HEALTH POLICY AND ANALYTICS
Oregon Educators Benefit Board

Kate Brown, Governor

Oregon Educators Benefit Board
Tuesday, December 1, 2020 – 1:00 p.m. to 3:30 p.m.
Video Conferencing Only

Click here to join the meeting

AGENDA

I.	1:00 p.m. – 1:05 p.m. Attachment 1 **ACTION**	**Call to order and approval of November 3, 2020 Board meeting minutes.** *Geoff Brown, Chair*
II.	1:05 p.m. – 1:25 p.m. Attachment 2	**COVID In-depth Analysis** *Jenny Marks and Brad Lawson, Willis Towers Watson*
III.	1:25 p.m. – 1:35 p.m. Attachment 3 **ACTION**	**SB 889 Committee Update – VBP Compact** *Sarah Bartlemann SB 889 Committee and Chris DeMars, Transformation Center Director*
IV.	1:35 p.m. – 1:45p.m.	**Director's Report** *Ali Hassoun, Director*
V.	1:45 p.m. – 1:55 p.m. Attachment 4	**Secretary of State Audit** *Ali Hassoun, PEBB/OEBB Director*
VI.	1:55 p.m. – 2:15 p.m. Attachment 5	**State of OEBB (information)** *Geoff Brown, Chair*
	2:15 p.m. – 2:25 p.m.	**BREAK**
VII.	2:25 p.m. – 2:35 p.m. Attachment 6	**Double Coverage Surcharge Report** *Linda Freeze, Benefits Manager*

VIII. 2:35 p.m. – 2:45 p.m. **SEOW Update**

Tom Syltebo, SEOW Chair

IX. 2:45 p.m. – 3:05 p.m. **Minimum Premium Presentation**
Attachment 7

Jenny Marks and Brad Lawson, Willis Towers Watson

X. 3:05 p.m. – 3:25 p.m. **Renewal Considerations/Timing**
Attachment 8
ACTION

Jenny Marks and Brad Lawson, Willis Towers Watson

XI. 3:25 p.m. – 3:30 p.m. **Other Business and Public Comment**

Adjourn

Oregon Educators Benefit Board
Meeting Minutes
November 3, 2020

The Oregon Educators Benefit Board held a regular meeting via video conference on November 3, 2020. Chair Geoff Brown called the meeting to order at 1:00 p.m.

Attendees (via phone)

Board Members:
Geoff Brown, Chair
Robert Young, Vice Chair
Bill Graupp
Bonnie Luisi
Susan Miller
Susan Rieke-Smith
JJ Scofield
Reed Scott-Schwalbach
Bob Stewart
Tom Syltebo

OEBB Staff:
Ali Hassoun, Director
Cindy Bowman, Director of Operations
Damian Brayko, Deputy Director
Rose Mann, Board Policy and Program Coordinator

Consultants:
Jenny Marks, Willis Towers Watson
Brad Lawson, Willis Towers Watson (via phone)

ଔ ଔ ଔ ଔ

I. Call to order, rollcall and approval of the October 6, 2020 Board Meeting Minutes (Attachment 1)

MOTION

JJ Scofield moved to approve the October 6, 2020 OEBB Board minutes. Reed Scott-Schwalbach seconded the motion. The motion carried unanimously.

II. OEBB Provider Diversity and Access (Attachments 2 and 3)

Kaiser – Sophary Sturdevant, Executive Account Manager, Keith Bachman MD, Internal Medicine, Permanent Quality Ambassador, Gwendolyn Turner, Equity, Inclusion, Diversity and Talent Engagement, Permanente Medicine and Michelle Teeples, Senior Director of Mental Health

Moda – Dr. Johnson, MD, MBA,FACS, President Moda Health, Karis Stoudamire-Phillips, Corporate Social Responsibility Director, Erica Hedberg, Manager, Government Programs, Astrid Sosa – Health Equity Administrator and John Clouse, Sr. Manager Data Science

III. Telehealth Utilization and Long-term Visioning/Strategies

WTW - Jenny Marks and Brad Lawson

Kaiser - George Go, MD, Director of Operations, Telehealth and Convenient Care and Keith Bachman, MD, Internal Medicine, Permanente Quality Ambassador

Moda Health Plans – Bill Dwyer, Director, Analytics and Erica Hedberg, Account Manager, Government Programs

IV. SEOW Update

Tom Syltebo, SEOW Chair, presented an update on SEOW.

V. Innovation Workgroup Update

Geoff Brown, IW Chair and JJ Scofield, IW Member presented an update on the Innovation Workgroup.

VI. Carrier and WTW Comments on Hospital Cap Rules

WTW: Jenny Marks and Brad Lawson
Kaiser: Becky Williams, VP, CFO

Moda Health Plans: Kraig Anderson, Sr. VVP and Chief Actuary

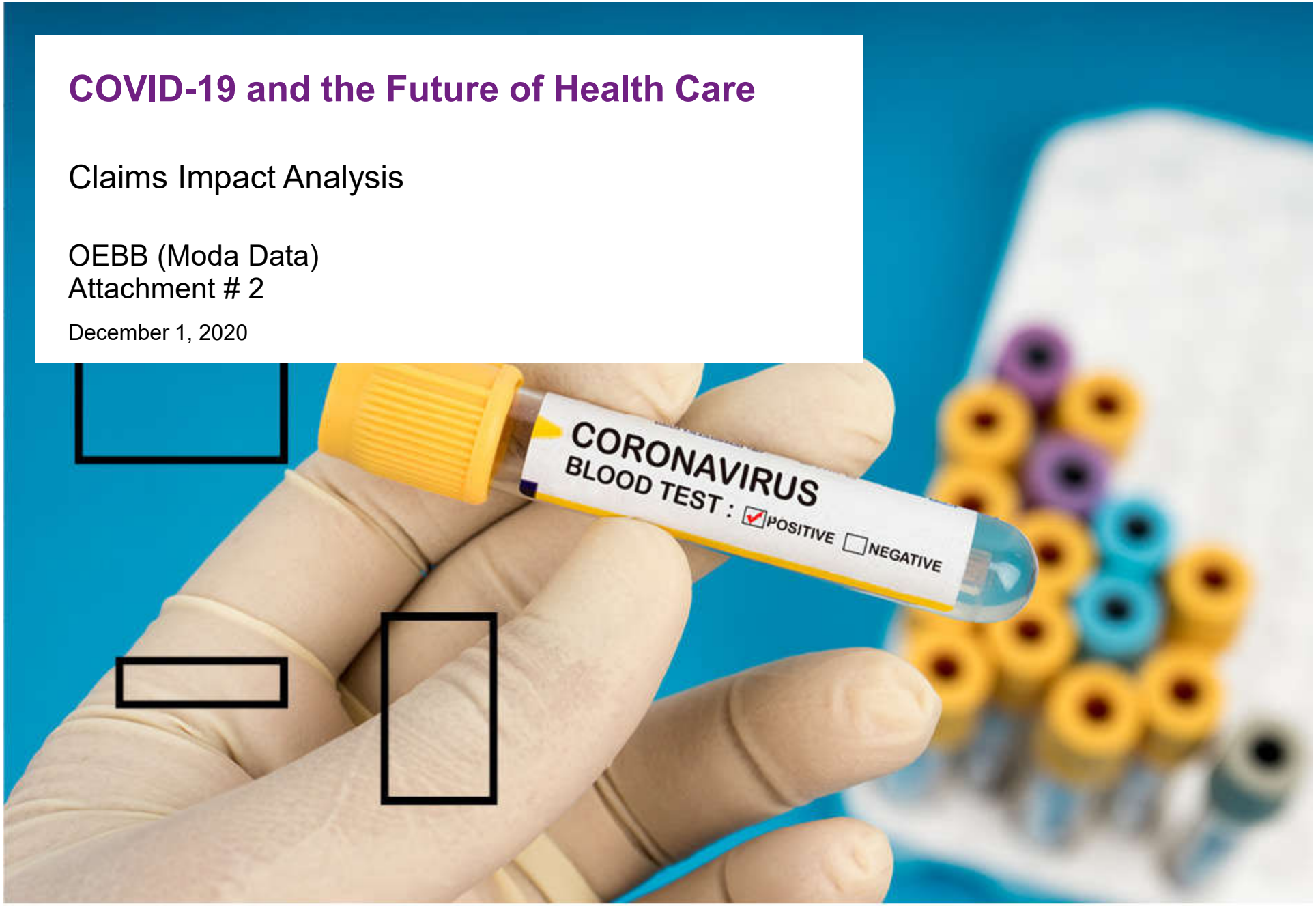
There being no further business to come before the Board, Chair Geoff Brown adjourned the meeting at 3:55 p.m.

COVID-19 and the Future of Health Care

Claims Impact Analysis

OEBB (Moda Data)
Attachment # 2

December 1, 2020



Willis Towers Watson

Disclaimer

This report was prepared for the sole and exclusive use of OEBB and on the basis agreed with OEBB. It was not prepared for use by any other party and may not address their needs, concerns or objectives. This report should not be disclosed or distributed to any third party other than as agreed with OEBB in writing. Willis Towers Watson does not assume any responsibility or accept any duty of care or liability to any third party who may obtain a copy of this report and any reliance placed by such party on it is entirely at their own risk.

Overview

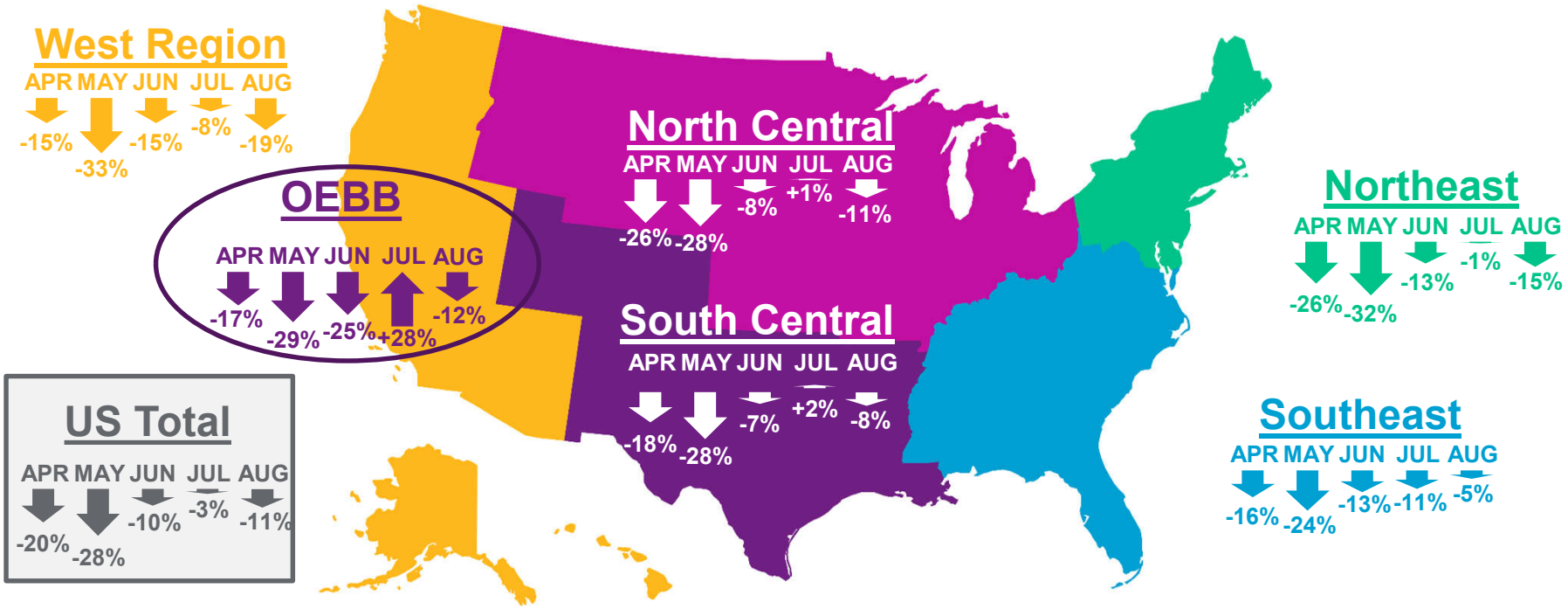
- In 2020, COVID-19 quickly changed health care delivery and utilization in ways unforeseen
- The COVID-19 pandemic has underscored the importance and usefulness of data to drive insights for strategic planning
- The full analysis provides a deep dive into:
  - Health care utilization as a result of COVID-19 and implications for health care value:
  - The influence of social determinants of health (SDoH) on health care utilization and outcomes
- The analysis includes Moda medical and pharmacy claim data
  - Prior period: incurred January – August 2019 with paid runout through September 2019
  - Current period: incurred January – August 2020 with paid runout through September 2020
- Kaiser data is not included in the analysis due to data lag

COVID-19 overview

COVID-19 Regional Impact on Health Care Spend

Benchmarks: Monthly Average of Change in Paid Claims Amount

- In most regions, the cost of COVID treatment and testing is far outweighed by reduced medical utilization (closure of hospitals, fear of seeking service, movement to lower cost telehealth services)
- Your employee's geography can significantly affect the timing and magnitude of these COVID-driven utilization changes:



- It's likely that a portion of services deferred will return in late 2020 or 2021, but continued COVID flare-ups could keep utilization suppressed in some areas

Source: Willis Towers Watson 2020 Health Care Financial Benchmarks Survey (N = 153, 1.0M EEs, $1.0B monthly claims)

Financial Overview

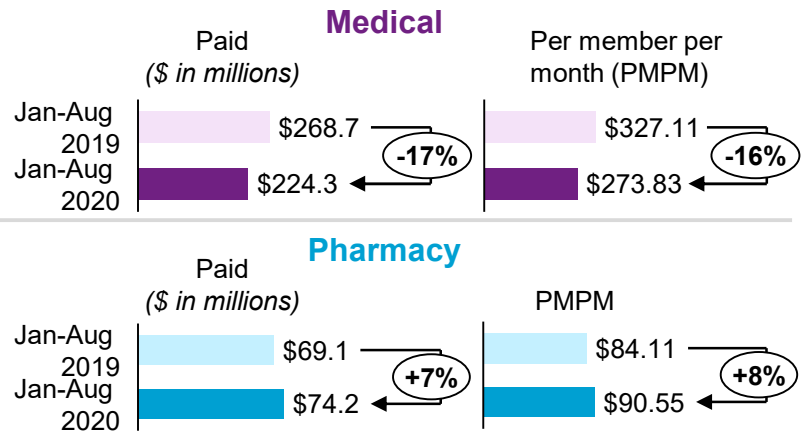
Incurred January – August with Paid Runout Through September

Insights

Insights

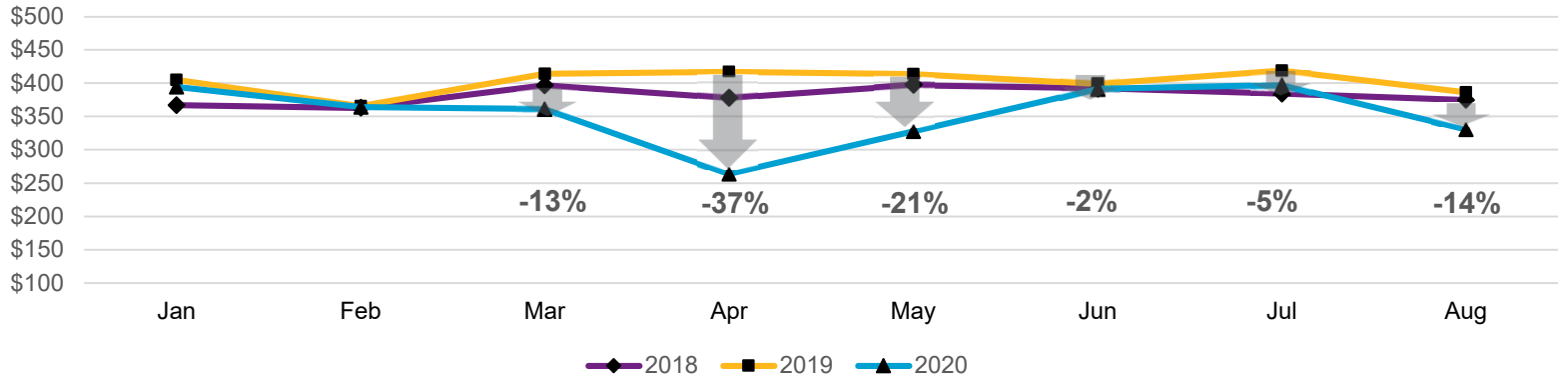
- Decrease in medical spend is expected to continue in 2020 as data continues to show a slow return of elective and non-emergency utilization
- Pharmacy spend under medical may increase in 4Q due to Remdesivir being approved for treatment of COVID-19
- Pharmacy spend increased in part due to stockpiling behavior and an ease in on 30-day supply limit restrictions
- For the plan year 2019 – 2020 OEBB paid claims are 12%, or $63M below the prior plan year
- For the plan year 2019 – 2020 OEBB paid claims are 6%, or $28M below the what was expected for the 2019 – 2020 plan year

Financials (incurred basis)



Monthly Incurred Medical and Pharmacy PMPM

January 2018 – Aug 2020



Medical YTD COVID-19 Financial Impact

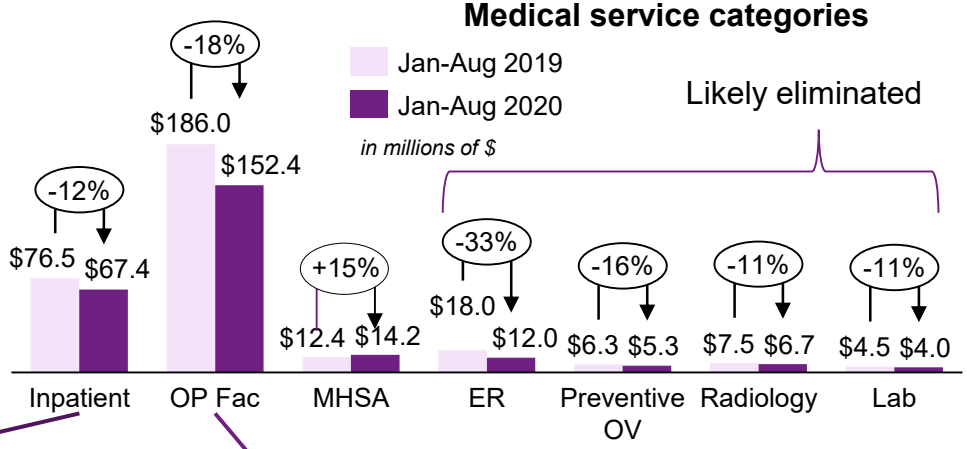
Incurred January – August with Paid Runout Through September

