, Eligible Employees, Dependents, Eligible Domestic Partners, and Eligible Early Retirees. OEGB may invite renewal proposals from those Contractors who provided the same or similar Benefit Plans or services in the year immediately prior. A Benefit Plan or services Contract is similar if it is reasonably related to the scope of work described in the Procurement under which such a Contract was awarded.

111-005-0048

Emergency Contract Procedure

OEGB may select a Contractor to provide Benefit Plans or services without following any of the procedures under OAR 111-005-0040, 111-005-0042, 111-005-0044, or 111-005-0046 when required by Emergency. OEGB will determine if an Emergency exists, declare the Emergency, and negotiate a Contract with the Contractor based on the following criteria: Contractor availability; capability; experience; approach; compensation requirements; previous litigation and remedy applied; customer service history with the OEGB, members and clients; debarment status; and references. OEGB will place emphasis on employee choice among high-quality plans, plan performance and information, a competitive marketplace, employer flexibility in plan design and contracting, quality customer service, creativity, affordability, and innovation and the improvement of employee health.

111-005-0050

Mistakes

(1) Treatment of mistakes. If OEGB discovers certain mistakes in a Proposal before award of the Contract, and the mistakes are not identified as those qualifying as non-responsive to the specifications of the Procurement, OEGB may take the following action:

(a) Waive or permit a Proposer to correct a minor informality. A minor informality is a matter of form rather than substance that is evident on the face of the Proposal, or an insignificant mistake that can be waived or corrected without prejudice to other Proposers. Mistakes including, but not limited to, signatures not affixed to the Proposal document, Proposals sent to the incorrect address, insufficient number of Proposals submitted, or incorrect format will not be considered minor.

(b) Correct a clerical error if the intended Proposal and the error are evident on the face of the Proposal, or other documents submitted with the Proposal, and the Proposer confirms the correction in writing. A clerical error includes, but is not limited to, a Proposer's error in transcribing its Proposal.

(2) Rejection for mistakes. OEGB may reject any Proposal in which a mistake is evident on the face of the Proposal and the intended correct Proposal is not evident or cannot be substantiated from documents accompanying the Proposal. In order to ensure integrity of the competitive Procurement process and to assure fair treatment of Proposers, mistakes discovered that are contrary to the specifications of the Procurement will be carefully reviewed and will be determined, under sole authority of OEGB, to be waived or not be waived.

(3) If OEGB discovers mistakes in the Proposal after award, and the mistakes are not considered minor, OEGB reserves the right to determine if the award will be revoked. OEGB will then re-evaluate Proposals deemed to be in second, third, fourth, etc., in the standings.

111-005-0055

Responsible Proposer

(1) Before awarding a Contract, OEGB must establish that the Proposer meets the applicable standards of responsibility. OEGB shall prepare a written determination of non-responsibility for a Proposer if OEGB determines that the Proposer does not meet the standards of responsibility.

(2) In determining whether a Proposer has met the standards of responsibility, OEGB shall consider whether a Proposer:

(a) Has available the appropriate financial, material, equipment, facility and personnel resources and expertise, or has the ability to obtain the resources and expertise, necessary to meet all contractual responsibilities.

(b) Completed previous contracts of a similar nature with a satisfactory record of performance. For purposes of this paragraph, a satisfactory record of performance means that to the extent that the costs associated with and time available to perform a previous contract remained within the Proposer's control, the Proposer stayed within the time and budget allotted for the procurement and otherwise performed the contract in a satisfactory manner. OEGB shall document the Proposer's record of performance if OEGB finds under this paragraph that the Proposer is not responsible.

(c) Has a satisfactory record of integrity. In evaluating the Proposer's record of integrity, OEGB may consider, among other things, whether the Proposer has previous criminal convictions for offenses related to obtaining or attempting to obtain a contract or subcontract or in connection with the Proposer's performance of a contract or subcontract. OEGB shall document the Proposer's record of integrity if OEGB finds under this paragraph that the Proposer is not responsible.

(d) Is legally qualified to contract with OEGB.

(e) Supplied all necessary information in connection with the inquiry concerning responsibility. If a Proposer fails to promptly supply information concerning responsibility that OEGB requests, OEGB shall determine the Proposer's responsibility based on available information or may find that the Proposer is not responsible.

(f) Was not debarred by OEGB in accordance with ORS 279B.130.

(3) OEGB may refuse to disclose outside of OEGB confidential information furnished by a Proposer under this section when the Proposer has clearly identified in writing the information the Proposer seeks to have treated as confidential and OEGB has authority under ORS 192.410 to 192.505 to withhold the identified information from public disclosure.

111-005-0080

Contract Amendments

OEGB may amend a Contract without additional competition in any of the following circumstances:

(1) The amendment is within the scope of the underlying Procurement.

- (2) These rules otherwise permit OEGB to award a Contract without competition for the goods or services to be procured under the amendment.
- (3) The amendment is necessary to comply with a change in law that affects performance of the Contract.
- (4) The amendment results from renegotiation of the terms and conditions, including the contract price, of a Contract and the amendment is advantageous to OEGB, subject to all of the following conditions:
 - (a) The work or services to be provided under the amended Contract are the same as the work or services to be provided under the unamended Contract.
 - (b) OEGB determines that the amended Contract is at least as favorable to OEGB as the unamended Contract.
 - (c) The amended Contract does not have a total term greater than allowed in the underlying Procurement after combining the initial and extended terms.

DIVISION 20

PROGRAM PARTICIPATION

111-020-0010

Entities Electing to Join OEGB

(1) Effective January 1, 2014 an Entity can elect to participate in benefit plans provided by the Board subject to the following conditions:

(a) The Entity completes and submits a Notice of Intent to join OEGB at least 90 days prior to the date OEGB coverage is to go into effect;

(b) OEGB will not transfer any deductibles or annual out-of-pocket maximums met with the prior carrier;

(c) For those members with an existing life insurance policy through the Entity, OEGB will transfer the life insurance amount in force on the last day the prior group coverage was in effect, rounded to the next highest \$10,000 increment, if requested and documented by the Entity.

(d) Early retiree participation in the OEGB plans will be limited to those individuals and eligible dependents currently enrolled in the Entity's medical, dental and/or vision plans and those Early Retirees who retire on or after the effective date of OEGB coverage and their eligible dependents.

(2) Entities electing to participate in benefit plans provided by the Board are limited to offering the coverages and plans provided by OEGB for medical, dental, vision, life, AD&D, disability plans, Employee Assistance Program (EAP) and Long Term Care (LTC). Entities cannot choose to offer some coverages or plans through OEGB and other coverages or plans outside of the OEGB benefits program.

(3) A Local Government must provide OEGB with medical plan premium rates and loss ratios for the two most-recent years, if available, with its Notice of Intent to join OEGB to allow OEGB's Consultant to perform an actuarial plan comparison. For self-funded groups, two years of claims experience data should be submitted in lieu of premium rates or loss ratios. The results of the actuarial analysis shall be used as follows:

(a) If the actuarial plan comparison for a Local Government demonstrates that costs are less than 10 percent over OEGB's costs during the same two-year period, the Local Government may participate in the OEGB plan(s) at current OEGB rates.

(b) If an actuarial plan comparison for a Local Government demonstrates that costs are equal to or greater than 10 percent higher than OEGB's costs during the same two year period, the Local Government may participate in the OEGB plan(s) subject to a special rate category, or surcharge, for up to three years. **After three years, the special rate category will be discontinued and the Local Government will move to OEGB's current rates.**

(4) The Local Government must submit a final Letter of Participation to OEGB at least 30 days prior to the effective date of participation.

(5) Local Governments providing a cash incentive to a member for opting-out of medical coverage that exceeds 75 percent of the cost of employee only coverage of the lowest cost OEGB **statewide** medical plan, **regardless of the Local Governments plan offerings**, may be assessed a surcharge of up to \$100 per month per opt-out election.

(6) Local Governments who elect to participate in benefit plans provided by the Board and then subsequently elect to leave OEGB and offer a plan or plans available through the health insurance exchange may re-elect to participate in benefit plans provided by the Board under the rate category the Local Government was in just prior to leaving OEGB on a one-time basis provided the Local Government completes and submits a Letter of Participation to OEGB at least 60 days prior to the date OEGB coverage is to go into effect.

(7) Once a Local Government re-elects to participate in benefit plans provided by the Board after leaving, they are not eligible to offer alternative plans through any other source or sponsor.

(8) Local Governments electing to join OEGB on or after April 1, 2015, are limited to using the tiered rate structure for medical, dental and vision plans.

OREGON EDUCATORS BENEFIT BOARD BUDGET UPDATE APRIL 2016

PRESENTATION OVERVIEW

2015-2017 Biennium Budget

Revolving Cash Balance

2016-17 Administrative Fee

2015-17 BIENNIUM LAB

- **OEBB Operating:**

OEBB Operations budget is \$11.7 million for the 2015-17 biennium.

