

Chair Kimberly Hendricks will convene a public meeting of the PEBB Board on Tuesday, March 15, 2022, at 9:30 a.m. The meeting will be held via Microsoft Teams video conferencing.

PEBB BOARD AGENDA MARCH 15, 2022

[Click here to join the meeting](#)

- I. 9:30 a.m. – 9:35 a.m. **Welcome & Approval of February 15, 2022, meeting minutes**
Attachment 1
ACTION
Kimberly Hendricks, Chair
- II. 9:35 a.m. – 9:50 a.m. **Board Election of Officers**
ACTION
Kimberly Hendricks, Chair
- In accordance with Section IV of the PEBB Bylaws, the election of officers occurs no later than March of even years. Kimberly Hendricks, as Chair, and Shaun Parkman, as Vice-Chair have served in the Chair and Vice-Chair positions for the limit of four years. Therefore, the board must elect a new Chair from labor members and a new Vice-Chair from management members. Action is requested.*
- III. 9:50 a.m. – 10:00 a.m. **Director's Report**
Information
Ali Hassoun, O/P Director
- IV. 10:00 a.m. – 10:20 a.m. **Innovation Workgroup Update**
Attachment 2
Information
 - Hospital Payment Cap Year One Audit Report (20 minutes)***Margaret Smith-Isa, Program Development Coordinator
Jenny Marks, CEBS, Director – Health & Benefits, and
Brad Lawson, Director, Health & Benefits, Willis Towers Watson*
- V. 10:20 a.m. – 10:30 a.m. **OAR 101-015-0005, 0011, 0026 and 0045; Request approval to file as permanent rules with the Secretary of State**
Attachment 3
ACTION
April Kelly, Program Benefits and Services Coordinator

10:30 a.m. - 10:40 a.m.

BREAK

VI. 10:40 a.m. - 12:10 p.m. **Round 2 Renewals - Medical/Pharmacy, Dental & Vision**
Attachment 4
ACTION *Andrew Hofheimer and Mitch Nigro, Emery Chen - Mercer Health and Benefits, LLC*

VII. 12:10 p.m. - 12:15 p.m. **Public Comment and Other Business**

Adjourn

Public Employees' Benefit Board Meeting Minutes February 15, 2022

The Public Employees' Benefit Board held a regular meeting on January 18, 2022, via Microsoft Teams video conferencing. Chair Kimberly Hendricks called the meeting to order at 9:30 a.m.

Attendees

Board Members:

Kimberly Hendricks, Chair
Shaun Parkman, Vice Chair
Greg Clouser
Andria Fultz
Dawn Mautner
Siobhan Martin
Kate Nass
Jeremy Vandehey

PEBB Staff:

Ali Hassoun, Director
Damian Brayko, Deputy Director
Brian Olson, Contracts Manager
Margaret Smith-Isa, Program Development Coordinator
Glenn Baly, Program/Policy Liaison
Rose Mann, Board Policy and Planning Coordinator

Consultants and Presenters:

Emery Chen, Mercer Health and Benefits
Andrew Hofheimer, Mercer Health and Benefits
Mitch Nigro, Mercer Health and Benefits

☪ ☪ ☪ ☪

I. Roll call and approval of January 18, 2022, Meetings Minutes (Attachment 1)

Chair Kimberly Hendricks called the meeting to order and called for a motion to approve the minutes from the January 18, 2022, PEBB Board meeting.

MOTION

Siobhan Martin moved to approve the minutes from the January 18, 2022, PEBB Board meeting. Jeremy Vandehey seconded the motion. The motion carried.

II. Introduction of New PEBB Board Members

New PEBB Board members Greg Clouser and Andria Fultz, introduced themselves to the Board.

III. VSP Network Update (Attachment 2)

Valerie Swyers, Market Director, Janessa Clegg, Supervisor Provider Network Development and Craig Rayl, Senior Relationship Manager presented an update on the provider network strategy for VSP.

- Plan Design and Access
- VSP's Routine Vision Fee Model
 - ✓ Medical vs Routine Vision Exam
 - ✓ Cost Equitability & Fee Model
- VSP Provider Network Strategy
- Critical Solutions in Oregon – Preventing Member Disruption
 - ✓ Group Authorized Provider Arrangement for PEBB Members
- Long-term Oregon Strategy – Retention and Recruitment
 - ✓ Creative Solutions
 - ✓ Retention Efforts
 - ✓ 90-day Recruitment Plan

IV. PEBB Risk-based Stabilization Fund Report (Attachment 3)

Emery Chen, Mercer Health and Benefits, LLC presented the following information regarding PEBB's risk-based stabilization fund.

- Determines if PEBB Has sufficient funds to cover future costs and any potential shortfalls.
 - ✓ Mercer projects costs versus funding over the next few years
 - ✓ Surpluses and deficits impact Risk Stabilization Fund
 - ✓ Risk Stabilization Fund is used to cover potential shortfalls
 - ✓ Recommend amount to hold in the RSF is based on Risk-based Capital (RBC)
 - ✓ Historical fluctuation in PEBB costs and Monte Carlo modeling was used to develop recommended fund range as a % of RBC
 - ✓ Reporting monitors Fund balance as actual costs emerge

V. PEBB Renewal Responses – Round 1 - (Attachment 4)

Andrew Hofheimer, Principal and Mitch Nigro, Senior Associate, Mercer Health & Benefits, LLC presented the first-round renewal responses for Plan year 2023.

- Program Overview
- Program Renewals and Considerations
- Next Steps

VI. PMAC and Worksite Wellness Coordinating Council Framework (Attachment 5)

Brian Olson, PMAC Coordinator, Theresa Cross, Wellness Manager and Steven Noeldner, PhD., MS, Well-being Vertical Leader, Mercer Health & Benefits presented short-term and long-term goals to identify and develop a well-being framework aimed at capturing the elements of PMAC, the council and the HealthEquity workgroup.

VII. PEBB Booster Incentive Payment Discussion (Handout A)

Ali Hassoun, Director presented a proposal to offer an incentive to PEBB members to receive a COVID booster shot.

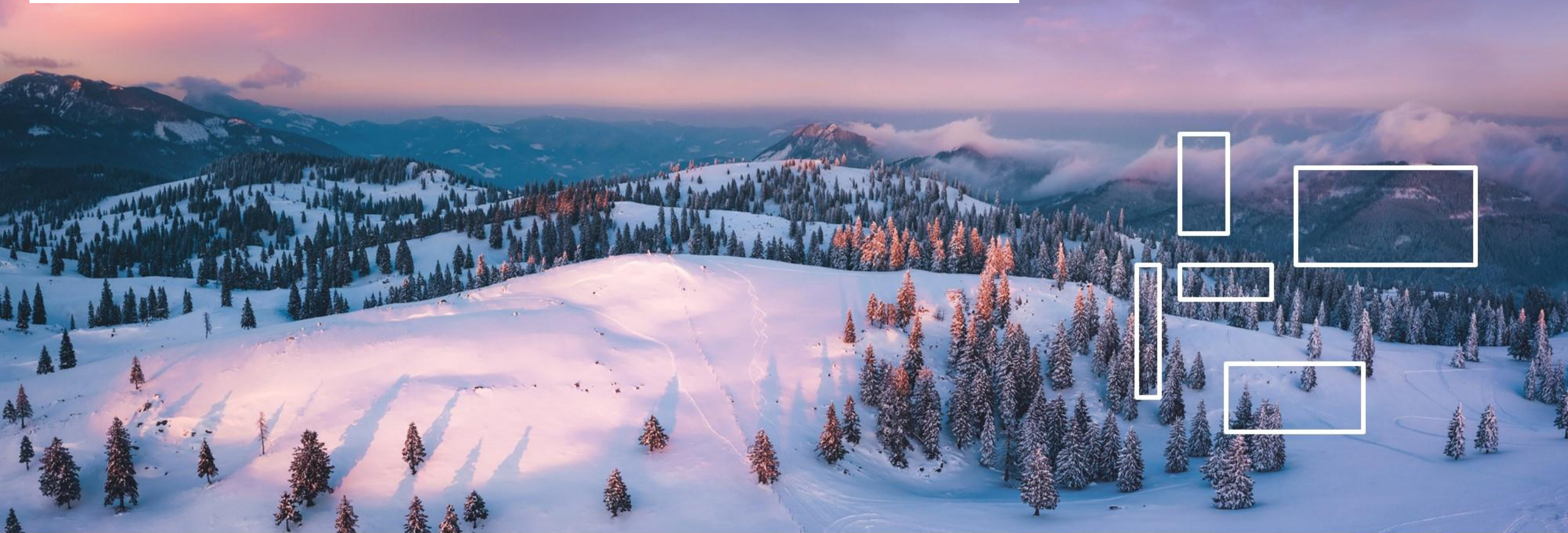
The Board came to consensus to move this item to Board Leadership for a final decision.

VIII. Other Business and Public Comment

There being no public nor further business to come before the Board. Chair Kimberly Hendricks adjourned the meeting at 12:35 p.m.

Innovation Workgroup Summary: Carrier Audit of Hospital Reimbursement

PB Attachment 2
March 15, 2022



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.

Willis Towers Watson is not a law firm and therefore cannot provide legal or tax advice. This document was prepared for information purposes only and it should not be considered a substitute for specific professional advice. As such, we recommend that you discuss this document with your legal counsel and other relevant professional advisers before adopting or implementing its contents. This document is based on information available to Willis Towers Watson as of the date of delivery and does not account for subsequent developments after that date.