Medical and Rx paid

($ in millions)

Medical and Rx Paid PMPM

Medical service categories



Inpatient

Inpatient MDC categories with the largest period over period decreases

MDC Category	% change	YTD change in spend from prior period (in millions)
Circulatory	-27%	-$2.8M
Liver Pancreas	-36%	-$1.1M
MSK	-31%	-$3.4M
Nervous	-47%	-$2.6M

Outpatient

Outpatient MDC categories with the largest period over period decreases

MDC Category	% change	Estimated YTD change in spend from prior period (in millions)
Circulatory	-39%	$-5.4M
Digestive	-24%	-$4.0M
Ear, Nose, Mouth, Throat	-25%	-$2.4M
Nervous	-32%	-$3.2M

Insights

- Experts predicted health care costs would increase substantially, yet elimination and deferral of care have far outweighed the COVID-19 treatment costs
- Opportunities exist to prevent a portion of deferred care that is low-value care from returning to the health care system

COVID-19 overview

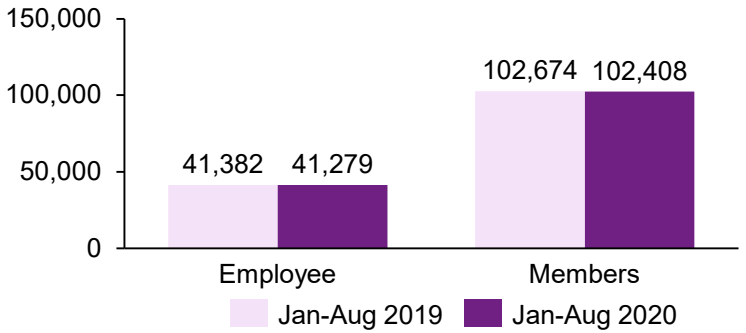
Medical Incurred January – September**

Insights

Insights

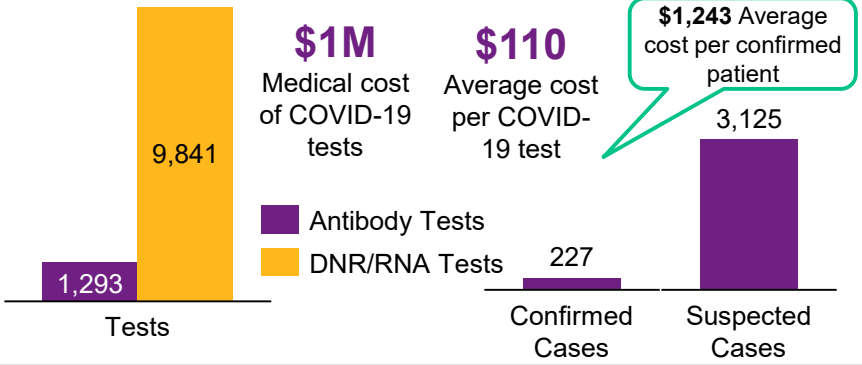
- As of late October 2020, U.S. total COVID-19 cases were 27.5 per 1,000*
- OEBB's COVID-19 case rate is 2.2 per 1,000 through September, which is significantly lower than the national rate
- The difference is largely due to the geographic distribution of OEBB's members in Oregon counties with lower COVID rates

Enrollment / Membership

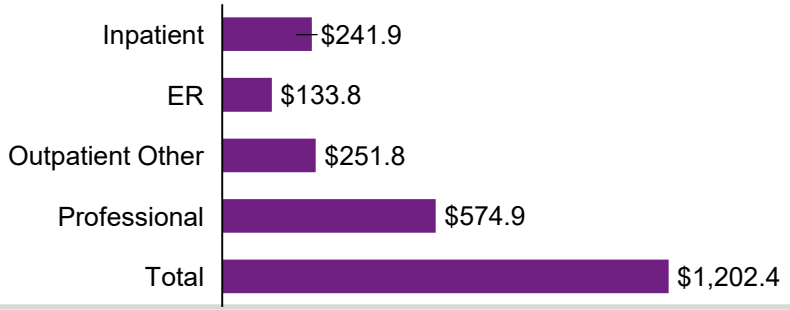


COVID-19 Cases and Spend

COVID-19 counts**



COVID-19 confirmed and suspected paid amount ($000s)**



*https://www.worldometers.info/coronavirus/country/us/

** COVID diagnostic data through September

Case study: Behavioral health impact

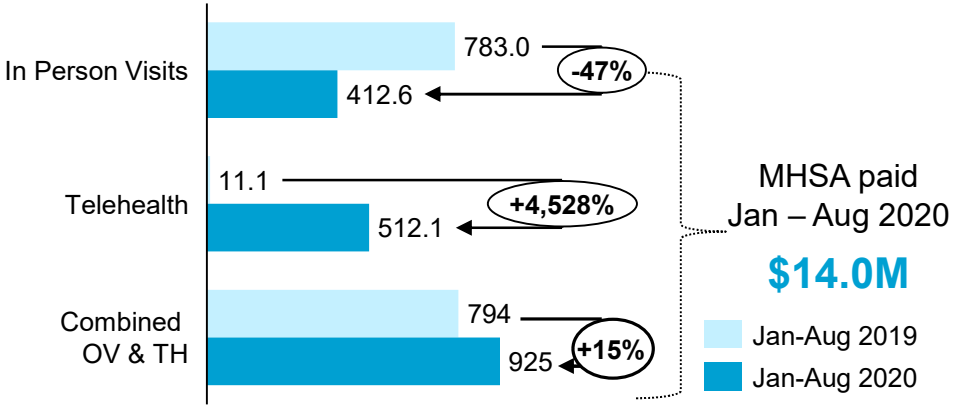
Medical incurred January – August with paid runout through September

Insights

Insights

- A Kaiser Family Foundation study found 45% of adults in the U.S. reported that their mental health has been negatively impacted due to worry and stress over the virus
- Behavioral health resources are needed to prevent poor mental health outcomes and/or loss of life
- In person visits were more than offset by adoption of virtual visits

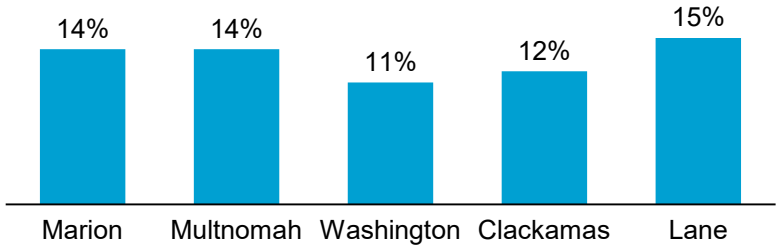
Behavioral Health Visits per 1,000



Value of Mitigating Change

SDoH county data for OEBB's top locations

Frequent mental distress
(% of adults > 14 days poor mental health in a month)



Ratio of mental health providers

Locations	County ratio
Marion	291:1
Multnomah	120:1
Washington	256:1
Clackamas	322:1
Lane	116:1

Case Study: Musculoskeletal

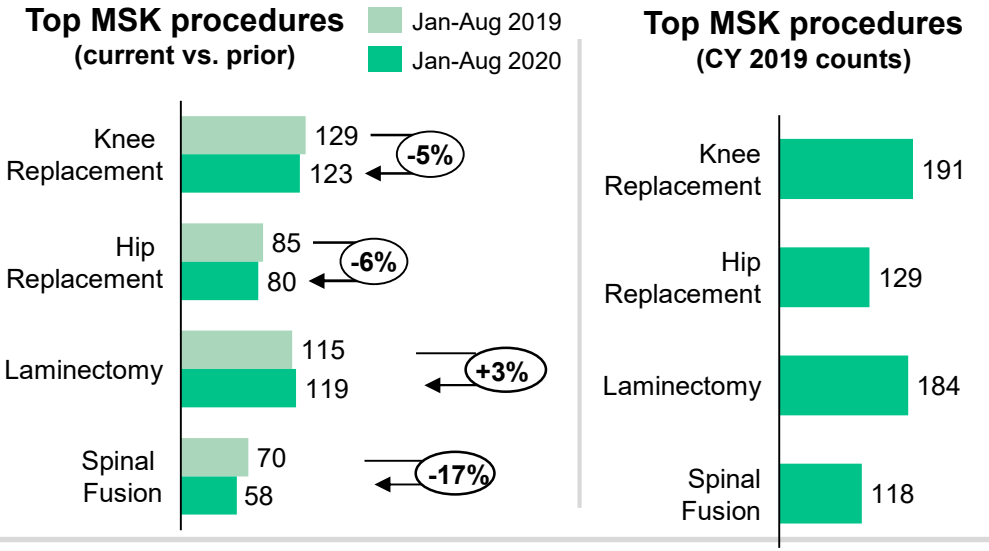
Medical Incurred January – August with Paid Runout Through September

Insights

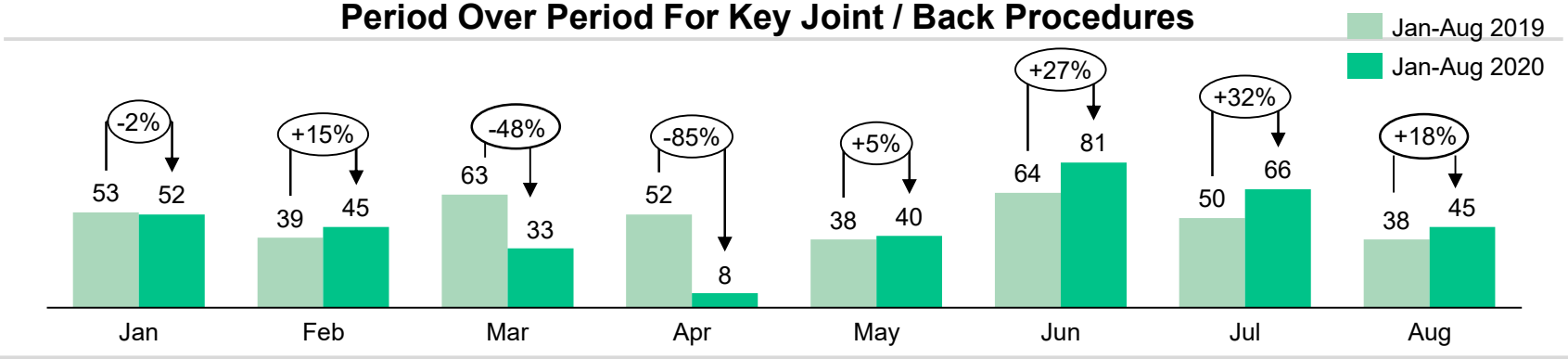
Insights

- Nearly 84% of all the orthopedic procedures performed in the U.S. have been delayed, postponed or canceled due to COVID-19*
- OEBB experienced period over period decreases in MSK procedures, period to date, March through June with increases through July and August
- Appropriately addressing and providing resources for pain management is top concern

Musculoskeletal Overview



Period Over Period For Key Joint / Back Procedures



*https://www.odtmag.com/content-microsite/odt_covid-19/2020-06-02/covid-19-to-impact-us-orthopedic-procedures-this-year

Health Care Cost Growth Target Implementation Committee:

Increasing the Use of Advanced Value-Based Payment

Chris DeMars
Director, Transformation Center
Deputy Director, Delivery Systems Innovation Office
Oregon Health Authority

Oregon Educators Benefit Board
OB Attachment 3
December 1, 2020

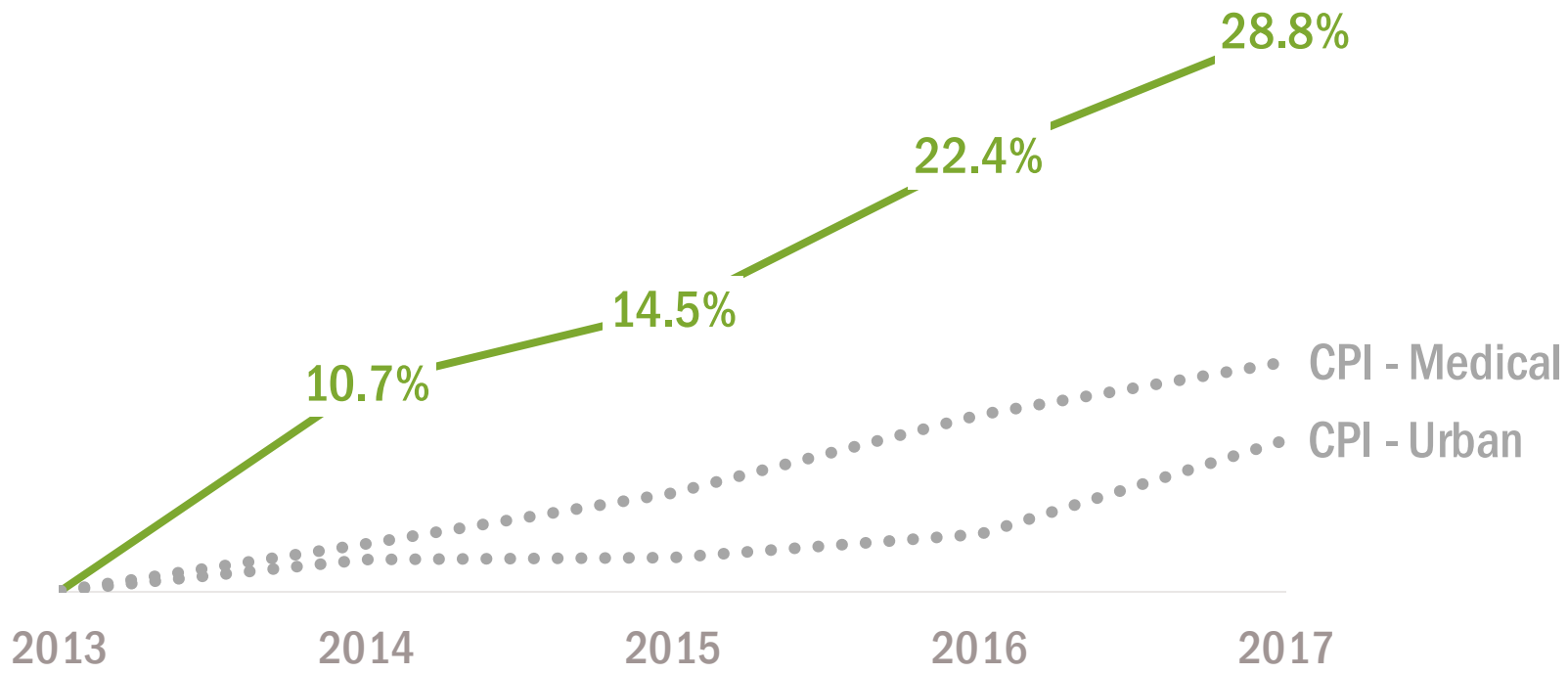
Agenda

- Context: Health Care Cost Growth Program
- Value-based Payment (VBP)
- Review: VBP Principles & VBP Compact Workgroup Charter

Context: Health Care Cost Growth Target Program

Problem: health care costs are growing

Total paid amounts per person increased 6.5 percent on average from 2013-2017.



APAC
ALL PAYER • ALL CLAIMS

Source: Oregon's All Payer All Claims database. Includes only claims-based payments for all lines of business. Non-claims payments such as value-based payments or alternative payment methodologies are not included. Carriers' profit margin and administrative overhead not included.

Solution: statewide cost growth target

Common goal

Payers and providers are publicly responsible for reducing health care cost growth.

Sustainable target

Selecting a target that ensures health care costs do not outpace other economic growth, such as general inflation or wages.

Transparency

Reasons for cost growth are studied and publicized, informing policy recommendations.

Total cost of care approach

Taking a total cost approach allows payers and providers to shift from volume to value-based approaches.

Health Care Cost Growth Target Implementation Committee Workstreams

Focus of today's conversation

Cost Growth Target

Data Use Strategy

Quality and Equity

Accountability

Taking Action

Value-based Payment

Taking Action

SB 889 requires the Implementation Committee to identify opportunities to lower cost, including looking at innovative payment models and transparency.

The Committee adopted Principles for increasing the use of advanced value-based payment (VBP) models in October.

https://www.oregon.gov/oha/HPA/HP/HCCGBMeetingDocs/VBP%20principles%20FINAL%2010.6.20.pdf

Implementing the VBP Principles

Stakeholders sign a voluntary VBP Compact, based on VBP Principles

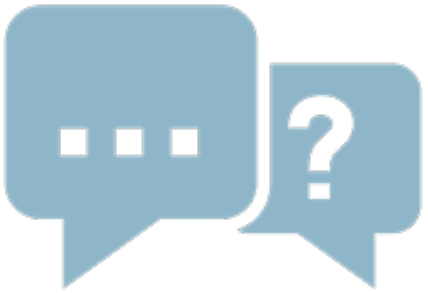
OHA staffs a VBP Compact Workgroup to support implementation

Review: VBP Principles & VBP Compact Workgroup Charter

Review

- VBP Principles
  - Advanced VBP models are a critical strategy to contain costs to meet the health care cost growth target.
    - Prospective budget-based & quality-linked payment should be the primary model used, when feasible
    - When they are not feasible, VBP models that include shared savings and downside risk should be used
    - Principles include specific VBP targets
  - VBP models should be designed to promote health equity & mitigate adverse impacts on populations experiencing health inequities

- VBP Compact Workgroup Charter
  - Drafted by representatives from OHA, Oregon Health Leadership Council, Oregon Association of Hospitals and Health Systems, Oregon Medical Association and PEBB
  - Charge: The Workgroup will identify paths to accelerate the adoption of VBP across the state; highlight challenges and barriers to implementation and recommend policy change and solutions; coordinate and align with other state VBP efforts; and monitor progress on achieving the Compact principles, including the VBP targets.



Questions? Reactions?

Is OEBB able to commit to signing the future VBP Compact, which will be based on the VBP Principles?