Through February 2016, OEBB has expended 25% of the total Operating Budget

- **OEBB Revolving:**

OEBB Revolving budget is \$1.5 billion for the 2015-17 biennium.

Through February 2016, OEBB has expended 32% of the total Revolving Budget

33% of the 2015-17 Biennium is complete

2015-17 BUDGET BY CATEGORY

2015-2017 Budget Category	Budget Dollars
Personal Services	\$4,515,600
Consultant Charges	\$3,167,357
IT Professional Services	\$2,368,300
Attorney General Charges	\$767,195
Other Supplies and Services	\$930,325
Total	\$11,748,777

REVOLVING ACCOUNT CASH BALANCE

As of February 29, 2016 the Cash balance is \$6,361,000

Revenue:

- All insurance premiums (pass through)
- Monthly Administrative Costs
- Carrier Penalty Payments
- Monthly Interest earnings
- Carry forward

Expenditures:

- All insurance premiums/claims
- Monthly Administrative Costs
- COBRA Subsidy payments
- Health and Wellness Programs

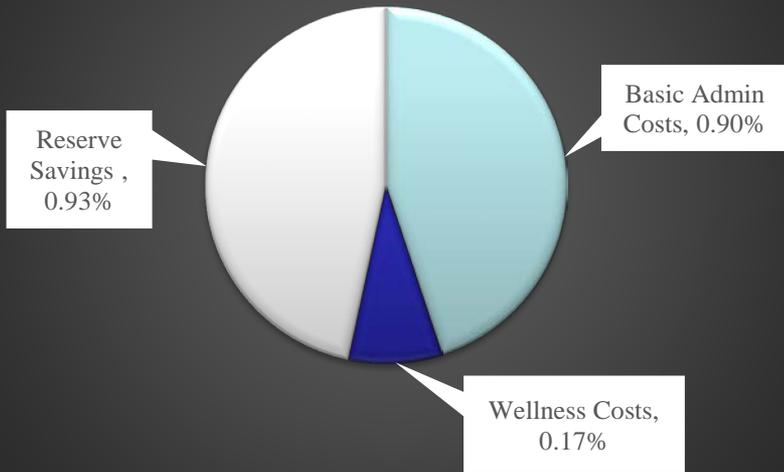
ADMINISTRATIVE FEE DEVELOPMENT

Items taken into account when developing the yearly administrative fee:

- Monthly cash requirements for Operating expenses
- Monthly cash requirements for Health and Wellness programs
- Current plan year composite rate
 - Based on March 1st enrollments
- Potential percentage of premium rate increase
 - For the 2016-17 Plan Year OEGB was allowed a budget increase of 3.4%

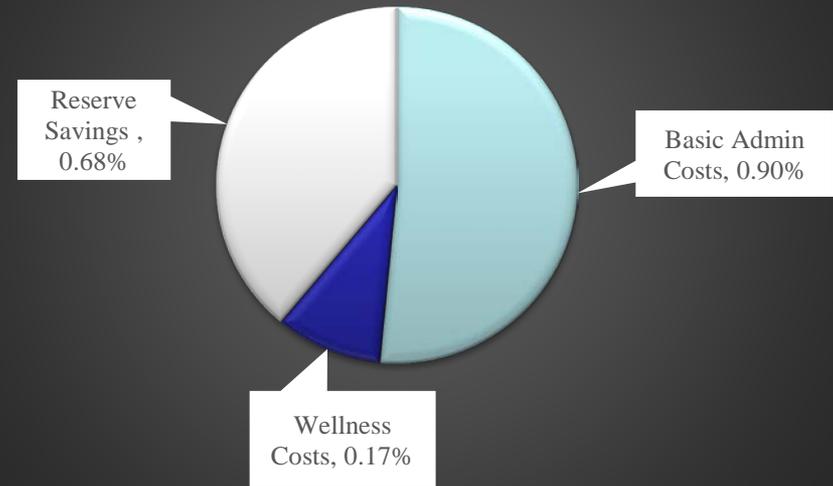
Administrative Fee: Percentage Increase Options

2.0% Admin Fee



■ Basic Admin Costs ■ Wellness Costs ■ Reserve Savings

1.75% Admin Fee



■ Basic Admin Costs ■ Wellness Costs ■ Reserve Savings

Administrative Fee: In Dollars

2.0% Admin Fee Increase (in dollars)

Basic Admin Costs \$560,833
Wellness Costs \$105,411
Reserve Savings \$579,051

Total Monthly Admin Fee Recv'd
\$1,245,295

Total Annual Admin Fee Recv'd
\$14,943,539

**Projected Reserve Increase for the
2016-17 Plan Year \$6,948,607**

1.75% Admin Fee Increase (in dollars)

Basic Admin Costs \$560,833
Wellness Costs \$105,411
Reserve Savings \$423,389

Total Monthly Admin Fee Recv'd
\$1,089,633

Total Annual Admin Fee Recv'd
\$13,075,596

**Projected Reserve Increase for the
2016-17 Plan Year \$5,080,665**

ADMINISTRATIVE FEE DEVELOPMENT

Current plan year administrative fee is 1.0%

OEBB Staff is recommending the administrative fee be increased to 2.0% for the 2016-17 plan year.

Increasing the administrative fee will allow future flexibility to self-insure, buy down premiums, or expand Wellness programs.

Revolving Account Cash Requirements

3/28/16

			High Estimate			Moderate Estimate			Low Estimate			
Health Programs	Member Count	Cost	Health Programs	Estimate Enrollments	Estimate Cost	Health Programs	Estimate Enrollments	Estimate Cost	Health Programs	Estimate Enrollments	Estimate Cost	
HTHU			assumption: 100% member increase			assumption: 50% member increase			assumption: 25% member increase			
Oct2014-Sept2015 Monthly Average	420	\$ 45,000	Monthly estimate	840	\$ 90,000	Monthly estimate	630	\$ 67,500	Monthly estimate	525	\$ 56,250	
12 months 2014-2015 Average	5,040	\$ 540,000	Yearly estimate	10,080	\$ 1,080,000	Yearly estimate	7,560	\$ 810,000	Yearly estimate	6,300	\$ 675,000	
Mood Helper			assumption: 100% member increase			assumption: 50% member increase			assumption: 25% member increase			
Plan Year 2014-15 Monthly	11	\$ 3,528	Monthly estimate	22	\$ 5,750	Monthly estimate	17	\$ 4,639	Monthly estimate	14	\$ 4,084	
Plan Year 2014-15 Annual	127	\$ 41,320	Yearly estimate	264	\$ 68,994	Yearly estimate	198	\$ 55,662	Yearly estimate	165	\$ 48,996	
Gym Subsidy			assumption: member reimbursed 12 times in one year			assumption: member reimbursed 7.5 times in one year			assumption: member reimbursed 4.5 times in one year			
1st Quarter (Jan16) Reimbursement	505	\$ 17,810	Quarterly estimate	2,713	\$ 40,695	Quarterly estimate	2,713	25,434	Quarterly estimate	2,713	15,261	
			Yearly estimate (4 quarters)	10,852	\$ 162,780	Yearly estimate (4 quarters)	10,852	101,738	Yearly estimate (4 quarters)	10,852	61,043	
Better Choices Better Health (Canary)			\$175 per enrollment/\$175 per completer			\$175 per enrollment/\$175 per completer			\$175 per enrollment/\$175 per completer			
10/15 - 2/29/2016	170	\$ 30,000										
10/15 - 2/29/2016	45		Yearly estimate	816	\$ 285,600	Yearly estimate	612	\$ 214,200	Yearly estimate	408	\$ 142,800	
DPP (YMCA)			\$429/per enrolled member			\$429/per enrolled member			\$429/per enrolled member			
Oct 2014 - Sept. 2015 (Enrollment)	11	\$ 4,719	Monthly estimate	4	\$ 1,645	Monthly estimate	2	\$ 1,001	Monthly estimate	1	\$ 393	
			Yearly estimate	46	\$ 19,734	Yearly estimate	28	\$ 12,012	Yearly estimate	11	\$ 4,719	
DPP (CCNO)			\$490/per enrolled member			\$490/per enrolled member			\$490/per enrolled member			
Oct 2014 - Sept 2015 (Enrollment)	2	\$ 980	Monthly estimate	8	\$ 3,716	Monthly estimate	2	\$ 1,143	Monthly estimate	0	\$ 82	
			Yearly estimate	91	\$ 44,590	Yearly estimate	28	\$ 13,720	Yearly estimate	2	\$ 980	
Online DPP (Canary)			\$480/per enrolled member			\$480/per enrolled member			\$480/per enrolled member			
	NA	NA	Monthly estimate	15	\$ 7,200	Monthly estimate	10	\$ 4,800	Monthly estimate	5	\$ 2,400	
			Yearly estimate	180	\$ 86,400	Yearly estimate	120	\$ 57,600	Yearly estimate	60	\$ 28,800	
Yearly Estimate Health Program Costs					\$ 1,748,098						\$ 1,264,932	\$ 962,338

Assumptions:

MoodHelper
Annual fixed rate fee of \$15,666 included in assumptions.