This material was not prepared for use by any other party and may not address their needs, concerns or objectives. This document may not be reproduced, disclosed or distributed to any other party, whether in whole or in part, other than as agreed with you in writing, except as may be required by law.

We do not assume any responsibility or accept any duty of care or liability to any other party who may obtain a copy of this material and any reliance placed by such party on it is entirely at their own risk.

In preparing this document, we have relied upon information provided to us by OEBB and PEBB medical carriers regarding medical claims and related elements. The scope of our engagement did not call for us to perform an audit or independent verification of this information, but we have reviewed this information for overall reasonableness and consistency. We are not aware of any errors or omissions in the data that would have a significant effect on the results of our calculations. We have relied on all the information provided as complete and accurate. The results presented in this document are dependent upon the accuracy and completeness of the underlying data and information. Any material inaccuracy in the data and information provided to us may have produced results that are not suitable for the purposes of this document, and such inaccuracies, as corrected by [client] or its third-party claim administrators, may produce materially different results that could require that a revised report be issued.

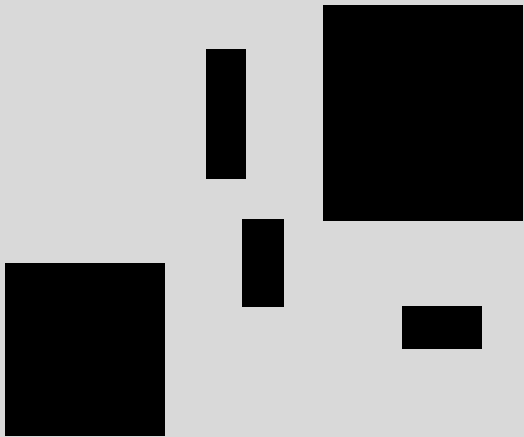
Agenda

- Executive Summary
- Audit Results
- Savings analysis
- Next steps

Executive Summary

- Willis Towers Watson was asked to perform an independent audit of OEGB/PEBB carriers' hospital reimbursements to ensure compliance with Senate Bill (SB) 1067
 - OEGB effective date 10/1/2019, PEBB 1/1/2020
 - SB 1067 limits facility reimbursements to 200% of Medicare for in-network hospitals and 185% for out-of-network hospitals
 - SB 1067 applies at a claim level, but compliance is determined at a hospital level
- Moda, Providence and Kaiser all separately meet the criteria per SB 1067
- In general, reimbursements at the hospital level are in compliance, although a few hospitals show modest overpayment
 - At the individual claim level, there does appear to be opportunity for further review with carriers
- As part of the Audit process, Willis Towers Watson was requested to review the savings achieved from SB 1067
 - Preliminary savings estimate from 2018 was \$81M, or 23% of facility claims subject to SB 1067
- Actual savings are estimated to be \$59M, or 14% of facility claims subject to SB 1067
- Lower than expected savings driven by
 - Delayed implementation of clarified rules - Preliminary 2021 data analysis following implementation of the clarified rules indicates lower average reimbursements compared to 2020 average reimbursements
 - Change in utilization due to COVID-19 pandemic
 - Lower than expected percentage of Medicare pre-SB 1067 (i.e., estimated savings may have been too high)

Audit Results



Audit Results

Total Claims — Combined and by Organization

	OEBB/PEBB Combined			OEBB		PEBB	
	# of Hospitals	Dollars	%	Dollars	%	Dollars	%
Total Allowed Claims	200+	\$621.6	100%	\$287.7	100%	\$333.9	100%
Claims outside of Oregon	100+	\$83.3	13%	\$38.1	13%	\$45.3	14%
Claims within Oregon — not subject to SB1067	67	\$135.4	22%	\$65.0	23%	\$70.4	21%
Claims within Oregon — subject to SB 1067	24	\$403.0	65%	\$184.7	64%	\$218.3	65%

Observations

- Combined facility allowed cost of \$622M for the OEBB 2019/2020 and PEBB 2020 plan years
- SB 1067 Medicare Cap impacted approximately 65% of facility claims over 24 hospitals
- For claims in OR, \$403M (75%) were subject to the cap
- Distribution of costs outside of OR, claims subject to cap and not subject to cap were similar for OEBB and PEBB
- Moda and Providence have similar percentage (61%/62%) of claims subject to SB 1067
- Kaiser has a larger percentage (85%) of claims subject to SB 1067

Audit Results

Repriced Inpatient and Outpatient Claims — Overpayments OEBB vs. PEBB

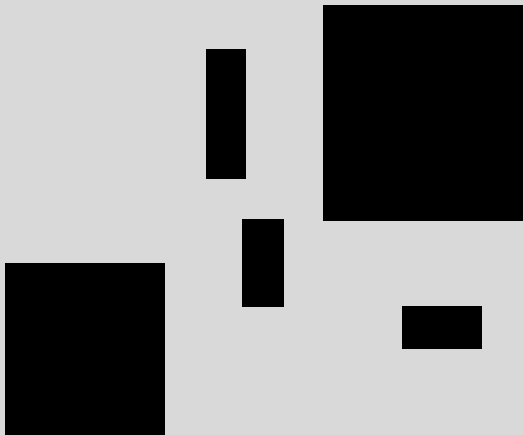
Inpatient and Outpatient	OEBB/PEBB Combined	OEBB 2019/2020	PEBB 2020
Claims within Oregon — subject to SB 1067*	\$392.2	\$180.6	\$211.6
% Medicare	179%	179%	179%
IP — overpayment at hospital level	\$0.5	\$0.2	\$0.3
IP — overpayment at admissions level	\$4.3	\$1.8	\$2.4
OP — overpayment at hospital level	\$0.2	\$0.0	\$0.1
OP — overpayment at admissions level	\$5.1	\$2.3	\$2.8

*A portion of Allowed claims were removed due to missing codes, some totals may not add due to rounding

Observations

- At a total program level, claim reimbursements of 179% for both OEBB and PEBB, is below the 200% Medicare reimbursement cap requirement
 - Moda and Providence at 183%, Kaiser at 162%
- When aggregating at the hospital level, both OEBB and PEBB had a modest level of overpayment, indicating some hospitals had average reimbursement levels over the 200% cap
 - Inpatient facility (IP) at \$0.5M, Outpatient facility (OP) at \$0.2
- When reviewing on a per admission level, both OEBB and PEBB had some level of overpayment, indicating some services were reimbursed under the 200% cap while others were reimbursed over the cap
 - IP at \$4.3M, OP at \$5.1M
- OEBB and PEBB had similar experience for both IP/OP and at hospital/admission level

Estimated Savings Analysis



Savings Analysis Summary

- Multi year look to see what savings could have looked like in a non-COVID year (2018/2019 OEGB, 2019 PEBB)
- Percentage of Medicare before SB 1067 is based on 2019 contracted rates
- Percentage of Medicare after SB 1067 is based on 2020 contracted rates

Total OEGB/PEBB										
Service Category	Based on 2019 Utilization					Based on 2020 Utilization				
	2019 Allowed*	% Medicare Before SB1067	% Medicare After SB1067	Earned Savings**	Estimated Savings if Capped***	2020 Allowed*	% Medicare Before SB1067	% Medicare After SB1067	Earned Savings**	Estimated Savings if Capped***
IP	\$199.7	182%	182%	\$0.2	\$26.8	\$190.0	176%	180%	-\$4.5	\$13.3
OP	\$247.2	249%	179%	\$69.6	\$67.8	\$169.5	243%	177%	\$63.7	\$50.5
Total	\$446.9	219%	180%	\$69.8	\$94.6	\$359.5	208%	179%	\$59.2	\$63.8

*Portion of Allowed removed due to missing codes and data differences between 2019 and 2020

**Earned Savings is calculated based on the difference in % of Medicare before and after implementation of SB1067 and represents actual savings that could have been (2019) or was (2020) achieved

***Estimated Savings if Capped is based on capping each admission at the required % of Medicare and represents the potential opportunity of savings under the clarified rules, assuming 2019 contracted Medicare percentage

Observations

- IP savings — pre-1067 Medicare percentage of 182% is less than 200% of Medicare, lower than initial estimates and limiting savings opportunity
 - 2019 estimated savings under the clarified rules is consistent with preliminary savings estimates
 - 2020 utilization mix drove negative savings compared to 2019, but would have still produced \$13M under clarified rules
- OP savings — pre-1067 percentage of Medicare is 240% – 250% Medicare, which is close to, but lower than preliminary estimates
 - 2020 earned savings are consistent with but lower than 2019 due to change in case mix
- Moda percentage of Medicare increased from 170% to 188% for a cost increase of \$7.3M
- Providence percentage of Medicare decreased from 199% to 187%, for a cost savings of \$4.7M
- Kaiser percentage of Medicare increased for both OEGB and PEBB, moving from 146% to 154% for a cost increase of \$2M
- 2020 Total earned savings of \$59M (14.2%), IP savings -\$4.5M (-2.4%), OP savings \$63.8M (27.3%)

