HEALTH WEALTH CAREER

Bdatt.3

OREGON PUBLIC EMPLOYEES' BENEFIT BOARD

4Q 2015 CLAIMS REPORT

April 19, 2016

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Seattle

CLAIMS REPORT OVERVIEW

- This report includes a snapshot of Statewide PPO, Providence Choice, Moda, AllCare PEBB and Kaiser plan experience, generated for PEBB's information - no Board action is required.
  - Trillium data is not included due to size of members enrolled
- Green and red dots either indicate either areas with large variances either with the benchmark or in year-over-year costs
- Includes year-over-year comparisons for the Providence plans
  - Current period for paid claims is 1/1/2015 – 12/31/2015
  - Current period for incurred claims is 10/1/2014 – 9/30/2015
- Moda and AllCare has claims for 1/1/2015 – 12/31/2015
- For Kaiser, the dashboard contains 24 months of data from 10/1/2013 – 9/30/2015
  - Current period for paid claims is 10/1/2014 – 9/30/2015
  - Current period for incurred claims is 7/1/2014 – 6/30/2015
  - Data is now provided through Truven
  - Claims data do not include Integrated Care costs which total about $14M under the current period and $15M under the prior period
    - Integrated care costs include: chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services
- A glossary is provided at the back of the presentation

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OVERVIEW OF CLAIMS

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OVERALL PAID CLAIMS
AGGREGATE ANNUAL COSTS

Aggregate Annual Costs					
Self-Insured Plans	**Two Years Prior**	**One Year Prior**	**% Change**	**Current**	**% Change**
Medical	$456,012,309	$476,784,542	4.6%	$485,702,018	1.9%
Prescription Drug	$66,814,985	$75,270,078	12.7%	$81,509,922	8.3%
Total	$522,827,293	$552,054,621	5.6%	$567,211,940	2.7%
Employees	41,205	41,305	0.2%	39,780	-3.7%
Members	108,398	109,425	0.9%	105,726	-3.4%
Fully-Insured Plans		**One Year Prior**		**Current**	**% Change**
Medical		$82,617,879		$100,280,599	21.4%
Prescription Drug		$13,498,914		$17,809,041	31.9%
Total		$96,116,793		$118,089,640	22.9%
Employees		8,315		10,429	25.4%
Members		21,360		27,004	26.4%
Total PEBB		**One Year Prior**		**Current**	**% Change**
Medical		$559,402,422		$585,982,617	4.8%
Prescription Drug		$88,768,992		$99,318,962	11.9%
Total		$648,171,414		$685,301,580	5.7%
Employees		49,620		50,209	1.2%
Members		130,785		132,730	1.5%

- Self-insured aggregate total paid claims increased 2.7% over the prior 12 months
  - Prior year increase was 5.7%
- Fully insured plans include Moda and AllCare for current time period

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PAID CLAIMS BY CATEGORY
ON A PER EMPLOYEE PER YEAR (PEPY) BASIS

Self-Insured
Per Employee Per Year (PEPY) Costs

Medical	Two Years Prior	One Year Prior	% Change	Current	% Change		% of Total
Facility Inpatient	$2,996	$3,113	3.9%	$2,959	-4.9%	●	20.8%
Facility Outpatient	$2,341	$2,574	9.9%	$2,864	11.3%	●	20.1%
Physician Inpatient	$409	$394	-3.6%	$417	5.8%		2.9%
Physician Outpatient	$1,746	$1,795	2.8%	$1,894	5.5%		13.3%
MHSA	$391	$407	4.0%	$514	26.4%	●	3.6%
Laboratory and Radiology	$1,193	$1,187	-0.5%	$1,235	4.1%		8.7%
Other Professional Services	$1,990	$2,074	4.2%	$2,326	12.2%	●	16.3%
Total Medical	$11,067	$11,543	4.3%	$12,210	5.8%		85.6%
Prescription Drugs	$1,622	$1,822	12.4%	$2,049	12.4%	●	14.4%
Total Net Payments	$12,688	$13,365	5.3%	$14,259	6.7%		100.0%

Fully-Insured
Per Employee Per Year (PEPY) Costs

Medical	One Year Prior	Current	% Change		% of Total
Facility Inpatient	$2,886	$2,381	-17.5%	●	21.0%
Facility Outpatient	$1,453	$1,723	18.5%	●	15.2%
Physician Inpatient	$334	$357	6.9%		3.2%
Physician Outpatient	$2,124	$2,007	-5.5%	●	17.7%
MHSA	$289	$277	-4.4%		2.4%
Laboratory and Radiology	$1,408	$1,316	-6.5%	●	11.6%
Other Professional Services	$1,441	$1,555	7.9%		13.7%
Total Medical	$9,936	$9,615	-3.2%		84.9%
Prescription Drugs	$1,623	$1,708	5.2%		15.1%
Total Net Payments	$11,559	$11,323	-2.0%		100.0%

Fully-Insured current year costs are understated by approximately $1,450 PEPY due to missing integrated care fees.
Prior year fees are understated by approximately $1,800 PEPY due to missing integrated care fees.

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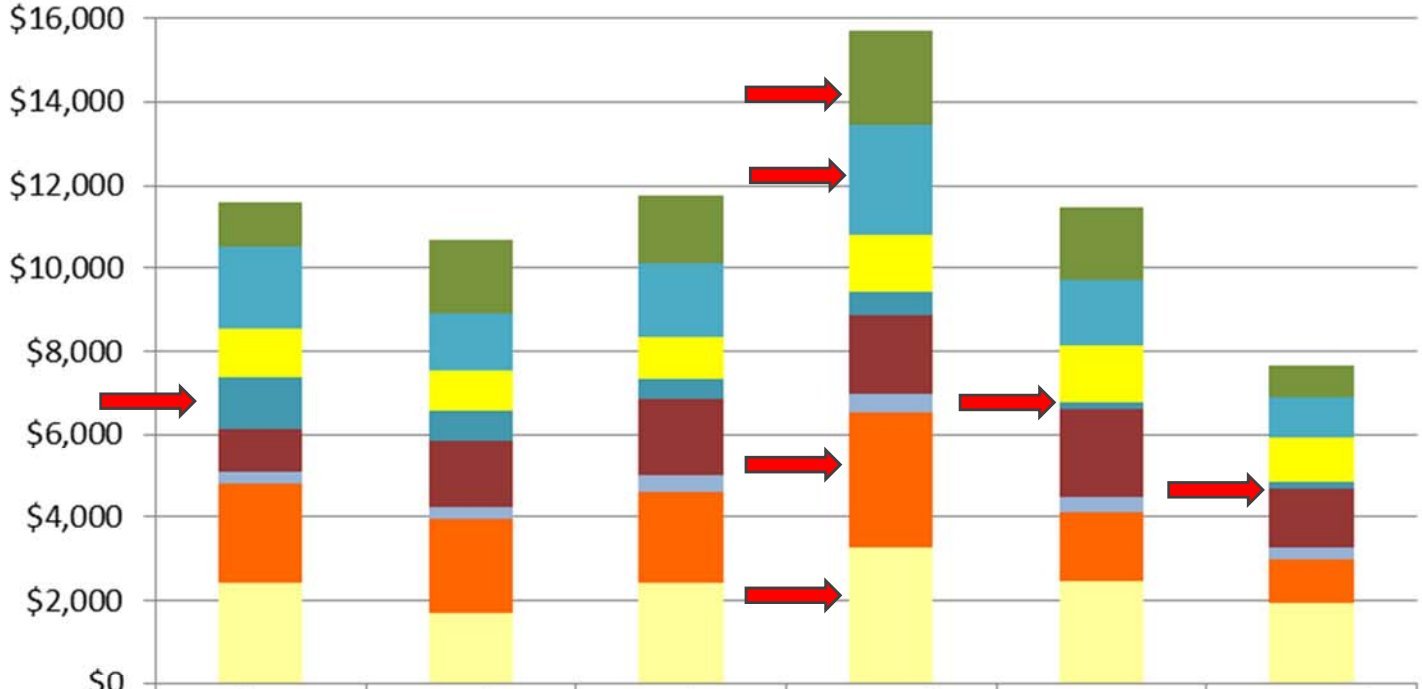
PAID CLAIMS BY CATEGORY
CURRENT ON A PEPY BASIS



	AllCare $11,593	Moda $10,667	Providence $11,761	Statewide $15,705	Kaiser HMO $11,490	Kaiser Ded $7,644
Prescription Drugs	$1,074	$1,757	$1,666	$2,271	$1,770	$760
Other Professional Services	$1,956	$1,360	$1,770	$2,647	$1,568	$972
Laboratory and Radiology	$1,173	$990	$1,005	$1,369	$1,379	$1,067
MHSA	$1,267	$726	$476	$536	$145	$156
Physician Outpatient	$1,052	$1,599	$1,855	$1,917	$2,148	$1,413
Physician Inpatient	$287	$269	$405	$424	$376	$300
Facility Outpatient	$2,368	$2,273	$2,144	$3,281	$1,617	$1,017
Facility Inpatient	$2,416	$1,692	$2,440	$3,259	$2,486	$1,958

- Data shows per employee per year costs by service category
- Moda and AllCare have 12 months of claims however claims were not adjusted for run-in period

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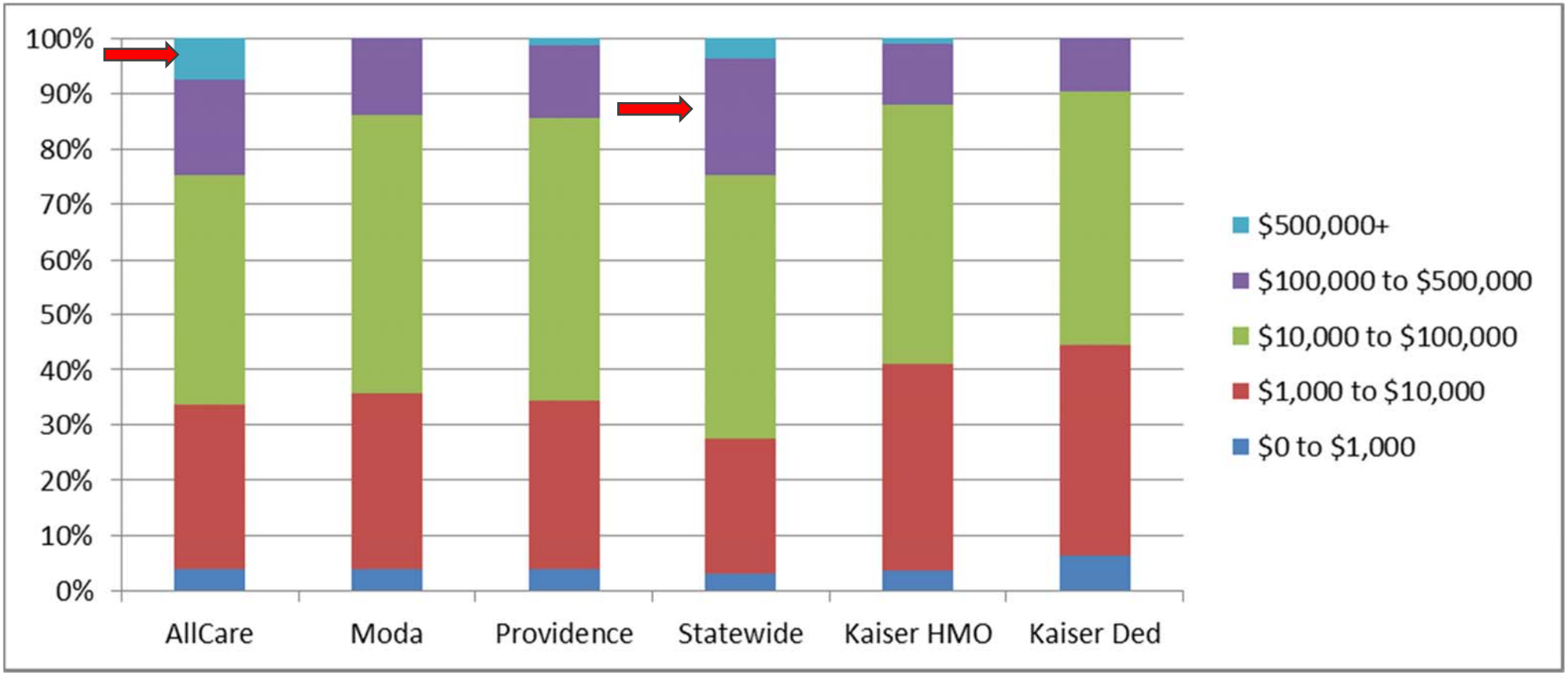
PAID CLAIMS BY SIZE
MOST RECENT 6 MONTHS



