

Public Employees' Benefit Board Meeting Synopsis October 16, 2018

The Public Employees' Benefit Board held a regular meeting on October 16, 2018, at the Health Licensing Office, 1430 Tandem Ave. NE, Suite 180, Salem, Oregon. Chair Shaun Parkman called the meeting to order at 9:30 a.m.

Attendees

Board Members:

Shaun Parkman, Chair
Kimberly Hendricks, Vice Chair
Bill Barr
Representative Mitch Greenlick
Dana Hargunani, MD
Kim Harman
Siobhan Martin
Mark Perlman
Jeremy Vandehey

Board Members Excused/Absent:

Senator Betsy Johnson

OEBB Staff:

Ali Hassoun, Interim Director
Cindy Bowman, Director of Operations
Rose Mann, Executive Assistant
Linda Freeze, Benefits Manager

Consultants (WTW):

Emery Chen, Mercer Health and Benefits, LLC
Robert Valdez, Mercer Health and Benefits, LLC
James Mathisen, Mercer Health and Benefits, LLC

[View meeting agenda and attachments.](#)

[View the meeting recording](#)

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I. Welcome and approval of September 18, 2018, Board Meeting Synopsis (Attachment 1) - [Video Recording 0:00:26](#)

MOTION - [Video Recording 0:00:43](#)

Siobhan Martin moved to approve the Board meeting synopsis of the September 18, 2018. Bill Barr seconded the motion. The motion carried 8 - 0.

II. State Employee Wellness Survey Funding (Attachment 2) - [Video Recording 00:01:33](#)

Margaret Smith-Isa presented information regarding the State Employee Wellness Survey Funding and requested Board approval of staff recommendation to continue the commitment to PEBB's funding for the 2019 survey.

MOTION - [Video Recording 0:12:34](#)

Bill Barr moved to approve staff recommendation for funding for the State Employee Wellness Survey funding. Dana Hargunani seconded the motion. The motion carried 8 - 0.

III. Senate Bill 1067 Double-coverage & Opt-out Elimination Fiscal Analysis (Attachment 3) - [Video Recording 00:13:12](#)

Emery Chen and Robert Valdez, Mercer Health & Benefit, LLC

IV. Pharmacy Benefit Trends (Attachment 4) - [Video Recording 01:04:49](#)

Virginia Rivas, West Market Pharmacy Lead, Mercer Health & Benefits, LLC

V. Oregon Prescription Drug Program(OPDP) (Attachment 5) - [Video Recording 01:26:21](#)

Trevor Douglass, OPDP Director

VI. Pharmacy Services and Programs Medical Carriers Attachments [Video Recording 01:41:26](#)

Dr. Keith Bachman, PEBB Medical Director and Sunshine Sommers, Manager, Clinical Pharmacy Services, Kaiser Permanente

Carly Rodriguez, Director of Clinical Pharmacy, Moda Health Plans

Helen Noonan-Harnsberger, PharmD, AVP and Aaron Masini, PharmD, Clinical Pharmacy Manager, Providence Health Plan

VII. Innovation Workgroup Update - [Video Recording 02:04:08](#)

Shaun Parkman, Chair and **Dana Hargunani** presented an update on the first meeting of the OEBB/PEBB Innovation Workgroup.

VIII. Other Business/Public Comment

There being no public comment nor further business to come before the Board, Chair Shaun Parkman adjourned the meeting at 12:30 p.m.

Public Employees' Benefit Board Retreat Synopsis November 15, 2018

The Public Employees' Benefit Board held a retreat on November 15, 2018, at the Clackamas Community College Wilsonville Training Center, Room 210W, 29353 SW Town Center Loop E, Wilsonville, Oregon 97070.

Attendees

Board Members:

Shaun Parkman, Chair
Kimberly Hendricks, Vic Chair
Bill Barr
Representative Mitch Greenlick
Dana Hargunani, MD
Kim Harman
Senator Betsy Johnson
Siobhan Martin
Jeremy Vandehey

Board Members Excused/Absent:

Mark Perlman

OEBB Staff:

Ali Hassoun, Director
Cindy Bowman, Director of Operations
Rose Mann, Board Policy and Planning Coordinator
Margaret Smith-Isa, Program Development Coordinator

Consultants (WTW):

Emery Chen, Mercer Health and Benefits, LLC
Robert Valdez, Mercer Health and Benefits, LLC
James Mathisen, Mercer Health and Benefits LLC
Michael Garrett, Mercer
Nick Albert, Mercer
Trisha Tyler, Mercer

[View meeting agenda and attachments.](#)

[View the meeting recording](#)

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I. Welcome and review agenda.