Gym Subsidy
Use PEBB ASH enrollment figures from 2015-16 plan year. OEBC program does not have enough history. 1st payment made in Jan16

Better Choices Better Health
1) 100% of enrollees are completers
2) \$350 per completer (2015-16 cost)
2) High estimate is based on 1% of the eligible population completing the program

DDP YMCA & CCNO & Online
1) 100% of enrollees are completers
2) High estimate is based on 1% of the eligible population completing the program

**OEBB-- 2016-17 Plan Year Operating Cash Requirements
Plan Year 2016-17
Operating Cash Requirements - Including Funding Health & Wellness Programs**

		3.40% *	
		% premium increase	
		2016-17	
2015/16 Medical Plan	Current Total Count	Medical Plan	Estimate Count
Total Medical Enrolled Members	53,479	Total	53,479
Composite Rate Per Member (Med/Den Only)	\$1,126		\$1,164
Monthly Premiums	\$60,217,354		\$62,264,744
Annual Premiums			\$747,176,928
Annual CASH Requirements			
Operating Cash Requirements			\$6,730,000
Revolving Health & Wellness Program Costs			\$1,264,932
		Total	\$7,994,932
		Administrative Fee	2016-17
			difference
		2.00%	
		Monthly Admin Fee	\$1,245,295
		Yearly Admin Fee	\$14,943,539
			\$6,948,607
		1.75%	
		Monthly Admin Fee	\$1,089,633
		Yearly Admin Fee	\$13,075,596
			\$5,080,665
		1.25%	
		Monthly Admin Fee	\$778,309
		Yearly Admin Fee	\$9,339,712
			\$1,344,780
		1.00%	
		Monthly Admin Fee	\$622,647
		Yearly Admin Fee	\$7,471,769
			(\$523,162)

NOTES:

* For the 2016-17 Plan Year OEBB was allowed a budget increase of 3.4%

Background on Strategic Planning

Strategic planning is intended to accomplish three important tasks:

- to clarify the outcomes that an organization wishes to achieve;
- to select the broad strategies that will enable the organization to achieve those outcomes;
- to identify ways to measure progress

As with any management tool, it is used for one purpose only: to help an organization do a better job – to focus its energy, to ensure that members of the organization are working toward the same goals, and to give the organization the ability to assess and adjust its direction in response to a changing environment.

- The process is strategic because it involves preparing the best way to respond to the circumstances of the organization's environment, whether or not its circumstances are known in advance
- The process is about planning because it involves intentionally setting goals (i.e., choosing a desired future) and developing an approach to achieving those goals.

Strategic planning assumes that an organization must be responsive to a dynamic, changing environment it is about fundamental decisions and actions, but it does not attempt to make future decisions. Strategic planning involves anticipating the future environment, but the decisions are made in the present. This means that over time, the organization must stay abreast of changes in order to make the best decisions it can at any given point – it must manage, as well as plan, strategically.

OEBB Process

We anticipate three meetings for BOW on strategic planning with a goal of presenting a draft to the Board in June. We will be sending a summary of our meetings to all Board members to keep them apprised of the progress.

We are working on a way to work collaboratively on documents to minimize the amount of time that needs to be spent in meetings and to allow BOW members flexibility in reviewing and commenting on documents.

Prior to first meeting

Workgroup members should review the attached material and send any questions and comments to Sue Wilson.

Meeting on February 25th at 10:00

Review mission, vision and guiding principles along with suggested revisions as it relates to Strategic Planning process and document.

Review and refine goal areas and develop goal statements.

Discuss next steps for developing initiatives and “what we will do” statements.

Prior to Meeting #2

Gather information from BOW members and others to create a draft of strategic initiatives for OEBC.

Draft will be sent to BOW members for review and comment.

Determine next steps in the process.

OHA Mission Statement (from 2013-15 budget document)

Oregon Health Authority

The mission of the Oregon Health Authority is helping people and communities achieve optimum physical, mental and social well-being through partnerships, prevention and access to quality affordable health care.

The Health Authority will transform the health care system of Oregon by:

- Improving the lifelong health of Oregonians
- Increasing the quality, reliability, and availability of care for all Oregonians
- Lowering or containing the cost of care so it's affordable to everyone

Each division of the Oregon Health Authority also has a specific area of focus to support the agency mission.

OEBB Vision (from 2013-15 budget document)

OEBB will work collaboratively with districts, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services.

Key components of the OEBB program are:

- Value-added plans that provide high quality care and services at an affordable cost to members.
- Collaboration with districts, members, carriers and providers that ensures a synergistic approach to the design and delivery of benefit plans and services.
- Support improvement in members' health status through a variety of measurable programs and services.
- Measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encourage members to take responsibility for their own health outcomes.

Vision & Guiding Principles Oregon Educators Benefit Board February 2015

1. VISION

OEBB will work collaboratively with participating educational entities and local governments, members, carriers and providers to offer value-added benefit plans that support improvement in members' health status, hold carriers and providers accountable for outcomes, and provide affordable benefits and services.

Key components of the OEBB program are:

- Support Oregon's health system transformation efforts promoting better health, better care and lower costs.
- Support improvement in members' health status through a variety of measurable programs and services.
- Value-added plans that provide high-quality care and services at an affordable cost to members.
- Measurable goals and programs that hold carriers and providers accountable for health outcomes.
- Encourage members to take responsibility for their own health outcomes.
- Collaboration with participating entities, members, carriers and providers that ensures a synergistic approach to the design and delivery of benefit plans and services.
- Benefits are in compliance with all state and federal laws and support participating entities' ability to comply with healthcare-related laws and regulations.

2. GUIDING PRINCIPLES

ORS 243.866 outlines specific criteria that OEBB is to emphasize in considering whether to enter into a contract for a benefit plan. The Board further defined those criteria to serve as a guide in carrying out its charge.

- Employee choice among high quality plans

Board Definition—OEBB will offer employees a range of affordable benefit plan designs that provide high-quality care and services.

- Encouragement of a competitive marketplace

Board Definition—OEBB will encourage competition in the marketplace in the areas of quality, outcomes, service and cost.

- Plan performance and information

Board Definition—OEBB will consider plan performance in the areas of quality, administrative processes, costs and outcomes in making its decisions. It will promote system-wide transparency that provides members with comprehensive information on these issues including decision-making resources and price transparency.

- Flexibility in plan design and contracting

Board Definition—OEBB will offer a range of affordable benefit plan designs that provide participating entities and employee groups with the flexibility to choose options through collective bargaining agreements and documented entity policies that meet their and their employees' financial and health needs.

- Quality customer service

Board Definition—OEBB will collaborate with participating entities and benefit plans to ensure that members receive efficient, effective and timely service in the areas of enrollment, benefit and service coverage, and claims administration and are highly satisfied with the benefits and services received.

- Creativity and innovation

Board Definition—OEBB will seek out plans and providers that use creative and innovative methods and practices that are evidence-based, have measurable outcomes and promote better health, better care and lower costs.

- Plan benefits as part of total compensation

Board Definition— OEBB will consider the impact of benefit costs on members’ compensation when designing, selecting and renewing benefit plans and programs.

- Improvement of employee health

Board Definition— OEBB will promote employee health and wellness through a variety of means with a focus on those activities supported by evidence of improvement in health outcomes.

- Cost Affordable to the participating entities, employees and taxpayers

Board Definition— OEBB will take into account the present and future costs of benefit plans (premiums, deductibles, copayments, etc.) in offering a range of affordable, high-quality benefit plan designs and will advance Oregon’s health system transformation efforts through the availability and promotion of coordinated care model health plans and increased transparency for members.

3. GUIDING PRINCIPLES OF BOARD OPERATIONS

- The Board will operate as a cohesive unit that provides for open discussion on topics, and
- The Board will operate in a transparent manner that fosters public trust, input and understanding of OEBB decisions and policies.

4. BOARD DECISION-MAKING PROCESS

- The Board should strive to reach consensus on general direction, strategies, and final decisions, but the use of parliamentary process is acceptable for final decision-making,
- Board members should strive to raise concerns about specific issues or items prior to final decision-making,
- Board members disagreeing with a final decision are free to express their views to stakeholder groups, but should respect the final decision and not campaign to undermine it,
- Public explanation of Board decisions will be conducted by the Chair or designated staff,

- Requests for reconsideration or tabling of decisions will be directed to the Chair through parliamentary procedure, and
- Board members concerned with methods or processes of addressing issues should direct their concerns to the Chair

5. ROLES OF BOARD, STAFF, AND CONSULTANTS

Board Roles

- Provide strategic direction and vision,
- Provide direction and context for the development of options,
- Prioritize and focus work of Board, workgroups, staff and consultants, and
- Make decisions that align with the intent and requirements of ORS 243.860 to 243.886.

Workgroup Roles:

- Workgroups will undertake further analysis, discussion and development of options/recommendations for Board decision,
- Each workgroup will contain at least one, but not more than four Board members along with representatives from select stakeholder groups when it is deemed appropriate, and
- Workgroups should provide periodic updates to the Board.