•Paid claims by member and by size over most recent 12 months of paid claims

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RISK SCORES

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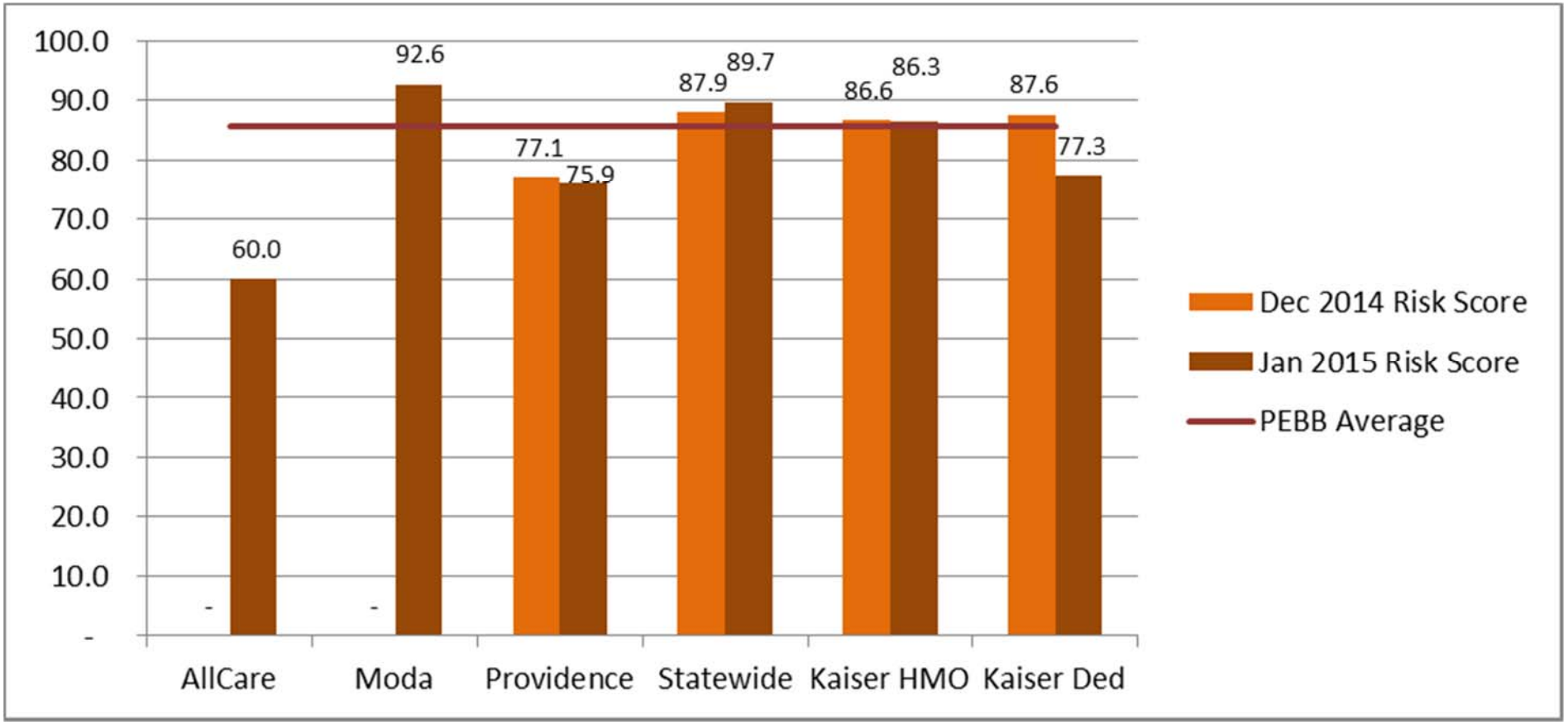
DCG RISK SCORES
DEC 2014 TO JAN 2015 MEMBERS



•Risk scores for members in both December 2014 and January 2015

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DCG RISK SCORES
SWITCHING BETWEEN PLANS DEC-14 AND JAN-15

From \ To	AllCare	Moda	Providence Choice	Statewide	Kaiser HMO	Kaiser Deductible	2014 Total
Providence	59	480	29,131	983	400	17	**31,070**
Statewide	1,393	2,111	6,300	65,666	358	17	**75,845**
Kaiser HMO	1	57	375	71	20,362	85	**20,951**
Kaiser Deductible	-	2	13	14	67	288	**384**
2015 Total	**1,453**	**2,650**	**35,819**	**66,734**	**21,187**	**407**	**128,250**

From \ To	AllCare	Moda	Providence Choice	Statewide	Kaiser HMO	Kaiser Deductible	2014 Total
Providence Choice	56.7	94.4	77.7	76.4	70.3	84.5	**77.1**
Statewide	61.0	93.7	72.9	90.1	75.2	34.5	**87.9**
Kaiser HMO	8.0	126.0	73.7	136.5	87.4	66.0	**86.6**
Kaiser Deductible	-	5.5	43.2	70.0	98.8	86.1	**87.6**
2015 Total	**60.0**	**92.6**	**75.9**	**89.7**	**86.3**	**77.3**	**85.5**

- Based on July 2014 to June 2015 risk scores for those enrolled in December 2014 and January 2015
- Moda has highest risk scores of 2015 plans; AllCare has lowest risk scores
- Members switching into Providence Choice and Kaiser Deductible had lower risk scores than the population that remained

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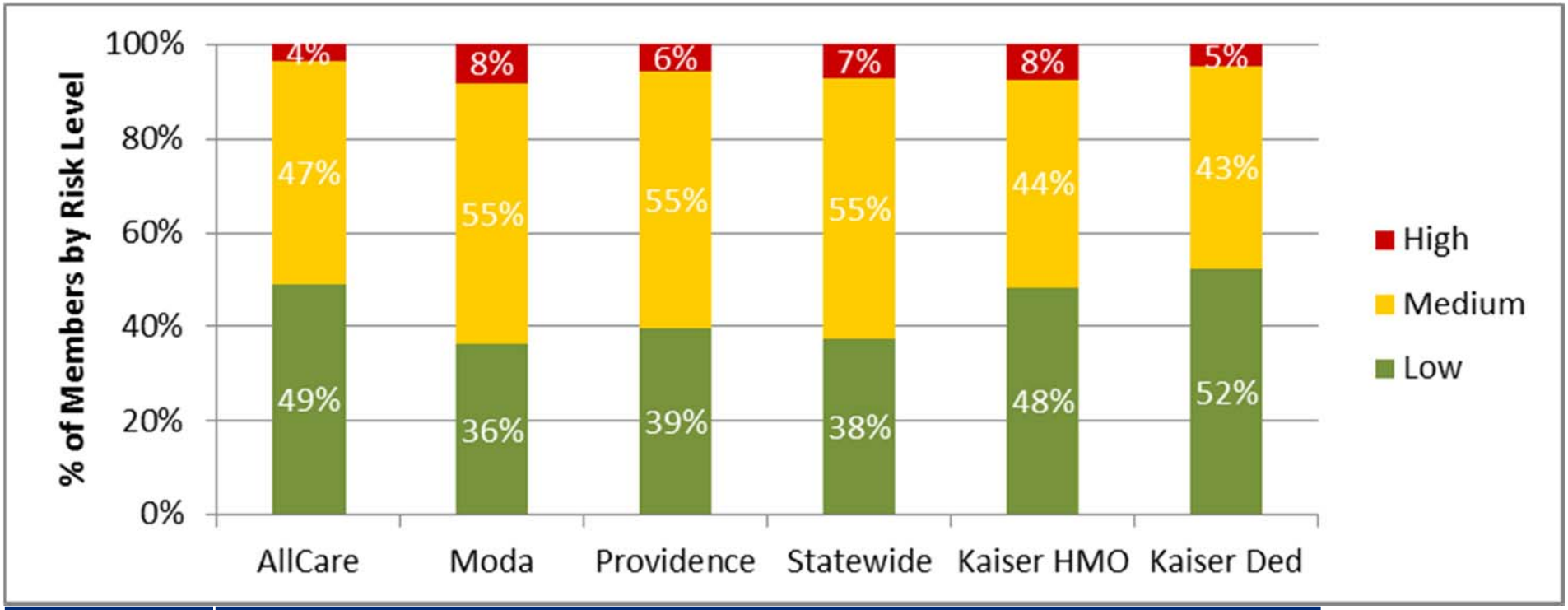
DCG RISK SCORES
RISK STRATIFIED MEMBERS



	% Cost per Member Risk					
High	38%	51%	43%	52%	47%	48%
Medium	55%	45%	53%	45%	44%	41%
Low	7%	3%	4%	3%	10%	11%

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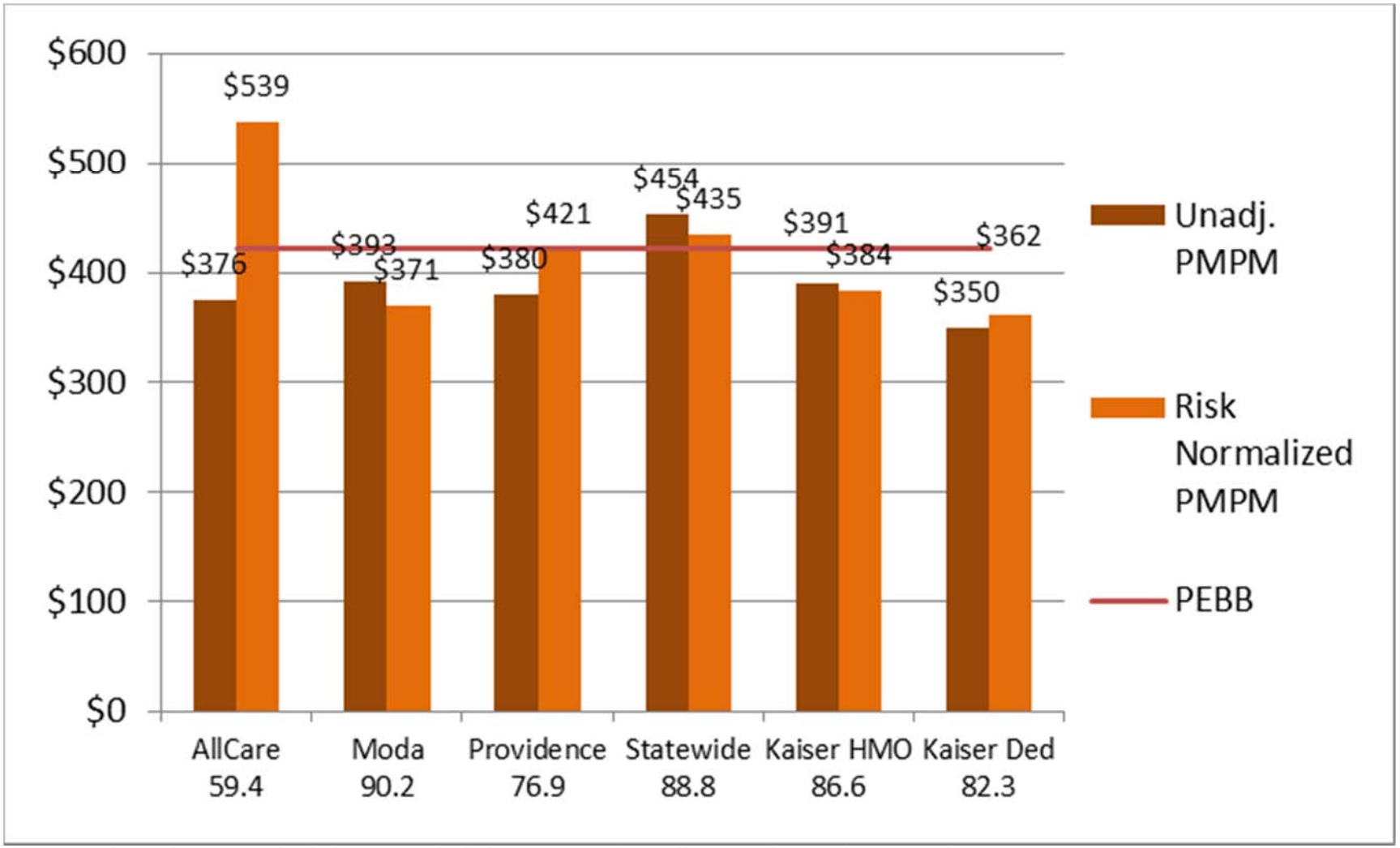
DCG RISK SCORES
RISK ADJUSTED CLAIMS



- Based on incurred claims and risk scores for all members from July 2014 to June 2015
- Excludes administrative fees
- Estimated Integrated Care Management costs for Kaiser is $57 PMPM (not included above)