Embargoed Until Wednesday, November 25, 2020 at 10:00am

Secretary of State
Oregon Audits Division

Oregon Health Authority: Public Employees' Benefit Board and the Oregon Educator's Benefit Board

Efforts Have Helped Limit Some Employee Health Care Costs, but PEBB and OEBB Can Do More to Manage Costs and Optimize Benefits

November 2020
Report 2020-39

Secretary of State Bev Clarno
Audits Division Director Kip Memmott

Embargoed Until Wednesday, November 25, 2020 at 10:00am

Secretary of State
Oregon Audits Division

Executive Summary

Oregon Health Authority: Public Employees' Benefit Board and the Oregon Educator's Benefit Board

Efforts Have Helped Limit Some Employee Health Care Costs, but PEBB and OEBB Can Do More to Manage Costs and Optimize Benefits

Why This Audit is Important

» Industry health care costs and premiums are continuing to significantly increase. Overall national health spending is projected to grow to nearly $6.2 trillion by 2028 and is unsustainable.

» Health insurance is a part of state employees' compensation, and, when combined with salaries and other benefits, helps the state meet its competitive employment goals.

» The Public Employees' Benefit Board (PEBB) administers health plans for 143,890 state government and university employees and their dependents.

» The Oregon Educator's Benefit Board (OEBB) administers health plans for about 157,860 school district, education service district, and community college employees and their dependents.

» The state only allows PEBB and OEBB premiums and claims costs to increase 3.4% per member per year. Health commercial insurance market trends are nearly double that — ranging from 7% to 8% for PEBB and 8% to 9% for OEBB.

What We Found

1. PEBB and OEBB have kept the growth in premiums relatively low, charged less than allowed for administrative fees, and implemented multiple cost containment strategies. (pg. 9)

2. PEBB and OEBB seem to effectively communicate open enrollment information. However, the programs fall short on member education on benefit use, transparency about board efforts to control costs, and obtaining feedback from employers and members. (pg. 11)

3. PEBB and OEBB rely on contractors for much of the work needed to provide health and wellness benefits. Our limited review of consultant contracts and invoices identified concerns with contract monitoring, contract terms, consultant invoices, and claims oversight. (pg. 13)

4. PEBB's reserve balance was significantly reduced by a $120 million legislative sweep, triggering a $12 million federal penalty. The board does not have a strategic plan for how to use reserve funds when the reserve accumulates more than needed to address claims and other program costs. (pg. 14)

5. Thirteen school districts obtain their health insurance outside of OEBB. These districts are not held to the legislative requirements that OEBB must adhere to and their health benefit costs and steps taken to contain costs are not publicly transparent. (pg. 15)

What We Recommend

Our report includes seven recommendations to PEBB and OEBB to further address managing health care benefit costs for state, university, community college, and K-12 employees. PEBB and OEBB agreed with all of our recommendations. Their response can be found at the end of the report.

We also offered two suggestions for the Legislature to consider.

The Oregon Secretary of State Audits Division is an independent, nonpartisan organization that conducts audits based on objective, reliable information to help state government operate more efficiently and effectively. The summary above should be considered in connection with a careful review of the full report.

Introduction

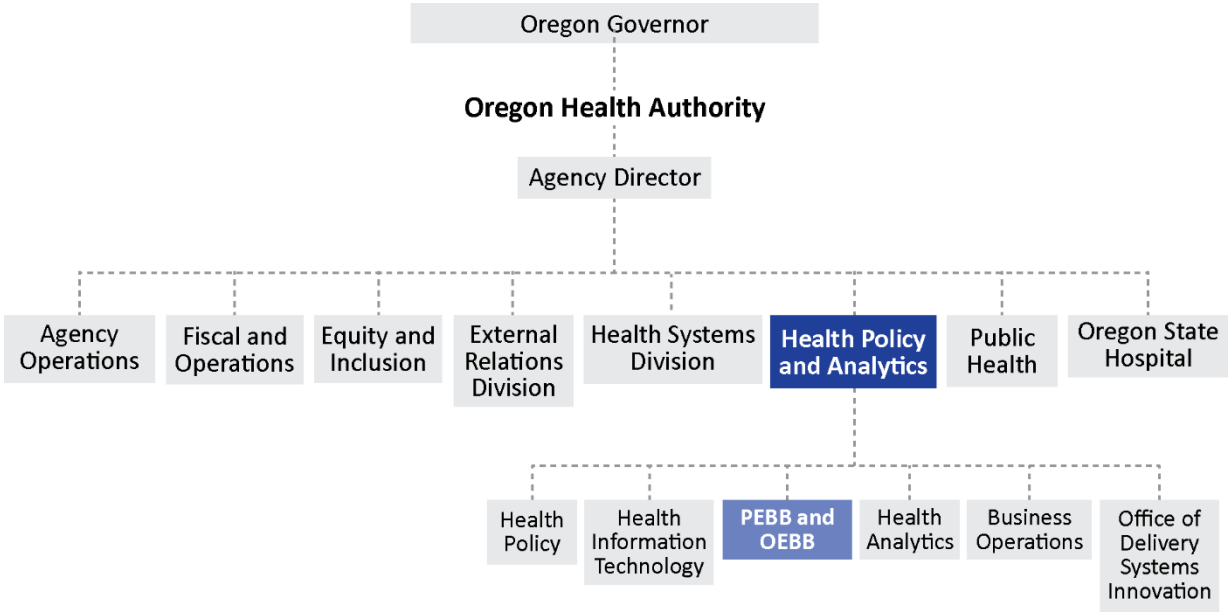
"Behind Medicaid, state and local employer contributions to public employee health insurance premiums represent the second largest cost driver for state health care expenditures."

- National Conference of State Legislatures

Like other states, employee health benefit plans for Oregon state workers have attracted attention from legislators, governor, and policymakers, often due to the impact of increasing health care benefits, a part of employee compensation. Health plan premiums are rapidly rising in states and other costs (e.g., deductibles and out-of-pocket costs) are also on the rise.

The Public Employees' Benefit Board (PEBB) and Oregon Educator's Benefit Board (OEBB) are responsible for providing health benefits to state workers and educators. In response to rising health care costs, the Oregon Legislature mandated an annual growth cap on per member costs and other cost containment requirements for state employees' health benefits in 2017. While the boards have been meeting this requirement, continuing to do so is challenging given the market in which the boards operate.

The purpose of our audit was to evaluate how PEBB and OEBB are managing health care benefit costs. Our audit work was limited due to the disruption caused by COVID-19 and its impact on the health care system and audit resources.



Oregon offers high-valued health benefits that help to mitigate lower employee wages

A 2015 Economic Policy Institute national report found government employees earned less than similar private-sector workers, despite having higher education levels. To address the wage disparity and entice people to work in public service, state agencies offset some of the difference with generous health and retirement benefits.

Two studies recently examined benefits for Oregon state workers compared to its neighbors. Milliman, commissioned by the Oregon Business Council, reported its study in 2019 and examined the value of health care benefits provided to Oregon's state workers compared to four

neighboring states — California, Idaho, Nevada, and Washington.[1] The study found, when comparing the costs of the most popular health plan in each state, Oregon state employees had the highest average total premium, employee contribution to premiums were the lowest, and employees paid a lower share of medical costs than three of the other states. For Oregon teachers, the study found the total premiums were generally lower than California or Washington, though there was wide variation in the premium contribution paid by teachers.

The Oregon Department of Administrative Services conducts a compensation study every two years, most recently in 2018. This study measured compensation of state workers against compensation in the sectors it most frequently competes in for applicants: county workers, neighboring states, and the private market.[2] The study found Oregon state workers have a lower wage than their counterparts, the state provides a comprehensive benefit plan consistent with those found in comparison markets, the employer health plan cost is similar to comparison markets, the health plan is more generous with lower out-of-pocket costs for employees, and total employee compensation (salaries and benefits) was 97.5% of market on average. This percentage is within Oregon's stated goal of compensating employees within 95% to 105% of the market range.

PEBB and OEBB administer health care benefits to over 301,000 Oregonians

Most states, like Oregon, have a dedicated agency to manage state employee health care plans, and at least 13 states have educator health care handled at a state level, either through a dedicated agency or combined with the state employee coverage. Oregon and many other states allow smaller entities — such as municipalities and districts — to opt into a state-administered plan.

Oregon administers benefits to public employees through two separate boards: PEBB for public employees and OEBB for educators. Together, the two boards are responsible for managing state employee health care plans to over 301,000 employees and their dependents, or about 7% of Oregonians.

Each board operates independently, has its own budget, and is comprised of a mix of management and labor.[3] Each board contracts with a national actuarial firm to identify benchmarks for program cost and design, monitor spending and utilization, and conduct studies to determine effectiveness and feasibility of their goals for employee health care. The firms also act as negotiators for the boards when determining coverage and premium rates with insurance carriers. Standing workgroups, such as the Joint Innovation Workgroup and OEBB's Strategies on Evidence and Outcomes Workgroup, help the boards coordinate efforts and develop shared solutions to issues.

Program Vision Statements

PEBB: "We seek optimal health for our members through a system-of-care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible and affordable."

OEBB: "OEBB will work collaboratively with participating entities, 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."

---

[1] Milliman Report "Comparison of Health Benefits Offered to State Employees and Teachers." January 4, 2019.
[2] DAS' 2018 Oregon Salary and Benefit Report, https://www.oregon.gov/das/HR/Documents/Salary-benefit-report-2018.pdf.
[3] By statute, PEBB and OEBB members serve four-year, repeatable terms. PEBB has at least eight voting members (four members represent the state as an employer and four represent employees) and two non-voting members who are also members of the Legislature. OEBB has at least ten voting members (four members represent the district boards and management, four represent employees, and two with expertise in health policy or risk management).

While the boards share many similarities and have an established partnership to deliver on their missions, there are notable differences.

Figure 1: PEBB and OEBB have some notable differences in how they administer their plans

	PEBB	OEBB
Plan Year	January 1 – December 31	October 1 – September 30
Employers	100+ state agencies, universities, state library, semi-independent agencies	250+ school districts, community colleges, education service districts, counties
Member Enrollment	56,610 employees/subscribers 143,890 total lives covered	66,040 employees/subscribers 157,860 total lives covered
Employer Contribution	Agencies pay 95% or 99%, and universities pay 95% or 97%, depending on plan choice	Each employer determines contribution amount
Plan Offerings	IRS Section 125 Cafeteria Plan – all employers must offer all 5 plans to all employees	Operates like an "Exchange of Plans" – each employer can choose to offer a subset of plans, or all 10 plans, to employees

For example, PEBB is largely self-funded meaning the board is responsible for paying the cost of members' claims and must carry enough reserves to cover the risk of expensive claims. Self-funding is a strategy where the employer (in this case, the state) pays a third-party administrator to process health care claims, but the employer is the payer of the claims. This gives more control over the benefits offered and eliminates most premium taxes, though it carries with it the financial risk for setting the premium levels and paying claims. Whereas with fully insured health plans, the insurance carrier is responsible for setting premiums and paying the medical costs. For the 2019 plan year, about 81% of PEBB members were enrolled in PEBB's self-funded medical plans, either Providence or Moda plans, and 19% were in fully insured plans offered by Kaiser. OEBB has many plan options, but all are fully insured.

PEBB also administers a "cafeteria plan," which requires all members be allowed to choose from all plans. In contrast, OEBB is set up as a health care exchange, providing a wide variety of plan options to meet the needs of its diverse membership, which are primarily school districts.

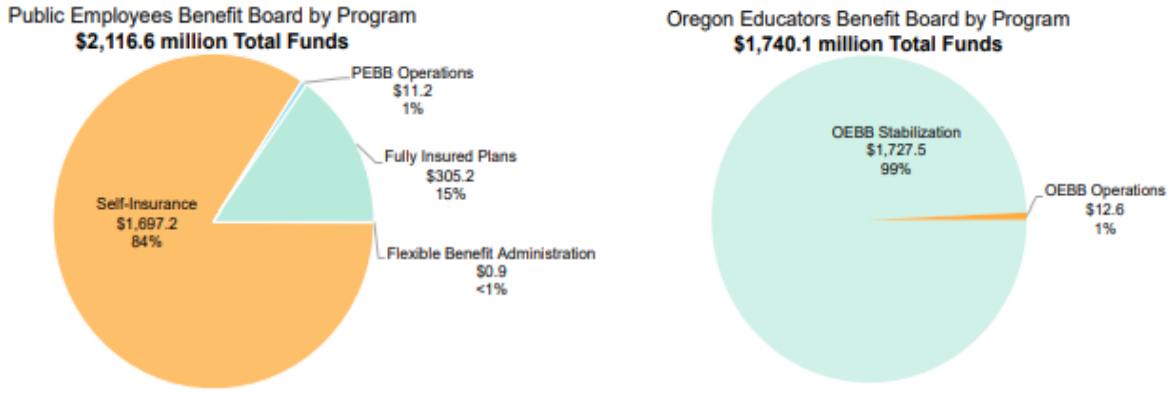
PEBB and OEBB are budgeted with Other Funds, revenue received from premium payments collected for all insured individuals.[4] Their combined 2019-21 legislatively adopted budget was $3.86 billion. As legislatively mandated by Senate Bill 1067, passed in 2017, PEBB and OEBB administrative functions were combined in 2018 to about 40 staff positions.

PEBB and OEBB program operations are funded through an administrative charge that is added to medical and dental insurance premiums. By statute, the administrative charge cannot exceed 2% of monthly premiums. Both programs are charging less than the 2% cap. For PEBB, the administration rate for the 2020 plan year is 0.90%. For OEBB, the administration rate is 1.3% for the 2019-20 plan year.

Our plan to analyze further cost details was halted due to complications and competing priorities arising from COVID-19.

[4] Of the PEBB premium payments collected from agencies and universities, nearly 45% is paid with General Fund moneys. According to program management, OEBB is estimated to derive approximately 57% of premiums from General Fund moneys.

Figure 2: PEBB and OEBB have a combined legislatively adopted budget of approximately $3.86 billion for 2019-21 biennium



Source: OHA 2021-23 Agency Request Budget

PEBB and OEBB benefits offer multiple plan choices with key decisions left to employers and members

PEBB and OEBB benefits offered to employers and members are based on factors such as union bargaining agreements, board mission and goals, and state mandates and directives. The boards annually negotiate with multiple insurance carriers to provide medical health plan coverage to members. Though there are different carriers, the coverage is similar with varying cost structures with the exception of OEBB high-deductible plans.

PEBB offers five medical plans, consisting of:

- Providence PEBB Statewide (36% members enrolled);
- Providence Choice (35% members enrolled);
- Kaiser Permanente Traditional (15% members enrolled);
- Kaiser Permanente Deductible (3% members enrolled); and
- Moda (9% members enrolled).[5]

OEBB offers 10 medical plans, consisting of:

- Seven Moda plans (71% members enrolled); and
- Three Kaiser Permanente plans (21% members enrolled).[6]

PEBB members select one of the five available plans. For those in OEBB, districts select which of the ten plans to offer their employees — some districts offer all plans, and some choose to offer less — and employees select a plan from those offered.

Union negotiations with employers participating in PEBB and OEBB dictate the employee contribution amounts and health care coverage to be offered. For PEBB, many state agency employees pay 1% or 5% of the monthly premium depending on the health care plan they selected.[7] For OEBB members, employees pay any remaining premium costs for the plan they

---

[5] Current enrollee counts as of March 2019, includes both employed and retired members (Kaiser enrollee counts were estimated between the two plans). There were approximately 2% of employees that did not enroll for PEBB medical coverage. Within each medical plan, there is a part-time employee plan offered. Also, Providence and Moda are self-funded medical insurance coverage.
[6] Current enrollee counts for the October 2018 to September 2019 benefit year, includes both employed and retired members. There were approximately 7% of employees that did not enroll for OEBB medical coverage.
[7] Some university employees pay either 3% or 5% of the monthly premium for PEBB plans.

select beyond what employers have agreed to contribute for coverage. Beyond contributing to the insurance premium either through PEBB or OEBB, covered employees must pay a share of the cost (e.g., deductible, copays, and coinsurance) when they use health care services.

PEBB participant premiums are based on four different coverage tiers: employee only, employee and children, employee and spouse or domestic partner, and employee and family. The premiums vary by the level of dependent coverage the employee selects. Dependents that can be covered include a current spouse, domestic partner, or an eligible dependent child. OEBB employers either use the four-tier structure or have one composite rate, which is one rate for all employees regardless of how many dependents are covered, for premiums.

Deductible: Amount employee pays before the plan begins paying for covered services.

Copays: A flat fee the employee pays for a covered service.

Coinsurance: Employee's share of a covered service after the deductible has been met (e.g., 20%).

Out-of-Pocket Maximum: The most employees will pay with a plan year for covered services.

Premium: The monthly cost for an employee's medical plan, which is shared between the employer and the employee.

Eligible retirees wishing to continue PEBB or OEBB coverage can do so until they qualify for Medicare, and they must self-pay the entire premium. Some OEBB employers contribute towards the premium cost for eligible retirees' health care.

Besides medical plans, PEBB and OEBB offer wellness programs, such as Healthy Team Healthy U and WW (Weight Watchers Reimagined) and coordinate dental and vision benefit plans. They also offer optional benefits for employers and members, such as life insurance, long-term care insurance, disability insurance, and an employee assistance program. PEBB also offers flexible spending accounts and commuter accounts.

Oregon legislative mandates seek to manage and contain the state's overall health care costs as well as PEBB and OEBB costs

With health care inflation rates exceeding the rate of state revenue growth, health care is taking a larger share of the state budget. Oregon's Legislature has implemented programs and initiatives to help contain and manage the state's overall health care costs.

Figure 3: Examples of some steps Oregon has taken to help manage state health care costs

Program or Initiative	Description
Oregon Health Policy Board	This board, created in 2009, is charged with overseeing the development and implementation of state health care policy.
Medicaid Coordinated Care Organizations	In 2012, Oregon changed its Medicaid program by establishing coordinated care organizations. The organizations provide a model to have health care providers work together in their local communities, focus on prevention, and help people manage chronic conditions.
Health Plan Quality Metrics Committee	This committee, established by 2015 legislation, is the single body created to align health outcome and quality measures used in Oregon and ensure measures and requirements are coordinated, evidence-based, and focused on a long-term statewide vision.

Primary Care Transformation Initiative	Legislatively mandated in 2017, this initiative on Oregon's primary care health infrastructure was to support innovation and care improvement in primary care, besides reporting of medical spending for primary care by certain health care payer and requiring health insurance carriers and coordinated care organizations to allocate at least 12% of health care expenditures to primary care by 2023.
Oregon Health Care Cost Growth Benchmark Program	Legislation in 2019 created a program to set a state spending target for all insurance companies, hospitals, and health care providers to rein in the increasing costs of health care.
Universal Health Care Task Force	This task force was created to recommend, for the 2021 legislative session, a design for a publicly funded health care plan for all Oregonians that provides equitable, affordable, comprehensive, and high-quality health care to all residents.