Estimated Savings by DRG — Inpatient

Total OEPP/PEBB								
DRG Description	DRG Code	2019 Util	2020 Util	2020 Allowed (\$)	% Medicare Before SB1067	% Medicare After SB1067	Earned Savings (\$)	Earned Savings (%)
ECMO or trach w MV 96+ hrs	003	4	13	\$5.6	127%	190%	-\$1.8	-33%
Neonate, birthwt >2499g, w minor prob	791	44	38	\$2.3	134%	178%	-\$0.6	-25%
Neonate, birthwt >2499g, w other prob	792	62	94	\$3.0	131%	167%	-\$0.7	-22%
Neonatal aftercare	793	91	117	\$6.1	62%	157%	-\$3.7	-61%
Neonatal diagnosis	794	557	549	\$9.6	49%	143%	-\$6.3	-66%
Neonate, birthwt >2499g, w mult major prob	789	21	21	\$1.2	99%	178%	-\$0.5	-44%
Craniotomy and endovascular intracranial procedures	025	32	29	\$2.2	225%	190%	\$0.4	18%
Coronary bypass w cardiac cath w MCC	233	8	13	\$1.4	226%	172%	\$0.4	32%
Perc cardiovasc proc w drug-eluting stent	247	64	89	\$2.9	231%	184%	\$0.7	26%
Major bowel procedures	331	66	62	\$1.7	231%	186%	\$0.4	24%
Neonate, birthwt >2499g, w/o mult major prob	787	124	145	\$2.6	214%	182%	\$0.4	17%
Neonate, birthwt >2499g, w minor abdom procedure	788	271	273	\$4.2	221%	184%	\$0.8	20%

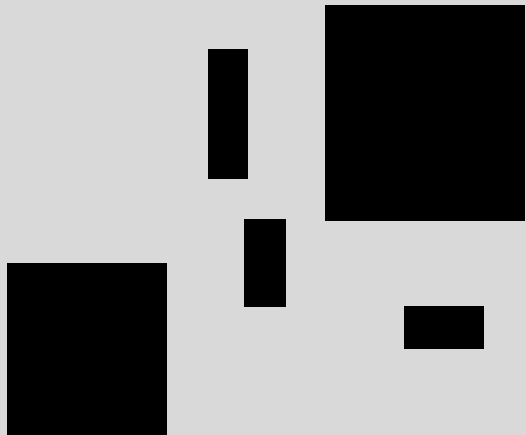
Comparison Against Commercial Benchmark*

Service Category	2020 Allowed (\$)	% Medicare Before SB1067	% Medicare After SB1067	2019 BM as % of Medicare
OEBB				
IP	\$88.6	167%	180%	203%
OP	\$77.0	248%	177%	200%
Total	\$165.6	205%	179%	202%
PEBB				
IP	\$101.4	183%	180%	197%
OP	\$92.4	238%	176%	192%
Total	\$193.8	209%	178%	195%
Total OEBB/PEBB				
IP	\$190.0	176%	180%	200%
OP	\$169.5	243%	177%	196%
Total	\$359.5	208%	179%	198%

Observations

- 2019 Benchmark as a percentage of Medicare is based on IBM Watson's 2019 MarketScan data
- Combined OEBB/PEBB was slightly higher than benchmark as a percentage of Medicare before SB 1067
 - OEBB costs were consistent with benchmark
 - PEBB costs were somewhat higher than benchmark
- Pre SB 1067, both OEBB/PEBB IP costs were below benchmark, averaging 176% vs. 200% for BM
- Pre SB 1067, both OEBB/PEBB OP costs were above benchmark, averaging 243% vs. 196% for BM
- After SB 1067, both OEBB/PEBB costs for IP, OP and in total are approximately 180%, which is lower than the benchmark which is near 200%

Summation and Next Steps



Next Steps

Audit Summary

- Both OEBB and PEBB meet the criteria established per SB 1067
- OEBB and PEBB carriers, Moda, Providence and Kaiser meet the criteria per SB 1067
- Most hospitals are meeting the criteria per SB 1067, however, there are a handful that appear to have modest overpayments
- When looking at the implementation of SB 1067 at the admission level there appears to be some overpayments and we will work with OEBB/PEBB carriers to reconcile and resolve

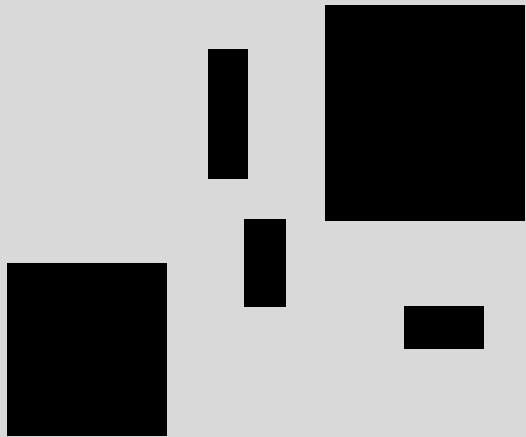
Savings Analysis

- While all carriers passed from an audit perspective, savings were less than expected for Inpatient
- Implementation of the clarified rules should result in higher, net savings for inpatient claims, though at a level lower than preliminary analysis portrayed

Next Steps

- Work with carriers to resolve potential per admission level overpayments
- Determine frequency of future audits
 - Willis Towers Watson recommends every three years
- Conduct an additional savings analysis once 2021 data is available

Appendix



Data Discrepancies

- Initially, Willis Towers Watson prepared for the audit by requesting claims data from OEGB and PEBB's data warehouse (IBM Watson Health)
- Review of the data revealed discrepancies between carrier and data warehouse data
 - Diagnostic Related Groupings (DRGs) used for billing of inpatient services were derived by IBM grouper technologies and in some cases differed from actual provider billed DRGs
 - Duplicate charges were identified in some of the data as a result of missing data flags to identify final DRG related billings
- As a result of the data discrepancies, Willis Towers Watson submitted data requests directly with the carriers to be used for the audit
- Follow up with IBM Watson Health and the carriers increased data warehouse data integrity
 - Data flags were added to carrier data to identify final payment references
 - Carriers are preparing to send additional data fields that identify carrier specific DRGs that can be used as needed in future analysis
 - IBM derived DRGs will continue to be used for cross carrier analysis to facilitate carrier comparison through data warehouse reporting

SB 1067 Defined Hospitals

Hospital	Include / Exclude	Hospital (Continued)	Include / Exclude (Continued)
Albany General Hospital	Included	Peacehealth Southwest Medical Center	WA — Excluded
Asante Ashland Community Hospital	Excluded	Portland Adventist Medical Center	Included
Asante Rogue Regional Medical Center	Included	Providence Medford Medical Center	Included
Asante Three Rivers Medical Center LLC	Included	Providence Milwaukie Hospital	Included
Bay Area Hospital	Excluded	Providence Newberg Medical Center	Excluded
Good Samaritan Regional Medical Center	Included	Providence Portland Medical Center	Included
Legacy Emanuel Hospital and Health Center	Included	Providence St Vincent Medical Center	Included
Legacy Good Samaritan Hospital and Medical Center	Included	Providence Willamette Falls Medical Center	Included
Legacy Meridian Park Hospital	Included	Sacred Heart Riverbend	Included
Legacy Mount Hood Medical Center	Included	Salem Health	Included
Legacy Salmon Creek Hospital	WA — Excluded	Santiam Memorial Hospital	Excluded
Legacy Silverton Medical Center	Excluded	Sky Lakes Medical Center	Excluded
McKenzie Willamette Medical Center Associates LLC	Included	St Charles Medical Center Bend	Included
Mercy Medical Center Inc	Included	St Charles Health System-Redmond	Excluded
Mid-Columbia Med Center	Excluded	Tuality Healthcare	Included
Oregon Health and Science University Hospital	Included	Willamette Valley Medical Center	Excluded
PeaceHealth Sacred Heart University District	Included		

Data Review

Hospital Detail — Inpatient and Outpatient

*Portion of Allowed removed due to missing codes

Hospital	Allowed*	Medicare Allowed	% Medicare	Over payment dollars	Overpayment % of Allowed
Adventist Medical Center	\$4.3	\$2.5	174%	\$0.0	0%
Asante Rogue Valley Medical Center	\$15.2	\$8.4	182%	\$0.0	0%
Asante Three Rivers Medical Center	\$4.3	\$2.3	185%	\$0.0	0%
Kaiser Sunnyside Medical Center	\$31.5	\$19.6	161%	\$0.0	0%
Kaiser Westside Medical Center	\$11.8	\$7.6	156%	\$0.0	0%
Legacy Emanuel Medical Center	\$12.7	\$7.0	181%	\$0.0	0%
Legacy Good Samaritan Hospital	\$5.7	\$2.8	202%	\$0.3	5%
Legacy Meridian Park Medical Center	\$5.3	\$2.8	187%	\$0.0	0%
Legacy Mount Hood Medical Center	\$3.3	\$1.8	185%	\$0.0	0%
McKenzie-Willamette Medical Center	\$8.0	\$4.3	188%	\$0.0	1%
Mercy Medical Center	\$6.6	\$4.5	146%	\$0.0	0%
OHSU Hospital	\$66.5	\$35.8	186%	\$0.1	0%
PeaceHealth Sacred Heart Medical Center — Riverbend	\$30.6	\$16.4	187%	\$0.0	0%
PeaceHealth Sacred Heart Medical Center — UD	\$1.2	\$0.6	210%	\$0.1	5%
Providence Medford Medical Center	\$3.5	\$1.9	189%	\$0.0	1%
Providence Milwaukie Hospital	\$1.6	\$0.9	192%	\$0.0	0%
Providence Portland Medical Center	\$21.7	\$12.0	180%	\$0.0	0%
Providence St Vincent Medical Center	\$23.7	\$12.6	188%	\$0.1	0%
Providence Willamette Falls	\$4.3	\$2.3	186%	\$0.0	0%
Salem Health Salem Hospital	\$73.5	\$41.6	177%	\$0.0	0%
Samaritan Albany General Hospital	\$7.9	\$4.4	180%	\$0.0	0%
Samaritan Good Samaritan Regional Medical Center	\$24.9	\$13.2	189%	\$0.0	0%
St Charles — Bend	\$20.9	\$11.3	184%	\$0.0	0%
Tuality Community Hospital	\$2.8	\$1.5	178%	\$0.0	0%