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UTILIZATION DATA

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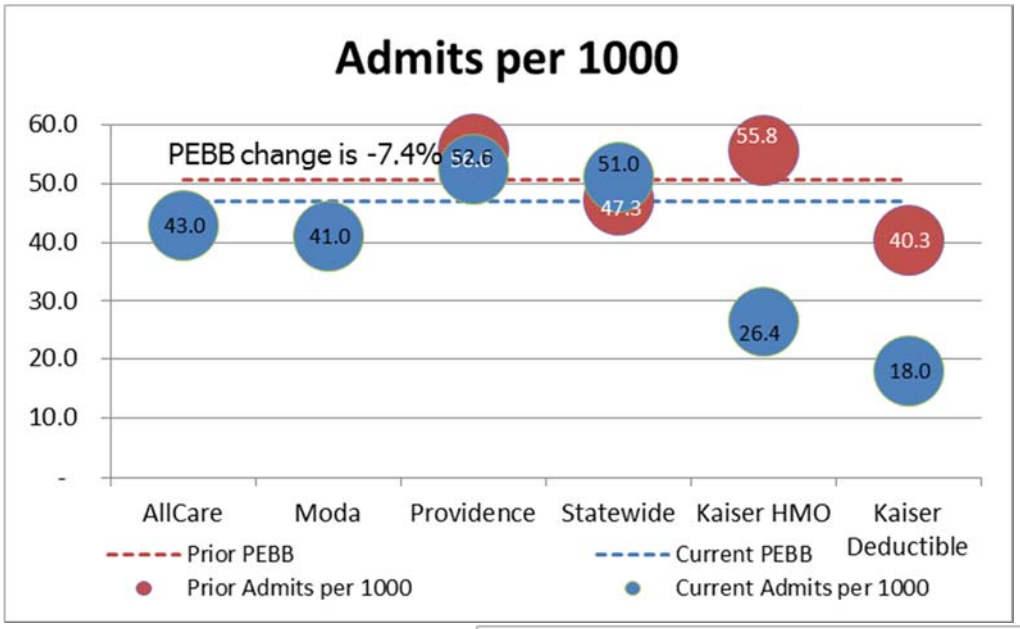
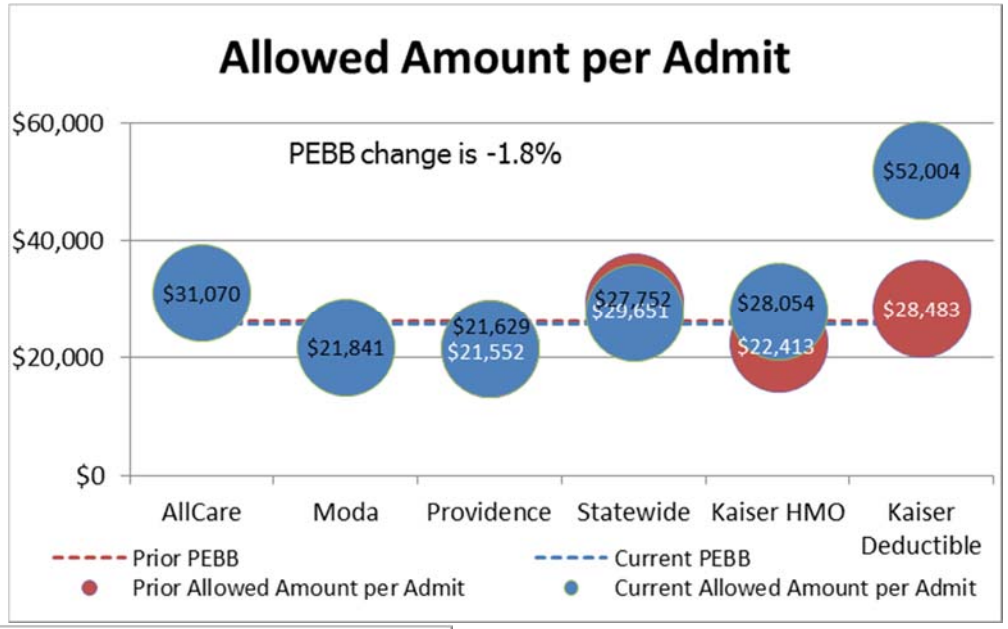
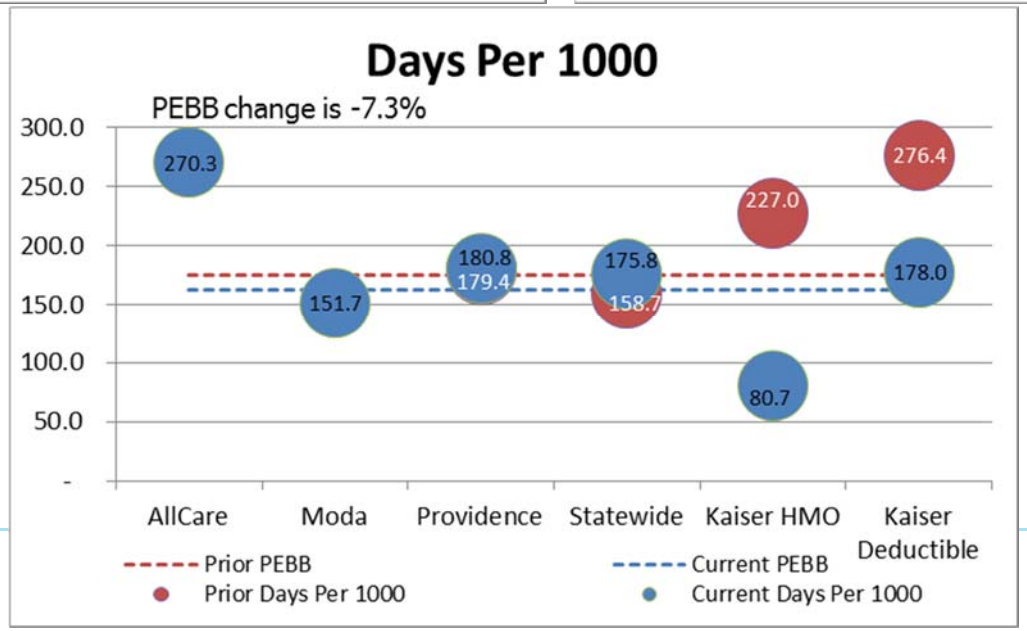
INPATIENT DETAIL
CURRENT VERSUS PRIOR







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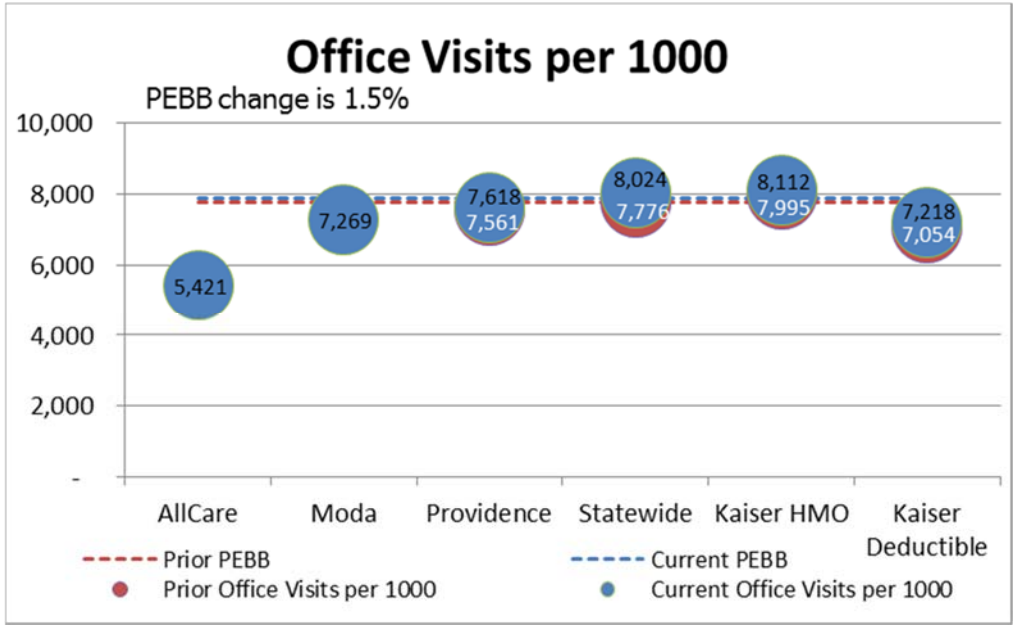
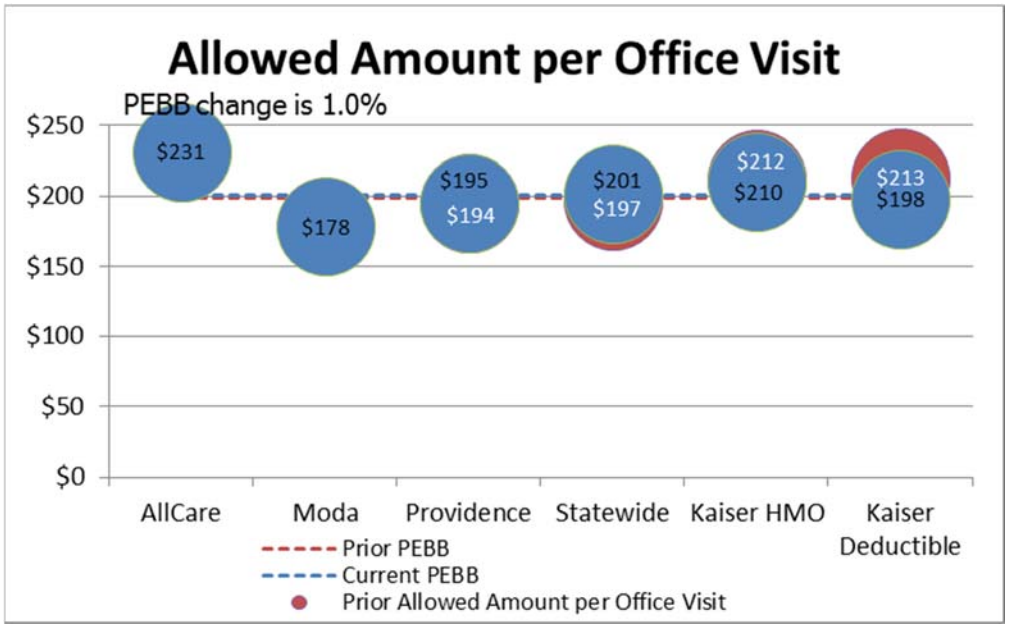
OUTPATIENT DETAIL – OFFICE VISITS
CURRENT VERSUS PRIOR