Further, with increasing pharmaceutical costs, Oregon enacted the Prescription Drug Price Transparency Act in 2018 to provide accountability of specific cost and price information from pharmaceutical manufacturers and health insurers.[8]

Oregon's Legislature also mandated requirements to contain state health care costs in specific state government programs, including PEBB and OEBB.[9] Legislation in 2017 set forth PEBB and OEBB requirements, such as:

- Limiting both annual growth in per member expenditures for health services and health benefit plan premiums to no more than 3.4%;
- Limiting payments to in-network hospitals to 200% and out-of-network to 185% of the Medicare allowable rate;
- Appointing the executive director of PEBB as executive director of OEBB, and requiring the combination of administrative functions and operations of PEBB and OEBB to the greatest extent practicable;
- Requiring any actuarial or technical support contracts the board enters into be solicited at least every three years and defines certain proposal information to include;
- Instructing a carrier or third party to audit dependent eligibility annually (legislatively changed in 2019 to allow PEBB and OEBB to conduct these as frequently as determined by the board); and
- Prohibiting duplicate health benefit plan coverage by public employees and opt out payments to PEBB/OEBB double-covered employees (legislatively changed in 2019 to allow for a surcharge fee).

PEBB and OEBB have kept annual premium increases notably lower than Oregon's health insurance market trends

Premium rates for health insurance plans are subject to varying factors. For PEBB and OEBB, some factors are within their control (e.g., plan design, level of reserves and fund balances, and

[8] The Prescription Drug Price Transparency Act requires pharmaceutical manufacturers to report on new prescription drugs costing more than $670 a month, or a shorter course of treatment, within 30 days of introducing the drug, and prescription drugs that had net yearly price increases of 10% or more and had a price of $100 or more for a one-month supply or for a course of treatment lasting less than one month during the previous year.

[9] To help contain costs and create more predictable budget environments, Oregon capped health care cost increases for the Oregon Health Plan at two percentage points below the national trend starting in 2012, which resulted in a growth cap of 3.4% per member per year. The Legislature extended this cap to health care costs in the PEBB and OEBB budgets in 2019.

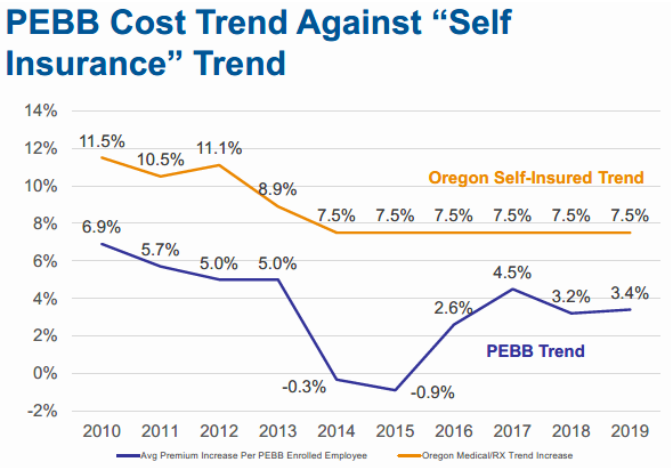
administrative costs), and some are not (e.g., age of members, the extent members use services, and health care inflation and market rates).

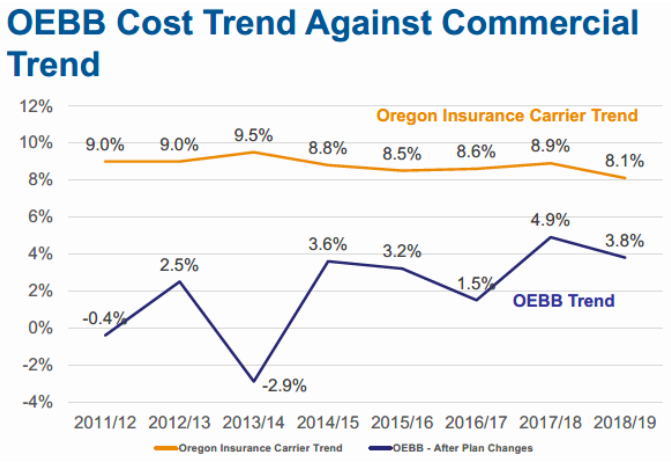
People get health coverage in a variety of ways, from employers, government program, and purchasing individually. **About 94% of Oregonians**, or approximately 3.9 million residents, **have health insurance**.

PEBB and OEBB contract with commercial health carriers to provide and manage health care coverage for their members. As such, premiums for fully insured plans and actual health care costs for self-insured plans are subject to the trends in those markets.

According to their actuaries, PEBB and OEBB have maintained their annual insurance cost increases at or below 3.4% since 2014, which was generally half the cost increases experienced in the commercial markets. Oregon's self-insurance market generally grew 7.5% a year and Oregon's commercial insurance market grew between 8% and 9% during the same time period.

Figure 4: PEBB and OEBB annual insurance health care premium costs have stayed lower than their relative market trends





Source: PEBB and OEBB actuarial consultant reports.

Each board appears to be outperforming national health care trends. OEBB's consultant reported that OEBB is 6% more efficient than national health care providers, and 4% more efficient than government health care providers for a 2018 savings of $45.5 million and $30.9 million, respectively.[10]

While the boards have been able to meet this requirement, management acknowledges keeping to that cap, when Oregon's commercial insurance market trend averages 6% to 7%, is its biggest challenge, as that equates to a combined annual savings requirement of $70 to $80 million.

PEBB and OEBB made some plan adjustments to facilitate health services with the COVID-19 pandemic

PEBB and OEBB have taken action to address potential concerns with benefit eligibility and plan costs with the COVID-19 pandemic. For example, the boards removed the member cost share for in-network testing and treatment related to COVID-19, as well as expanding telehealth services.

[10] The consultant's study involved 2,248 companies in 18 industry groups including governments across the United States and was normalized for four things to compare plans between entity groups - age and gender, family status (size), geography, and plan value.

Both programs also enacted a temporary rule through 2020 to continue health coverage for people in a leave without pay status due to COVID-19. Consultants have advised the boards that expenses are expected to drop in 2020 as elective procedures are cancelled. However, these costs are expected to be shifted to an upcoming plan year and this is a consideration in boards' decisions as they plan for unexpected expenses in future years.

Further, PEBB and OEBB created a webpage for members on resources to help with mental and physical wellbeing support during COVID-19, which are offered through the Employee Assistance Program and carriers.

Audit Results

Health care is an expensive and complex industry. PEBB and OEBB must balance containing health care costs in an environment where health costs continue to rise faster than inflation and meet their goals of improved member health. PEBB and OEBB go through a rigorous process each year of analyzing options and negotiating with carriers to meet cost and quality needs.

Our intended review of plan benefits, wellness programs, claims processing, and data handling, as well as cost analyses, were not conducted due to COVID-19 impacts on resources and priorities.

Our limited review found that PEBB and OEBB have implemented strategies to help address costs, but those strategies have some limitations. We also found areas where the program could make further improvements to help manage costs in: communication and member education, contract administration and oversight, and managing PEBB stabilization reserves. Additionally, while PEBB and OEBB have legislatively required caps placed on them that they have met, we found there is no similar directive for school districts outside of OEBB to contain health care costs.

Like other states, Oregon's PEBB and OEBB implement multiple strategies for state health care cost containment

PEBB and OEBB boards put forth considerable effort to try to provide quality benefits that are affordable to employers and members. They regularly use information from consultants, work groups, and program staff to explore cost containment measures. This includes budget, financial benchmarks, and other statistics, such as plan enrollment and benefit utilization. The boards also coordinate with the Oregon Health Policy Board and Oregon Health Authority on health initiatives and health plan quality metrics.

Half of Oregon adults have at least one chronic disease (e.g., cancer, lung or cardiovascular diseases, diabetes, or asthma), and **many citizens have risk factors for developing or complicating a disease**.

Each benefit year, PEBB and OEBB boards go through a rigorous process of decision-making to meet financial and benefit coverage goals. Boards review previous plan year information (e.g., aggregate costs, large claims, and chronic condition costs) and consultants present data from their national surveys of health plans and compare survey results to initial carrier offerings for the new plan year. This process involves multiple rounds of communication and negotiations with the carriers over the course of several months.

Both boards have implemented multiple recognized strategies to help manage plan costs. Examples of strategies include:

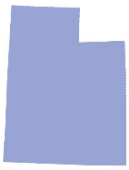
- pooling state employee health benefits with other entities (e.g., municipalities);
- reviewing costs and member utilization trends (e.g., different types of care obtained, where getting care, and specialty drug medications);
- prioritizing preventive care;
- moving to value-based payments for services;
- incentivizing members to select lower cost plans that promote the use of coordinate care;
- offering wellness services and programs; and
- regularly ensuring dependents are eligible.

Similarly, other states are addressing rising health care costs. A strategy used by nearly all the states is to offer self-funded plan options. PEBB offers multiple self-funded plans to members,

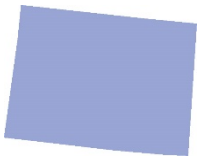
and OEBB offers only fully insured plans. Oregon has also considered the feasibility of modeling processes successful in other states such as Maryland's hospital payment rate setting process.

We found some states have taken unique initiatives to help reduce their health care costs that may be of benefit to Oregon. Recognizing each state varies widely on state employee health care plan eligibility, plan benefits, premiums, and cost-sharing arrangements, not all of these may be directly applicable in Oregon.[11]

Some other states provide financial incentives for members to shop for lower costs services from approved high-quality providers, known as right-to-shop programs. For example, Florida's shared savings program gives credits to a member's account or can be provided as a reimbursement for out-of-pocket medical expenses when members shop around and choose lower cost services on select procedures.



For Utah public employees, the state has a pharmacy tourism program. This program pays for members to travel to Canada or Mexico to fill prescriptions for certain high-cost medicines (e.g., multiple sclerosis disease modifying therapies, which have increased annually at rates five to seven times higher than prescription drug inflation). The state has found a three-month supply of these medications to be much less expensive in Canada or Mexico.



Colorado allows health care cooperatives to directly negotiate health care prices with providers. The Peak Health Alliance in Summit County found this approach reduced premiums by 15% to 20% for its collective of small and large businesses and individuals. The state is considering an expansion to a statewide purchasing alliance.

Some states have created or implemented statewide prescription drug cost controls. Maryland, for example, created a prescription drug affordability board with the authority to establish the maximum costs for certain drugs, including some of the most expensive medications, that state and local governments purchase for employees and programs.

California is creating a statewide purchasing system for prescription drugs where a coalition of public and private purchasers would pool purchasing power to negotiate lower prices with drug manufacturers. Further, a few states have enacted legislation for prescription drug importation like Vermont, which has developed a plan to administer a wholesale prescription drug importation program using Canadian suppliers.

As mentioned, health care is expensive and complex. Even the best cost containment strategy cannot address all the factors that go into health care costs such as the expense of new technologies and medications, provider consolidation, the age of members, and disease prevalence. As the boards continue their efforts and look for further ways to contain costs and maintain quality coverage, OHA has a policy package option for its 2021-2023 budget to align PEBB and OEBB with other publicly funded programs (e.g., Oregon Health Plan, the Marketplace, and other local governments) for stronger state purchasing power to improve care and lower costs.

[11] Our research was conducted prior to COVID-19; the pandemic may affect how these initiatives operate.

PEBB and OEBB can enhance communication with members and employers

We found PEBB and OEBB seem to effectively communicate open enrollment information to members but fall short in multiple areas including educating members on selecting and using their benefits, providing clarity on board efforts, and obtaining and analyzing feedback from employers and members. Improvements in these areas would help the programs better identify issues, more effectively roll out cost-control measures, and help employees better manage costs and their own health care. When members understand, use, and appreciate their health care benefits, they are more likely to optimize them to stay healthy, which ultimately helps to contain health insurance costs in the long run.

PEBB and OEBB need to better educate members on their benefits and board efforts to more effectively implement cost containment strategies

Employees are key partners in containing health care costs — they select the health plans purchased and choose the services to use each plan year. As employees share in the cost of premiums and insurance claims, it is important they know how to effectively select and use the health care plan best suited for their situation to optimize cost and health outcomes.

OEBB's enrollment guide cover (2020-21 plan year).

Health care plan selection can be overwhelming, and employees may form incorrect assumptions about benefits (e.g., an assumption that the most expensive plans are the best). To help, PEBB's and OEBB's communication with members has mainly revolved around open enrollment, the one-month time period when members are selecting their plans for the next plan year. Open enrollment communications focus on plan option information, enrollment requirements, and high-level summaries of insurance coverage provided. This information is provided in multiple ways (e.g., webinars, emails, and physical mailers). PEBB also provides a virtual benefits counselor, an online benefit comparison tool, and payroll deduction estimator on its website to help members with enrollment decisions.

Once plans have been selected, education should also be provided to help members understand and effectively use their benefits. For example, explaining covered preventative care and other health services as well as providing information on how to evaluate choices and costs when faced with a medical situation (e.g., primary doctor, specialist, urgent care, or emergency room) or treatment. This could also reduce the stress of not knowing how much their care will cost.

PEBB's enrollment guide cover (2020 benefit year).

Helping members understand their benefits and options empowers them to be more active in health decisions such as evaluating the cost of services prior to making health care decisions (e.g., the same procedure can have a large cost difference depending on the provider used). A well-informed consumer can make better choices and more optimally use health plan features to get the care needed to prevent or manage conditions. Better-informed consumers can also help identify and report incorrect billings, keeping the system accurate and accountable.

Further, PEBB and OEBB generally do not proactively give members details about the board's ongoing administration of benefits, including efforts and decisions made to help control benefit costs and the reasons behind the decisions. Generally, meeting recordings

and materials are available online for recent PEBB and OEBB board meetings, subcommittees, and workgroups, but members would need to listen to hours of discussion involving dense information and industry terminology to figure out what applies to them and how it affects their situation.

Members have little opportunity to understand from the programs the extent boards represent their interests. Educating members on board actions and decisions and the reasoning behind those decisions could help members be more informed about cost containment efforts and help better engage in the boards' cost-control measures being implemented.

PEBB and OEBB need to obtain more feedback from employers and members to better inform board decisions

PEBB and OEBB are missing opportunities for obtaining feedback from employers and members. There is limited contact between board members and plan members to help each group understand the needs and goals of the other. While board and member goals may be simple — stay healthy, keep costs down — the experiences of members as they obtain and pay for their health care are not consistently collected for board decision making.

HealthCare.gov has member experience as one of its three categories for quality ratings of health plans, which is based on surveys of member satisfaction with their health care and doctors, and the ease of getting appointments and services.

One example of an underused feedback mechanism is PEBB's and OEBB's annual survey of employees. These surveys focus almost exclusively on members' experience interacting with program staff, not about their other benefit experiences such as access to benefits, experiences with carriers and providers, or the extent of their satisfaction with benefits. This is a missed opportunity for the boards to learn key information about how well the benefits are serving members and to address problems they are having.

Another underused avenue is obtaining members' input. PEBB's member advisory committee, comprised of labor and management members, was created with the intent to provide advice and feedback to the board. The committee has focused, at the request of the board, on PEBB's wellness offerings for the past two years. The committee, supported by program staff and consultants, has monthly discussions of issues impacting members. Program management stated committee members regularly bring individual concerns from members at their respective agencies for discussion, but these are informal and are not tracked.

OEBB, however, does not have an equivalent member committee to help represent its over 250 employers. Having such a committee could enable more informed decision-making, improve success with initiatives, and promote better communication and relations.

PEBB and OEBB staff take a combined average of **5,000 calls a month during open enrollment**, with an annual combined average of **31,000 calls a year**.

Customer service calls from members is another feedback opportunity not used effectively to identify member issues and inform board decisions. When members call the programs with questions or concerns, staff track and categorize the calls. However, the categories have not been tracked consistently. For example, program staff stated that contact reasons have been removed or consolidated in the system, causing affected calls to be reclassified as "unknown." From October to December 2017, PEBB classified nearly 52% of calls as unknown. Without having consistent and known categories, ensuring staff are using the categories consistently, and analyzing the information to inform management and board decisions, the value of the feedback collected is substantially reduced.

Communication is a vital component for any program. Identifying ways to better inform members throughout the plan year and encouraging their feedback will help to strengthen the programs and ensure cost containment measures are understood and more effectively implemented.

Contract and claims oversight improvements need to be implemented to ensure transparency and accountability

PEBB and OEBB rely on contractors to perform much of the work needed to attain their boards' missions. There are gaps in the program's oversight that can be improved to ensure clarity and accountability of contracted services.

PEBB and OEBB contract annually with consultants for actuarial services and to negotiate carrier contracts. They also contract with carriers to deliver medical services to members and handle medical claims processing. In reviewing the consultant contracts and a sample of consultant invoices, we found issues with contract monitoring, contract terms, consultant invoices, and claims oversight. Specifically:

Contract monitoring has not been prioritized and implemented by program management. Although various staff track some aspects of the contracts, the programs have no systematic process for identifying contract deliverables and confirming they are received. For one consultant contract we reviewed, the consultant had not submitted annual work plans for 2019 or 2020, though required by the contract. Staff also did not calculate and track the not-to-exceed amount on the same consultant's contract. We estimated payments to the consultant in 2019 exceeded the contract's maximum amount by $83,000, and payments in 2020 through April exceeded the maximum amount by almost $290,000. If the work was part of the contract, then the consultant was overpaid. If this was additional work, then the contract should have been revised to ensure contract terms clearly defined the extra work to be done and the cost.

In 2019, PEBB and OEBB spent a combined total of **$3.8 million** to their **actuarial consultants.**

In their last completed plan year, **PEBB and OEBB members incurred** a total of **over $1.5 billion in claims.**

Contract terms in one consultant contract we reviewed did not have a defined cost tied to the work. The contract terms did not clearly state what work would be completed for what total cost. Additionally, the contract had a not-to-exceed (NTE) amount stated in terms of a percentage of premiums paid rather than a set amount. While permissible, defining the NTE as a percentage creates tracking issues for monitoring as noted in the previous paragraph. Without clearly defined work and corresponding cost, contractors cannot be held accountable in a clear, transparent way. Further, neither PEBB's nor OEBB's consultant contracts had identified performance measures in their contracts, which is a good accountability practice for contractors to demonstrate the quality of work being delivered.