Observations

- All three OEBB/PEBB carriers had total facility reimbursements under the 200% cap
- At a hospital level, all three carriers had modest overpayments, indicating general compliance on a by hospital basis for both IP and OP
- At an admission level, all three carriers had some admissions that appear to be paid above the 200% cap
 - Largely offset by payments under the cap when looking at a hospital or total carrier level
 - IP overpayments were approximately 1.1%, OP overpayments were approximately 1.2% (1.6% Kaiser)

Audit Results

Repriced Inpatient and Outpatient Detail — Overpayments by Entity/Carrier

	Total	OEBB			PEBB			
	Total	Moda	Kaiser	Total	Providence	Kaiser	Moda	Total
IP Allowed (\$M)*	\$221.9	\$78.0	\$25.2	\$103.2	\$83.6	\$22.5	\$12.6	\$118.7
IP Allowed as % Medicare	180%	188%	162%	181%	187%	154%	183%	180%
IP Overpayment (by Admission)	\$4.3	\$1.4	\$0.5	\$1.8	\$1.7	\$0.3	\$0.4	\$2.4
IP Overpayment (by Hospital)	\$0.5	\$0.2	\$0.0	\$0.2	\$0.2	\$0.0	\$0.1	\$0.3
OP Allowed (\$M)*	\$170.3	\$62.3	\$15.1	\$77.4	\$71.8	\$12.5	\$8.6	\$92.9
OP Allowed as % Medicare	177%	179%	170%	177%	178%	166%	182%	177%
OP Overpayment (by Admission)	\$5.1	\$1.7	\$0.6	\$2.3	\$1.9	\$0.6	\$0.3	\$2.8
OP Overpayment (by Hospital)	\$0.2	\$0.00	\$0.04	\$0.04	\$0.01	\$0.02	\$0.1	\$0.15

*Portion of Allowed removed due to missing codes, some totals may not add due to rounding

Preliminary Savings Estimates – Pre-SB 1067

- Before SB 1067 was implemented, carriers provided high level savings estimates for IP and OP
- Preliminary savings estimates
 - Initial claim savings projected at \$81M (23% of facility claims subject to SB 1067)
 - IP projected savings of \$24M (15%), OP projected savings of \$57M (30%)
- Comparison to original anticipated savings estimates (November 2018)
 - Original repricing of 2017 incurred claims by Moda and Providence
 - Kaiser data was not included due to lack of Outpatient data
 - Inpatient facility (IP) claims were estimated to be at 235% of Medicare
 - Outpatient facility (OP) claims were estimated to be at 284% of Medicare
- For 2020 renewals Kaiser projected combined \$14M OEPP/PEPP savings (15% of facility claims subject to SB 1067)

Methodology — Glossary

Name	Definition
Uncompensated Care Adj. (UC)	An adjustment made for hospital care provided for which no payment was received from the patient or insurer.
Hospital Specific Payment (HSP)	Additional revenue for sole community hospitals (SCHs) and Medicare-dependent hospitals (MDHs), which are types of rural hospitals.
Low Volume Adj.	Additional revenue given to hospitals with discharges under a certain threshold and were located a certain amount of distance from another acute care hospital paid under IPPS.
Value Based Purchasing Adj. (VBP)	An adjustment made based on the quality of care that the hospital delivers.
Readmission Reduction Adj.	Reduces payments to IPPS hospitals for excess readmissions, starting October 1, 2012. CMS calculates the payment reduction and component results for each hospital based on its performance during a rolling three-year performance period.
Indirect Medical Education Adj. (IME)	Medicare increases the operating and capital payment rates of hospitals paid under the IPPS to reflect the teaching hospitals' higher indirect patient care costs compared to non-teaching hospitals, referred to as indirect medical education (IME).
Disproportionate Share Hospital Adj. (DSH)	An adjustment for hospitals that serve a proportionately large volume of low-income patients or other patients under the Medicaid program.
GAF	Capital Geographic Adjustment Factor
CCR	Cost to Charge Ratio: Cost required to operate a hospital divided by total revenue

Summary and Background

PEBB staff began reviewing rules for proposed updates in the summer of 2019 with anticipation to start rulemaking in early 2020. The identified proposed updates were “housekeeping” in nature and were meant to update our rules with our current processes and/or clarify language. In March/April 2020 Agency Rule Coordinators were given a directive that all non-COVID related rulemaking needed to be put on hold.

PEBB staff resumed the rule review process and started with Division 15, primarily because in the 2021 Legislative Session, Senate Bill (SB) 748 was passed that expanded eligibility for disabled dependents. Those amendments are reflected under Oregon Administrative Rule (OAR) 101-015-0011(4).

These proposed amendments were brought to the Board at your December 21, 2021 Board meeting. OAR 101-015-0011(4) was filed temporary so it aligned with the effective date of the bill. All proposed amendments from OAR 101-015-0005, -0011, -0026, & -0045 were filed with the Secretary of State, and a Notice of Proposed Rulemaking was sent out. In January, these rules were open for public comment and a rules hearing was held. No comments were received. Staff did review all proposed amendments again after the public comment period closed. PEBB staff are requesting the approval to file the amended language permanent with the Secretary of State’s office. In doing so, we will also repeal the temporary rule for OAR 101-015-0011 we had in place.

Rule Language

Division 15 ELIGIBILITY

101-015-0005 Eligible Individuals

(1) The following individuals are eligible to participate in PEBB-sponsored benefit plans:

(a) An eligible employee as defined in OAR 101-010-0005(~~48~~**20**).

(b) A permanent position seasonal or intermittent employee who meets the following requirements:

(A) An individual hired for the first time if expected to work a 90-**calendar** day continual period and works at least half-time or in a position classified as job share. The eligible employee must enroll within 30 days of the hire or eligibility date; or

(B) An individual hired for the first time working at least half-time or in a position classified as job share who was not expected to work a 90-**calendar** day or more continual period and works longer than a 90-day continual period. The employee is eligible for enrollment retroactively effective to the first day of the month following the original hire or eligibility date; or

(C) A previously ineligible employee returning to work is eligible for benefit plans after 60 calendar days of employment within the current or immediately previous plan year. The 60 calendar days of employment need not be consecutive.

(c) An appointed temporary or impermanent employee who (i) as of the date of hire, is expected to work an average of 30 or more hours per week for a 90-day continual period, or (ii) has worked an average of 30 hours or more per week for a full initial measurement period (1,560 hours) and is in a subsequent benefit eligible stability period.

(d) A current spouse, domestic partner, or an eligible dependent child listed by the person who is eligible under subsection (1)(a), (b), (c), or (d) of this rule on the required enrollment form or the electronic equivalent.

(e) An appointed and elected official. Eligibility for benefit plans begins on the first day of the month following the date the official takes the oath of office.

(2) The eligible employee is responsible to maintain a valid PEBB enrollment for all eligible family members receiving coverage. **Failure to maintain valid eligibility will result in the removal of coverage.** See OAR 101-020-0025.

101-015-0011 Dependent Child

(1) A dependent child must meet the following eligibility conditions to receive PEBB health plan coverage:
(a) The child is:

(A) An eligible employee's, spouse's, or domestic partner's son, daughter, stepson, stepdaughter, adopted child; or

(B) A Child by Affidavit **which** includes but **is** not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child who lives in the household of the eligible employee, and is the eligible employee's IRS dependent. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. The exception would be newborns or adopted children who are automatically covered as an eligible PEBB individual the first 31 days from birth or placement without documentation and Affidavit in place. The Affidavit and documentation must be on file the first of the month following the event date in order to meet eligibility and continue coverage under the PEBB plans. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first; An eligible employee may not add a child by affidavit age 18 or older to PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18; or,

(C) The biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria:

(i) The child's parent will not be older than age 26 ~~on the last day of the plan year~~, is unmarried and without a domestic partner. Both the child's parent and the child live in the household of the eligible employee, and both the child and grandchild are the eligible employee's IRS dependent **and must claim both child and grandchild on their most recent years tax return.** The child's parent has PEBB health coverage through the eligible employee. The grandchild is automatically covered as an eligible PEBB individual the first 31 days from birth without documentation and Affidavit in place. The Affidavit and any appropriate documentation must be on file the first of the month following the event date ~~in order~~ to meet eligibility and continue coverage under the PEBB rules. An eligible employee may not add a grandchild age 18 or older to their PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18.

(ii) ~~The child will not have attained age 27 in the plan year.~~ **Once the child no longer meets the requirements of section (5) of this rule, the child and grandchild will no longer be eligible.** ~~The exception is a child who meets all the requirements of section (4) of this rule.~~

(D) Covered if the eligible employee loses their spouse or domestic partner by death, the dependents (i.e. child of domestic partner, stepchild, grandchild) may continue PEBB health plan

coverage provided they are currently enrolled, and eligibility is still being met. For biological, stepchildren or children of domestic partners, coverage ends the last day of the month in which they turn 26. For Child by Affidavit of Dependency, coverage ends the last day of the month in which the court ordered guardianship ends or age 18. For Grandchild by Affidavit, eligibility ends when the grandchild no longer meets the definition of Grandchild by Affidavit.