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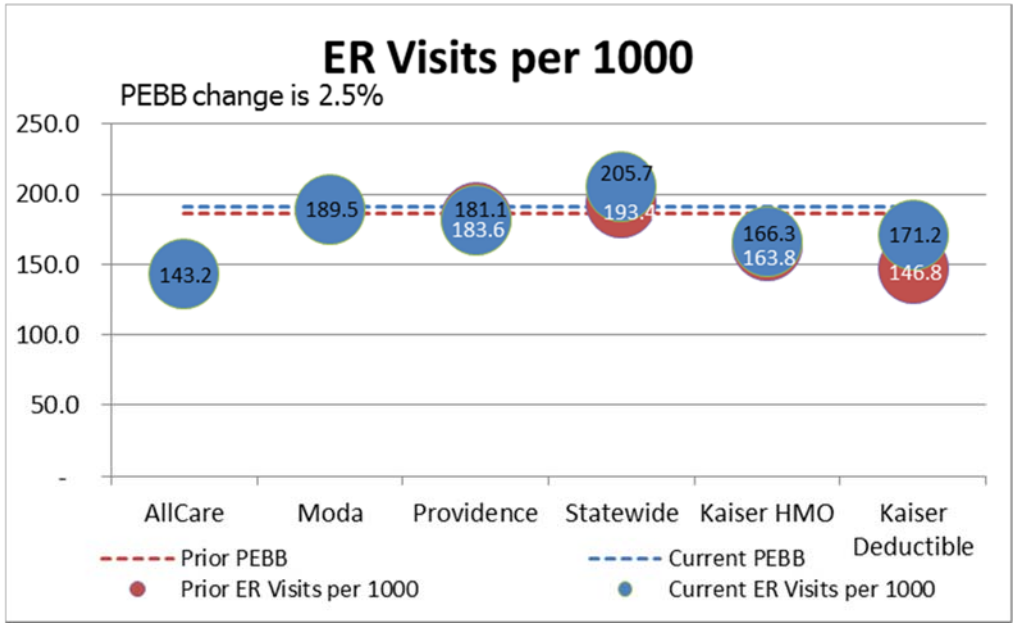
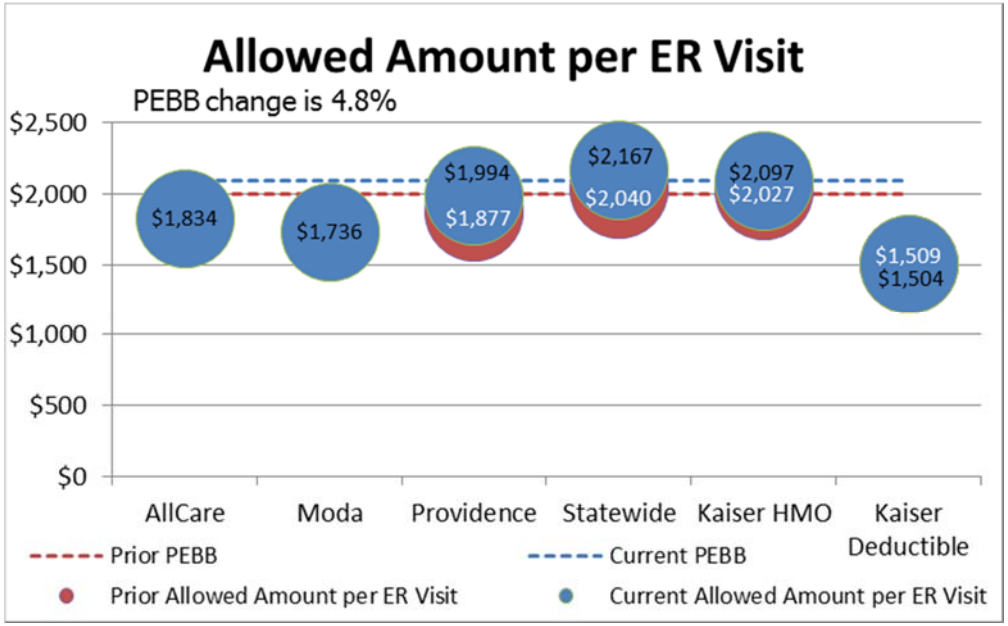
EMERGENCY ROOM DETAIL
CURRENT VERSUS PRIOR





	2015	2014	2013
ER Visits per 1000 (Total)	195.9	187.8	181.1
ER Visits (resulting in admit)	15.2	15.2	16.5

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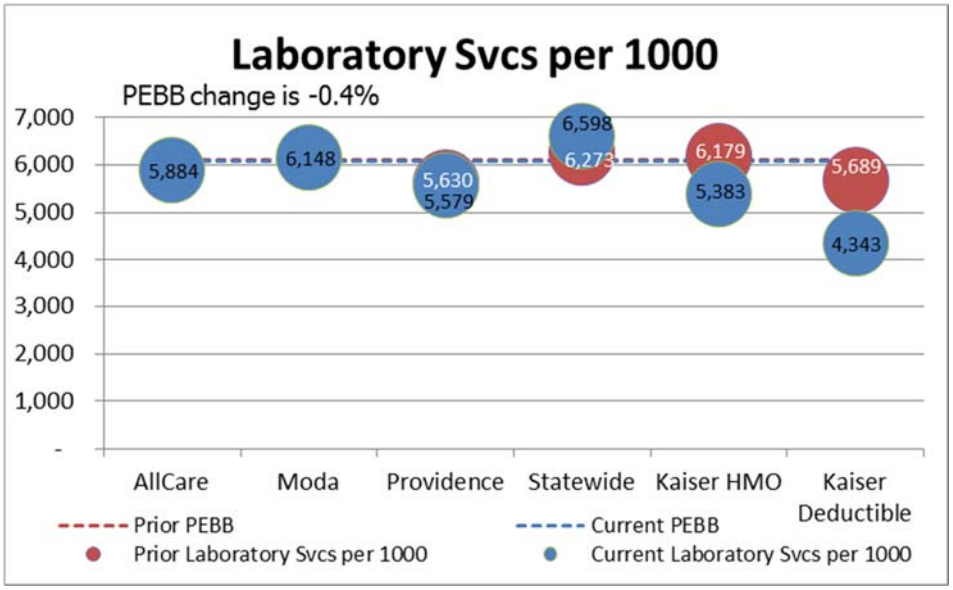
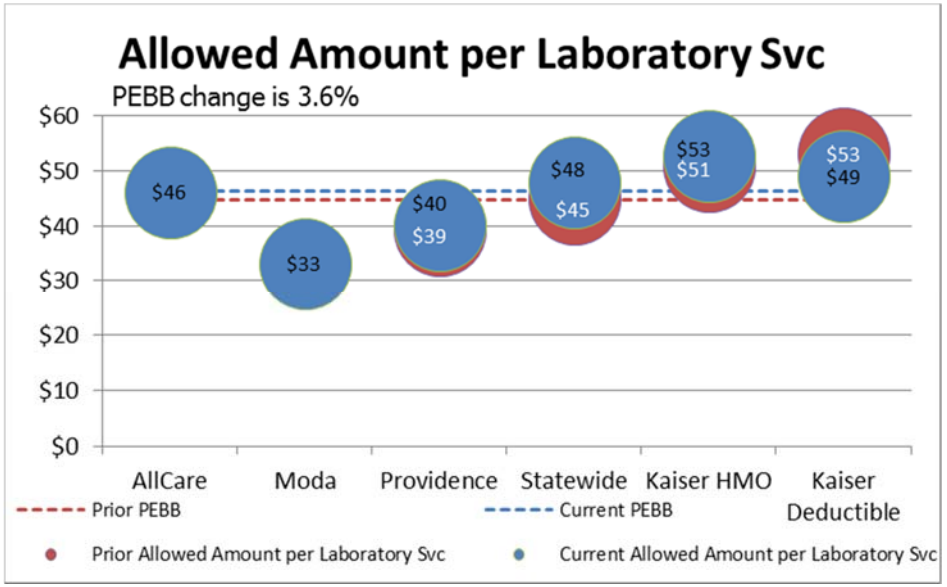
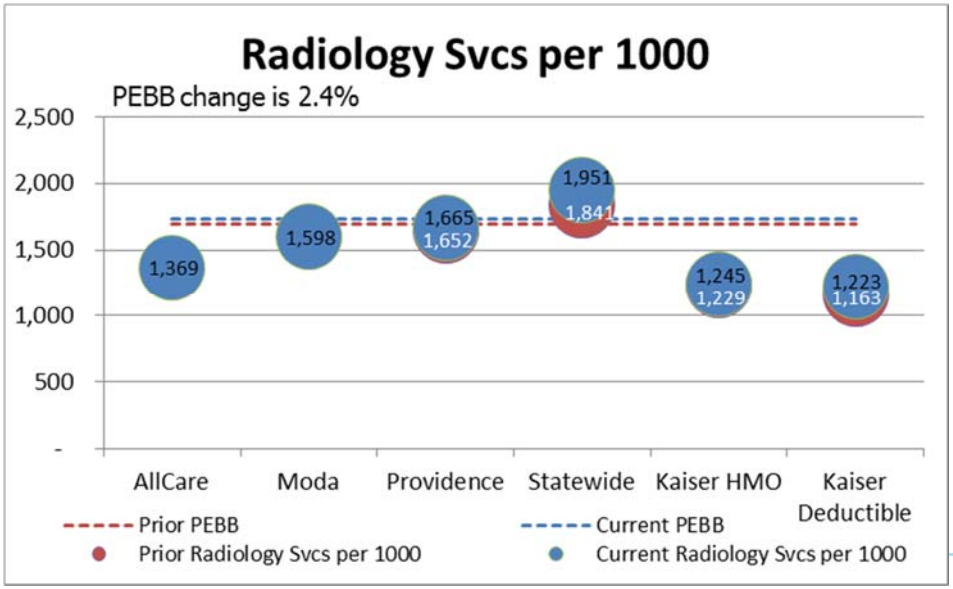
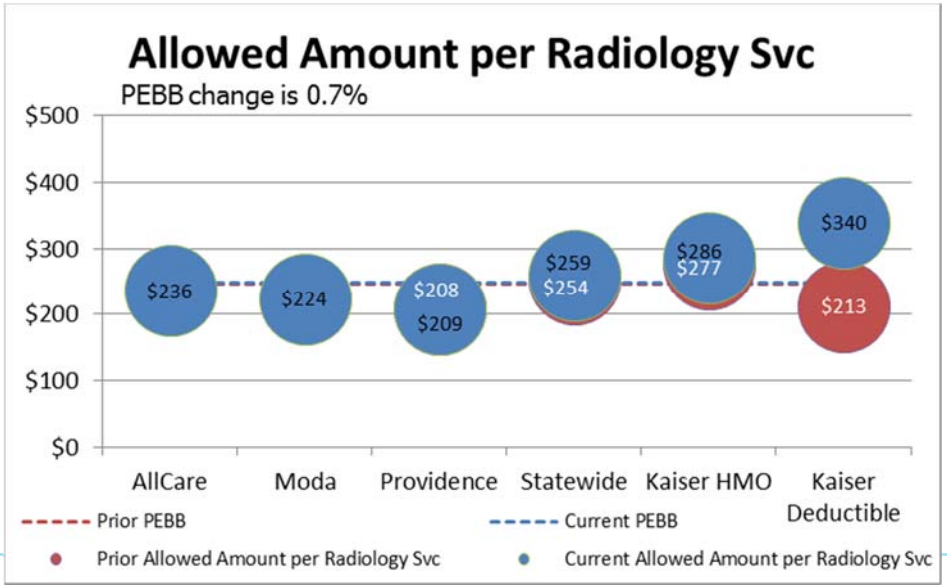
LAB AND RADIOLOGY DETAIL
CURRENT VERSUS PRIOR