Consultant invoices lacked information to verify amounts billed and contract compliance. The invoices we reviewed for one particular contract did not have enough information to verify amounts billed were mathematically accurate and adhered to contract terms. The contract's terms defined compensation by staff hour, but invoices did not provide the individual staff rates used to calculate the invoice cost. Additionally, with no contract budget to compare to, cost accountability could not be verified.

Claims oversight by the programs is not comprehensive. In the sample of carrier contracts that we reviewed, there were various provisions to help address aspects of improper claims such as required reports, claims processing accuracy measures, and clinical audits of claims that exceed high dollar thresholds. Though, program staff stated that information is not consistently

"The financial **losses due to health care fraud are estimated in the tens of billions of dollars each year** [in the U.S.]. A conservative estimate is 3% of total health care expenditures."

The National Health Care Anti-Fraud Association

reviewed and used. Management reported there are some efforts taken by carriers to identify and address improper claims, including fraudulent claims; however, it is not something the program monitors. While their consultants perform some claims data analysis, program management clarified that this work is high level and not necessarily specific to improper payments. PEBB had a claims audit conducted of two of their carriers in 2016, which included medical claims, pharmacy claims, clinical assessments, and behavioral health program assessments, though it was unclear if all audit findings were fully resolved.

Having limitations in contract administration and monitoring processes puts greater financial, legal, and reputational risk on those involved. PEBB and OEBB need to ensure all of their contracts are appropriately administered to ensure clear contract terms, monitoring, and accountability. Proper contract administration includes defining and assigning responsibilities, as well as ensuring staff have the proper training and knowledge of the contract terms. PEBB and OEBB also need to have a comprehensive strategy for ensuring claims accuracy and have that reflected in their contracts. Without proper monitoring and oversight of claims and claims data such things as system errors, billing errors, misapplied benefit rules, incorrect billings, and fraud could go undetected and impact plan costs.

PEBB's reserve needs better planning and legislative sweeps have reduced the balance

Most PEBB members have enrolled in self-funded plans, where PEBB is responsible for paying claims costs. PEBB maintains a reserve balance to cover its share of costs when claims and other program costs exceed monthly premium contributions, such as unanticipated specialized hospital care. PEBB has set a targeted reserve level, but the board does not have a strategic plan for using funds when the reserve accumulates more than needed. This has left the reserve open to Legislative sweeps and resulting federal penalties.

PEBB began moving toward self-funded plans in 2006 to better control premium cost increases and help save money. PEBB plans were mostly self-funded by 2010. Under self-funded plans, PEBB pays for employees' health benefits with its own funds (collected from premiums) and assumes direct risk for paying benefit claims, with any moneys remaining saved in reserve. The PEBB board, based on consultant recommendations, sets the premium rates, which includes a calculation for the reserve. PEBB has historically targeted a middle reserve level.[12]

According to program management, PEBB's reserves grew considerably higher than anticipated over the years as the board used a conservative reserve calculation based on national and market projections, while actual costs came in lower than projected. Rather than using some of the reserve to lower premiums, or other allowable services to reduce benefit plan costs, the reserve continued to grow for multiple years. PEBB's reserve was reduced significantly by the Legislature when it was used to help balance the state's budget. The Legislature swept

Multiple legislative sweeps lessen PEBB reserves by about $147.5 million — $135 million to balance the budget and about $14.5 million in federal fines.

[12] Consultants have proposed four rate stabilization reserve ranges – low, mid-point (low to middle), middle, and high. The greater the range, the more funds that should be maintained in the reserve. For example, going from the low level to the mid-point level or from the mid-point level to the middle level, increases the targeted reserve level by $10.5 million.

$120 million from PEBB's nearly $435 million reserve in Spring 2017 and is set to take another $15 million in 2021.

As a result, PEBB was fined $12 million for the first sweep from the federal government. The Office of Management and Budget's A-87 Circular requires that allocating the cost of plans to agencies be done on a consistent basis and there should be an equitable distribution of costs based on benefits received. The legislative sweep violated those required cost principles. Likewise, the program is expected to be fined $2.5 million from the second sweep in 2022.

Per **OAR 101-001-0015**, PEBB may use its reserves for the four following purposes:

- reimburse insurers for contracts payments (e.g., if benefit expenses exceed premium revenues);
- minimize premium increases and the impact on premium contributions due to benefit plan changes;
- pay for expenses critical to PEBB program administration (e.g., data processing); and
- pay for services, programs, or studies that will reduce benefit plan costs.

In accordance with state statute, the board has opted to use some reserves to help pay for program costs such as program incentives (e.g., the Health Engagement Model) and taxes (state tax on commercial health insurance plans). Reserve funds have also been used to align tiers, such as employee and family, within each medical plan so the program would avoid a tax penalty. Recently, in June 2020, the board discussed options and approved using some reserve funds to buy-down premiums to help with agencies' budgets in addressing forecasted budget concerns and economic uncertainties of the COVID-19 pandemic.

However, the board does not have a formal policy or strategic plan for determining the appropriate reserve amount to be maintained or for the steps to take when the reserve reaches higher or lower than targeted levels. Having a policy or plan could help ensure reserve funds are more effectively used toward meeting the program mission and containing plan costs.

Not all school districts are required to adhere to legislatively mandated OEBB cost containment requirements

The Legislature mandated requirements for PEBB and OEBB to help contain state employee health care costs. Although OEBB manages plans for most educators and staff, including all education service districts and community colleges, there are some school districts that obtain health care for all or some employees on their own.[13] As of June 2020, there are 13 school districts that do not use OEBB for overseeing all their health plans. These districts are not held to the legislative requirements the other educator entities must adhere to and their health benefit costs and steps taken to contain costs are not transparent.

Prior to OEBB, Oregon's educational entities purchased and administered health care benefits on their own. They obtained benefits on the open market through brokers, directly from carriers, the Oregon School Boards Association Health Trust, the Oregon Education Association Choice Trust, or the Oregon School Employees Association.[14] With this, there were about 90 different medical plans offered throughout Oregon school districts. OEBB was created to centralize health care benefit administration for school districts and education service districts. The intent was to increase stability in premium rates and reduce administrative costs.

When OEBB started in 2008, districts with a previously established trust or were self-funded could opt out of OEBB. Otherwise, districts were required to join OEBB when their current

[13] Please refer to Appendix A and B for a complete list of employers participating in PEBB and OEBB.
[14] With how these were designed, school districts could join or leave the plans at their discretion.

School districts obtaining health care outside of OEBB for all its employees
Ashland
Beaverton
Fern Ridge
Medford
North Clackamas
St. Paul
Springfield
Three Rivers
West Linn-Wilsonville

Districts obtaining health care outside of OEBB for its teachers
Bethel
Central
Corvallis
Portland

collective bargaining contracts expired, no later than October 2010. This meant that some districts or subgroups were not required to join for up to two years.

Restrictions were later legislatively relaxed, allowing districts to delay joining if a comparability assessment proved that their benefit plans were comparable to OEBB's in both cost and plan design. Legislation in 2013 eliminated the requirement for regular comparability assessments and allowed districts already outside of OEBB to remain so indefinitely with no reporting requirements. School districts already in OEBB were not allowed to opt out. Since OEBB's creation, each regular legislative session has had bills proposed to allow districts participating in OEBB to opt out. Though none of the bills moved out of committee, 17 bills have been put forward since 2009.

School districts outside of OEBB collectively comprise about 14,500 employees, including approximately 28% of the state's teachers. These districts are not held to the same OEBB legislatively mandated cost containment requirements, such as the 3.4% growth and payment caps, surcharges for double coverage through the state, and regular dependent eligibility verification. Further, their costs and cost containment strategies are not transparent and shared.

Additionally, information on which schools covered by OEBB plans is not readily provided. Given there are school districts where only some of the employees are covered and other districts not in its program, OEBB should clearly state the extent school districts and their employees are covered by OEBB plans such as on its website and externally with stakeholders.

In 2020, the Oregon School Boards Association approached OEBB management to work with multiple education associations — the Oregon School Boards Association, the Oregon Education Association, the Coalition of Oregon School Administrators, the Oregon School Business Professionals Association, and the Oregon School Employees Association — to facilitate better communication about OEBB and engage in data sharing.

However, without appropriate cost reporting for all school districts, the state does not know whether health benefit costs are being effectively contained. Comprehensive reporting of health care benefits and cost by all school districts is not within OEBB's authority. Such a change would require action by the Legislature to determine and require the reporting and analysis needed to ensure all school districts are adequately containing health care costs. As an example, Wisconsin, which does not have state managed insurance pool for educators, requires its school districts to annually report plan design and cost information to the state about health insurance programs provided to district employees.

Recommendations

To strengthen cost containment, communication, and contract administration, we recommend PEBB and OEBB:

1. Regularly communicate to members further educational opportunities in addition to open enrollment for members to learn how to better understand the details of their insurance coverage and how to utilize their benefits to make optimal health and cost decisions.

2. Periodically communicate to employers, members, and stakeholders about the board's ongoing administration of benefits, cost containment efforts, and the anticipated effects on affordability and accessibility of health care coverage to stakeholders, including employers and members.

3. Consistently collect, analyze, and share results of employers' and members' experiences to better inform board decisions; for example, consistently track customer service calls to the programs, ask about benefit and claim experiences on the annual member survey, and obtain information from carriers on claims calls and appeals.

4. Promptly enhance oversight and clarity of consultant and carrier contracts, which should include:

    a. ensuring consultant contracts have clearly defined deliverables that are of value and the related costs;

    b. identifying deliverables in current contracts, and monitoring and enforcing deliverables are contract compliant;

    c. verifying invoices for mathematical accuracy and contract compliance by staff who have the pertinent training and knowledge of contract terms; and

    d. having a comprehensive program for identifying improper claim payments that is reflected in contracted services.

To better manage its reserve, we recommend PEBB:

5. Develop a formal strategic plan that includes elements such as the appropriate amount to be maintained in reserve and steps to take when the reserve reaches higher or lower levels than targeted.

To further strengthen communication and information for decision-making, we recommend OEBB:

6. Clearly communicate the extent school districts participate in OEBB (e.g., when communicating externally to stakeholders such as in Legislature communications and on OEBB's website).

7. Create a member advisory committee or an alternative method for member advice and feedback to the board.

To help ensure adequate cost transparency and that cost containment strategies are being used by all school districts in the state, we offer the following for the Legislature to consider:

8. Consider requiring school districts outside of OEBB to regularly report on their health care cost containment efforts.

9. Consider having OEBB and school districts not participating in OEBB to regularly report basic facts and costs of their health plans.

Objective, Scope, and Methodology

Objective

The purpose of this audit was to evaluate how PEBB and OEBB are managing state employees' health care benefit costs.

Scope

This audit focused on the cost containment measures and management practices PEBB and OEBB have implemented to address rising health care costs. Our intended review of plan benefits, wellness programs, carrier contracts, claims processing, and data handling, as well as cost analyses, were not conducted due to COVID-19 impacts on resources and priorities.

Methodology

To address our objective, we interviewed PEBB and OEBB board chairs, program management, and staff. We also interviewed legislative members, board consultants, school districts, and management at agencies in other states responsible for employee benefits.

We reviewed PEBB and OEBB laws and rules, legislative mandates placed on the boards for cost containment and associated legislatively required reports, and board meeting minutes and materials. We also listened to recordings of select board meetings, legislative testimony, and work group meetings. Further, we reviewed comprehensive annual financial reports and union agreements for school districts to obtain public information on benefits, and studies and reports related to employee health benefit cost containment practices and efforts to reduce health care spending.

We obtained and reviewed the lists of 2020 participating employers from PEBB and OEBB. We also reviewed management performance metrics, consultant reports to the boards, communication mailers and guides to employers and members, PEBB carrier audit reports, and dependent eligibility verification removal rates.

We also obtained and reviewed two years of monthly member services call data from PEBB and OEBB for the volume and reason for member calls. We also reviewed five years of data on the annual number and type of appeals made by members to the program.

We performed a limited, high-level review of key PEBB and OEBB contracts and contract administration. We obtained copies of recent consultant contracts and reviewed them for content and key controls for review. For each of the consultants, we also obtained and reviewed two to three months of 2019 invoices for contract compliance. Further, we compared the 2019 consultant not-to-exceed provisions to payments and expanded this comparison for one consultant into 2020.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We sincerely appreciate the courtesies and cooperation extended by officials and employees of PEBB and OEBB during the course of this audit.

Appendix A: Employers Participating in PEBB

The following are 107 Oregon employers participating in the PEBB program for medical insurance as of May 2020:

Appraiser Certification and Licensure Board

Beef Council

BenefitHelp Solutions

Board of Accountancy

Board of Chiropractic Examiners

Board of Clinical Social Workers

Board of Dentistry

Board of Examiners for Engineering and Land Surveying

Board of Geologist Examiners

Board of Massage Therapists

Board of Optometry

Board of Parole and Post-Prison Supervision

Board of Pharmacy

Board of Tax Service Examiners

Bureau of Labor and Industries

Columbia Drainage Vector Control District

Commission for The Blind

Commission on Indian Services

Commission on Judicial Fitness and Disability

Community College Association

Construction Contractors Board

Corrections Enterprise

Criminal Justice Commission

Dairy Products Commission

Department of Administrative Services

Department of Agriculture

Department of Aviation

Department of Consumer and Business Services

Department of Corrections

Department of Education

Department of Energy

Department of Environmental Quality

Department of Fish and Wildlife

Department of Forestry

Department of Geology and Mineral Industries

Department of Human Services

Department of Justice

Department of Land Conservation and Development

Department of Parks and Recreation

Department of Public Safety Standards and Training

Department of Revenue

Department of Transportation

Department of Veterans Affairs

District Attorneys and their Deputies

Division of State Lands

Dungeness Crab Commission

Eastern Oregon University

Employment Department

Employment Relations Board

Film & Video Office

Government Standards and Practices Commission

Health Related Licensing Board

Higher Education Coordinating Commission

Housing and Community Services

Judges

Judicial Department

Land Use Board of Appeals

Landscape Contractors Board

Legislative Administration

Legislative Assembly

Legislative Counsel Committee

Legislative Fiscal Office

Legislative Policy and Research Committee

Legislative Revenue Office

Long Term Care Ombudsman

Mental Health Regulatory Agency

Office of the Governor

Oregon Advocacy Commissions Office

Oregon Business Development Department

Oregon Forest Resources Institute

Oregon Health Authority

Oregon Hop Commission

Oregon Institute of Technology

Oregon Liquor Control Commission

Oregon Medical Board

Oregon Military Department

Oregon Patient Safety Commission

Oregon Potato Commission

Oregon Racing Commission

Oregon Real Estate Agency

Oregon Salmon Commission

Oregon State Library

Oregon State Lottery

Oregon State Marine Board

Oregon State Police

Oregon State Treasury

Oregon State University

Oregon Tourism Commission

Oregon Travel Information Council

Oregon Trawl Commission

Oregon Wheat Commission

Oregon Youth Authority

Physical Therapist Licensing Board

Portland State University

Psychiatric Security Review Board

Public Defense Services Commission

Public Employees Retirement System (PERS)

Public Utility Commission

Secretary of State

Southern Oregon University

State Board of Architect Examiners

State Board of Nursing

Teachers Standards & Practices

University of Oregon

Water Resources Department

Watershed Enhancement Board

Western Oregon University

Appendix B: Employers Participating in OEBB

The following are over 250 employers participating in the OEBB program for medical health insurance as of May 2020:

Adel SD 21

Adrian SD 61

Alsea SD 7J

Amity SD 4J

Annex SD 29

Arlington SD 3

Arock SD 81

Ashwood SD 8

Astoria SD 1

Athena-Weston SD 29RJ

Baker SD 5J

Bandon SD 54

Banks SD 13

Bend-LaPine SD 1

BenefitHelp Solutions (BHS)-TPA

Bethel SD 52*

Blachly SD 90

Black Butte SD 41

Blue Mountain Community College

Brookings-Harbor SD 17C

Burnt River SD 30J

Butte Falls SD 91

Camas Valley SD 21J

Canby SD 86

Cascade SD 5

Centennial SD 28J

Center for Advanced Learning - CS

Central Curry SD 1

Central Linn SD 552

Central Oregon Community College

Central Point SD 6

Central SD 13J*

Chemeketa Community College

Clackamas Community College

Clackamas ESD

Clatskanie SD 6J

Clatsop Community College

Colton SD 53

Columbia Gorge Community College

Columbia Gorge ESD

Condon SD 25J

Coos Bay SD 9

Coquille SD 8

Coquille Valley Hospital

Corbett SD 39

Corvallis SD 509J*

Cove SD 15

Crater Lake Charter Academy

Creswell SD 40

Crook County SD

Crow-Applegate-Lorane SD 66

Culver SD 4

Dallas SD 2

David Douglas SD 40

Dayton SD 8

Dayville SD 16J

Diamond SD 7

Double O SD 28

Douglas County SD 15

Douglas County SD 4

Douglas ESD

Drewsey SD 13

Dufur SD 29

Eagle Point SD 9

Eagle Ridge High School

Echo SD 5

Eddyville Charter School

Elgin SD 23

Elkton SD 34

Enterprise SD 21

Eola Hills Charter School

Estacada SD 108

Eugene SD 4J

Falls City SD 57

Forest Grove SD 15

Fossil SD 21J

Four Rivers Community School

French Glen SD 16

Frontier Charter Academy

Gaston SD 511J

Gervais SD 1

Gladstone SD 115

Glendale SD 77

Glide SD 12

Grant ESD

Grants Pass SD 7

Greater Albany Public SD 8J

Gresham-Barlow SD 10J

Harney County Health District

Harney County SD 3

Harney County SD 4

Harney County Union High SD 1J

Harney ESD Region XVII

Harper SD 66

Harrisburg SD 7J

HB2557

Helix SD 1

Hermiston SD 8

High Desert ESD

Hillsboro SD 1J

Hood River County

Hood River County SD

Huntington SD 16J

Imbler SD 11

InterMountain ESD

Ione SD R2

Jefferson County SD 509J

Jefferson ESD

Jefferson SD 14J

Jewell SD 8

John Day SD 3

Jordan Valley SD 3

Joseph SD 6

Josephine County

Junction City SD 69

Juntura SD 12

Klamath Community College

Klamath County

Klamath County SD

Klamath Falls City Schools

Knappa SD 4

La Grande SD 1

Lake County SD 7

Lake ESD

Lake Oswego SD 7J

Lane Community College

Lane ESD

Lebanon Community SD 9

Lewis and Clark Montessori Charter School

Lincoln County SD

Linn Benton Lincoln ESD

Linn-Benton Community College

Long Creek SD 17

Lowell SD 71

Luckiamute Valley Charter School

Malheur ESD Region 14

Mapleton SD 32

Marcola SD 79J

McKenzie SD 68

McMinnville SD 40

Milton-Freewater Unified SD 7

Mitchell SD 55

Molalla River SD 35

Monroe SD 1J

Monument SD 8

Morrow SD 1

Mt Angel SD 91

Mt Hood Community College

Multnomah ESD

Myrtle Point SD 41

Neah-Kah-Nie SD 56

Nestucca Valley SD 101J

Newberg SD 29J

Nixyaawii Community School

North Bend SD 13

North Central ESD

North Douglas SD 22

North Lake SD 14

North Marion SD 15

North Powder SD 8J

North Santiam SD 29J

North Wasco County SD 21

Northwest Regional ESD

Nyssa SD 26

Oakland SD 1

Oakridge SD 76

Ontario SD 8C

Oregon Cascades West COG

Oregon Charter Academy

Oregon City SD 62

Oregon Coast Community College

Oregon Trail SD 46

Oregon Virtual Education

Paisley SD 11

Parkrose SD 3

Pendleton SD 16

Perrydale SD 21

Philomath SD 17J

Phoenix-Talent SD 4

Pilot Rock SD 2

Pine Creek SD 5

Pine Eagle SD 61

Pinehurst SD 94

Pleasant Hill SD 1

Plush SD 18

Port Orford-Langlois SD 2CJ

Portland Community College

Portland SD 1J*

Powell Butte Community Charter School

Powers SD 31

Prairie City SD 4

Prospect SD 59

Rainier SD 13

Redmond SD 2J

Reedsport SD 105

Region 18 ESD

Reynolds SD 7

Riddle SD 70

Riverdale SD 51J

Rogue Community College

Rogue River SD 35

Salem-Keizer SD 24J

Santiam Canyon SD 129J

Scappoose SD 1J

Scio SD 95

Seaside SD 10

Self-Pay Retirees

Sheridan All Prep Academy

Sheridan SD 48J

Sherman County SD

Sherwood SD 88J

Siletz Valley Charter School

Silver Falls SD 4J

Silvies River Charter School

Sisters SD 6

Siuslaw SD 97J

South Coast ESD

South Harney SD 33

South Lane SD 45J3

South Umpqua SD 19

South Wasco County SD 1

Southern Oregon ESD

Southwestern Oregon Community College

Spray SD 1

St Helens SD 502

Stanfield SD 61

Suntex SD 10

Sutherlin SD 130

Sweet Home SD 55

Teach NW

Tigard-Tualatin SD 23J

Tillamook Bay Community College

Tillamook SD 9

Treasure Valley Community College

Troy SD 54

Ukiah SD 80R

Umatilla SD 6R

Umpqua Community College

Union SD 5

Vale SD 84

Vernonia SD 47J

Village School

Wahtonka Community School

Wallowa SD 12

Warrenton-Hammond SD 30

Web Academy Public Charter School

West Lane Technical Learning Center

Willamette ESD

Willamina SD 30J

Winston-Dillard SD 116

Woodburn SD 103

Yamhill Carlton SD 1

Yoncalla SD 32

* - not all district employees are covered by OEBB; some employees are provided with health care benefits from the district's employee trust

Embargoed Until Wednesday, November 25, 2020 at 10:00am

HEALTH POLICY AND ANALYTICS
Public Employees' Benefit Board
Oregon Educators Benefit Board
Kate Brown, Governor

Oregon Health Authority
500 Summer Street NE, E-88
Salem, OR 97301-1063
Toll-free 888-469-6322

November 20, 2020

Kip Memmott, Director
Secretary of State, Audits Division
255 Capitol St. NE, Suite 500
Salem, OR 97310

Dear Mr. Memmott,

This letter provides a written response to the Audits Division's final draft audit report titled *Efforts Have Helped Limit Some Employee Health Care Costs, but PEBB and OEBB Can Do More to Manage Costs and Optimize Benefits*.

It was a pleasure working with the audit staff assigned to PEBB and OEBB from the Secretary of State's Office. We thought the audit was conducted very professionally, was fair to PEBB and OEBB, and overall was very well done. We welcomed the opportunity for a professional, third-party evaluation of our programs and thought the time and resources we dedicated to assist the auditors was time well spent.

Cost containment is without a doubt the biggest challenge the boards face each year. Yet the boards have been able to maintain top quality benefit offerings for PEBB and OEBB members while meeting the 3.4% annual rate of growth the legislature has mandated. Beating the commercial insurance market trend of 6-7% each year is not the only cost containment challenge. Securing the Operating budget authority to invest in new communication mediums and dedicated contracting resources are identified as top priorities of the board as reflected in this year's board meeting agendas focused on supporting members moving to a more virtual workplace, along with new legislatively mandated RFP's and alterations to benefit designs forced by COVID-19.

As detailed in this report, there is still much work to be done. The PEBB and OEBB boards remain committed to alignment and participation in the SB 889 Statewide Cost Growth Committee's proposed "Compact" around value-based payments and the statewide cost growth target. The future looks bright to leverage the purchasing power of the boards and other publicly-funded programs, and even expand the size of the risk pools by welcoming new local government entities. The boards remain focused on embracing innovation, centering around health equity, and executing on their short- and long-term strategic plans even while battling a pandemic.

Below is our detailed response to each recommendation in the audit.

RECOMMENDATION 1
To strengthen cost containment, communication, and contract administration, we recommend PEBB and OEBB:

Regularly communicate to members further educational opportunities in addition to open enrollment for members to learn how to better understand the details of their insurance coverage and how to utilize their benefits to make optimal health and cost decisions.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	PEBB New Hire training Q4 2020 Comms Strategy Phases 1-4 throughout 2021 and 2022, complete in Q3 2022 OEBB carrier benefits videos Q2 2021	Cindy Bowman 971-600-8969

Narrative for Recommendation 1
PEBB staff are currently collaborating with Rise Partnership, SEIU, and DAS to develop training and materials for newly hired State employees. Rise Partnership and SEIU began piloting the training with DAS in October 2020.

In 2019, the PEBB Board directed our consultant, Mercer, to develop a comprehensive communications strategy.

- Staff will begin work in Q1 2021 with Mercer, to develop and implement a dedicated new hire section for the PEBB website, with supporting materials. This section is aimed at guiding new employees through the benefits decision-making process.
- PEBB will also work with Mercer to create a monthly calendar for "Did you know?" emails, integrating carrier resources where possible. Calendar is targeted for Q4 2020 completion; implementation to begin Q1 2021.

PEBB and OEBB, in collaboration with contracted insurance carriers will create educational resources including webinars, targeted videos, downloadable flyers and newsletters. The goal to create the same "on demand" experience we have during open enrollment. Open Enrollment focuses on choosing the right plan. This resource hub will be focused on how best to use your plan once chosen.

RECOMMENDATION 2
To strengthen cost containment, communication, and contract administration, we recommend PEBB and OEBB:

Periodically communicate to employers, members, and stakeholders about the board's ongoing administration of benefits, cost containment efforts, and the anticipated effects on affordability and accessibility of health care coverage to stakeholders, including employers and members.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	July 1, 2021	Cindy Bowman 971-600-8969

Narrative for Recommendation 2
PEBB and OEBB already sponsor and lead employer focus groups. They are the PEBB Information Exchange (PIE) and OEBB Business Information Exchange (BIE) and were created to communicate and exchange information on emerging issues from board meetings, act as a conduit to the boards and place an emphasis on disseminating Board decision-making around benefits, cost-containment efforts, and making sure information is getting to the right places at the right time. These focus group meetings have been on hold during COVID-19 but will re-emerge on a more frequent basis with an expanded outreach to other stakeholders.

PEBB and OEBB will include a more detailed breakdown of board discussions, the decision-making process, and take a more pro-active role in disseminating information. Examples would include adding a new section to the PEBB monthly "Did you know" and will expand PEBB and OEBB Board web pages to highlight board decisions.

RECOMMENDATION 3
To strengthen cost containment, communication, and contract administration, we recommend PEBB and OEBB:

Consistently collect, analyze, and share results of employers' and members' experiences to better inform board decisions; for example, consistently track customer service calls to the programs, ask about benefit and claim experiences on the annual member survey, and obtain information from carriers on claims calls and appeals.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	July 1, 2021	Cindy Bowman 971-600-8969

Narrative for Recommendation 3

OEBB currently has "benefit-experience" related questions on the annual member survey. Rather than expand the number of questions in the survey, staff will work with contracted insurance carriers to collect and synthesize information annually about: utilization of benefits, claims processing timeliness, member call resolution, overall satisfaction as well as information related to benefit appeals.

PEBB currently performs a customer-service focused survey that does not contain benefit utilization questions. PEBB will seek to align with OEBB over the next year and request the carriers collect the same information.

RECOMMENDATION 4

To strengthen cost containment, communication, and contract administration, we recommend PEBB and OEBB:

Promptly enhance clarity and oversight of consultant and carrier contracts, which should include:

a) ensuring consultant contracts have clearly defined deliverables that are of value and the related costs;

b) identifying deliverables in current contracts, and monitoring and enforcing deliverables be contract compliant;

c) verifying invoices for mathematical accuracy and contract compliance by staff who have the pertinent training and knowledge of contract terms; and

d) having a comprehensive program for identifying improper claim payments that is reflected in contracted services.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	New processes established and documented by end of 2021	Brian Olson (503) 983-4446

Narrative for Recommendation 4

a) **Ensuring consultant contracts have clearly defined deliverables that are of value and the related costs.**

We have implemented new processes and regular meetings with both consultants to better track assigned work and approve invoices, which have gone well and have been effective. We have also asked Mercer to provide additional information as part of their invoice process, which has been helpful. We plan to build on all this going forward. In addition, we have decided to move to a raw dollar NTE, which will be

amended into the consultant contracts for the upcoming terms. Furthermore, we are addressing these various needs through our development of an upcoming Consultant RFP. Currently, we have Contracts staff working with other department staff and leadership to identify what our exact consultant needs are going forward and how to best build that into the next procurement.

b) **Identifying deliverables in current contracts, and monitoring and enforcing deliverables be contract compliant**.
Contracts staff worked with leadership to review and refine carrier contractual reporting requirements, scoping down what was not needed and being actively monitored. In the future, we will review each report and ensure it is assigned to specific staff with the requisite expertise to review.

Staff is developing several updated contract administration processes, including those tied to monitoring and enforcement. We are currently focusing on the annual contract renewal process. This updated process will be a full end to end process that actively incorporates contract deliverables and analysis into real time decision-making processes for the subsequent plan year renewals. We envision reporting certain information from contracts to consultants and the Boards at the very beginning of the annual renewal process and again before the end of the process after we have a more complete picture of the prior year (due to claims lag). We also envision asking consultants and certain staff to take a more active role in determining reporting needs and required performance measures during the renewal process itself and around the time we provide contract report information to the decision-makers. We anticipate partially standing up new processes in 2021 and then refining and adjusting them near the end of 2021 based on our experience.

c) **Verifying invoices for mathematical accuracy and contract compliance by staff who have the pertinent training and knowledge of contract terms**.
See comments in a) regarding changes in how we review consultant work and invoices.

d) **Having a comprehensive program for identifying improper claim payments that is reflected in contracted services**.
This will be partially addressed through the process work described above in b). Specifically, we will review the current claims-related contract deliverables staff receive (there are some claims reports as well as some claims-related performance measures) and determine whether the deliverables are adequate and appropriate. As part of the renewal process work, we will identify when and where the contract deliverable information will flow into the annual renewal process. We will then determine how that information will be coupled with more detailed and complex claims information our consultants typically develop and present during the renewal process. We will also need to determine how that information together is best used to lead to Board renewal decisions.

RECOMMENDATION 5

To better manage its reserve, we recommend PEBB:

Develop a formal strategic plan that includes elements such as the appropriate amount to be maintained in reserve and steps to take when the reserve reaches higher or lower levels than targeted.

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	Oct. 1, 2021	Ali Hassoun 503-779-4385

Narrative for Recommendation 5

The PEBB board maintains the Stabilization Fund (also known as "the reserve") in the state treasury. The board works with its consultant actuary each year to project an amount in the Stabilization Fund sufficient to meet both anticipated and unanticipated fluctuations in claims costs. The Board has used the fund to stabilize premiums, subsidize the employee premium share, and fund programs designed to reduce premium increases, but the board has no formal policy for how to manage funds in the event that reserves exceed the fully funded target level.

When the PEBB Reserve exceeds the targeted fully funded reserve level, the legislature has in recent years legislated a "fund sweep" of those excess reserves that have resulted in an OMB Circular A87 Federal payback for an unallowable transfer. Over the next 12 months the PEBB board will consider developing a "Formal" reserve policy that includes direction for handling of excess funds in the reserve when they exceed the target. One item to note is that PEBB's legislatively adopted biennial budget is developed using a 3.4% annual increase. For the board to "buy-down" a higher than anticipated annual contract renewal beyond the 3.4%, it would likely need to secure additional budget limitation from the legislature in an Emergency Board rebalance request, or full legislative session. A formal reserve policy may inhibit future fund sweeps.

RECOMMENDATION 6

To further strengthen communication and information for decision-making, we recommend OEBB:

Clearly communicate the extent school districts participate in OEBB (e.g., when communicating externally to stakeholders such as in Legislature communications and on OEBB's website).

Agree or Disagree with Recommendation	Target date to complete implementation activities	Name and phone number of specific point of contact for implementation
Agree	January 31, 2021	Damian Brayko 503-559-3763

Narrative for Recommendation 6

Because a total penetration figure will be more meaningful than a raw number to most audiences, staff will add a statement to the OEBB website indicating the percentage of education-based entities covered by OEBB. Since local government entities can participate in OEBB but were never required to, staff will also add the raw number of local government entities who have chosen to participate in OEBB. Staff will use these figures in future communications to the Legislature, such as the Ways and Means presentation in January 2021.

RECOMMENDATION 7 To further strengthen communication and information for decision-making, we recommend OEBB: Create a member advisory committee or an alternative method for member advice and feedback to the board.		
Agree or Disagree with Recommendation	**Target date to complete implementation activities**	**Name and phone number of specific point of contact for implementation**
Agree	October 31, 2021	Damian Brayko 503-559-3763

Narrative for Recommendation 7

Staff will present the OEBB board with a proposal to establish an OEBB advisory committee similar to PEBB's Member Advisory Committee (PMAC). Staff will seek both OEBB entity representatives and OEBB members from across the state to serve on the committee and will look to center health equity in the proposal. Accordingly, staff will seek to add diverse candidates in all committee recruitments. The intent would be to first secure approval from the board, then formally establish the group with a charter and bylaws by the end of October 2021, and to establish a desired meeting frequency at the initial committee meeting by January 2022.

Please contact Damian Brayko at 503-559-3763 or Ali Hassoun at 503-779-4385 with any questions.

Sincerely,
Ali Hassoun
Director,
Oregon Educators Benefit Board /
Public Employees' Benefit Board

cc:

Embargoed Until Wednesday, November 25, 2020 at 10:00am

Audit Team

Ian Green, M.Econ, CGAP, CFE, CISA, Audit Manager

Jamie Ralls, CFE, Audit Manager

Karen Peterson, Principal Auditor

Wendy Kam, MBA, CFE, Staff Auditor

Jeffrey Watson, Staff Auditor

About the Secretary of State Audits Division

The Oregon Constitution provides that the Secretary of State shall be, by virtue of the office, Auditor of Public Accounts. The Audits Division performs this duty. The division reports to the elected Secretary of State and is independent of other agencies within the Executive, Legislative, and Judicial branches of Oregon government. The division has constitutional authority to audit all state officers, agencies, boards and commissions as well as administer municipal audit law.

This report is intended to promote the best possible management of public resources.
Copies may be obtained from:

Oregon Audits Division
255 Capitol St NE, Suite 500 | Salem | OR | 97310

(503) 986-2255
sos.oregon.gov/audits

The State of OEBB

OB Attachment 5

December 1, 2020

Why OEBB?

- Increase purchasing power
- Pool data for analysis
- Allow small districts to
  - Provide larger group benefits
  - Gain lower overhead costs

Who we serve: Year one

- Participating entities: 223
- Medical lives insured: 65,542

Who we serve: Today

- Participating entities: 252
- Total lives insured: 131,302

Insurance premium under OEBB management

Total annualized insurance premiums for all plans offered:

- 2008 $ 643,154,784*
- 2020 $ 888,917,742

*Life Insurance and Disability plans were not offered until 2010

OEBB Charter

- Senate Bill 426 charges the Board to provide:
  - Employee choice
  - Encourage a competitive Market place
  - Plan performance and information
  - District flexibility in plan design and contracting
  - Quality customer service
  - Creativity and innovation
  - Improvement of employee health
- The Board added a principle of long term financial sustainability (All the care you need, Only the care you need)

Choice

2008:

- 11 Medical plans plus pharmacy options (Three plan providers)
- 8 Dental plans plus orthodontia options
- 6 Vision plans

2020:

- 10 Medical/Rx plans (Two plan providers)
- 7 Dental plans
- 6 Vision plans
- Plus Life insurance, AD&D, Short term disability and Long term disability insurance options

Impact on the marketplace, Creativity and Innovation

Since inception, OEBB has initiated 47 provisions and changes designed to facilitate access, quality, health and wellness, and prevention*. (See appendix)

- 8 Wellness
- 22 Pharmacy
- 2 Dental
- 13 Medical
- 1 Mental Health
- 1 Customer Service

* Over and above insurer book of business changes and Federal and State mandates.

Information and Performance

- Data warehousing and analytics via Watson
- Consultant benchmarking report
- Pharmacy analysis
- Dental quality
- Mental health utilization and analysis from health plans
- Specialty program reports addressing chronic illnesses
- Clinical quality reports
- Utilization reports from Wellness vendors
- Utilization and diagnosis summary reports from the EAP
- Special topics as requested from plan providers

Quality Customer Service

- Annual adjustments to performance guarantees
- Annual satisfaction survey

Improvement of Employee (and Family) Health

- Attention to primary care and mental health
- Programs to focus on chronic diseases:
  - Incentive cost sharing
- Health coaches
- WW
- Healthy Team Healthy You
- Prediabetes classes
- Support of the Children's Program
- Support of the Tooth Taxi

Sustainability

- Relativity adjustments
- Addressing cost of services:
  - PCPCH focus
  - Reference Pricing on certain procedures
  - Bariatric Centers of Excellence
- Oregon Pharmacy Drug Program

Why have we grown?