Interaction with Staff and Consultants:

- Staff and consultants should feel free to suggest direction to the Board (at least as a starting point) rather than only waiting for the Board to determine its desired direction,
- Staff and consultants should feel free to identify implications for the Board if they believe that the Board may be going in a direction that may not be wise or may require more resources than anticipated to accomplish,
- Consultants should provide leadership in identifying issues, options, and timelines necessary to accomplish the work, and
- Requests for additional research or work by staff or consultants will be directed to the Chair or come through the workgroups.
- Staff will implement decisions of the Board.

Goal Area	Business and Strategic Issues
<p>High Quality Affordable Plans</p>	<p><i>What are reasonable premium and out of pocket costs for members?</i></p> <p><i>How do we engage all entities in the conversation so we have a better idea of what this means to all the entities?</i></p> <p><i>How does OEBC measure quality of and access to care for OEBC members?</i></p> <p><i>Legislation requires premium increases of no more than 3.4 percent per year. What is the Board's and staff's role, and the carrier's role to ensure compliance?</i></p> <p><i>What is the board's role in explaining to the Legislature the impact of the 3.4% limit?</i></p> <p><i>Should we use the federal standard for affordability?</i></p> <p><i>How do we keep up with the reality of what health care will be in the next ten years?</i></p>
<p>Member Wellness & Population Health</p>	<p><i>How much can and should OEBC drive new models of care delivery?</i></p> <p><i>How can OEBC increase engagement in the Healthy Futures program, including health assessment completion and participation in OEBC, employer, or community sponsored healthy activities?</i></p> <p><i>How do we educate members about the value of data and provide incentives for participation?</i></p>
<p>Streamlined Operations & Organizational Effectiveness</p>	<p><i>How can we use Benefit Enrollment System Modernization to integrate various administrative activities, provide a better end user experience, and make it easier for OEBC and Entity personnel to make benefit and eligibility updates.</i></p>
<p>Member Outreach and Communication Effectiveness</p>	<p><i>How can health care cost and quality metrics become more transparent?</i></p> <p><i>How can OEBC more effectively engage members, particularly those with chronic health conditions?</i></p> <p><i>Do we need a Communication Plan?</i></p> <p><i>How do we insure that our communication is strategic and transparent?</i></p>

	<p><i>How do we really know what those with chronic health conditions really want and how they want the communication? Can we get away from guessing or using incomplete data?</i></p> <p><i>Should we include a methodology goal for outreach, including surveys?</i></p>
<p>Member Service</p>	<p><i>How do we provide excellent customer service with increased work activities with reduced staffing levels.</i></p>
<p>Business Planning</p>	<p><i>How should financial stability be defined and evaluated?</i></p>

General comments:

Liked the column in the North Carolina plan "why it's important."
 Like the idea of some pilot programs
 See the plan as something to work towards
 Should revisit the plan if we see a significant change in the RFP
 Like the idea of sub-goals with outcomes included
 A strategic plan should help OEBC work as a team and lessen divisiveness
 The vision and principles are so broad that they don't really indicate priorities.
 Strategic plan is a living, morphing document. Don't need to revise it annually, but should make sure it is brought out and reviewed in terms of how we're doing.

BOW Attachment 7 – OEBC Plan Structure and Draft Goals

	Objectives	Initiatives	Performance Outcomes
Date	<p>Offer High-Quality, Affordable Health Plans</p> <ul style="list-style-type: none"> Provide plan/benefit designs that clarify present and future costs that are affordable to members Offer members at least two distinct plan options that meet established affordability criteria Use performance measures that ensure carrier accountability and adherence to federal, state, and board benefit mandates 	<ol style="list-style-type: none"> Is this a design issue or a communication issue? Define affordability for OEBC plan offerings Engage entities at regular intervals to ensure that the affordability definition remains relevant to all districts Monitor/audit utilization and plan performance to ensure high quality plans Incorporate criteria specific to legislative cost requirements (3.4%) into carrier contracts and the RFP Evaluate vendor and carrier contracts at regular intervals to ensure a balanced portfolio of quality plan and program offerings 	<ul style="list-style-type: none">
Date	<p>Support Member Wellness and Population Health</p> <ul style="list-style-type: none"> Increase engagement in Healthy Futures and other wellness programs and activities with member accountability for health Educate members about the value of health data and provide incentives for participation in Healthy Futures Offer evidence-based wellness programs applicable to a broad base of OEBC members 	<ol style="list-style-type: none"> Design outcomes-based wellness programs that focus on quantitative goals (lowering tobacco and obesity rates) Partner with insurance and wellness vendors to pilot/promote innovative wellness programs Identify specific quantitative wellness goals and track progress Partner with Public Health to promote healthy worksites Partner with carriers and providers to identify and engage members with chronic health conditions 	<ul style="list-style-type: none">
Date	<p>Create Streamlined Operations and Organization Effectiveness</p> <ul style="list-style-type: none"> Modernize the Benefit Enrollment System to enhance the end user experience Ensure OEBC’s workforce is well-trained and fully equipped to perform their job functions efficiently and effectively. 	<ol style="list-style-type: none"> Survey members and entities about the enrollment experience to inform the system modernization effort Develop programming and system enhancements in response to members and stakeholders needs Create group and individual development plans in line with organizational needs Streamline work processes to allow staff to focus on priority areas 	<ul style="list-style-type: none">
Date	<p>Provide Enhanced Member Outreach and Communication Effectiveness</p> <ul style="list-style-type: none"> Adopt a detailed and transparent communication plan that addresses the needs of members, employer entities, and stakeholders Provide members and stakeholders with clear and relevant information about costs and critical metrics 	<ol style="list-style-type: none"> Identify key stakeholders for communication Identify most frequent subscriber/entity concerns and provide outreach using various media Leverage innovative technology to connect more frequently with members Work with partners to develop consistent messaging to members Improve outreach and target messaging related to specific health conditions Align with OHA and commercial insurers to obtain healthcare market data and track cost and quality metrics 	<ul style="list-style-type: none">
Date	<p>Cultivate a Customer Service Culture</p> <ul style="list-style-type: none"> Focus staff resources on meeting the needs of members and stakeholders driven by data analysis Broaden interaction and communication with employer entities Partner with employer entities and vendors to create a culture that rewards quality and timely service to members 	<ol style="list-style-type: none"> Develop a menu of open enrollment resources to assist subscribers and entities Enhance data sources and increase data analysis Expand data collection within employer entities and produce annual reports Capture OEBC population data and create consistent analytics 	<ul style="list-style-type: none">
Date	<p>Create a Financially Sustainable Organization</p> <ul style="list-style-type: none"> Create an organization that addresses current business needs and is financially responsive to changes 	<ol style="list-style-type: none"> Explore funding mechanisms that could be used by OEBC to increase its ability to be financially viable while responding to legislative and market changes Perform annual carrier audits to ensure financial stability of plan providers and identify areas of concern Monitor health care market trends and identify impact of trends on OEBC 	<ul style="list-style-type: none">

Ohio's Insurance Industry



A Strategic Plan for the Office of Insurance and Financial Development

- Share the Ohio Story
- Strengthen our Strengths
- Cultivate Top Talent
- Invest in our Regional Assets
- Focus on our Customers

Ohio

Department of Development

Ted Strickland, Governor
Lee Fisher, Lt. Governor

Lisa Patt-McDaniel, Director

Our Vision

Ohio is *The State of Perfect Balance*® – a place where every individual can achieve a balance between growing economic prosperity and a fulfilling quality of life.

Our Mission

Enhance the business climate for Ohio's insurance industry and develop innovative ways to retain and create insurance industry jobs for Ohioans.

Our Promise and Tactics

The Office of Insurance and Financial Development will focus on the insurance industry by working to strengthen our strengths and emphasizing collaboration, speed, and ease of use.

Our Guiding Principles

1. Be the change maker, instead of simply reacting to change.
2. Work in seamless collaboration with public, nonprofit, and private sector partners, locally, regionally, and statewide.
3. Invest in what matters most.
4. Innovate with new, more effective solutions and create a positive customer experience.
5. Execute, organize, and align to achieve our goals.

Office of Insurance and Financial Development

James Raussen, Director • 614 | 728 6675
www.insurance.development.ohio.gov

5 Goals

Strategies

Initiatives

Performance Targets

Share the Ohio Story

Market Ohio's strengths to domestic and foreign insurance companies.

- 1. Create a communication strategy encouraging insurers and agencies to create jobs in Ohio.
- 2. Execute a marketing campaign promoting Ohio as THE insurance state and a great place to do business.
- 3. Emphasize Ohio's business friendly infrastructure to encourage insurance business expansion projects.

- Brand Ohio as THE insurance state.
- Make Ohio an attractive location for insurance call centers, data centers, and service centers.
- Implement a marketing program promoting insurance job creation opportunities.