(2) During Open Enrollment, **as a new hire and during annual open enrollment**, the employee may enroll a Child by Affidavit or Grandchild by Affidavit if the appropriate notarized affidavit and court ordered documentation is submitted within seven calendar days after open enrollment closes. ~~The exception is for a newly eligible employee after the closure of the open enrollment period but before the start of the new plan year. The employee must complete the paper open enrollment forms and submit the required court ordered documentation and notarized affidavit, as listed in section (3) of this rule, to the agency before the start of the new plan year.~~ If the employee does not submit the court ordered documentation as required, the child's enrollment will not activate. PEBB Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first.

"Example: Jack's foster child Joe is receiving PEBB coverage. Jack's legal documentation used at the time of Joe's enrollment stated that Jack will no longer be responsible for Joe when Joe turns 18. Joe's birth date is November 11, if there is no change to the court ordered responsibility, Joe's PEBB coverage will terminate November 30 the year he turns 18.

(3) ~~Newly eligible employees or employees~~ **Employees** with a midyear change requesting to enroll a Child by Affidavit or Grandchild by Affidavit must submit the appropriate court ordered documentation and the notarized Child by Affidavit or Grandchild by Affidavit to the agency within the allowable enrollment time. The agency will not process the employee's enrollments until the employee submits all of the following:

- (a) Completed and signed appropriate forms;
- (b) Completed and notarized affidavit; and
- (c) Court ordered documentation as required.

(4) There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability, when all the criteria in this section are met.

(a) The employee must submit to PEBB any appeal and enrollment forms to enroll a disabled child age 26 or older, or to indicate the child disabled in the PEBB benefit record when the child is already receiving coverage.

(b) The child's attending physician must submit documentation of the child's disability to the employee's health plan. The health plan provides a medical review of the physician's medical documentation and provides PEBB a disability determination based on the review.

(c) When the employee requests to enroll a disabled child over the age of 26:

(A) **(i) The child must be the employee's qualifying IRS dependent and must be claimed on the eligible employees' most recent years tax return, or**

(ii) The child files a tax return and demonstrates that their adjusted gross income does not exceed 150 percent of the federal poverty level (FPL), or

(iii) The employee is the legal guardian of the disabled dependent child.

(B) The physician must verify to the health plan that the disability existed before the child attained age 26.

(C) The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

(D) The employee must provide evidence to PEBB that the child has had continuous health plan coverage, group or individual, prior to attaining age 26 and the coverage remains in effect. The other coverage must continue until the employee's medical plan approves the child's health status as disabled and the PEBB plan is effective. If the child has not had continuous coverage, the child is not eligible for PEBB coverage.

(d) When a disabled child is receiving coverage beyond the age of 26, the employee's health plan can

review the child's health status at any time and determine if the child continues to meet the criteria for a disabled child.

(e) If a disabled dependent child's PEBB health coverage terminates for any reason after the age of 26, the child is ineligible for future enrollment as a dependent child under that PEBB coverage. The exception is termination of the child's coverage due to the employee's termination of employment when the employee is rehired later into a PEBB benefit eligible position. In this situation, to enroll the child again as disabled all PEBB criteria for disabled child within (4) of this rule must be met.

(f) Imputed taxes may apply, per IRC provisions, when an employee enrolls and covers dependents on their PEBB coverage that are not claimed on their federal taxes, and thus are not tax dependents.

(5) Beginning January 1, 2019, PEBB will terminate all plan coverage for dependent children who reach age 26 during a calendar year at midnight on the last day of the month in which the dependent turned 26. PEBB will not terminate coverage for children age 26 or older when approved by the health plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability pursuant to section (4) of this rule. The exception ~~would be~~ is Child and Grandchild by Affidavit, see section B(i).

**101-015-0026
Domestic Partnership**

(1) Certificate of Registered Domestic Partnership. When a Registered Domestic Partnership exists and the eligible employee wants to enroll the domestic partner or the domestic partner's eligible children in benefit plans, the employee may electronically enroll or submit enrollment update forms to the agency at the appropriate time as defined by PEBB enrollment rules.

(2) PEBB Affidavit of Domestic Partnership. An eligible employee and an individual of the opposite ~~sex~~, or ~~of the same sex~~ without a Certificate of Registered Domestic Partnership, who want enrollment in PEBB plans as Domestic Partners must meet all of the following criteria:

(a) Are both at least 18 years of age;

(b) Are responsible for each other's welfare and are each other's sole domestic partners;

(c) Are not married to anyone;

(d) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(e) Currently share the same regular permanent residence;

(f) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Financial information must be provided if requested, and;

(g) Eligible employees must submit enrollment forms and a notarized affidavit to enroll domestic partners and children. To enroll eligible dependent children of a domestic partnership by affidavit in benefit plans, whether or not the enrollment includes the domestic partner, the employee must submit an Affidavit of Domestic Partnership.

(A) For ~~open~~ enrollment, the agency must receive the notarized affidavit within five business days following close date of the ~~open~~ enrollment period. ~~The exception is for an employee who is a newly~~

~~eligible employee after the closure of the open enrollment period but before the start of the new plan year. The employee must complete paper open enrollment forms and submit the notarized affidavit to their agency before the start of the new plan year. The agency or PEBB will not process an employee's domestic partner or partner's children until the enrollment documentation submission is complete.~~

(B) ~~Newly eligible employees or employees~~ **Employees** with qualified mid-year changes may only enroll a domestic partner or partner's children by submitting the correct enrollment forms and notarized affidavit within the allowable time for the enrollment type. Agencies will not process a domestic partner or a partner's children's enrollment until the enrollment documentation submission is complete.

(3) An imputed value for the fair market value of the domestic partner and domestic partner's dependent children's insurance premium will be added to the eligible employee's taxable wages.

(4) An eligible employee ending a domestic partnership established under the PEBB Affidavit of Domestic Partnership must complete and submit a Termination of Domestic Partnership form and enrollment update forms to the agency within 30 days of the event. ~~If the domestic partnership was established under the Certificate of Registered Domestic Partnership, only enrollment update forms must be submitted to the agency within 30 days of the event.~~ Insurance coverage for the domestic partner and domestic partner's dependent children ends the last day of the month that in which eligibility is lost.

101-015-0045 Eligibility Verifications and Reviews

(1) PEBB shall plan and conduct eligibility verifications and reviews to monitor compliance with PEBB administrative rules. Reviews shall include but are not ~~be~~ limited to the following:

- (a) Dependent eligibility;
- (b) Employee eligibility;
- (c) Election change limitations; and
- (d) Plan enrollment limitations.

(2) Employee eligibility, election change and plan enrollment reviews may occur on a random basis throughout the year, or if anomalies in data warrant a formal review. The Eligible Employee is responsible to submit documentation upon request.

(3) Dependent eligibility reviews shall be completed as needed. The Eligible Employee, Retiree, Self-Pay or COBRA participant is responsible to submit documentation upon request. In the event the required documentation is not provided to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent's coverage will be terminated prospectively. Retroactive terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 101-010-0005.

(4) If an Eligible Employee does not complete the dependent eligibility review and moves to a different Agency under PEBB, their terminated dependent records may be locked in the PEBB benefit management system. The Eligible Employee must submit documentation to PEBB to be verified before the dependent records are unlocked.

(5) An Eligible Employee adding a new or previous dependent to enrollments after failing to verify dependent eligibility will be required to provide DEV documentation along with the enrollment form to PEBB. Enrollments will not take effect until the verification of eligibility. The effective date of coverage is the first of the month following receipt of the form and all appropriate verification documents by PEBB.

2023 Round 2 Renewal Responses

Oregon Public Employees' Benefit Board

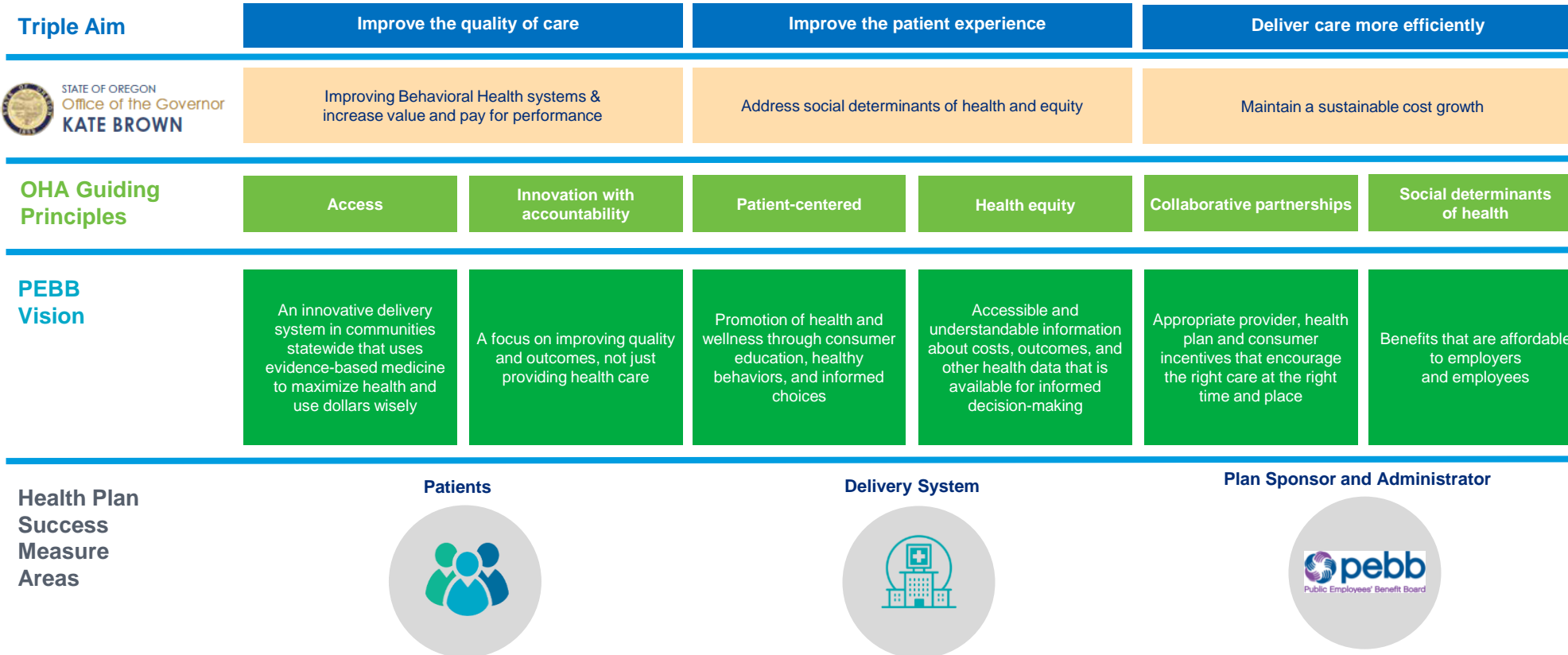
March 15, 2022
Andrew Hofheimer
Emery Chen