- Initially, Costs came in below expectations
  - Lower administrative fees
  - Lower professional fees
  - Leveraged advice
  - Credible data
  - Innovation
- Continue to beat cost trend
- Recently, at or below 3.4% mandate
- Added wellness benefits

OEBB vision (As stated on Oregon.gov)

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

OEBB vision key components

- Support Oregon's health system transformation efforts promoting better health, better care and lower costs (triple aim?).
- Support improvement in member's 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.
- Collaboration with participating entities, members, carriers and providers that ensure 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.

Oregon Health Authority Mission Statement

The mission of the Oreggon 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.

Coordinated Care

Through the Coordinated Care Model (CCM), Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.

Key elements of the coordinated care model include:

- Best practices to manage and coordinate care;
- Shared responsibility for health;
- Performance is measured;
- Paying for outcomes and health;
- Transparency and clear information; Maintain costs at a sustainable rate of growth.

Summary of Common Goals

- Continuous health and quality of care improvement
- Choice of plans
- Sustainable cost management
- Ability to measure care outcomes and costs
- Understand purchaser's needs
- Communicate rationale and decisions

Future challenges

- Continue to innovate
- Continued focus on quality and measurement
- Understanding and addressing diverse needs
- Communicate with all audiences
  - Why decisions were made
  - How to use
- Sustainable costs

OEBB Innovations

	Year Implemented	Type of Innovation	Program/Innovation	Description
1	2008	Rx	Oregon Prescription Drug Program / Northwest Prescription Drug Consortium	A pharmacy purchasing collaborative established by the states of Oregon and Washington, for which Moda is the administrator and OEBB is a Participating Program.
2	2009	Rx	Critical Access Pharmacies	Enhanced reimbursement for certain pharmacies in rural communities.
3	2009	Rx	Strategic Medication Assessment and Review of Therapy ("SMART")	Proactive clinical team review of prescription claims before payment, to reduce clinical or prescribing errors and promote appropriate use. Savings for OEBB since this program began has been $1,548,000.
4	2009	Medical	Quit for Life Program	Tobacco cessation program that includes coaching and medications at no cost to members
5	2010	Rx	High Cost Generics	Places selected generic medications at higher cost share tiers and applies step therapy, to proactively direct utilization to clinically appropriate generic medications that offer the best value.
6	2010	Rx	Non-Traditional Group Purchasing Organization (GPO) Program	Accesses Group Purchasing Organization medication pricing for selected claims via selected pharmacies, to lower claims costs.
7	2010	Rx	Pacific Value Network pharmacy network	Customized pharmacy network for groups/plans that are part of the Northwest Prescription Drug Consortium. This network provides robust access to thousands of pharmacies but excludes Walgreens to drive deeper network discounts.
8	2010	Rx	Specialty Split Fill	Provides a 14- or 15-day supply of certain specialty medications with a high risk for discontinuation for the first 90 days of therapy. This program decreases potential waste and increases clinical touch points to assess side effects and barriers to adherence.
9	2010	Rx	Value Tier	Low member cost share tier (for OEBB currently $4 per 31-day supply or the medication's cost, whichever is less) for safe, effective, high-value medications to treat common chronic conditions in order to remove economic barriers and promote adherence.
10	2010	Rx	Compound medication management	Management and review of claims for compounded medications, to ensure they are medically necessary and appropriately priced.
11	2010	Medical	Additional Cost Tier (ACT)	The Additional Cost Tier (ACT) is designed to encourage exploration of less invasive treatment alternatives by applying either a $100, or $500 additional copayment on to preference sensitive procedures including: arthroscopy,

OEBB Innovations

				bariatric surgery, hip replacement, knee replacement, upper endoscopy, spine surgery for pain.
12	2010	Dental	OEBB Children's Program	Delta Dental of Oregon and OEBB partnered together to create the Children's program. It provides basic dental services to children in Oregon who do not have dental insurance. Funding for the program is provided by Oregon dentists and is administered by Delta Dental of Oregon.
13	2010	Medical	Incentive Care Office Visits	Incentive care office visits provide lower copayments for office visits for asthma, diabetes, heart conditions, cholesterol, and high blood pressure. This applies to both primary care and specialist office visits
14	2010	Wellness	WW (formally Weight Watchers)	Access to both in person workshops and digital platform to help members reach wellness goals - to lose weight, eat healthier, move more, and develop a more positive mindset.
15	2011	Medical	PLAN 4 ODS Community Care Plan	Community Care Network to delivere the most cost-effective benefits to our members. Individualized care and integrated support from an interconnected group of providers that deliver proven results.
16	2011	Rx	Opioid Management	Detailed point-of-service and retrospective management of members' use of opioids, to encourage appropriate use and prevent misuse.
17	2012	Rx	OTC alternative benefit exclusion (e.g., exclude proton pump inhibitors)	Excludes coverage for products for which low-cost, safe, and effective over-the-counter medication alternatives are available.
18	2013	Medical	Comprehensive Coordinated Care (C3) Program	Comprehensive Coordinated Care (C3) program focused on high risk members with multiple chronic conditions and complex chronic disease. Members receive waived cost sharing for primary care and mental health office visits. Members also receive a dedicated advocate to help coordinate their care.
19	2013	Medical	Reference Price Program	Prior to the Reference Price program, there was substantial variations in cost throughout the State. A set rate for major joint surgeries, bariatric surgery, and oral appliances was established and providers could choose to accept that rate or not. Members are responsible for charges above the reference price.
20	2013	Medical	Wellness Visit	A wellness visit applies to members who are age 21 and older, and shall include a comprehensive medical evaluation including an age 20and gender appropriate history, family medical history, examination, counseling, anticipatory guidance, and risk factor reduction intervention. The medical evaluation may include assessment of and counseling for BMI, nutrition and diet, activity and blood pressure.

OEBB Innovations

21	2013	Wellness	Healthy Team Healthy U (HTHU)	A program that targets overall health to maximize results and create health minds, healthier bodies, and a healthier workplace.
22	2013	Wellness	Better Choices Better Health	Online chronic condition management program
23	2014	Rx	Ardon Health specialty pharmacy	Ardon Health specialty pharmacy, based in Portland, OR, started in 2014 and has since achieved numerous certifications and awards for quality and clinical expertise. Ardon Health provides specialty pharmacy services to OEBB members.
24	2014	Medical	Synergy and Summit	The Synergy and Summit coordinated care plans included a value-based payment risk model that partnered with hospitals, specialists and primary care providers. The model steered members toward primary care and rewarded PCPs for meeting quality metrics.
25	2015	Rx	Post Service Claim Edits on medical pharmacy drugs	Apply pre-payment claims edits to improve quality and accuracy for drugs managed under the medical benefit across all outpatient sites of care.
26	2015	Rx	Medical drug coding with NDCs for medical pharmacy drug claims	Require unique National Drug Codes for medical claims for medications, for all providers, to improve control, utilization management, pricing, claim settlement, and analytics for provider-administered medications.
27	2016	Rx	Medication Use Evaluation	Medication Use Evaluation
28	2017	Rx	Site of Care	Directs select infused specialty medications to clinically appropriate and lower cost sites of care.
29	2017	Wellness	OEBB/Moda Wellness Advisor Program	The program uses an oral health assessment completed by a dental provider to find out a member's risk of tooth decay, gum disease, and oral cancer. Based on the risk score, the member may qualify for additional cleanings, fluoride treatments, sealants, and periodontal maintenance.
30	2017	Wellness	Virtual Lifestyle Management (VLM)	Online diabetes prevention program
31	2018	Rx	Choice90 retail pharmacy benefit	An electronic medication prior authorization and prior authorization workflow tool that improves transparency of coverage requirements for prescribers and expedites the turnaround time and communication of coverage decisions.
32	2018	Rx	CoverMyMeds electronic medication prior authorization	An electronic medication prior authorization and prior authorization workflow tool that improves transparency of coverage requirements for prescribers and expedites the turnaround time and communication of coverage decisions.

OEBB Innovations

33	2018	Rx	High Performance Formulary	An evidence-based formulary (i.e., preferred drug list) that offers a wide choice of safe and effective medications while encouraging use of medications that offer the best value.
34	2018	Medical	Comprehensive Primary Care Plus (CPC+) Program	Comprehensive Primary Care plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally based multi-payer payment reform and care delivery transformation. Oregon is one of 18 regions throughout the country participating in the model and includes 19 Oregon payers.
35	2019	Rx	Pharmacy Benefit Optimization	Shifts reimbursement for select provider-administered specialty medications to the pharmacy benefit from the medical benefit, to promote more predictable and lower costs.
36	2019	Rx	Pilot program for Statin Use in Persons with Diabetes	An effort to increase statin use among 40-75-year-old members with diabetes, to improve health status and prevent cardiovascular risk, as well as improve member/provider communication.
37	2019	Rx	Pilot program for Statin Use in Persons with Cardiovascular Disease	An effort to increase statin use among 40-75-year-old members with cardiovascular disease, to improve health status and prevent additional cardiovascular risk, as well as improve member/ provider communication.
38	2019	Rx	Specialty rebate management	Multiple rebate contracting methods, including primary and secondary rebate aggregators, price protection/inflationary caps, outcomes-based rebates, and direct manufacturer contracts to lower the net cost of medications. As a Participating Program of the Oregon Prescription Drug Program (OPDP), OEBB receives 100% of rebates collected for OEBB member claims.
39	2019	Medical	Coordinated Care 2.0 - PCP 360	OEBB moved to a new coordinated care plan to incentivize more members to engage in coordinated care. Members select a PCP 39360, a high-quality primary care provider that meets the OHA requirements of a Patient Centered Primary Care Provider (PCPCH). The PCP 360s are engaged in a total cost of care value-based payment arrangement that rewards providers for staying under a 3.4% total cost of care growth target.
40	2020	Rx	Real Time Benefit Check	Enables providers to access members' specific pharmacy benefit details (e.g., deductible status, copay information), to reduce errors and guide providers toward cost-effective treatment options.
41	2020	Rx	Specialty Lite	Allows up to 90-day fills for certain well-tolerated, chronic specialty medications.

OEBB Innovations

42	2020	Medical	Meru	A 12-week mobile therapy to help reduce stress, depression and burnout that includes Confidential access to a personal, remote therapist, Mindfulness and behavioral techniques, and Wearable biofeedback training to increase focus and manage stress.
43	2020	Medical	Livongo	Digital diabetes management tool that provides a smart meter and unlimited testing supplies to members at no cost to them. The program provides access to coaches to advise on nutrition, lifestyle, diabetes, weight loss, and high blood pressure.
44	2020	Medical	CirrusMD	An app that allows members to text with a doctor 24 hours a day, 7 days a week, 365 days a year with no cost to the member.
45	2020	Medical/Customer Service	Moda 360	An evolution of the coordinated care model, Moda 360 connects members to a Health Navigator that helps to guide them through the health care system and connect them with programs and resources that are right for them.

OEBB Surcharge

House Bill 2266 (2019) established that OEBB impose a surcharge for an OEBB member who enrolls a spouse or dependent in their medical coverage who is also enrolled in medical coverage as an OEBB member themselves or as an PEBB member through the Public Employees' Benefit Board. This rule prescribes how the double coverage surcharge works.

Prior to Open Enrollment, OEBB sent 1,376 Surcharge Awareness Letters out to members (subscriber) that would potentially have this surcharge applied to them. This communication alerted potential surcharge members (subscribers) of HB 2266 and how this affected them.

During Open Enrollment, members (subscribers) were asked specific questions about eligible dependents having double medical coverage with either OEBB or PEBB. If they answered questions attesting to double medical coverage, a $5 surcharge was added to their enrollment.

After Open Enrollment, OEBB/PEBB ran a process to determine the accuracy of members (subscribers) responses and either attached or unattached the surcharge accordingly.

Members (subscribers) that had the surcharge attached were sent a communication from OEBB alerting them to the $5 surcharge and options available to them if they did not want the double medical coverage.

As of November 23rd, we have sent out 110 communications for OEBB and 24 for PEBB. On the OEBB side, we have noticed around 12 members (subscribers) have dropped dependents due to them having other medical coverage. None of these 12 members (subscribers) have contacted OEBB to drop these dependents. We see this happening at the entity level using very specific QSCs of gained other group coverage. So, to the best of our knowledge, these are actual QSCs and not due to the surcharge.

OEBB/PEBB plans to monitor the HB 2266 surcharge through the month of February (which is the PEBB Open Enrollment Correction Period) and we will reevaluate our process at this time.

OEBB 2021 – 2022 Renewal Planning Discussion and Timeline

Oregon Educators Benefit Board

Board Meeting Attachment 8

December 1, 2020

Willis Towers Watson

Disclaimer

Willis Towers Watson has prepared this material for Oregon Educators Benefit Board's (OEBB) sole and exclusive use and on the basis agreed with you. It was not prepared for use by any other party and may not address their needs, concerns or objectives. This material should not be disclosed or distributed to any third-party other than as agreed with you in writing. Willis Towers Watson does not assume any responsibility or accept any duty of care or liability to any third-party who may obtain a copy of this material and any reliance placed by such party on it is entirely at their own risk.

Agenda

- Review decisions and program changes for the 2020 – 2021 plan year
- Overview of enrollment and plan cost changes
  - RSR funding status
- Objectives for 2021 – 2022 renewal
- Considerations and themes for the upcoming renewal
  - What is renewing?
- Decision timeline

2020 – 2021 Plan Year Renewal

Overview

Goals for 2020 – 2021	Actions taken
Ensure sustainable and appropriate rates for each plan design	▪ Reviewed rate relativities for Moda plans; decision to review/adjust rate relativities every three to four (3 to 4) years ▪ Adopted adjusted Moda and Kaiser renewal positions to ensure sustainable and competitive rates ▪ Reduced rates for some short-term disability plans
Ensure members have a meaningful choice of plan designs	▪ Maintained ten (10) medical plan choices, six (6) dental plan choices and six (6) vision plan choices ▪ Considered addition of a new Kaiser plan option — deferred decision to the 2021 – 2022 plan year ▪ Continued focus on health and wellbeing resources, education, support, benefits
Consider plan design or program changes that improve the efficiency of the program or further OEBB's goals such as: ▪ Advancing coordinated care efforts ▪ Value based payment models ▪ Initiatives developed in the IWG	▪ Pharmacy optimization programs adopted ▪ Oncology site of service program ▪ Moda360 ▪ Preventive care coverage enhancements ▪ Reviewed carrier capabilities for expert medical opinion services, centers of excellence
Meet legislative requirement for 3.4% growth cap	▪ Projected medical/dental/vision cost change of 2.65% before taxes and fees
Incorporate other legislatively required benefit/program changes	▪ ACA insurer tax discontinued for 2021 — which further reduced the carrier renewals ▪ Implemented $5/month surcharge for subscribers electing coverage under both OEBB and PEBB

2020 – 2021 Plan Year Renewal

Detail

	2020 – 2021 Rate Change		Plan Change Adopted
Medical	**Before Taxes/Fees**	**After Taxes/Fees**	
Kaiser	-2.52%	-2.98% for most plans (-2.52% aggregate)	▪ Additional preventive care services covered before the deductible ▪ Additional funds added to RSR due to favorable renewal position
Moda	+4.75%	+2.4% for most plans (+3.35% aggregate)	▪ Moda360 concierge/navigation with telemedicine, behavioral health and diabetes management solutions ▪ Rx: chemotherapy site of service steerage ▪ RX: enhanced coverage of selected specialty medications for a 90-day supply ▪ Improved prior authorization process for PT/ST/OT, chiropractic and alternative care ▪ Use of RSR funds to mitigate renewal increase
Dental	**Before Taxes/Fees**	**After Taxes/Fees**	
Kaiser	+0.50%	0.00%	
Delta Dental	+0.35%	-0.16%	▪ Retained benefit level for members in incentive plans ▪ Hypertensive identification program ▪ Caries management benefit
Willamette Dental Group	4.49%	3.4%	

2020 – 2021 Plan Year Renewal

Detail

Vision

	2020 – 2021 Rate Change		Plan Change Adopted
Vision	**Before Taxes/Fees**	**After Taxes/Fees**	
Kaiser	-0.47%	-0.83%	
Moda	-0.52%	-1.46%	▪ Retained benefit level for members in incentive plans ▪ Coverage for hypertension screening
VSP	0%	0%	

Weighted Average	2020 – 2021 Projected Change in PEPM Costs	
	Before Taxes/Fees	**After Taxes/Fees**
Total Combined Medical, Dental, Vision (Weighted)	2.65%	1.58%

Overview of Enrollment Changes for 2020 – 2021

Enrollment and Tier Elections

- Enrolled subscribers decreased 1.2%
  - Enrolled membership decreased 1.4%
- Enrollment by plan remained largely stable
- Slight increase (0.5%) in Kaiser enrollment

Plan Distribution	2019-20	% of Total	2020-21	% of Total	Year over year change
Moda Plan 1	6,936	11%	7,232	11%	296
Moda Plan 2	4,728	7%	4,719	7%	-9
Moda Plan 3	3,655	6%	3,430	5%	-225
Moda Plan 4	6,074	9%	5,608	9%	-466
Moda Plan 5	6,318	10%	6,693	10%	375
Moda Plan 6	9,110	14%	8,188	12%	-922
Moda Plan 7	4,304	7%	4,530	7%	226
Kaiser Plan 1	9,149	14%	9,151	14%	2
Kaiser Plan 2	2,778	4%	2,902	4%	124
Kaiser Plan 3	1,813	3%	1,756	3%	-57
Opt Out / Waive	11,175	17%	11,333	17%	158
Total	66,040	100%	65,542	100%	-498