- Improve the perception of Ohio.**
- 1. Announced insurance job creation projects.
 - 2. Announced call center, data center, and service center projects.
 - 3. Improve perception of Ohio among insurance executives and site selection consultants.

Strengthen our Strengths

Enhance the attractiveness of Ohio's insurance business climate.

- 1. Develop a comprehensive program of insurance job creation incentives.
- 2. Execute a marketing program to increase insurance industry awareness of Ohio's attractive business climate for growth and expansion.

- Strengthen our business climate to encourage insurance companies to both retain and grow operations in Ohio, creating future employment opportunities.
- Educate insurers and site selection consultants on available state expansion programs and incentives.
- Educate policymakers on the strength of Ohio's insurance industry and advocate for business climate enhancements and good public policy.

- Build a more competitive insurance expansion climate.**
- 1. Awareness of insurance executives and site selection consultants about Ohio's expansion incentives.
 - 2. Announced insurer expansion projects.
 - 3. Policymaker awareness of economic impact of Ohio's insurance industry.

Cultivate Top Talent

Attract and retain insurance industry talent while promoting employment opportunities in the industry.

- 1. Create excitement about career opportunities in Ohio's insurance industry.
- 2. Create awareness about available insurance jobs in Ohio.
- 3. Develop insurance education opportunities to cultivate top talent.

- Create the Ohio Means Insurance Jobs Web site.
- Promote Ohio insurance internship opportunities.
- Execute a marketing program to promote careers in Ohio's insurance industry.
- Develop a demand-driven Ohio Insurance Education curriculum.

- Grow and attract a highly educated insurance industry workforce.**
- 1. Insurance courses offered.
 - 2. Qualified graduates, associate degree, or greater.
 - 3. Number of hits on Ohio Means Insurance Jobs Web site.
 - 4. Number of insurance internships.
 - 5. Awareness of university students about insurance careers.
 - 6. Perception of insurance executives about quality of Ohio's insurance workforce.

Invest in our Regional Assets

Invigorate our regions as centers for insurance company expansion.

- 1. Support and catalyze regional collaboration to support growth in the insurance industry.
- 2. Leverage the distinct assets in each region to promote insurance growth opportunities.

- Establish a "Know Your Customer" program to educate Department of Development regional offices about the insurance industry.
- Establish a rigorous company and agency visitation program.

- Build an effective insurance regional outreach program.**
- 1. Number of insurance company/agency visits.
 - 2. Announced job creation projects.
 - 3. Industry perception of regional office outreach and support.

Focus on our Customers

Operate government at the speed of business.

- 1. Create an even more customer-focused Office of Insurance and Financial Development.
- 2. Strengthen collaboration between the state, insurance industry, and the university system.

- Create a one-stop-shop approach for company expansion and job creation.
- Foster meaningful relationships between the industry and the university system.

- Develop an agile and transparent Office of Insurance and Financial Development.**
- 1. Customer Experience Survey of Office of Insurance and Financial Development clients.
 - 2. Speed of customer responses.
 - 3. Perception of industry executives about Office of Insurance and Financial Development.

Six Desired Outcomes:

Job Creation • Agility • Sustainability • Innovation • Opportunity • Prosperity



**Board of Trustees
of the
State Health Plan for Teachers and State Employees**

**Strategic Plan
2014 – 2018**

September 19, 2014

Adopted: 
Janet Cowell, Chair

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EXECUTIVE SUMMARY

The State Health Plan for Teachers and State Employees (Plan) was created by statute to make available comprehensive health benefits for eligible teachers, employees, retirees and their eligible dependents. The Plan is governed by the State Treasurer, Board of Trustees (Board) and the Executive Administrator, who carry out their duties and responsibilities as fiduciaries for the Plan. The Board is responsible, by statutory mandate, for developing and maintaining a strategic plan for the Plan. This document outlines the strategic plan for the years 2014 through 2018.

The strategic plan is organized by first identifying the Plan's mission, vision and values followed by "guiding principles" that describe the intent and motivation behind the Plan's actions. Next, the Board has identified three strategic priorities for 2014-2018: 1) Improve members' health; 2) Improve members' experience; and 3) Ensure a financially stable State Health Plan. A description of what each means, what will be done, and why it is important, is also included. Specific initiatives designed to achieve each strategic priority are then identified and described again in terms of what each means, what will be done, and why it is important. Finally, a roadmap is provided that identifies major projects and programs within each initiative along with key decision points regarding contracts or benefits, launch dates, and an indication of the magnitude relative to members impacted or resources needed.

This strategic plan is designed to align the mission and vision of the State Health Plan with the programs and services provided to its members, and along with the values expressed, will serve as a guide over the period identified. This document is considered a "living document." That is, specific projects and programs are expected to be modified on a frequent basis, as appropriate, with the priorities, initiatives and measures being revisited on an annual basis as agreed upon by the Board.

Ongoing performance monitoring, detailed project plans and other progress updates will be provided on a regularly scheduled or as needed basis. Background information, including environmental scans and other supporting analyses and conclusions used by the Board in the development of this strategic plan, are available on the Plan's website at www.shpnc.org under the Board of Trustees quick link.

MISSION

Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being.

VISION

Our vision is to be a health plan that is a leader in North Carolina in providing access to cost-effective, quality health care and wellness programs on behalf of our membership.

VALUES

Member Focus – Keeping the member at the forefront of our actions

Collaboration – Partnering with individuals and other stakeholders on behalf of our members

Transparency – Acting in an open manner with the highest possible degree of integrity in all we do

Quality – Striving for the best quality of care and service for our members

STRATEGIC PLAN GUIDING PRINCIPLES

The following guiding principles were used in developing the strategic priorities and measures of success for the State Health Plan's strategic plan:

1. The State Health Plan's **Mission Statement** will serve as the primary guide in the development of a strategic plan.

"Our mission is to improve the health and health care of North Carolina teachers, state employees, retirees, and their dependents, in a financially sustainable manner, thereby serving as a model to the people of North Carolina for improving their health and well-being."

2. It is the intent of the Board and Plan leadership team to ensure that the **perspective of the member**, including experience and value, is factored into the strategic plan.
3. It is the intent of the Board and Plan leadership team to support the development of benefit offerings that are **affordable** to state employees, retirees and their dependents and the State of North Carolina. Therefore the Board and Plan leadership team will make every effort to work on behalf of the members and State of North Carolina to develop the competitively priced offerings that **improve the health and well-being of its members**.
4. The Board and Plan leadership team recognize the responsibility to work to ensure that members have **access to quality care** and that their **patient experience is continuously improved**.
5. Given the Plan's responsibility to serve members across the state, the Board and Plan leadership team recognize the need to develop benefit offerings and programs that **balance cost and access to quality care**. Access includes addressing issues such as distance to providers, cost and length of time to schedule an appointment.
6. There needs to continue to be a **sense of urgency** to ensure the Plan remains financially stable to fulfill the mission of improving the health and health care of its members. That said, the Board and Plan leadership team acknowledge that the ability to make operational changes requires time and resources. Therefore, it is prudent to have a **reasonable period of stabilization** to manage recent member and operational impacts and to have time to measure the results of recent changes. Continuous measurement and monitoring will be an integral part of the strategic planning process.
7. The Board and Plan leadership team recognize the opportunity to develop benefit offerings and programs that will require longer time horizons to determine measurable results. Therefore, it is the intent of the Board and Plan leadership team to **develop a balanced portfolio of both near and long term strategic initiatives**.
8. It is the intent of the Board and Plan leadership team to effectively manage premiums that members are required to pay for coverage and for out-of-pocket health care expenses. The Board and Plan leadership team **support the development of programs and benefit offerings that encourage healthy lifestyles** and the appropriate use of incentives and cost sharing as levers in influencing the use of health care services and improving the health of plan members. Ongoing communication and education will be critical.
9. The Board and Plan leadership team acknowledge that there will be a dependency on the **support of the North Carolina General Assembly** to fund or operationally execute on the strategic plan. The Board and Plan leadership team will work collaboratively with that constituency to ensure the strategic plan fulfills the mission of the Plan.
10. Given the dependency on 3rd party vendors, business partners, providers and other stakeholders the Plan, working in the best interests of the Plan members and State of North Carolina, will take a **collaborative and partnership approach** with all stakeholders in developing and executing on the strategic plan. This will include utilizing others' areas of expertise and information to guide the decisions and actions of the Board and Plan leadership team.
11. The Board and Plan leadership team recognize their **fiduciary responsibility** first and foremost to the members of the Plan but also to the State of North Carolina and its citizens.
12. It is the intent of the Board and Plan leadership team to act in a manner that is in **the best interests of all members** of the Plan and actively work toward **consensus** that will enable the fulfillment of the mission of the Plan.