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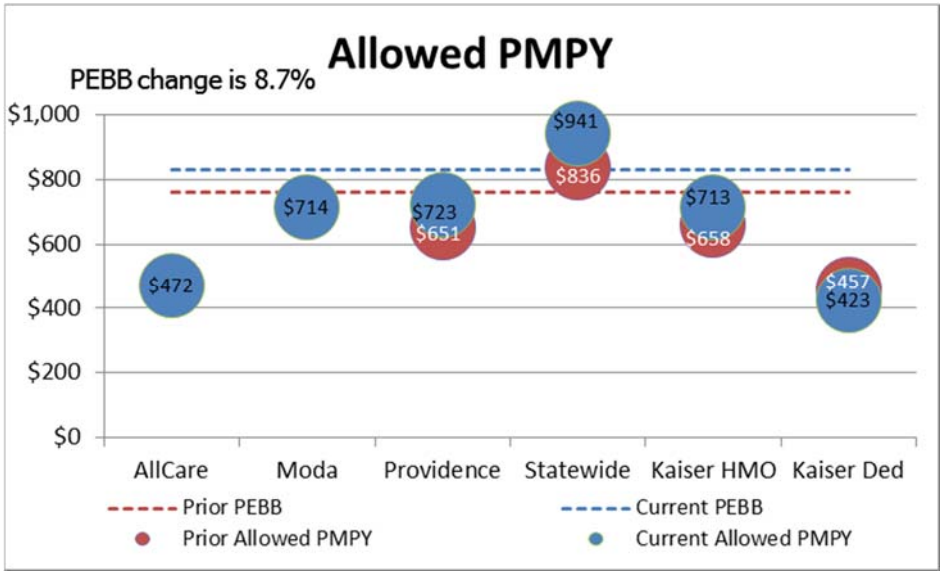
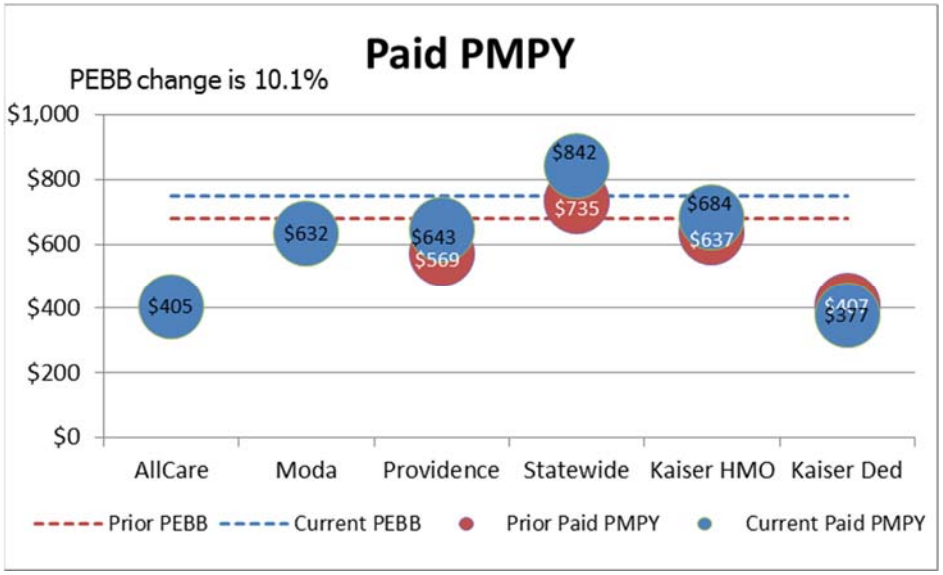
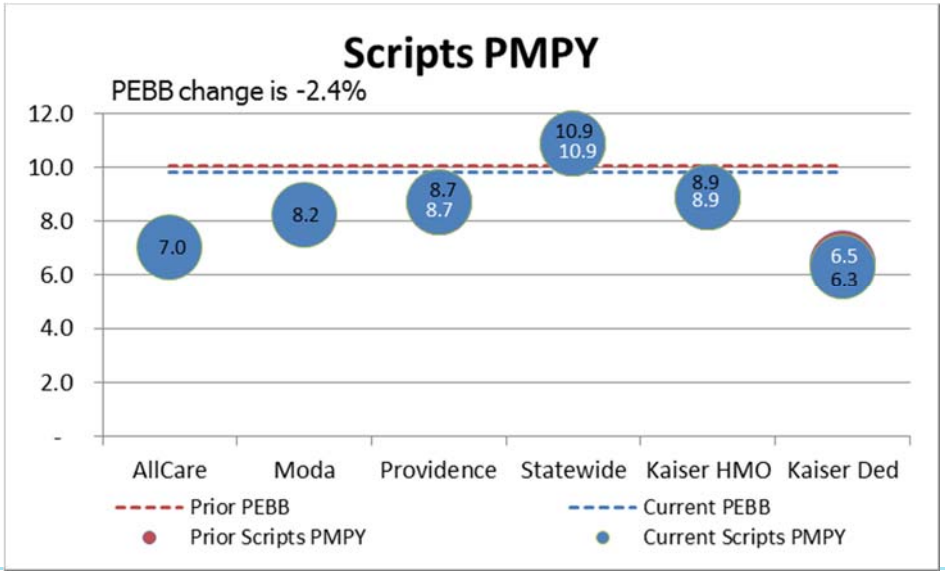
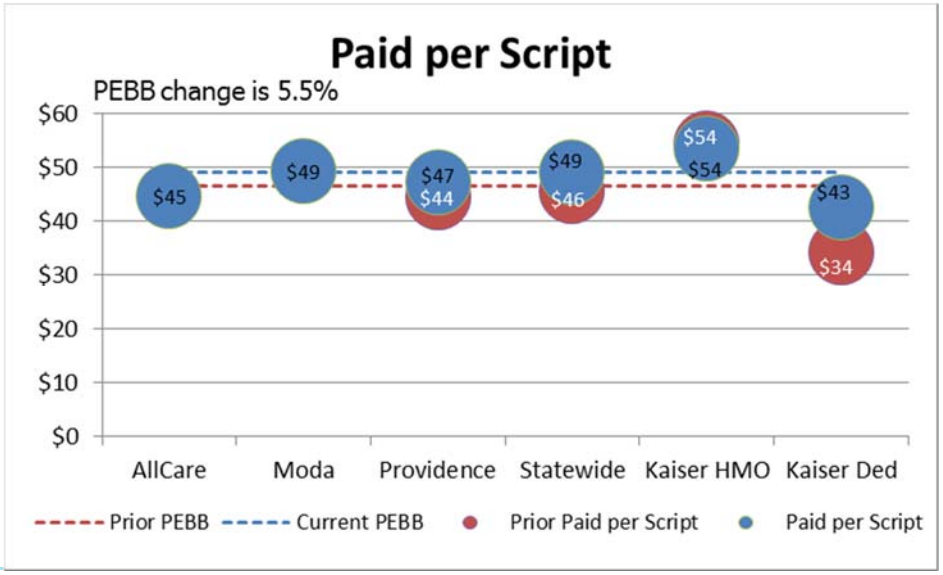
PHARMACY DETAIL
CURRENT VERSUS PRIOR









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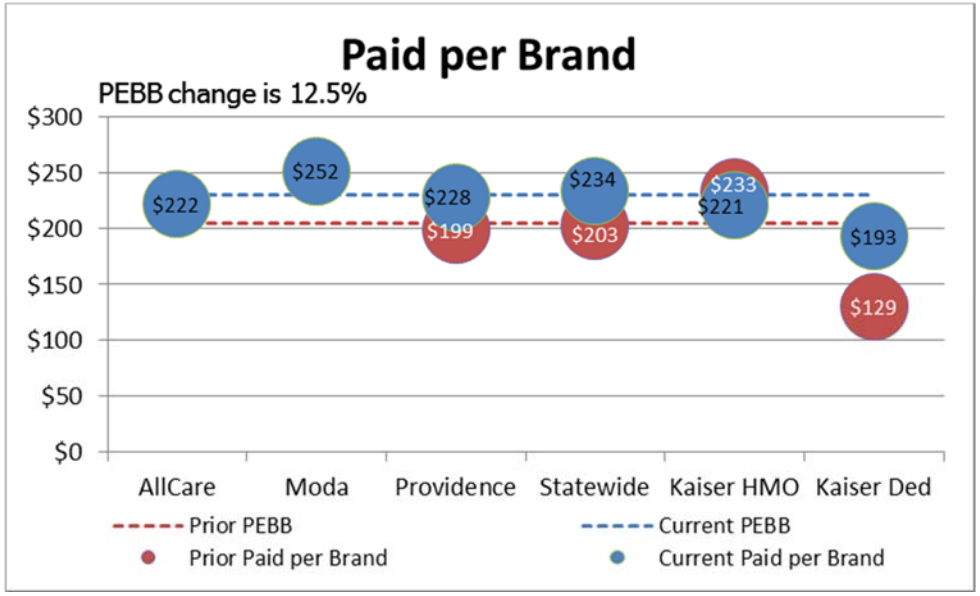
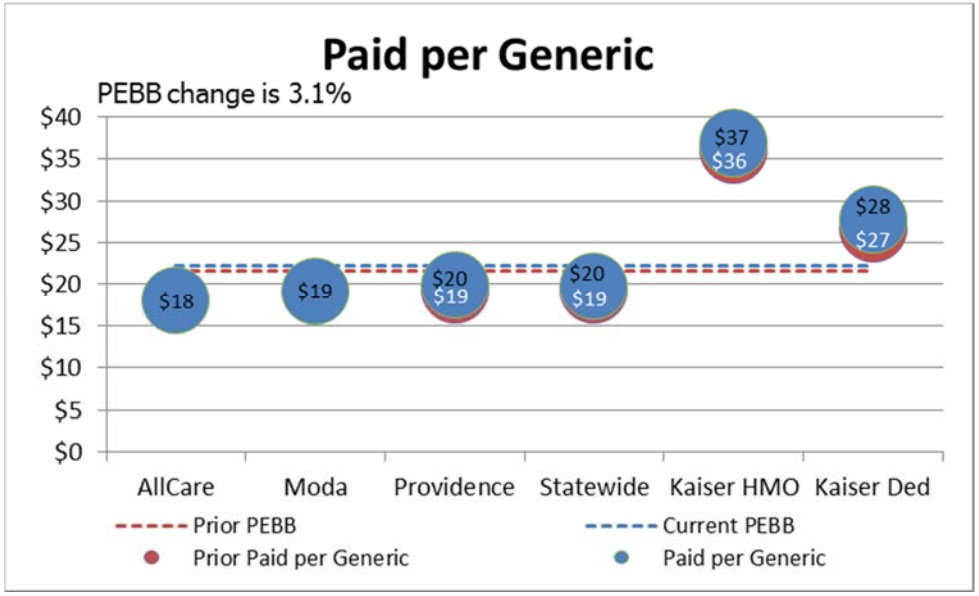
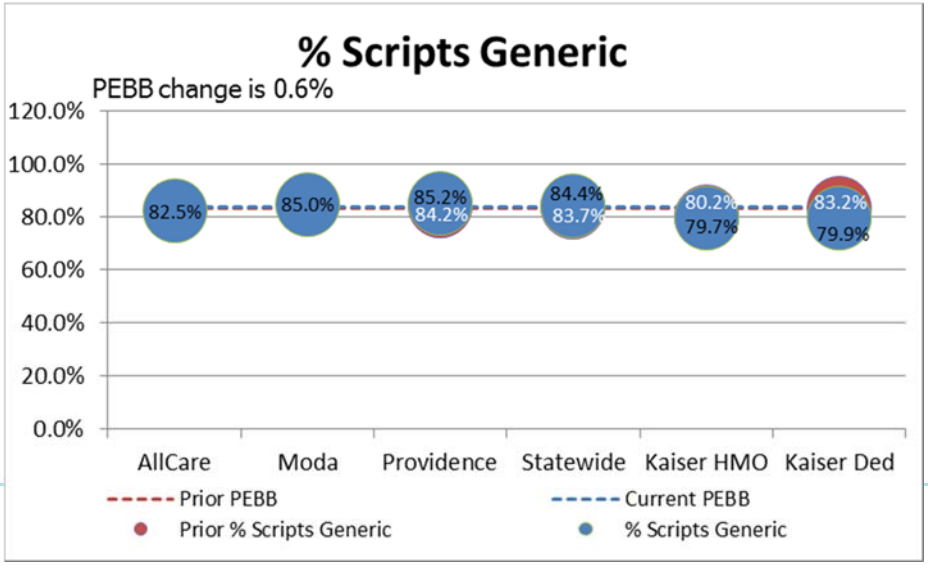
PHARMACY DETAIL
CURRENT VERSUS PRIOR







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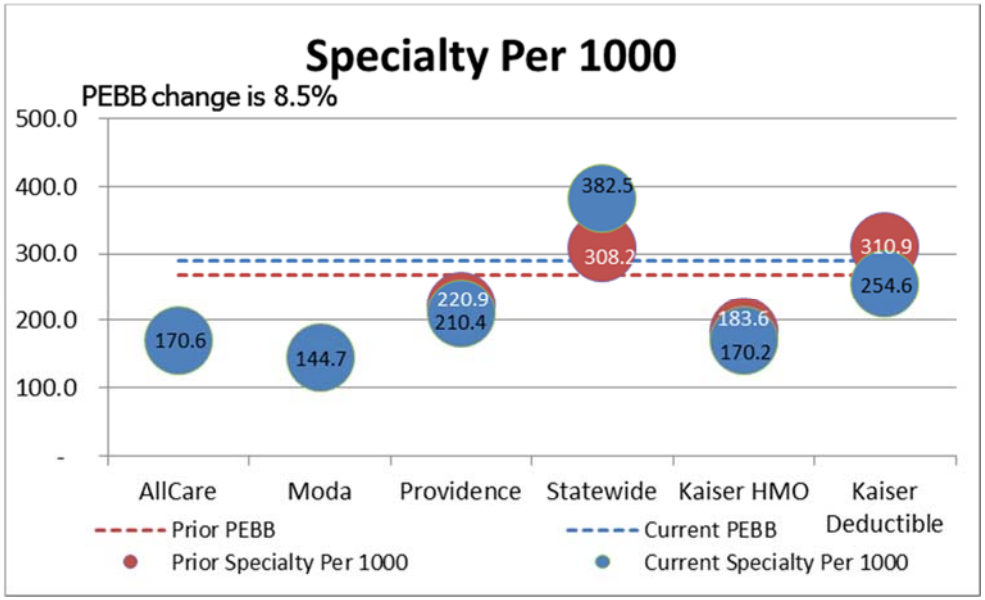
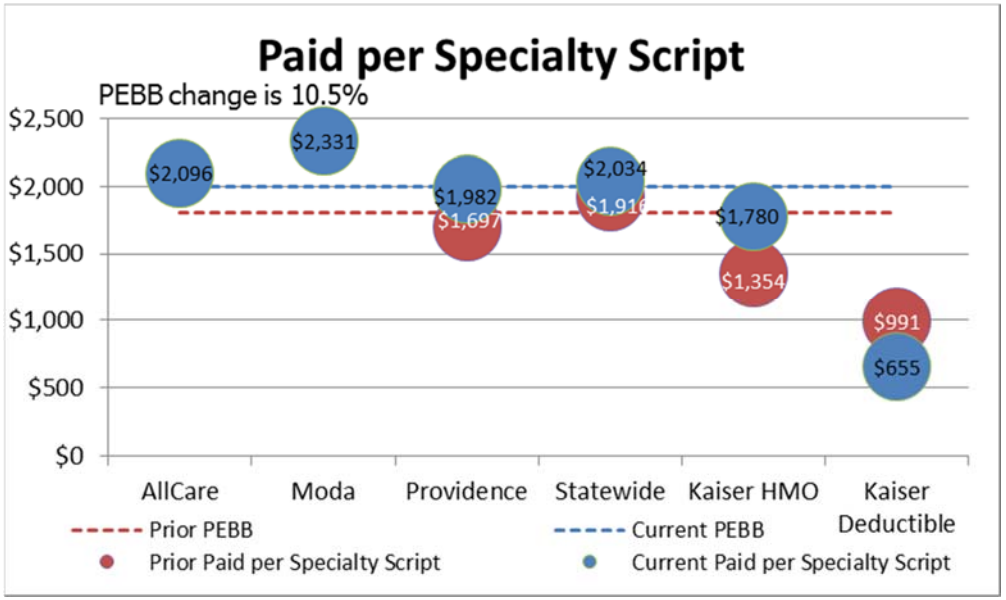
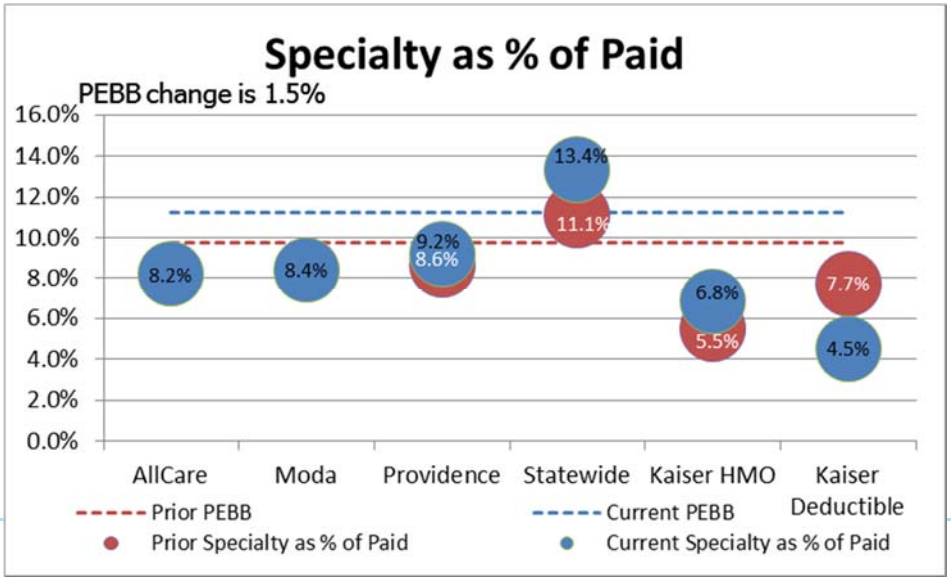
PHARMACY DETAIL– SPECIALTY DRUGS
CURRENT VERSUS PRIOR