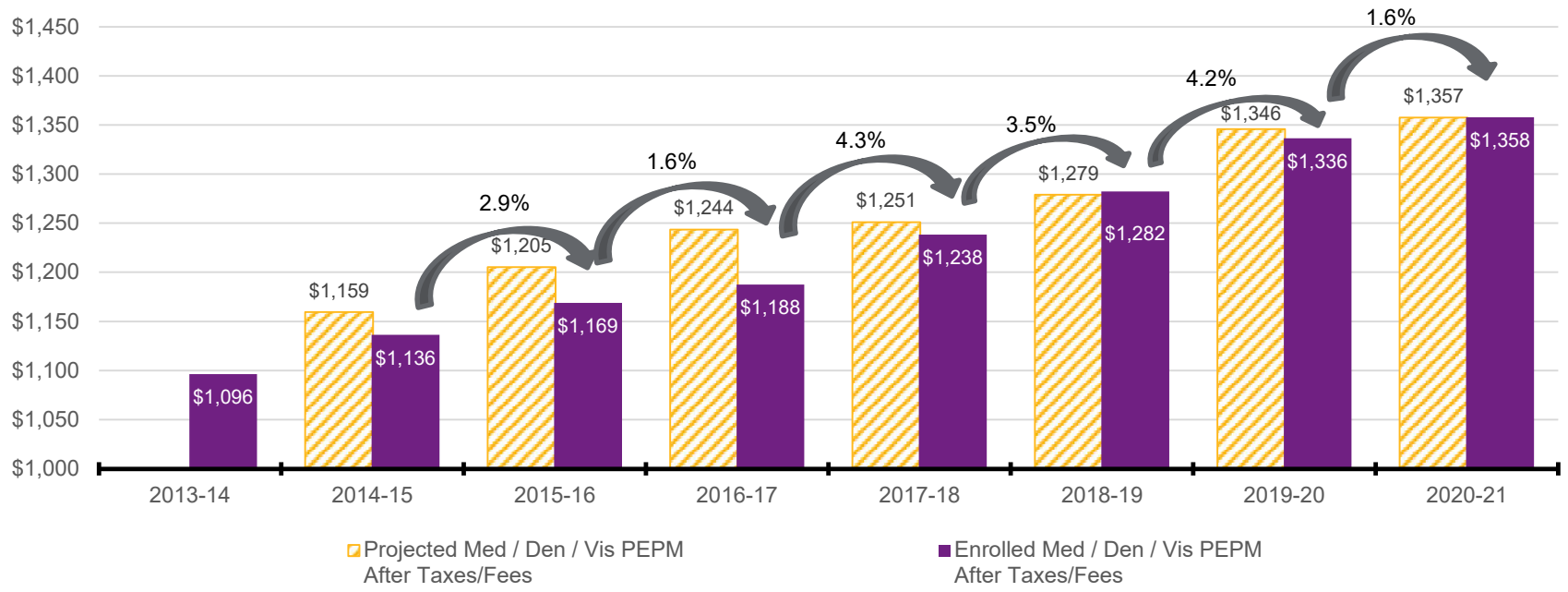
Observations:
- Slight increase in enrollment in plans 1,5,7
- Larger reduction in plan 6 enrollment

- There was a slight shift in enrollment towards the tiered plans from composite

Tier Distribution	2019-20	% of Total	2020-21	% of Total	Year over year change
Employee Only	13,662	25%	13,659	25%	-3
Employee and Spouse	6,194	11%	6,101	11%	-93
Employee and Children	4,916	9%	5,061	9%	145
Family	6,630	12%	6,861	13%	231
Composite	23,464	43%	22,528	42%	-936
Total	54,866	100%	54,210	100%	-656

Projected and Actual Per Employee Per Month (PEPM) Costs

- Cost change for 2020 – 2021 was projected to be 1.6% (including tax/fees) higher than 2019-2020
- Expected cost change based on open enrollment results aligns with renewal projections



PCP360 Participation (Moda)

- 70% of Moda members have a designated PCP360
- 9% increase in PCP360 Selection from 2019 – 2020
- Moda expects PCP360 participation to increase following post open enrollment outreach efforts

	2019 – 2020 PCP360 Enrolled	2020 – 2021 PCP360 Enrolled
Subscriber	25,862	27,589
Dependent	38,445	42,332

Rate Stabilization Reserve

Rate Stabilization Reserve	Moda	Kaiser
Balance as of October 1, 2020	$30.8M	$10.8M
Projected Balance — October 1, 2021	$26.1M	$15.9M

Goals and Objectives for 2021 – 2022

- Ensure sustainable and appropriate rates for each plan design
  - Suggest reviewing rate relativities every three years
- Ensure members have a meaningful choice of plan designs
- Consider plan design or program changes that improve the efficiency of the program or further OEBB's goals such as:
  - Advancing coordinated care efforts
  - Value based payment models
  - Initiatives developed in the Innovation Workgroup
- Meet legislative requirement for 3.4% growth cap on expenditures
- Incorporate other legislatively required benefit/program changes
- Incorporate health equity considerations into decision making

Considerations for 2021 – 2022 Renewal

- COVID-19 introduces new uncertainty in projecting expected utilization and costs for 2021 – 2022
- Understand impact of hospital reimbursement cap and clarified rules on projected costs
- Incorporate and consider initiatives from the Innovation Workgroup
  - Centers of Excellence Request for Information
  - Lodestar Request for Information
- Legislative changes
  - Federal administration may introduce new health care changes
  - Supreme Court ruling on ACA expected in May/June 2021
  - Health care transparency rule (beginning 2022)

Renewal Lines of Coverage

Vendor	Line of Coverage	Contract Period	Contract Renewing?
Moda	Medical/Rx	10/1/2020 – 9/30/2021	Yes
Kaiser	Medical/Rx	10/1/2020 – 9/30/2021	Yes
Delta Dental of Oregon	Dental	10/1/2020 – 9/30/2021	Yes
Kaiser	Dental	10/1/2020 – 9/30/2021	Yes
Willamette Dental Group	Dental	10/1/2020 – 9/30/2021	Yes
Moda	Vision	10/1/2020 – 9/30/2021	Yes
Kaiser	Vision	10/1/2020 – 9/30/2021	Yes
VSP	Vision	10/1/2017 – 9/30/2021	Yes
The Standard	Life, AD&D, STD, LTD	10/1/2018 – 9/30/2022	No
Benefit Help Solutions	COBRA	10/1/2018 – 9/30/2021	Yes
Reliant Behavioral Health	EAP	10/1/2018 – 9/30/2021	Yes

Timeline for Reviewing Renewal Options and Finalizing Decisions

Meeting	Take-Away	Action
January Board Meeting	▪ Carriers/consultants propose potential changes to OEBB medical, dental, vision plan design or programs	▪ Review and request additional information
February Board Meeting	▪ Preliminary medical, dental and vision, EAP, COBRA renewals presented ▪ Additional plan design change proposals for medical, dental, vision plans and/or OEBB programs	▪ Review and request additional information
March Board Meeting	▪ Final dental, vision, EAP, COBRA renewal proposals and options presented ▪ Additional medical plan benefit change proposals reviewed	▪ Approve final dental/vision plan design changes and renewal proposals ▪ Review and request additional information on medical proposals
April 6th Board Meeting	▪ Final medical plan rates and options presented (overall and by plan)	▪ Approve medical plan design changes and renewal proposals
April 27th Board Meeting	▪ If needed — approval all remaining medical, dental, vision plan rates and changes	▪ Approve final medical plan rates

Minimum Premium Funding Arrangement

OEBB Board Meeting- Attachment 7

December 1, 2020

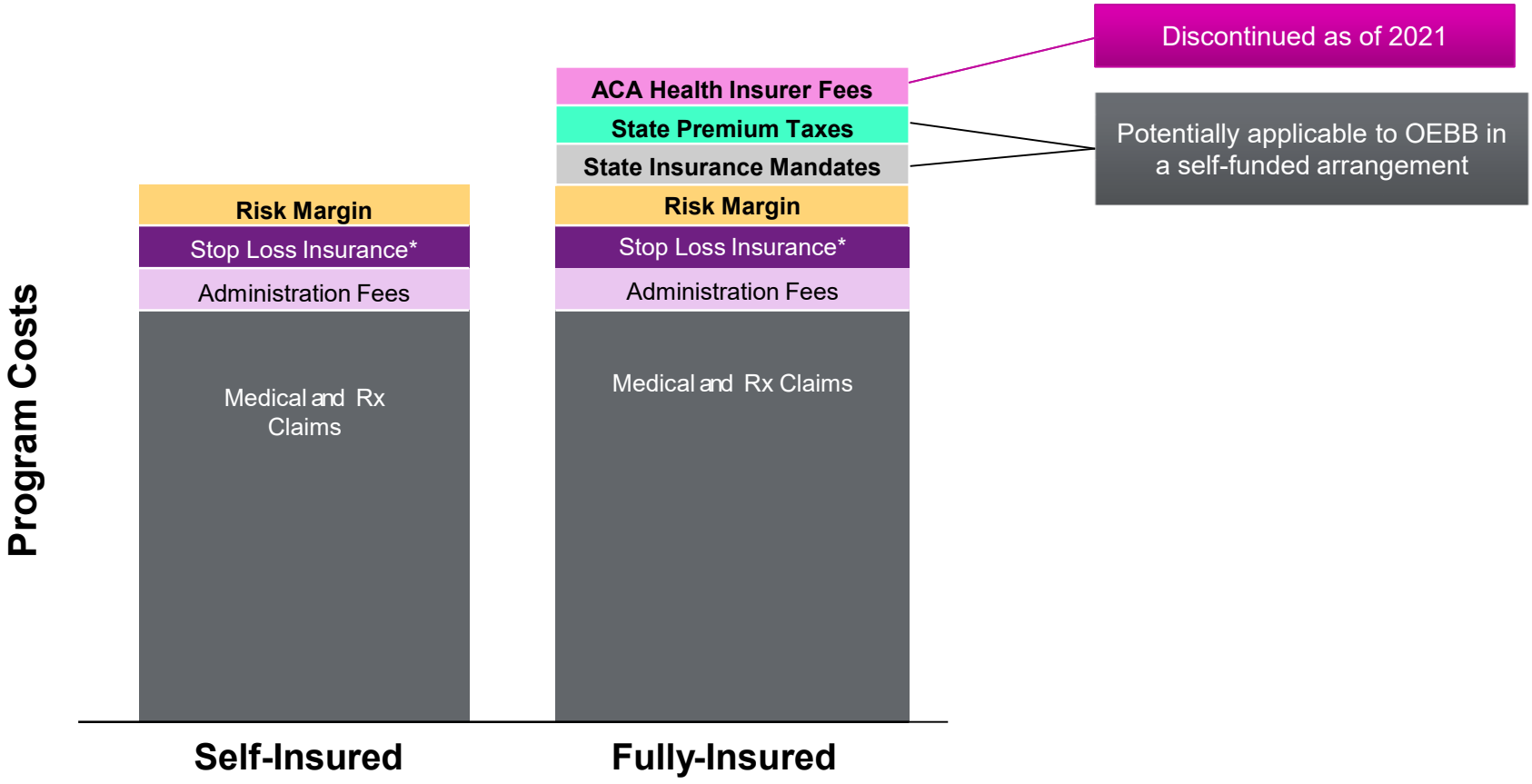
Willis Towers Watson

Background

- Prior to OEBB formation, school district entities had varied health care benefit programs with varied funding arrangements
- OEBB was created in 2007 through Senate Bill 426 to provide a common benefit program and risk pool
  - SB 426 did not include state funding to establish a reserve account necessary for a self-insured arrangement
- OEBB benefit plans were initially established with a fully-insured arrangement with Kaiser and a minimum premium arrangement with Moda
  - Determined to be the best approach for new program
- Today, we will review the difference between a fully-insured and self-insured arrangement as well as an overview of OEBB's hybrid minimum premium arrangement

Components of Premium Cost

Comparison Between Funding Mechanisms



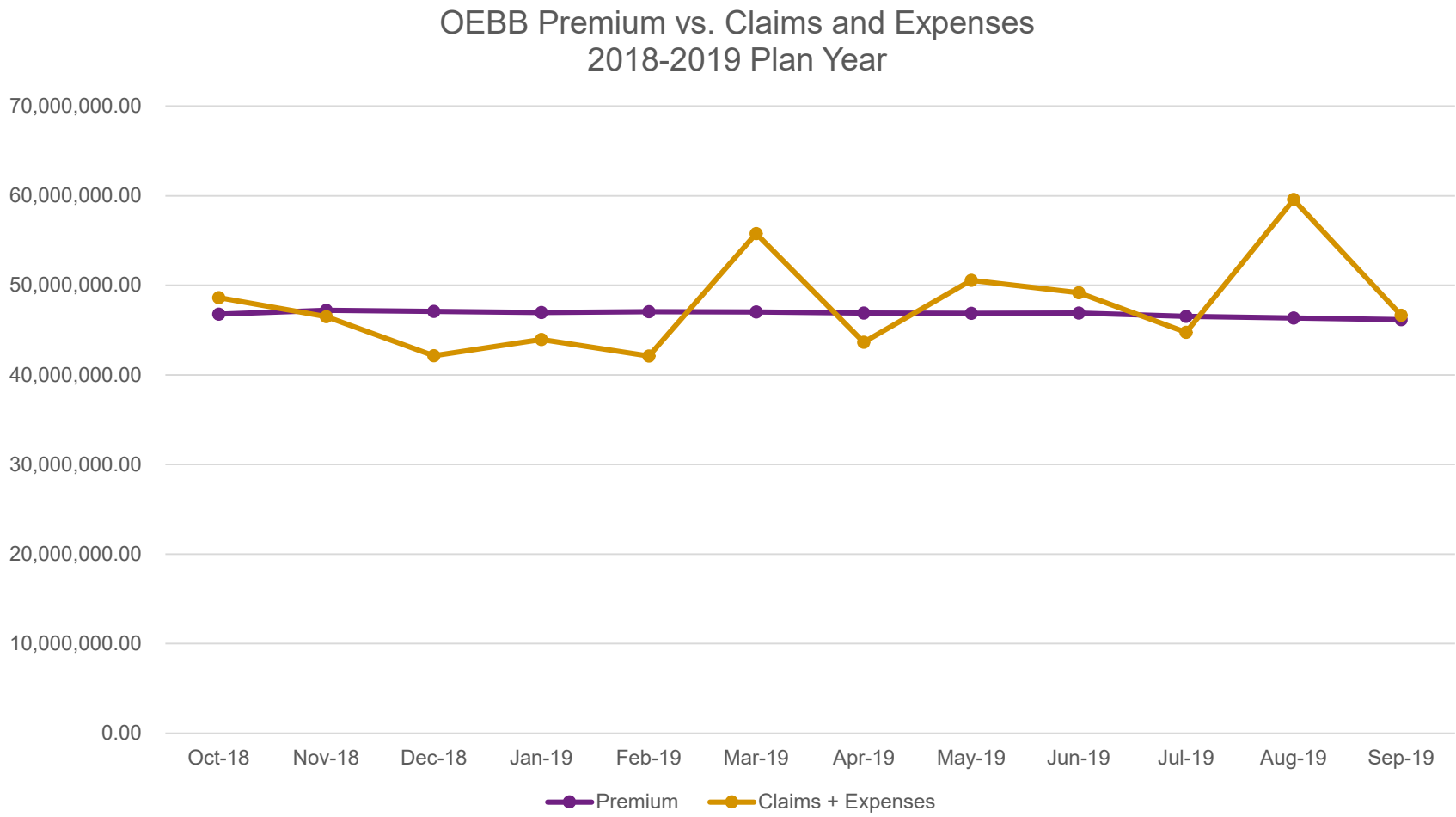
*If applicable

Funding Options

Medical/Rx and Dental

	Fully-Insured	Hybrid Arrangements (Minimum Premium)	Self-Insured
Variability in Costs	Month-to-month and annual budget stability — but at a cost	Predictable maximum monthly costs with true up at end of the year	Month-to-month variability in claims costs
Who establishes premium rates?	Insurance company sets premium rates	Insurance company sets rates with agreement from plan sponsor	Plan Sponsor establishes a health care budget for the year and develops premium equivalent rates based on the projected budget
Who bears risk?	Insurance carrier: ▪ If claims and expenses exceed premiums, the insurer covers the difference ▪ If claims + expenses are lower than premium, insurance carrier retains the difference	Shared risk between carrier and plan sponsor	Plan Sponsor: ▪ A reserve budget is established ▪ If claims + expenses are higher than budgeted, plan sponsor draws on reserves. ▪ If claims + expenses are lower than budgeted, the surplus is retained by plan sponsor

The Variability of Claims and the Stability of Premiums



A Hybrid: OEBB's Minimum Premium Arrangement

- The minimum premium plan combines features from both a self-insured and fully-insured arrangement
- Functions largely as a self-insured plan, but with a cap placed on the amount of claims paid in any given month
  - OEBB pays a monthly premium that has been established based on the expected claims, administrative expenses and regulatory fees
    - Maximum claims are established based on expected claims plus margin
- If claims are over the maximum, Moda pays the difference and this begins to accumulate into a deficit
- If claims are under the maximum, the difference (a surplus) is paid to Moda to reduce the cumulative deficit, or to accumulate into a surplus (reserve) to be used in the future
- Deficit amounts aren't added to the renewal for next year's premium
- All actual claims data/experience is used to calculate the following year's renewal
- Upon plan termination a final settlement is done after 15 months
  - If a deficit has accrued, the liability remains with Moda
  - If a surplus has accrued, the surplus will be returned to OEBB

A Hybrid: OEBB's Minimum Premium Arrangement

- Example: deficit year

2018 – 2019	
Projected Costs (Claims + Expenses)	$561.8M
Actual Costs (Claims + Expenses)	$573.4M
Difference	**($11.6M)**

- Example: surplus year

2019 – 2020	
Projected Costs (Claims + Expenses)	$587.1M
Actual Costs (claims + expenses)	$559.7M
Difference	**$27.4M**

- Deficit amount are tracked separately and aren't added to the renewal for next year's premium
- Surplus amounts are also tracked for separately and can be used to establish a reserve fund

OEBB's Minimum Premium Arrangement

Advantages	Disadvantages

▪ Lower cash flow volatility
  ▪ Claim payments are capped at a maximum threshold each month
▪ Deficit amounts are not added to the renewal calculations
▪ Year-end deficit and runout (claims paid after the termination of the contract) are limited at termination of the plan year, so risk is transferred to Moda
▪ Moda maintains IBNR reserves
  ▪ OEBB accrues interest on reserves
▪ Surplus and deficit can be pooled between medical and dental plans
	▪ Potentially higher cost than self-insured arrangement
	  ▪ Note that as a public plan, OEBB may still be subject to state and federal regulatory fees
	▪ If claims experience is not favorable (claims exceed the maximum expected each month), OEBB builds up a deficit amount which can mask poor plan performance
	  ▪ OEBB may pay down the deficit over time if the plan runs a surplus (i.e., low claims during COVID pandemic)