A business of Marsh McLennan

1. Round 2 Renewal Responses and Follow-ups
2. Utilization Follow-ups
3. Next Steps
4. Appendix

Agenda

Guiding Principles



Key Health Equity Strategic Pillars



Stakeholders

The Board acknowledges that members are the most important stakeholder in achieving health equity, and that the voice of the members, particularly from the priority populations, will need to be proactively sought and amplified.

The Board believes that all stakeholders, including itself, need to incorporate health equity strategies, including:

- Members
- Board
- OHA
- Elected officials, including legislators
- Benefit carriers and vendors
- Health systems, providers, and staff
- Consultants



Decision Making Based on Health Equity Lens

- The Board and OHA will make policy and operational decisions through the lens of health equity, incorporating our strategies, stakeholders, priority populations, and health equity metrics
- The Board expects that PEBB's carriers, vendors, and consultants will also make their policy and operational decisions through a health equity lens for the PEBB population



Priority Populations

The priority populations include:

- Black, Indigenous, People of Color, and American Indian/Alaska Natives
- People with low incomes
- People who identify as LGBTQ+
- People with disabilities
- People living in rural areas
- Consider addition of Veterans, Multi-generational, Women, and People with visible and invisible disabilities, per feedback from the Board Retreat



Health Equity Metrics

Three strategies to address quality, inequities, and disparities:

- Reporting on a standard set of quality measures
- Monitoring for unintended consequences
- Improving equity



Bridge and Long-Term Benefit Strategies

The Board believes that its bridge strategies can be designed to enhance health equity for the PEBB members, and those strategies include:

- Advocacy services
- Expert medical opinion
- Centers of excellence
- Digital health solutions

The Board believes that its long-term strategy for advancing value-based care payments and the Coordinated Care Model can be designed to enhance health equity.

Recap of Prior Board Meeting

Decisions Made

Coordination of Benefits:

- Currently, if a PEBB member is covered under their own and partner's plan, they may not have access to both set limits for the limited or capped benefit on select health plans.
- Certain healthcare benefits have a defined limit or cap coverage by a set dollar amount defined by the health plan.

The Board Voted to:

- Align Providence Health Plan with Moda and Kaiser to allow dual covered members access to both lines of coverage effective 1/1/2022.
- Allowing this change would ensure parity between plans giving PEBB members the same benefit regardless of carrier.

Composite Rates

Historical and Projected

Year	Composite Rate Using Prior Year's March Census	% Change	Composite Rate Using Plan Year's March Census	% Change
2014	\$1,333.58		\$1,327.47	
2015	\$1,321.53	-0.9%	\$1,313.06	-1.5%
2016	\$1,356.47	2.6%	\$1,347.31	2.0%
2017	\$1,416.93	4.5%	\$1,405.13	3.6%
2018	\$1,464.20	3.3%	\$1,452.68	2.5%
2019	\$1,513.98	3.4%	\$1,495.83	2.2%
2020 (w/Premium Tax and 2.676% funding assessment)	\$1,594.86	5.3%	\$1,588.17	4.9%
2021 (w/Premium Tax and -0.855% funding assessment)	\$1,607.63	0.8%	\$1,597.78	0.2%
2022 (w/Premium Tax) - with Final Plan Changes	\$1,660.52	3.3%		
2023 (w/Premium Tax) - Preliminary	\$1,706.00	2.7%		

- Projected composite rate is below the 3.4% limitation
- Projected 2023 needed funding is \$7.1M below the 3.4% cost cap

Renewal Overview

Financial Roll Up

Carrier	Line of Coverage	Admin Fee Increase	Final Premium /Accrual Rate Increase with Plan Changes	Total Projected 2023 Active Premiums	Plan's Share of Composite Increase
Providence - Statewide	Medical/Rx	3.2%	1.3%	\$362,500,000	0.3%
Providence - Choice	Medical/Rx	2.6%	5.7%	\$344,700,000	1.3%
Kaiser	Medical/Rx	n/a	4.9%	\$198,500,000	0.7%
Moda (includes Moda360)	Medical/Rx	0.2%	5.0%	\$145,600,000	0.5%
Moda/DDOR	Dental	1.7%	-1.5%	\$50,100,000	-0.1%
Willamette Dental Group	Dental	n/a	-2.5%	\$14,800,000	0.0%
Kaiser	Dental	n/a	3.4%	\$9,400,000	0.0%
VSP	Vision	0.0%	-4.0%	\$10,800,000	0.0%
The Standard	Basic Life	n/a	0.0%	\$1,100,000	0.0%
Total				\$362,500,000	2.7%

Carrier	Line of Coverage	Fee Increase
ASI*	FSA and Commuter	-10.1%
BHS	COBRA/Retiree Admin	0.0%
Canopy	EAP	0.0%

} Coverage is not included in the composite rate

*ASI reduced fees by \$0.30 per employee per month due to recently introduced cardless pay and direct payment enhancements that have increased efficiencies.

Round 2 Renewal Responses and Follow-ups



Medical Renewals

Self-Insured Administrative Fees

Statewide			
	2021	2022	2023
Total	\$57.29	\$58.27	\$60.15
% Increase		1.7%	3.2%

Choice			
	2021	2022	2023
Total	\$75.44	\$75.52	\$77.50
% Increase		0.1%	2.6%

Moda Medical Administration			
	2021	2022	2023
Total	\$78.32	\$78.32	\$78.32
% Increase		0.0%	0.0%

Moda 360 Fixed Fees ¹			
	2021	2022	2023
Total		\$4.97	\$5.12
% Increase			+3.0%

¹ Additional charges apply for members participating in the diabetes program, behavioral health clinic, or telemedicine

Mercer requested both carriers to provide further information and justification for the proposed fee increases

Providence

Admin fees are the sole source of revenue for Providence (PHP) and cover operational costs associated with administering PEBB plans. Key points, per PHP:

- Wellness programs including health management consulting support, health coaching, tobacco cessation, diabetic care management, Virta Health Type 2 Diabetes Reversal
- Digital point solutions including Learn 2 Live Cognitive Behavioral Therapy (cCBT) program
- Hybrid telehealth programs including Behavioral Health Concierge virtual program, Kaia Health pain management program, Providence ExpressCare Virtual
- Pass through vendor program management including WebMD and WW (Weight Watchers)

Wages in Oregon are expected to grow by 4% for years after 2022, and inflation is expected to cool from the current level to 5%. Wages account for 60% of admin costs.

Moda

Moda continues to build capacity and expand capabilities to existing and new programs into Moda 360. Recent chat and push notifications have been added as well as a member dashboard that is slated for 2023.

Moda continues to invest in systems, tools, and people to ensure the best support for customers. As part of this investment, periodic inflation-based increases are necessary to update the infrastructure Moda uses to serve customers.

Medical Renewals

Coordination of Care between Kaiser Medical and Dental

Kaiser's overall goal is to connect the dots between oral and overall health for those enrolled in both medical and dental.

Since many medical illnesses have oral manifestations, dentists can help spot life-threatening conditions, such as diabetes and oral cancers. Dentists can detect these diseases at the earliest stage because they see patients on a routine rather than a problem-driven basis. Early detection improves the patient's odds of a positive health outcome and helps mitigate costs.

- **Family Practice and Pediatric clinicians** complete an oral health assessment and apply fluoride to all infants and children, starting at the age of primary tooth eruption until age six
- Referrals out to dental offices when a member has an observed dental need but has not seen a dentist recently

- Shared electronic health records
- Website and app access
- Text and app notifications

- **Dental** teams will scan for gaps in care including preventive screenings, immunizations, vaccinations, HbA1c tests, and diabetes lab tests
- Licensed practical nurses are embedded into select dental offices

Medical Renewals

Diabetes Prevention Program Update

PEBB's Medical Carriers will utilize a third-party vendor for the CDC certified Diabetes Prevention Program

Minimum Requirement	Providence & Kaiser <i>Omada</i>
CDC Certified	Yes
The ability to Identify, proactively outreach and recruit PEBB members who are the most risk for diabetes, using the CDC Prediabetes Risk Test	Yes, outreach and identification services are encompassed in Omada's Enrollment Outreach Coordinators (EOCs). EOCs can customize and do targeted customized communication. The identification process also included the CDC Prediabetes risk screener.
Reporting on PEBB specific metrics <i>Customer service metrics</i> <i>Identification of eligible population</i> <i>Utilization and primary access points</i>	Reporting package meets metrics and CDC standards; overall satisfaction with customer support, detailed list of members who applied, status of application, account set-up and utilization reports.