Priority	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	<p>Population health management is a model for managing all aspects of member health from wellness to chronic disease with a focus both on engaging members in their health and improving the quality and coordination of care within the health care system. The goal is maintaining or improving the health of members and lowering medical claims cost for members and the Plan.</p>	<ul style="list-style-type: none"> • Maintain or improve member health as appropriate including the support of members with chronic conditions • Engage health care providers in improving the quality and coordination of care • Identify and address gaps in access to quality care or in the care itself • Promote a culture of wellness 	<p>51% of members have at least one chronic condition and account for 76% of claims expenditures. Duplication of services and the provision of services in higher cost settings significantly contribute to the cost of care. Better coordination of care and better health of the population can improve member well-being and lower costs for both members and the Plan. In addition, offering programs and products that attract membership for all stages of health ensures a more stable Plan.</p>
Improve Members' Experience	<p>The member experience includes the relationship members have with the Plan including enrollment, access to information, benefit designs, and affordability of coverage; services and programs provided by the Plan and its vendor partners; and access to providers and quality care through effective relationships with the Plan's network providers. The Plan also seeks to foster and improve the direct relationship between the member and the provider including the provider's practice and staff.</p>	<ul style="list-style-type: none"> • Improve communication with members about benefit design, enrollment, and eligibility to promote health literacy • Increase transparency of the cost of care and the quality of network providers • Provide reliable, quality services for enrollment, claims processing, and population health management • Address member concerns regarding Plan operations, benefit design, coverage, and costs • Develop partnerships and benefit designs that improve members' experience with providers and practices 	<p>Members who are informed and satisfied with their service experience are more likely to engage with the Plan and participate in benefit designs and programs aimed at improving their health, leading to improved health and well-being for the member and lower health care costs for the both the Plan and the member.</p>
Ensure a Financially Stable State Health Plan	<p>The Plan must address the cost of health care, the delivery of health care, and the utilization of benefits in order to minimize State and member premium contributions, provide a cost-effective and sustainable benefit and optimize the benefits offered to members within the financial resources available.</p>	<ul style="list-style-type: none"> • Manage the cost of medical claims • Manage the cost of pharmacy claims with a specific focus on specialty pharmacy management • Encourage members to use benefits appropriately and to be informed consumers of medical services • Develop programs focused on reducing fraud, waste, abuse and overuse • Collaborate with the General Assembly and Office of State Budget and Management to help ensure predictable funding for health benefits 	<p>Financial stability and cost management protect the State and members from large premium increases. Maintaining a strong reserve balance enables the Plan to invest in initiatives to improve health and experience while managing future cost increases and cash flow. The Plan's expense trend has been at or below the medical Consumer Price Index for the last four fiscal years and reserves at the end of FY 2014 were approximately four times the targeted amount. Recent experience has allowed the Plan to offer more options and enhanced benefits for 2014 and forgo premium increases for the State and members in 2015.</p>

STRATEGIC INITIATIVES

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Improve Members' Health	Maximize Patient Centered Medical Home (PCMH) Effectiveness	The Patient Centered Medical Home model is a way of organizing primary care that emphasizes care coordination (including appropriate setting) and communication to transform primary care to include population health management. Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.	<ul style="list-style-type: none"> Support providers and practices in serving as PCMHs through data analytics, care management, and/or enhanced payment through the Population Health Management Services vendor to designated PCMH groups Groups will be identified for support/partnership (directly or through vendor partners) based on willingness to engage and opportunity for improved patient outcomes based on review of available clinical measures Develop metrics and benchmarks to demonstrate the impact of improved care delivery and coordination such as medication adherence, reduced ED use, hospital readmissions and nationally benchmarked HEDIS measures Design and communicate incentives and other benefit designs that encourage members to have designated PCMHs serve as their primary care provider 	<ul style="list-style-type: none"> At the heart of the PCMH are the patient and the primary care physician who serves as the key to better coordination of care and patient engagement For 2014, 98% of members in the 80/20 and 99% of members in the CDHP plans selected a primary care provider Increasing the number of primary care providers that are PCMHs will help ensure timely access to care and increase the focus on quality of care indicators such as: <ul style="list-style-type: none"> Diabetes HbA1c testing rate is 88.9% while the national benchmark at the 75th percentile is 91% and at the 90th percentile is 94% Cholesterol LDL-C testing rate is 81.3% while the national benchmark at the 75th percentile is 87% and at the 90th percentile is 89%
	Assist Members to Effectively Manage High Cost, High Prevalence Chronic Conditions	Focused programs designed to assist members and their providers to effectively manage a member's chronic condition(s). The targeted chronic conditions include asthma, COPD, cardiovascular diseases & diabetes. This includes a focus on members with multiple and complex chronic conditions.	<ul style="list-style-type: none"> Develop chronic care management programs focused on high volume and high cost conditions where there is opportunity to collaborate with providers to improve both quality of care and member engagement Collaborate with other state entities and stakeholders, including the NC Department of Health and Human Services, on addressing how to improve these conditions across the state 	<ul style="list-style-type: none"> Members with at least one chronic condition account for 76% of total cost of care (Non-Medicare) Prevalence of high cost chronic conditions (for actives): Hypertension 25%, Asthma/COPD – 10%, Diabetes – 9%, CAD – 3% Members with one or more chronic conditions utilize \$7,664 of services while healthy members (those without a chronic disease related claim) utilize about \$1,283, roughly 1/6th the cost of those with a chronic condition 2013 medication adherence rates for active members with diabetes was 46%, hypertension is 57% and high cholesterol was 65%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Improve Members' Health</p>	<p>Offer Health-Promoting and Value-Based Benefit Designs</p>	<p>Benefit designs that reduce barriers to care and are directed at sustaining long-term health and managing chronic disease and incent members to seek treatment from high quality, cost effective providers</p>	<ul style="list-style-type: none"> • Offer benefit designs that provide no-cost access for preventive care, encourage utilization of PCMHs and use of high quality primary care providers, encourage healthy behaviors and engage members • Consider additional value-based benefit designs that offer quality and cost options around providers, treatments and medications • Incent members to make long-term healthy lifestyle choices and more effectively manage chronic disease 	<ul style="list-style-type: none"> • Access to high quality care at cost effective settings helps sustain health and allow for management of chronic disease • When offered a premium credit, 84% of active members selecting the CDHP and 80/20 plan options completed a health assessment, chose a PCP and attested they did not smoke or were enrolled in a smoking cessation program
	<p>Promote Worksite Wellness</p>	<p>Any employment based activity or employer sponsored benefit aimed at promoting healthy behaviors (primary or secondary prevention). These are programs that require longer time horizons by which to measure results and impacts.</p>	<ul style="list-style-type: none"> • Using the NC HealthSmart program, partner with state agencies to influence environmental and workplace policies and tailor programs suited to the different strata of membership across the state • Develop programs and approaches that ensure the continuous engagement of members throughout the year • Create a culture of wellness to include participation and support from employing units and agency leadership 	<ul style="list-style-type: none"> • National data suggests that worksite wellness programs help employees feel more valued • 45% of employees say these programs encourage them to stay with their employer

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
Improve Members' Experience	Create Comprehensive Communication & Marketing Plan	Providing members with materials they can understand to help them effectively utilize their health benefits. Communicating regularly, not just at Annual Enrollment, to allow members the opportunity to maximize their experience and improve their access to the health care services available to them.	<ul style="list-style-type: none"> Develop a comprehensive and continuous communication strategy, including print, email, web-based and mobile applications and media, regarding benefit plan options, how to get the most value out of the benefit programs and explain the value of the benefits that are offered, including: <ul style="list-style-type: none"> Improve member contact information Develop a branding campaign in coordination with the Department of State Treasurer Regularly meet with provider community to distinguish Plan services from BCBSNC services Demonstrate the value of and promote Plan offerings 	<ul style="list-style-type: none"> Health benefits are utilized throughout the year and therefore, regular benefits communications will assist members with benefit questions and managing their care There are opportunities to increase the use of online communication channels because fewer than 1% of members now access NCH^{Smart} resources online Over 80% of retired members prefer written materials while active members prefer online communications. This demonstrates the need for a variety of communication channels
	Improve the Member Enrollment Experience	Members are able to enroll in and access the benefits they choose and their premium credits are accurately reflected. Enrollment tools meet current technology standards. Streamline customer service calls and online access.	<ul style="list-style-type: none"> Develop a consistent and stable platform for members' enrollment experience Provide a customer service call center to provide members with timely and accurate enrollment and benefit information Ensure that enrollment data is accurately collected, maintained and transmitted in a timely manner Where possible, provide single sign-on from the originating secure site to other sites to eliminate the need for multiple passwords and user IDs 	<ul style="list-style-type: none"> Enrollment is the gateway to the provision of benefits and it is imperative that the member's enrollment experience is as simple as possible and that enrollment information is accurately captured, displayed and transmitted to ensure access to appropriate benefits and to improve the trust of members Having multiple contact numbers and login IDs can be a barrier to access and timeliness of service Improving member experience can enable increased engagement
	Promote Health Literacy	Provide access to tools and resources designed to assist members in understanding costs, treatment and provider options to support members in communicating with their provider and engaging in their health care decisions.	<ul style="list-style-type: none"> Develop and market tools and resources, particularly web-based and mobile applications, that provide cost and quality transparency metrics and assist members in making informed choices on treatment options, cost, provider selections, and site of service 	<ul style="list-style-type: none"> Providing tools to access high quality, site appropriate, and low cost care encourages improved health outcomes, raises member satisfaction, and reduces Plan cost growth Only 0.2% of members access the provider portal, which houses the current transparency tools Web-based and mobile platforms improve accessibility to information