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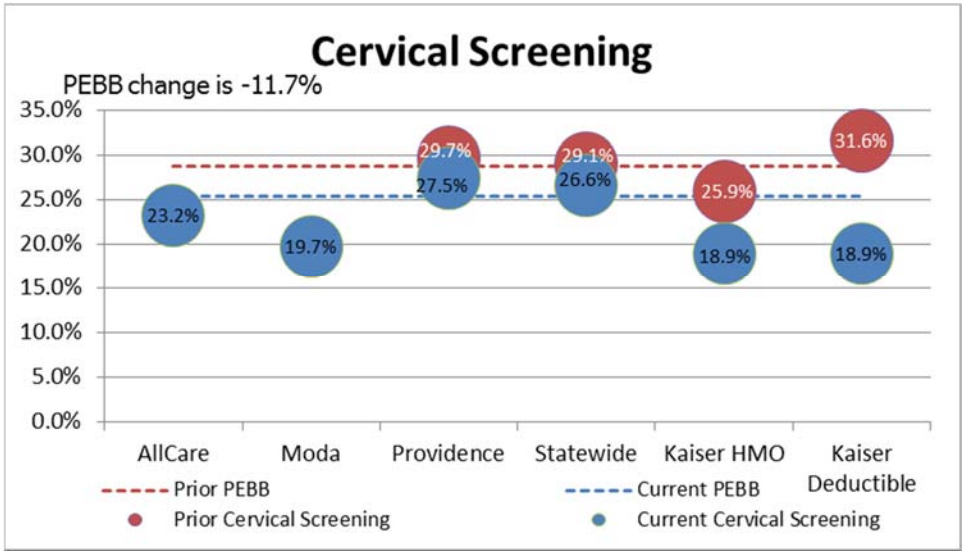
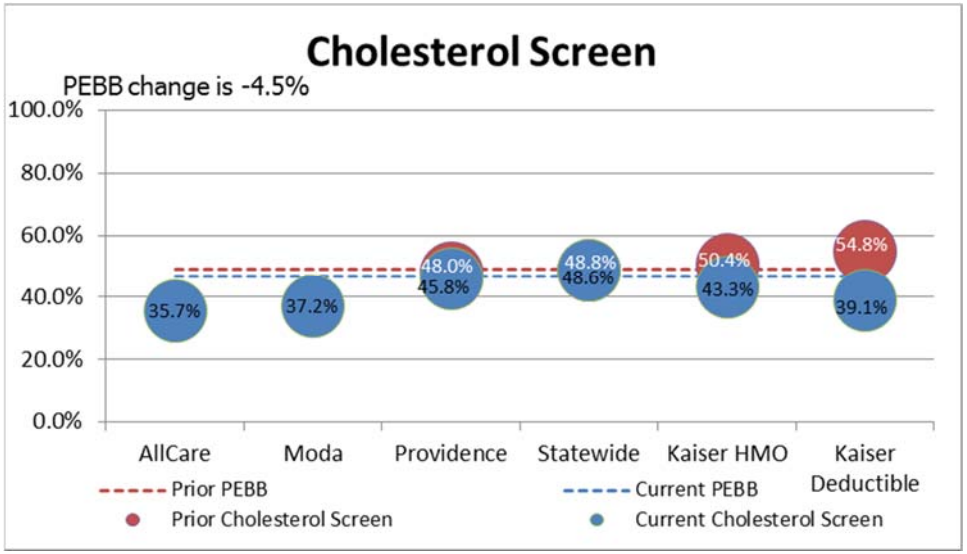
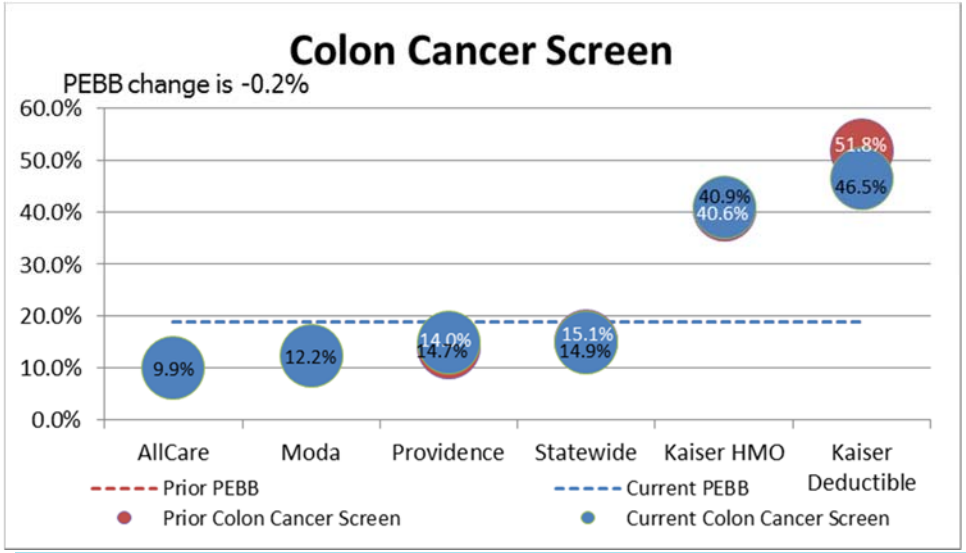
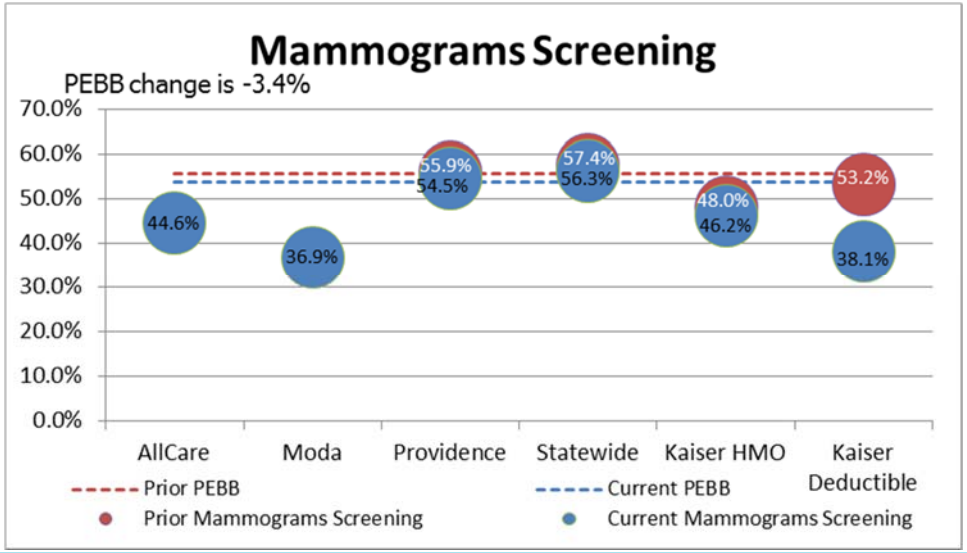
PREVENTIVE SCREENINGS
CURRENT VERSUS PRIOR - INCURRED