Moda is working on contracting with two possible digital health point solutions that would meet minimum requirements.

Other preferred but not required criteria requested includes:

- Accessibility for members with vision and/or hearing loss
- Addressing and assessing food insecurities, food deserts and cultural cuisine preference
- Those without reliable Wi-Fi and/or technology tools
- Referrals to healthcare providers and community-based organizations
- Performance guarantees at risk

Non-Medical Renewals

Vision Service Plan

Coverage for Retinal Screening in Lieu of Dilatation

- Retinal screening uses high-resolution imaging systems to take pictures of the inside of the eye
- Vision Service Plan (VSP) Retinal Screening Coverage does include all Retinal Scan technology, including Optomap
- VSP currently caps the cost of this additional exam at \$39

PEBB has the option to reduce this cost to a \$10 copay:

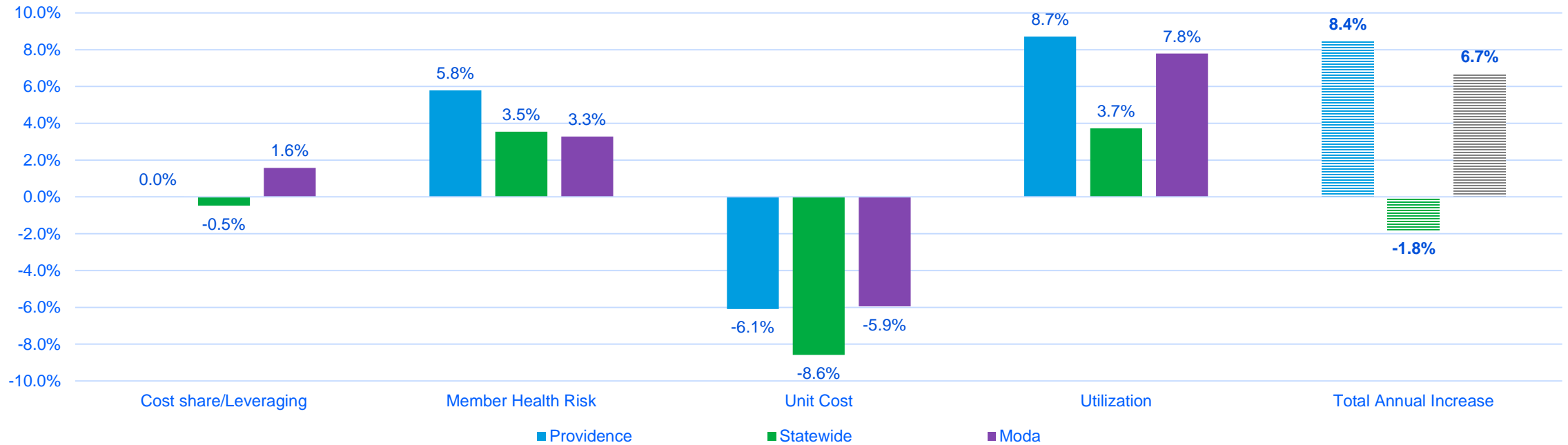
- Reducing this to a \$10 copay would **increase cost about \$500,000 or 5%** of total expected claims

Utilization Follow-ups

2

Self-Insured Plan Components of Trend

2021 (Through Sept) versus 2020



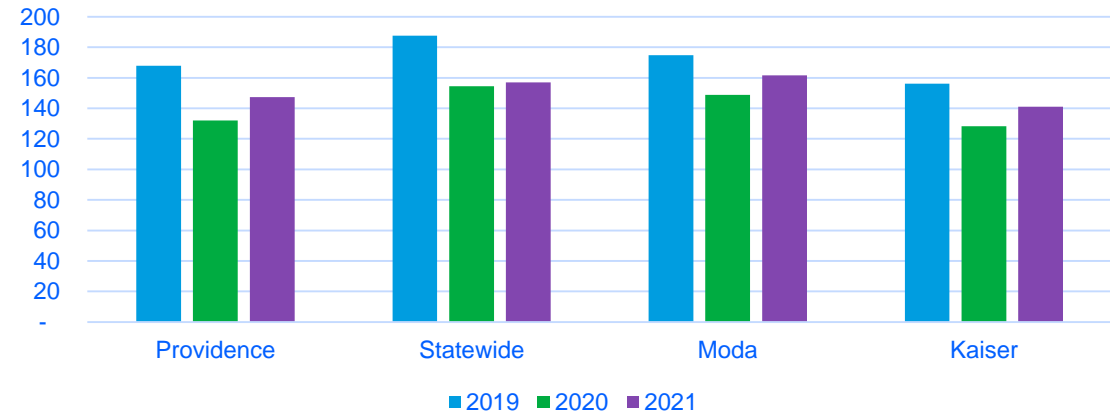
Choice	Statewide	Moda
Inpatient costs decreased 8% with unit cost decreases having the largest impact	Inpatient costs decreased 26% with unit cost, service mix, and utilization all reducing costs	Inpatient costs decreased 22% with utilization decreasing 14% and costs decreasing 15%
Rx increased 11% due to specialty drug utilization	Outpatient costs increased 10% due to increased utilization of outpatient surgeries	Rx increased 12% due to specialty drug utilization
Outpatient, Physician, and All Other services increased due to utilization increases	Professional and outpatient specialty drug costs decreased due to utilization and cost	Outpatient (13%), Physician (15%), and All Other services (15%) increased due to utilization; unit cost decreased

Emergency Department Coding

Usage of Emergency Rooms:

- Visits per 1,000 members increased in 2021 through September from 2020 but remains below 2019.
- Statewide has the smallest increase in 2021.
- In 2021, Moda members utilize services at the highest rate.

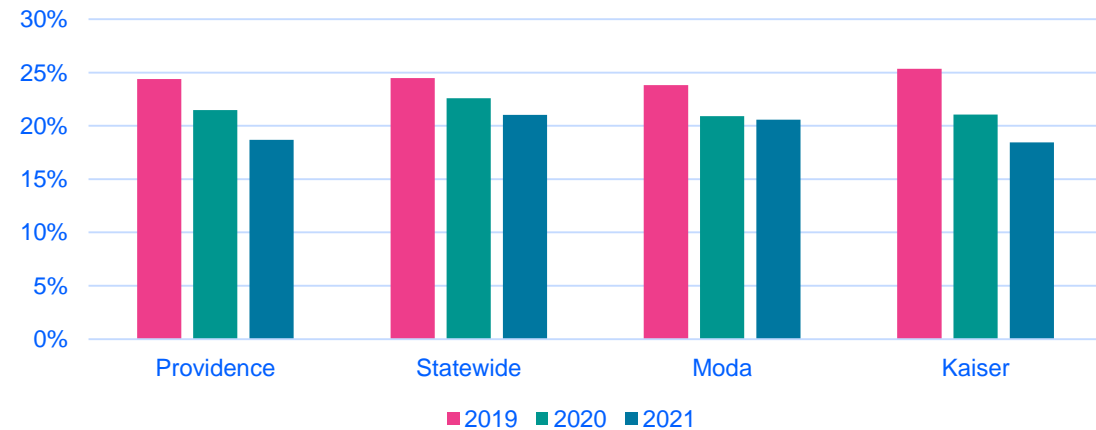
Visits Per 1,000 Members



Visits by NYU Classification:

- Non-emergent visits decreased as a percentage of services from 2019 to 2021.
- Moda has the smallest decrease in 2021.

NYU Non-Emergent as % of Total Visits

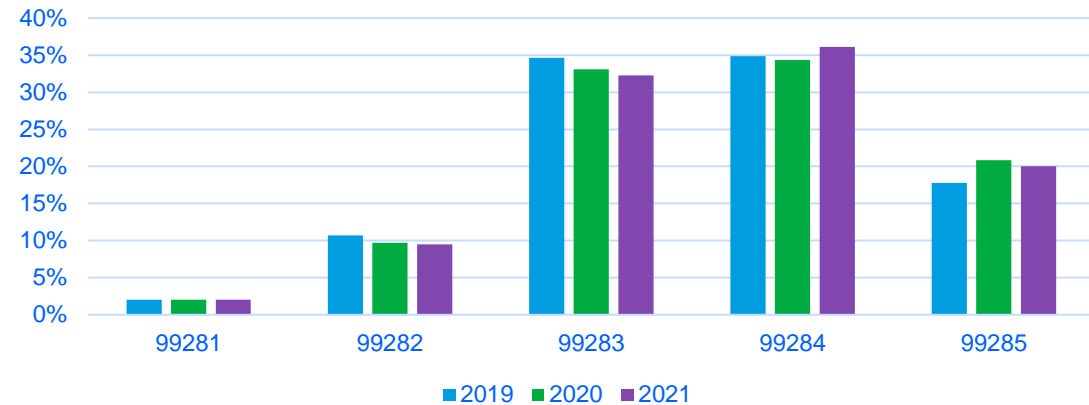


Emergency Department Coding

Emergency Department CPT Codes:

- Severity level of emergency department visits can be stratified by CPT code.
- 99285 is the highest level; 99281 is the lowest.
- Over time, percentage of visits coded at the highest levels (99284 and 99285) continues to increase.
- 2021 coding has moderated.