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Ensure a Financially Stable State Health Plan</p>	<p>Target Acute Care and Specialist Medical Expense</p>	<p>The management of specific categories/ treatments of care that exceed the Plan forecast and/or medical expense trends. The management of member out-of-pocket costs in high cost services and care settings such as hospitalizations and specialized medical care. The management of fraud, waste, abuse and overuse of medical services.</p>	<ul style="list-style-type: none"> • Develop and implement targeted programs or benefit designs that specifically address the following: <ul style="list-style-type: none"> ○ Appropriate use of emergency rooms and urgent care centers ○ Avoidable inpatient admissions, readmissions, duplicative care ○ Use, costs and/or site of service for specialty medical services ○ Implement targeted programs focused on reducing fraud, waste, abuse and overuse of medical services. ○ Reinforce payment for necessary care only and minimize payment for unnecessary, duplicative care (e.g., preventable patient safety incidents otherwise known as "never events") 	<ul style="list-style-type: none"> • Hospital inpatient costs averaged \$3,266 per day in 2013 and represented \$612 million in spending (17.5% of total) • The average cost of a hospital stay for Plan members was \$15,553 in 2013 • Emergency room costs represent another \$146 million in medical costs (4.2%)
	<p>Target Pharmacy Expense</p>	<p>The management of specialty medications across the medical and pharmacy benefits as well as fraud, waste, abuse and overuse of pharmaceuticals</p>	<ul style="list-style-type: none"> • Implement targeted programs or benefit designs that manage the cost, use, and/or site of service of specialty medications • Implement targeted programs focused on reducing fraud, waste, abuse and overuse of pharmaceuticals 	<ul style="list-style-type: none"> • Pharmacy costs are 29% of total plan medical costs • 2.6% of non-Medicare membership uses specialty medications under the medical benefit which accounts for 6.7% of total plan (non-Medicare) medical payments • Medical specialty pharmacy trend is 11.3% • <2 % of members use specialty medications under the pharmacy benefit which accounts for 22% of plan pharmacy cost. This is projected to be 50% by 2018. • Specialty pharmacy (pharmacy benefit) trend is currently 16%

Priority	Initiative	What It Means	What We Will Do	Why It Is Important
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Ensure a Financially Stable State Health Plan</p>	<p>Pursue Alternative Payment Models</p>	<p>Shift away from the current pay for volume approach in health care to paying for outcomes based on evidence based metrics. Utilize the spectrum of alternative payment strategies, ranging from PCMH to pure capitation, to more efficiently compensate providers to provide care in the most effective setting. Take a long-term, prospective view to improve member health to manage cost growth versus only short-term price reductions.</p>	<ul style="list-style-type: none"> Partner with current and future third party administrators (TPA)/carriers to identify opportunities to incent quality of care and pay for outcomes while facilitating the development of successful evidence-based practices that are emerging in North Carolina Partner with other payers, where appropriate, to implement consistent approaches to alternative payment strategies throughout North Carolina Engage with providers who are able to work directly with the Plan on value based payments and metrics 	<ul style="list-style-type: none"> Moving away from pure fee for service provides an incentive to focus on better coordination and effective care 15.6% of hospital admissions had a readmit within 30 days Average inpatient cost per day has increased by 4.4% over the past year
	<p>Ensure Adequate, Stable Funding from the State of North Carolina</p>	<p>Work to secure the necessary stable funding sources by maintaining stakeholder confidence in and support for the Plan.</p>	<ul style="list-style-type: none"> Act in an open and transparent manner as appropriate in all interactions with the Governor, Office of State Budget and Management (OSBM), General Assembly, Fiscal Research Division (FRD), state agencies and the public Use all reasonable tools, processes and assumptions to accurately forecast revenues, expenses, and required premium contributions Proactively work with the Governor, OSBM, General Assembly, and FRD to protect the Plan's reserves and ensure adequate funding is appropriated each year to enable the Plan to achieve its mission Partner with employee and retiree stakeholder groups to support the Plan's funding and legislative requests 	<ul style="list-style-type: none"> Maintaining the confidence in and support for the Plan by key stakeholders in a time of fiscal challenges and competing priorities will help ensure adequate funding is available over the long term, thereby producing a stable financial environment to support the mission of the Plan Maintaining stable funding helps prevent against benefit erosion and allows the Plan to offer and evaluate the cost-effectiveness of alternative benefit designs, incentives and pilot programs as well as invest in programs and initiatives to improve the member experience and access to quality care

STRATEGIC MEASURES OF SUCCESS

Priority	Description	Metric	Rationale	Timeframe/Baseline
Improve Members' Health	PCMH utilization	Increase % of members receiving care from a NCQA recognized PCMH	PCMH practices provide an opportunity to improve care and care coordination for members	Annual comparison to year-end 2013
	Quality of care measure	Increase % of members with targeted high prevalence conditions receiving care according to national clinical standards	Monitoring delivery of clinical quality of care standards ensures Plan members are receiving quality health care	Annual comparison to year-end 2013
	Worksite wellness	Increase number of worksites offering worksite wellness initiatives	The number of worksites offering onsite wellness initiatives are a proxy for measuring a culture of wellness across State agencies	Annual comparison to year-end 2013
Improve Members' Experience	Customer satisfaction	Maintain or improve overall customer satisfaction score	Overall customer satisfaction is a proxy to monitor the overall Plan's effectiveness	Annual comparison to year-end 2012
	Annual Enrollment service level agreements (SLA)	Improve Annual Enrollment customer service SLAs	Enrollment is the gateway to the provision of benefits and an opportunity to instill trust in the member	Annual comparison to year-end 2013 (from October 2013 enrollment period)
	Member engagement	<ul style="list-style-type: none"> • Increase in the number of active members registered as users on TPA's website • Increase in the usage of TPA's provider search and transparency tools by active members • Increase in attendance at educational roadshows 	Measuring members engaged in communication and health literacy efforts is a proxy for measuring the Plan's effectiveness at targeted member outreach	Annual comparison to year-end 2013
Ensure a Financially Stable State Health Plan	Net income/loss	Net income/loss actual at or above certified or authorized budget (as forecasted by actuaries) for plan year	Provides a comprehensive measure of Plan finances	Annual comparison
	PMPM claims expenditures	PMPM claims expense at or below certified or authorized budget (as forecasted by actuaries) for plan year	Claims expense is the main variable driving financial performance	Annual comparison
	Member cost-sharing	% of total claims cost paid by members through copays, deductibles and coinsurance at or below benchmark	Member cost-sharing is an important component in member affordability	Annual comparison to year-end benchmark

Note: All years are based on the calendar year ending in December, unless specifically noted as fiscal year (FY). Measures will be reported as part of the Plan scorecard and updates will be provided according to the financial reporting schedule.

VENDOR CONTRACT DEPENDENCIES

The following chart outlines the anticipated effective dates of new contracts as well as the optional renewal and termination dates for existing contracts that are important to the strategic plan. The timing of contract terminations and the length of time required to procure new vendors may impact the strategic initiatives as well as the sequence and timing of the initiatives. The estimated length of time to change vendors or make significant changes to existing contracts can take between 18 and 24 months including development, procurement and implementation. The Board is required to approve all contracts with a value of \$500,000 or more.

Vendor dependencies and contract requirements will be continuously assessed as the details of the deliverables of specific projects and programs are developed. Depending on the final detailed design of each initiative as well as other contracting or vendor selection or negotiation issues, the vendor contract reference chart and the timelines associated with each initiative outlined in the roadmap on the following pages could be modified. In addition, the chart below only reflects active contracts. Additional vendor contracts may be required in order to implement the initiatives, and Board approvals will be acquired as needed.

Vendor Contract Reference Chart

Category / Contractor	2014		2015		2016		2017		2018	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
TPA / BCBSNC						▲ 12/31/16		▲ 12/31/17		▲ 12/31/18
TPA / MedCost LLC		▲ 10/1/14								
MA / Humana						▲ 12/31/16		▲ 12/31/17		▲ 12/31/18
MA / UnitedHealthcare						▲ 12/31/16		▲ 12/31/17		▲ 12/31/18
PBM / Express Scripts				▲ 12/31/15		▲ 12/31/16				
PHMS / ActiveHealth Management		▲ 12/31/14		▲ 12/31/15						
COBRA & Billing / COBRAGuard						▲ 12/31/16		▲ 12/31/17		▲ 12/31/18
EES / Benefitfocus				Termination Expected by 12/31/15		▲ 12/31/16		▲ 12/31/17		▲ 12/31/18
EES / Aon-Hewitt		▲ 8/31/14								

 New Contract	 Option to Renew Contract	 Contract Terminates
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STRATEGIC ROADMAP

July 2014 – December 2018

Background and Definitions

The charts on the following pages outline the high level roadmap for each of the strategic initiatives included in the strategic plan. Each chart includes a brief description of the project or program, any associated contract decisions and/or benefit approvals, an estimated launch date, and an indication of the magnitude of impact relative to the membership. Although not necessarily described in the charts, each of the projects or programs include planning (discovery interviews, market research, synthesis, and gaining consensus), building (developing detailed designs, acquiring necessary approvals, contracts, staff, and training), and implementation (communication, launch, and ongoing monitoring and management). Details on specific programs or benefit designs will be communicated as proposals are developed. The purpose is to organize the major work streams and key milestones, particularly those that will require Board approval. The Plan leadership team will provide updates to the Board proactively on progress as appropriate and as needed.