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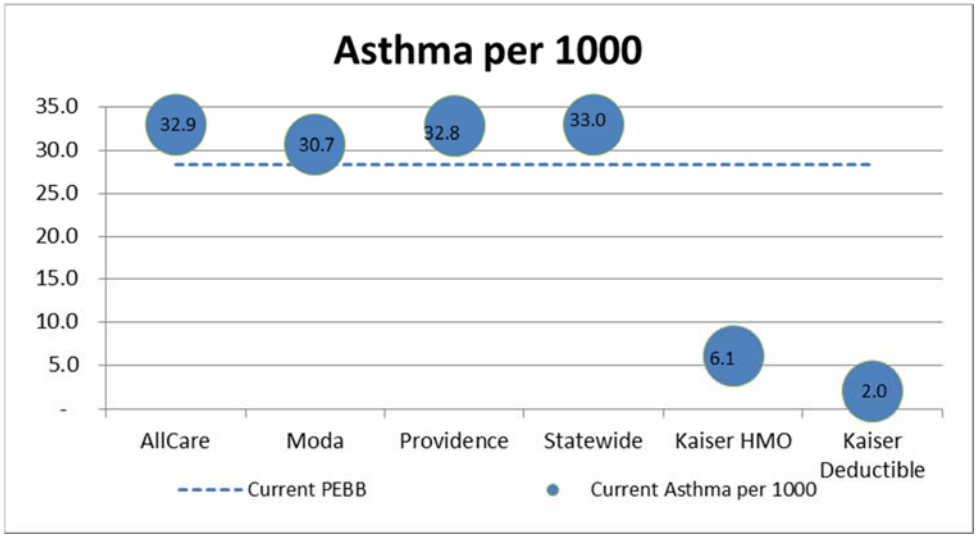
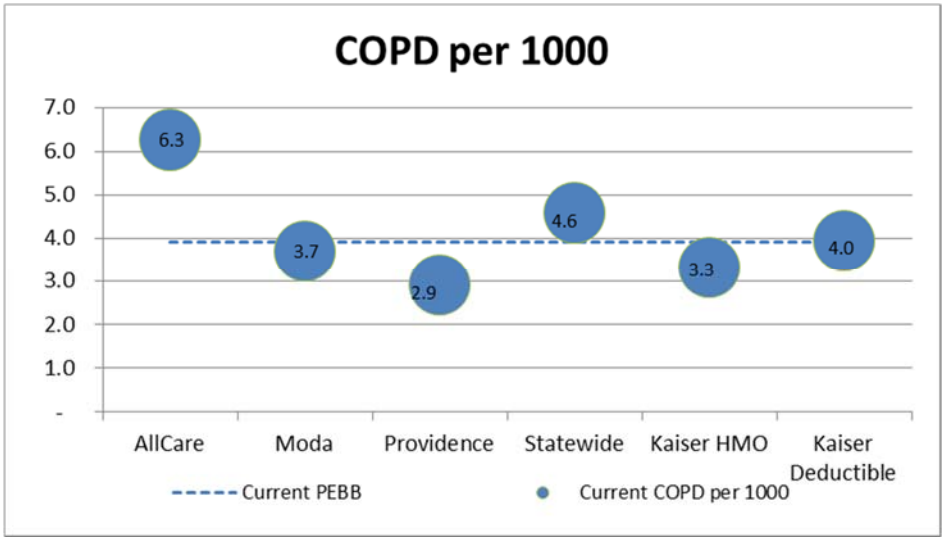
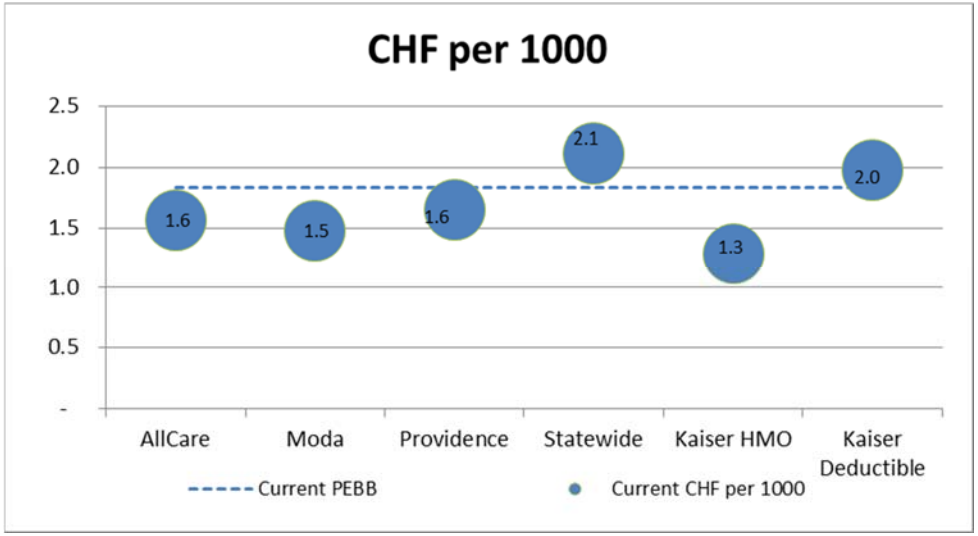
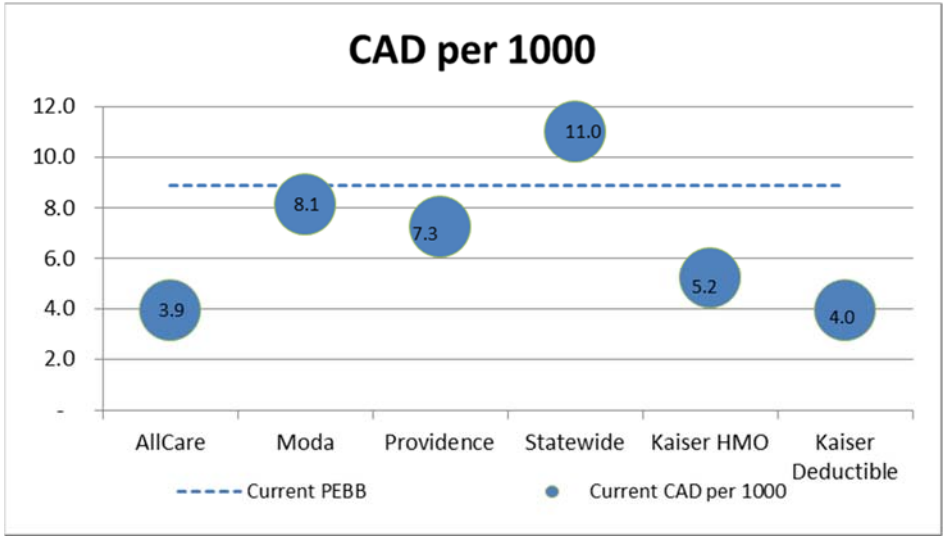
CHRONIC CONDITIONS
CURRENT - INCURRED









•Patients with claims indicating the various chronic conditions

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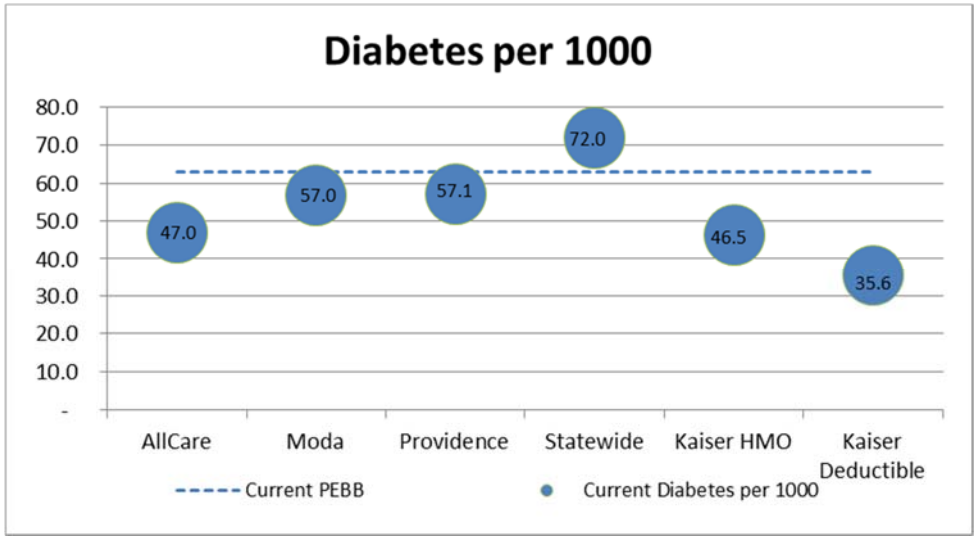
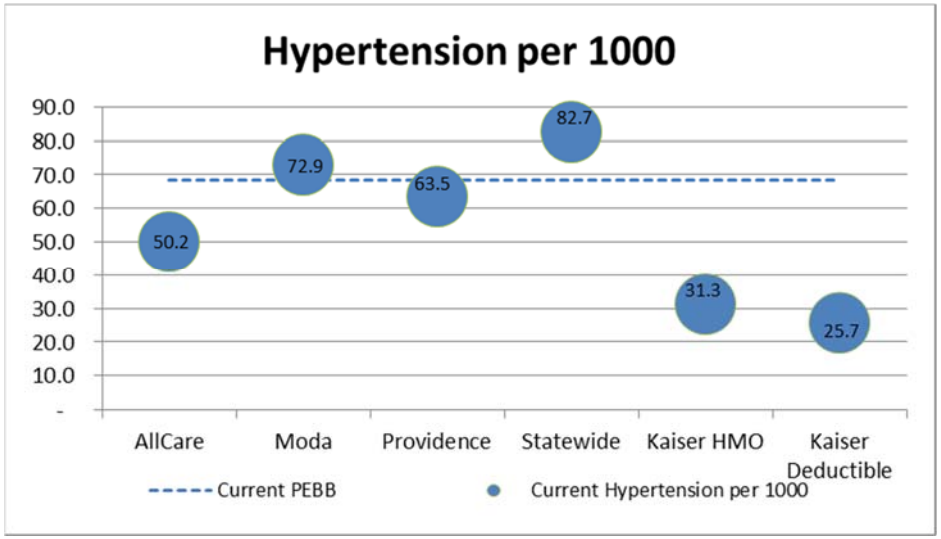
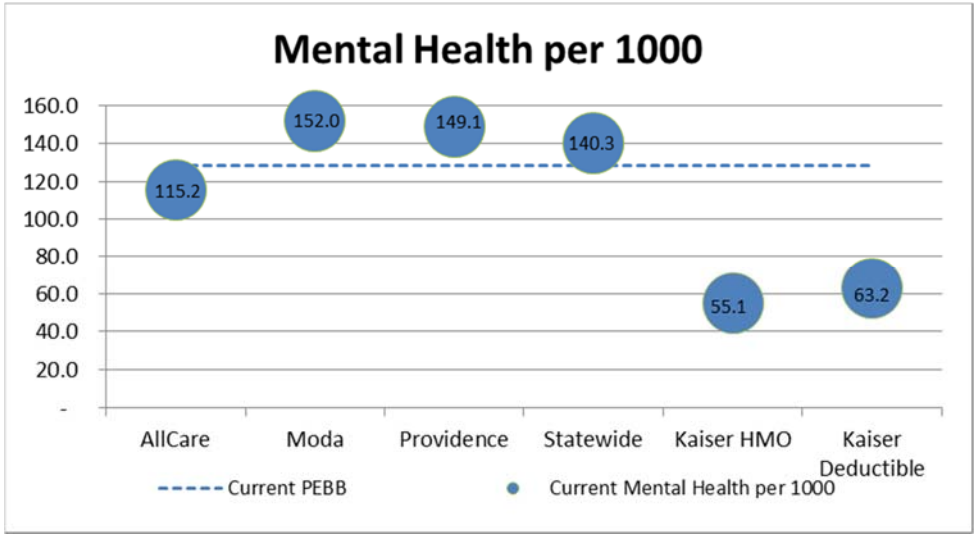
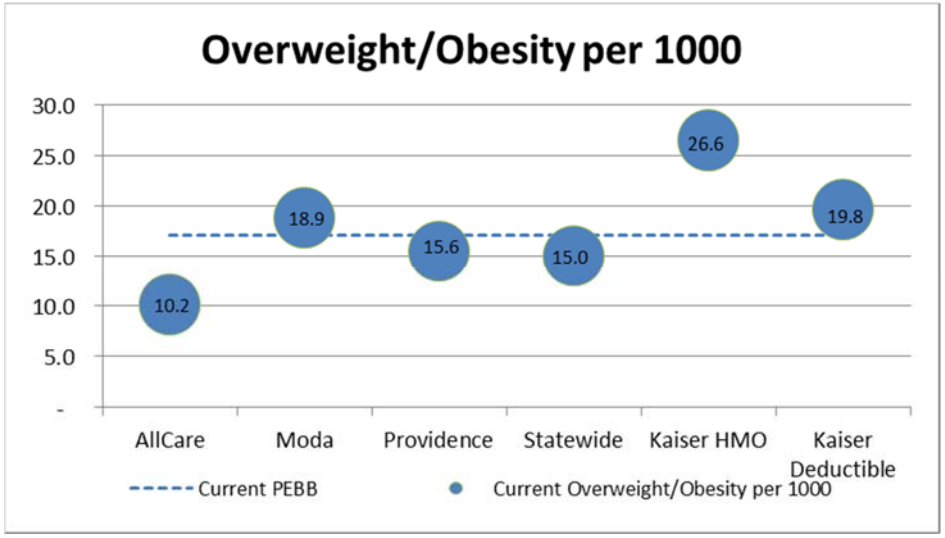
CHRONIC CONDITIONS
CURRENT - INCURRED