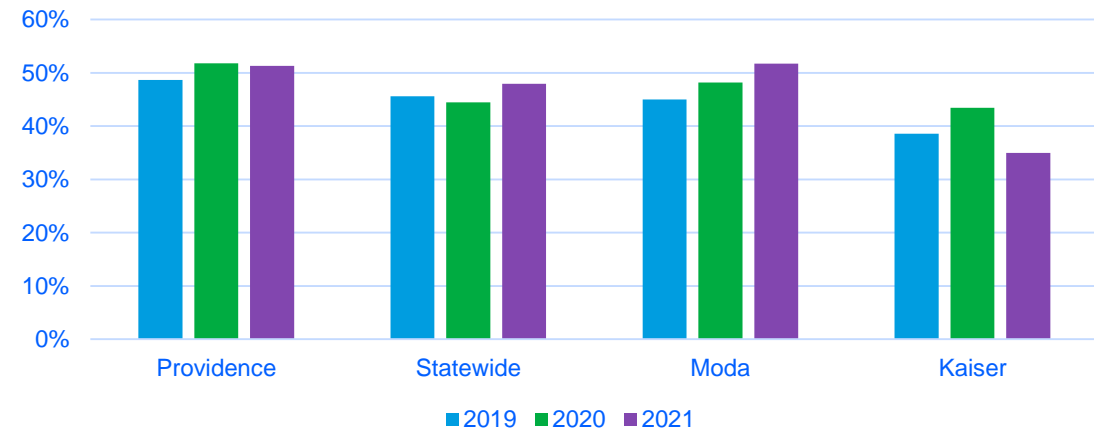
Emergency Department Visits by CPT Code



Non-Emergent Visits by Level:

- NYU Non-emergent visits coded as level 4 or 5 (99284 or 99285) generally increased during 2020, with the exception of Statewide.
- During 2021, more Statewide and Moda non-emergent visits were coded at 4 and 5.
- Level 4 and 5 visits decreased as a percentage of total Kaiser non-emergent visits.
- 56% of 2021 total PEBB ED visits are coded level 4 or 5.

Non-Emergent Coded as Level 4 or 5



Next Steps

3

April Board Meeting

- Review round three carrier responses
 - Will Include best and final offers
- Approve final plan changes for 2023
 - Include a Health Equity lenses on proposed changes
- Composite update with further evaluation of carrier recommendations
 - Including outline of all Board decisions needing to be made

Appendix

4

Moda and Providence

Considerations and Plan Enhancements

Moda	Considerations	Annual Cost/(Savings) Impact	Mercer Recommendation
Site of Care	<ul style="list-style-type: none"> Program extension for select therapeutic oncology medications that target and treat cancer Targets about 14 therapies affecting about 6 members currently 	-0.1% or -\$123K	Implement site of care due to minimal disruption
Diabetic Testing Supplies	<ul style="list-style-type: none"> Move the coverage of diabetic glucose monitors and testing supplies from the medical benefit to the pharmacy benefit. In doing so, members would need to go to a retail pharmacy versus a durable medical equipment provider Member cost shares would not change Moda will send member communication as well as move all prior authorizations under the medical benefit to the pharmacy benefit to minimize member disruption 56 members are currently getting through a durable medical equipment provider 	-0.04% or -\$50K	Accept plan change due to minimal member disruption
Total costs		- \$185K	

Providence	Considerations	Annual Cost/(Savings) Impact	Mercer Recommendation
Manufacturer Coupon Rx Program	<ul style="list-style-type: none"> Giving members the power to maximize manufacturer coupons on high cost specialty drugs to further savings achieved by the plan Members would see no disruption as there would continue to be little to no cost shares 	- \$8M	Accept this program as it only benefits members

Coverage for Medically Necessary Breast Reduction Surgery

- Today, coverage for medically necessary breast reduction surgery for cisgender women with other indicators is not covered for PEBB members under Providence and Moda health plans. However, this coverage is in place under Kaiser.
- In years past, this coverage was available under Providence and Moda, but was removed as a benefit cost saving measure.
- In order to achieve plan parity, as well as provide an equitable benefit to all PEBB members, Mercer requested the cost impact for the following criteria:
 - Treatment for transgender men as part of their gender affirmation treatment
 - Treatment for women with breast cancer
 - Treatment for cisgender women with other indicators for medically necessary surgery, such as back pain

Providence	Moda	Kaiser
<ul style="list-style-type: none">• Cost impacts would be +\$400K	<ul style="list-style-type: none">• Cost impacts would be +\$185K	<ul style="list-style-type: none">• Covered as medically necessary

Non-Medical Plan Changes

VSP and Delta Dental of Oregon

VSP	Considerations	Annual Cost/(Savings) Impact	Mercer Recommendation
Frame Allowance	<ul style="list-style-type: none"> Increase Walmart/Sam's Club frame allowance to \$150 for the Base plan and \$225 for the Plus plan Current frame allowances are \$80 for the Base plan and \$125 for the plus plan at Walmart/Sam's Club There were a total of 378 claims with a frame purchased at Walmart in the last 12 months 	+0.0%	Due to minimal claims impact, <u>increase the frame allowance</u> so that members have the same benefit at Walmart as they would at other locations
Delta Dental of Oregon	Considerations	Annual Cost/(Savings) Impact	Mercer Recommendation
Orthodontia Benefit	<ul style="list-style-type: none"> Current orthodontia benefits cover up to a lifetime maximum of \$1,500 on the full-time PPO and Premier plan Consider increasing this to \$1,800 	+1.0% or +\$464K	<u>Increase maximum</u> to make benefit more competitive with market

According to Mercer 2021 National Employer Survey of State Government Groups 500+, the median lifetime maximum for orthodontia services is about \$1,625.

Budget/Cost Assumption

Data

- Claims information provided by: Providence, Moda, DDOR, VSP
- Enrollment information provided by: Providence, Moda, DDOR, VSP
- Enrollment information by plan and tier provided by: PEBB
- Projections use incurred claims through December 2021
- Budget projections based off enrollment for the month of: January 2021
- Includes the following employee classes: actives, retirees, COBRA

COVID-19 Caveats

- Given the existing uncertainty regarding COVID-19, Mercer estimated the impact of COVID-19 with the caveat that it should be considered an informed estimate based on limited and changing anecdotal and actual information.
- The financial impacts of COVID-19 reflects our best thinking as of February 2022. Our estimates will change (up or down), and perhaps rapidly, and to a significant degree, as more experience and information emerges.
- Experience should be monitored as appropriate and feasible, with adjustments made to projections as needed.
- There are many unknowns at this time, all of which could impact our cost estimates. As these variables change and we learn more, we will update our estimates.
 1. Prevalence and severity
 2. Outbreak duration
 3. Government actions
 4. Testing protocols and availability
 5. Treatment alternatives and vaccine availability and requirements

Budget/Cost Assumptions

Underwriting Methodology

- Mercer uses underwriting techniques, based on actuarial guidelines, to project the future plans costs for the self-funded plans. The key factor in projecting future results is the prior experience of a group, especially when the group consists of a large population. The process of forecasting past claims experience into the future takes into account plan designs, member demographics, trends and group credibility. These processes are widely accepted within the insurance market as the standard to establishing budget and premium levels that are appropriate to cover future risks.
- As a starting point to developing the Jan 2023–Dec 2023 period funding rates, Mercer collected monthly paid claims and enrollment for Oregon PEBB's medical and pharmacy self-funded plans from the respective vendors (as previously stated in the Assumptions section). Mercer has utilized the information provided by you and/or your vendors/carriers to develop the enclosed budget projections. As such, Mercer has not independently verified this information for accuracy.
- The average cost per enrolled employee was then calculated by dividing the total claims paid by the average number of enrolled employees in each plan on an incurred or lagged basis as previously state in the Assumptions section.
- Once the average claims costs per employee were calculated, claims costs were projected to the Jan 2023–Dec 2023 period by application of trend factors. The trend factors used in the projections are within the acceptable trend ranges published by Mercer's Actuarial and Financial Group.
- These guidelines are published for active and retiree populations, by benefit plan and product. They fall within the framework established by the Actuarial Standards Board, which has responsibility for the development of actuarial standards of practice used by all professional organizations. The primary components of medical trend include the following:
 - Inflation in unit prices for the same services
 - Changes in utilization of the same services
 - Out-of-pocket leveraging
 - New technology/services (increases or decreases depending on the mix and cost of services)
 - Cost shifting from public payors (Medicare and Medicaid) to private plan payors
 - Population aging
- After application of trend, a margin was also added. Credibility reflects a degree of confidence and accuracy in using the past group's specific information in projecting future costs. A mixture of the size of the group and the period of time the data reflects, determines a group's credibility. Generally, the larger the group and/or the longer the period of available historical information, the greater the degree of confidence and accuracy of using a past group's specific data to project the future costs. Higher margin levels are required for smaller groups since it is designed to cover the potential variation and volatility in actual cost relative to the projected costs.
- The last step is the addition of the administrative fees to the projected costs. These fees include medical and pharmacy administrative costs, and the addition of stop loss premiums. The combination of the administrative fees and trended claims costs allows us to establish funding levels that are appropriate to cover future risks. It is important to remember that these projections are only estimates. As with all estimates, they are based upon the information available at the point in time and are subject to unforeseen and random events. They must be interpreted as having a likely range of variability from the point estimate.



Services provided by Mercer Health & Benefits LLC.

A business of Marsh McLennan

Copyright © 2022 Mercer Health & Benefits LLC. All rights reserved.