In addition, the estimated milestones take into consideration the dependencies on vendor contracts based on what is known at the time of planning. The dates on the charts that follow are **not intended to communicate actual contract dates or otherwise indicate that Board approval will be required for every contract decision**. As a planning document, the charts are intended to indicate the possibility of vendor contracts or Board action and final decisions and actions will depend on the details of each initiative.

The following reference table outlines the elements of the work and timelines included in the charts:

Term or Key Indicator	Definition
Projects & Programs	Short description of the major work efforts that will be delivered in support of the initiative
	Possible Board benefit approval point. The need for any approvals will depend on the final detailed design of any new project or program.
	Possible contract decision point – reflects the anticipated point in time when a decision regarding contract extensions or amendments or Board approval of a new contract is required. Contract decisions may or may not require Board action. The need for any approvals will depend on whether it is a new contract with a value of \$500,000 or more.
	Indicates the estimated launch date for small or moderately sized projects or programs. For example, pilots, regional programs or projects impacting a relatively small number of Plan members.
	Indicates the estimated launch date for large, statewide projects or programs. For example new products or a disease management program available statewide that impacts a large number of members.

Strategic Priority: Improve Members' Health

Projects & Programs		Jul – Dec 2014	2015	2016	2017	2018
PCMH	PCMH Pilot: PCMH pilots established with at least 4 health care systems or provider groups. The goal of the pilot is to identify a statewide standard for the PCMH model, to inform the next iteration of the Plan's contract with its population health management vendor and to assess the readiness of these health care systems for alternative payment methods.	◆				
	PCMH Model: Implementation of the PCMH model statewide. This will take place through the contract with the population health management vendor.	 Contract Decision- PHMS			◆	
High Prevalence Conditions	High Prevalence High Cost Care Management: Develop and implement a high utilizer care management/coordination plan for members with a diagnosis of diabetes, asthma/COPD, hypertension or CAD in partnership with the Plan's population health management vendor. The intent of the initiative is to promote the delivery of appropriate and timely care within appropriate settings.	◆		◆		
	Chronic Pain Pilot: Implement a new program designed to identify and address prescription abuse, improve the safety of members who are taking narcotics and identify care management options.				◆	
	Transition of Care Program: Target high priority members who are transitioning out of the hospital for care management to assist in reconciling prescriptions post discharge (Medication Therapy Management – MTM), coordinating follow-up appointments as necessary and to providing education and information on conditions. This will be accomplished through the contract with the population health management vendor.	 Contract Decision - ADT feeds	◆			
Value-Based Benefits	Value Based Benefit Design: Implement the next generation of wellness activities, premium credits, and incentives to increase member engagement and accountability, improve medication adherence, reduce waste and encourage the use of quality providers.			◆		◆
Worksite Wellness	Wellness Champions Pilot: Develop a network of wellness champions within worksites to lead employees in worksite wellness initiatives. The Plan will provide incentives that reward those worksites with high levels of participation as well as support worksite with resources like speakers and toolkits.		◆			
	Multipronged Three County Pilot: A three pronged, two year pilot in Greene, Jones and Lenoir counties aimed at addressing the high prevalence, high cost chronic conditions of diabetes, asthma, COPD, hypertension, CAD, and stroke. The Plan and its vendors would help develop capacity to implement wellness initiatives within worksites in three counties, develop provider engagement with Plan membership and empower members in seeking appropriate health care and leveraging community resources.		◆			

Strategic Priority: Improve Members' Experience

Projects & Programs		Jul – Dec 2014	2015	2016	2017	2018
Communication & Marketing	Coordinated Communication Campaign: Implement a communication approach for Retiree Health Benefits that is coordinated with the Retirement System and the Department of State Treasurer.		◆			
	Medicare Primary Communication: Enhance current Medicare Primary learning module and develop additional outreach strategies.		◆	◆	◆	
	Active and Non-Medicare Primary Communication: Develop learning module for Active and non-Medicare Primary members to enhance their health literacy and understanding of Plan Benefits.		◆	◆	◆	
Enrollment Experience	New Eligibility and Enrollment vendor: Transition all eligibility and enrollment services to a new vendor no later than July 1, 2015. In order to launch the new services all testing must be completed by March 31, 2015, and the communication plan with members, vendors and other stakeholders completed by December 31, 2014.	 Contract Decision	◆			
	Annual Enrollment and Benefit Design Communication: Implement a comprehensive communication and marketing campaign each year regarding Annual Enrollment and benefit designs. Focus campaigns to emphasize the healthy activities required to earn premium wellness credits and value-based designs.		◆	◆	◆	◆
Health Literacy	BlueConnect Launch: BCBSNC is implementing a new member web portal in January 2015. Partner with BCBSNC to develop a communication strategy to increase engagement and utilization with the new functionality.	◆				
	Transparency & Literacy Tools Program: Implement programs that promote and incentivize members to utilize web-based transparency tools for identifying high quality, cost effective providers; calculate their best plan options based on expected utilization; and identify resources to assist with chronic conditions.			◆		
	Incentive Rewards Program: Implement a program that rewards members for healthy lifestyles, use of preventive benefits, and benefit engagement. An example of a potential reward is a Fitbit® for participating in a walking program or engaging with a health coach.				◆	

Strategic Priority: Ensure a Financially Stable State Health Plan

Projects & Programs		Jul – Dec 2014	2015	2016	2017	2018
Acute Care and Specialists	Avoidable Admissions and Emergency Department Visits: Implement a telehealth option to provide a less costly alternative to an ED visit but that also provides the member with direct and immediate access to a physician.		◆			
	Place of Service: Incent members through benefit design to utilize the appropriate provider in the most cost effective setting for health care services. For example, incent members to choose a location without an associated facility fee.			◆		
Pharmacy	Specialty Pharmacy Management: Implement programs that encourage the cost effective use of specialty pharmacy drugs including member and provider incentives regarding drug infusion site of care, equity in member cost share across pharmacy and medical benefits, and utilization management.			◆		
	Enhanced Fraud Waste & Abuse Program: Replace the high utilization program, which restricts a member to one pharmacy due to the high utilization of targeted drugs (controlled substances and muscle relaxants) with a comprehensive Enhanced Fraud, Waste and Abuse Program. The Enhanced Program includes a review of both medical and pharmacy claims to accurately identify members who meet the robust criteria for restriction to one pharmacy and up to two prescribers for controlled substances and other drugs of abuse. The goal is to decrease fraud, waste and abuse (which includes improper use) of controlled substances and other drugs of abuse.		◆			
Alternative Payment Models	Alternative Payment Models: Implement alternative payment models with 2 to 3 accountable care organizations (ACOs) and then expand.		◆		◆	
Adequate, Stable Funding	Communication with State Government Leadership: Provide the Governor, General Assembly and other key stakeholders with regular updates and targeted communications on the Plan's strategic plan and financial results as well as policy and programmatic priorities through contact with the Office of the Governor, committees and individual members of the General Assembly, leadership staff, OSBM, FRD and state agencies.	◆	◆ ◆	◆ ◆	◆ ◆	◆ ◆
	Legislative Agenda: Develop and communicate funding requirements and requests for statutory changes for the long and short sessions to address the Plan's administrative, financial and policy needs and provide information, actuarial notes, and educational sessions as needed and requested.		◆		◆	◆

LIST OF ACRONYMS

ACO	Accountable Care Organization
ADT	Admissions, Discharge and Transfer
BCBSNC	Blue Cross Blue Shield of North Carolina
CAD	Coronary Artery Disease
CDHP	Consumer-Directed Health Plan
COPD	Chronic Obstructive Pulmonary Disease
ED	Emergency Department
EES	Eligibility and Enrollment Services
FRD	Fiscal Research Division
HEDIS	Healthcare Effectiveness Data and Information Set
MA	Medicare Advantage
MTM	Medication Therapy Management
NCQA	National Committee on Quality Assurance
OSBM	Office of State Budget and Management
PBM	Pharmacy Benefit Manager
PCHM	Patient Centered Medical Home
PCP	Primary Care Provider
PHMS	Population Health Management Services
SLA	Service Level Agreement
TPA	Third Party Administrator