•Patients with claims indicating the various chronic conditions

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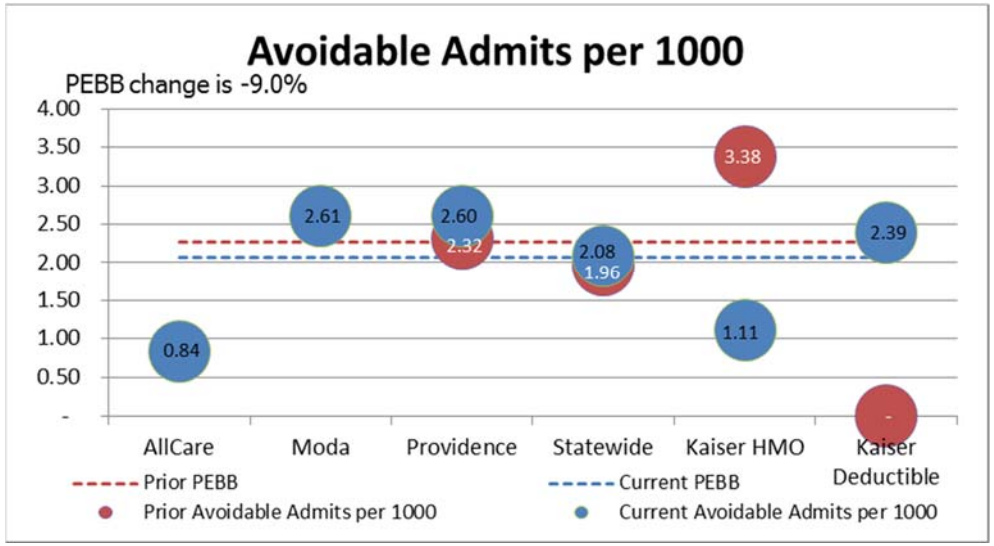
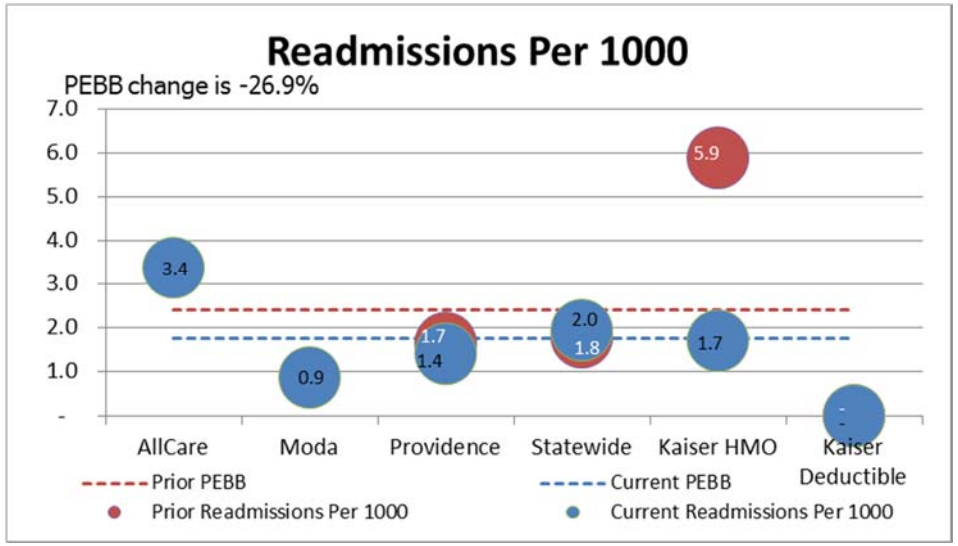
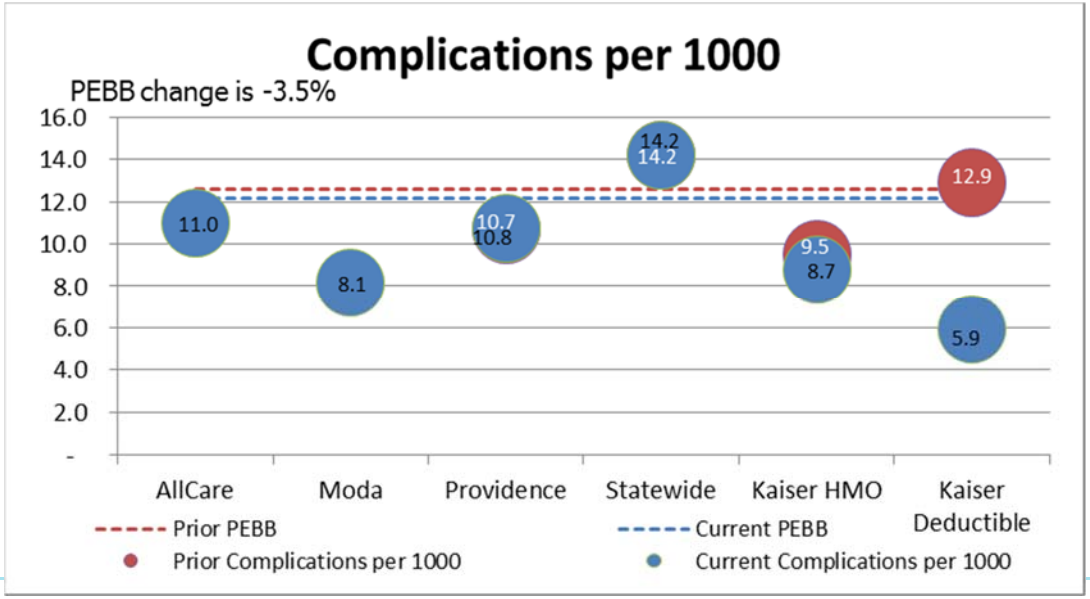
QUALITY MARKERS
CURRENT VERSUS PRIOR - INCURRED







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QUALITY MARKERS - DELIVERIES
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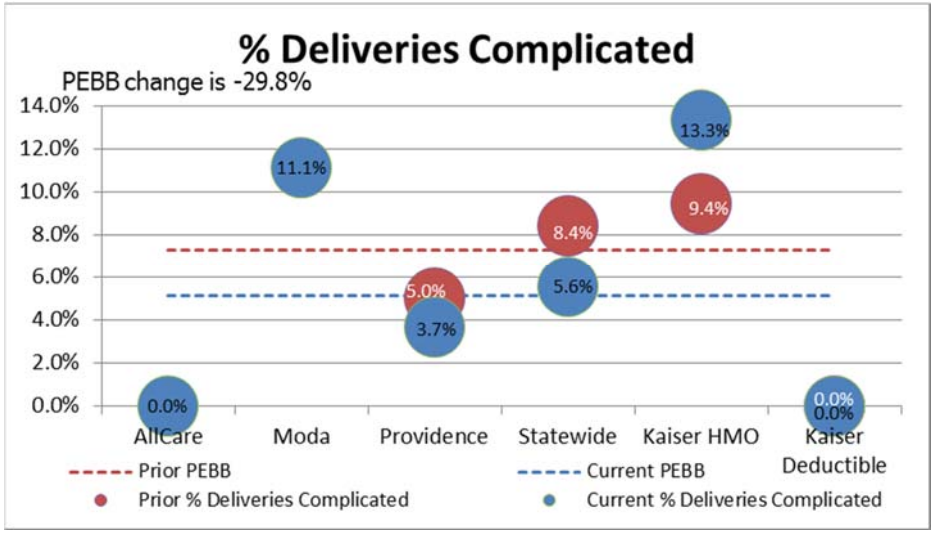

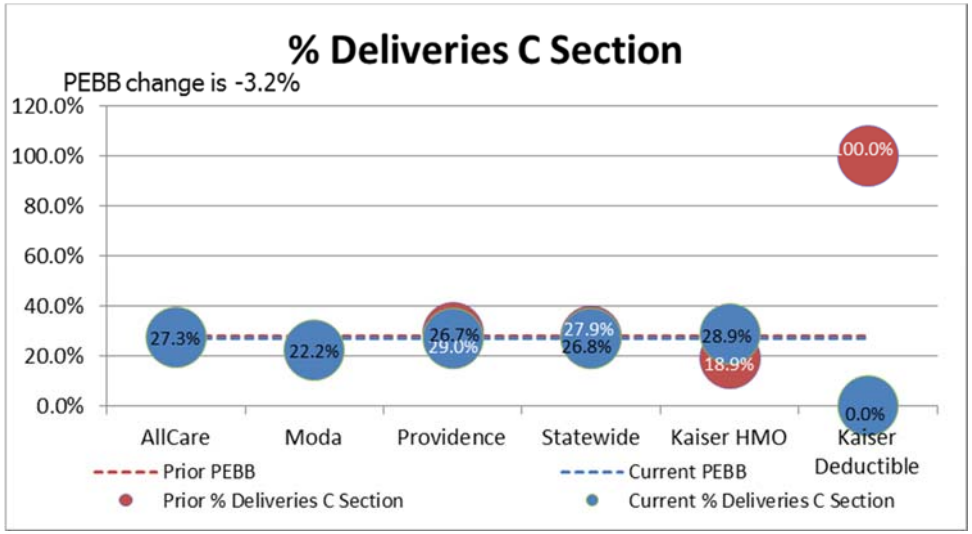

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GLOSSARY

Glossary Definitions, Part 1
Age Gender Score is calculated as the allowed amount PMPY Med & Rx for the US Total MarketScan client-specific age/gender adjusted benchmark, divided by the raw non-adjusted allowed amount PMPY Med & Rx for the US total MarketScan Benchmark. The adjusted benchmark (numerator) is client specific based on the age/gender mix of the population; the non-adjusted value (denominator) is the same across all clients. The numerator varies when we update the new Marketscan benchmarks (once a year), and if there is a shift in the age/gender mix of the population when the score is recalculated with each dashboard run.
Allowed Amt Med + Rx Cost Per Patient represents the average amount of submitted charges eligible for payment for services provided under medical coverage as well as prescriptions filled that are included in condition specific episodes of care, per condition specific episode of care patient with appropriate coverage. It is the amount eligible after applying pricing guidelines, but before deducting third
Avoidable Admissions Per 1000 Members is the average number of acute admissions for conditions that generally would not result in inpatient admission if appropriate prior treatment occurred, per 1000 members with medical coverage per year.
Cervical Cancer Screening Rate identifies tests used to screen for cervical cancer that were performed on females, age 21 through 64.
Cholesterol Screening Rate identifies the cholesterol tests used to evaluate cholesterol levels as part of an adult (age 18 and older) cardiovascular assessment. Cholesterol tests are defined as lipid serum cholesterol tests and blood lipoprotein tests, including VLDL, HDL, IDL, and LDL.
Colon Cancer Screening Rate identifies the tests or procedures used to screen for colorectal cancer that were performed on adults, age 51-80.
Complications Per 1000 Patients is the average number of patients who received services provided under medical coverage that were reported on a claim with a principal or secondary diagnosis complication of care resulting from a healthcare intervention, per 1000 unique members with medical coverage.
Days Supply is the number of days that a prescription drug will provide treatment for.
Deliveries % Complicated is the number of deliveries where the patient was identified as having a delivery complication, expressed as a percentage of the total number of deliveries.
Discount is the discount amount for any plan pricing reductions for facility and professional services. This includes reasonable and customary charge discounts, negotiated discounts, fee schedule
Emergency Room Visits Per 1000 (**ER Visits**) is the average number of emergency room facility visits per 1000 members with medical coverage per year.
Generic Efficiency is the percentage of drugs filled as generic out of all drugs that could have been filled as generic.
Inpatient Admits Per 1000 (**IP Admits**) is the average number of acute admissions per 1000 members with medical coverage per year.
Inpatient Days Per 1000 (**IP Days**) is the average number of days from acute admissions per 1000 members with medical coverage per year.
Mammogram Screening Rate identifies the mammography procedures used to screen for breast cancer that were performed on females, age 40 - 69.
Member includes employees, spouses and children.

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GLOSSARY

Glossary Definitions, Part 2
Net Payment is the amount the plan paid. It represents the amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been
Out of Pocket is the amount paid out-of-pocket by the member for facility, professional, and prescription drug services. This generally includes coinsurance, copayment, and deductible amounts. expenses not covered by the plan and contributions required for plan enrollment.
Outpatient Surgeries Per 1000 (**OP Surgs**) is the average number of outpatient surgeries per 1000 members with medical coverage per year.
PEPM/PEPY: Per Employee Per Month and Per Employee Per Year. Paid PEPM/PEPY medical rates are calculated assuming a 2 month enrollment lag. Paid PEPM/PEPY prescription drug
PMPM/PMPY: Per Member Per Month and Per Member Per Year. Paid PMPM/PMPY medical rates are calculated assuming a 2 month enrollment lag. Paid PMPM/PMPY prescription drug rates
Physician Office Visits Per 1000 (**Dr. OVs**) is the average number of professional office visits, per 1000 members with medical coverage per year.
Preventive Care Visits is the Percentage of unique members who had a preventive visit and defined by service subcategory *24.
Preventive Screening Rates (Colon Cancer, PSA, Mammogram, Cholesterol, Cervical Cancer) are the number of patients who received facility or professional preventive screening services, expressed as a percentage of the average number of members for whom this test is appropriate.
PSA Screening Rate identifies the Prostate Specific Antigen (PSA) tests used to screen for prostate cancer that were performed on males, age 50 and older.
Readmission Rate Per 1000 is the average number of acute admissions that occurred within 15 days of a previous acute care admission for the same patient, regardless of the diagnosis, per medical coverage per year.
Relative Risk Score provides the expected health risk of a group relative to a mean score of 100. The risk score reflects the underlying illness burden of a group based on age, sex and diagnosis data for group members. Scores were developed using the Diagnostic Cost Group (DCG) method developed by Verisk HealthCare, Inc. A score greater than 100 indicates that a group has a higher than average burden of illness; a score less than 100 indicates a more favorable level of health risk compared to MarketScan average.
Scripts Per 1000 Rx is the average number of prescriptions filled per 1000 members with prescription drug coverage per year. The number of prescriptions filled is generally equal to the number of original or replacement pharmacy claims minus the number of voided pharmacy claims.
Submitted Charge is the amount of charges submitted by the provider for all claims. It represents the gross charge amount before applying pricing guidelines or deducting third party, copayment, coinsurance, or deductible amounts.
Third Party Payments are the portion of Submitted charges paid by other plans through coordination with your group's plan.

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