Shaun Parkman, Chair welcomed everyone and reviewed the retreat agenda.

II. OHA CCO 2.0 Value-based Purchasing

Chris Demars, OHA Transformation Center Director presented information on the OHA CCO2 Value-based Purchasing.

A “value-based payment” is a payment to a provider – so payments to insurers that incentivize quality/lower cost are VBP-like, but the primary goal is to ensure that insurer/payer reimbursement to providers is designed to move away from Fee for Service (FFS) and shift to value based approaches.

Metrics alignment to support VBP -

Shaun Parkman stated that metrics in OHA contracts apply to insurers/carriers, so it is a step removed from how the metric/incentive is applied to providers. Insurers determine this through their network contracts – and don’t do this uniformly.

The expectation (not necessarily a requirement) is that CCO/carriers apply the metrics included in their OHA contracts to the payment approaches they establish in their provider contracts. Ongoing tension the Board will have to navigate – how to require/ensure focus on the same key outcome metrics for health plan VBP efforts while still allowing flexibility for carriers to negotiate provider contracts. PEBB contracts with carriers do not prescribe how carriers administer performance metrics in provider contracts.

VBP for PCPCH clinics - Requirement that CCOs pay all PCPCH clinics a PMPM “infrastructure” payment based on PCPCH tier level

Dana Hargunani stated infrastructure payments are key to building capacity within clinics to prepare them to move into the VBP realm and take on more risk associated with achieving outcome targets; Statewide target is 12% of total payments - these will be in Primary Care. PEBB is already at this 12% target.

There is not great data, but the current estimate is that roughly 35-40% of CCO payments are Value Based Payments. This is a weighted average so bigger CCOs weight more heavily. CCO 2.0 expectation is that all CCOs will be at 20% by 2020.

The CCO 2.0 expectation is that by 2023/2024 there will be some proportion of payments in VBP category 3A (APMs with shared savings with upside risk only) and Category 3B (APMs with shared savings and downside risk).

The Transformation Center is a resource for sharing best practices in quality improvement and innovation in CCOs – resource for Innovation Workgroup. Initial reticence among CCOs regarding sharing their best practices; however, in recent years CCOs are more willing to share their initiatives/best practices.

Applying VBP strategies to PEBB

It was noted that PEBB plans directly compete for market share and their geographic coverage areas overlap. This creates a different ecosystem for collaboration and sharing best practices.

Bill Barr stated that improving quality/cost for PEBB carriers extends beyond just what is included in PEBB contracts –it includes leveraging other areas of their market share, provider networks to further spread VBP and quality improvement approaches throughout their commercial book of business and total book of business.

Strategic Discussion

Emery Chen and Robert Valdez, Mercer Health & Benefits, LLC presented information on possible opportunities for PEBB.

Mercer clarified that PEBB’s ASO provides many more services than claims processing and network leasing. Examples are total cost of care targets in Salem area, withhold arrangements with facilities, PCPCH infrastructure payments by tier. The challenge is implementing these strategies on a broad/comprehensive basis – particularly in areas where there is no competition

Board members were asked to rank their top three criteria for evaluating strategic options through an anonymous polling survey. The top 5 responses were:

- Amount of Savings 35%
- Improved Health Outcomes 28%

- Timeframe for Saving 12%
- Ease of Implementation 9%
- Improved Experience for Members 7%

Concierge/ Advocacy for Statewide PPO

Vendors in market place generally have an expertise that is not available through traditional health plan customer service. Best in class vendors will put fees at risk related to cost savings targets - rough estimate of costs is ~\$8-12 PMPM.

Poll results –A (would like to dig deeper as soon as feasible) 67%; B (This sounds promising, but I am not entirely sure about it) 22%; D (significant concerns, need further discussion) 11%

Expert Medical Opinion

Voluntary program for members; could elect to require participation for certain procedures (for example, those that are susceptible to overuse). This allows members to easily access a second opinion for medical issues. Access to medical experts may be particularly beneficial in rural areas where members don't have access to expert providers locally. Additional benefit for members to seek second opinion/guidance for family members for whom they may be coordinating care. The average cost PEPM is \$2 to \$5. Another option would be to audit medical charts against evidence-based guidelines to get a better estimate of opportunity.

Poll results –A (would like to dig deeper as soon as feasible) 60%; B (This sounds promising, but I am not entirely sure about it) 30%; D (significant concerns, need further discussion) 10%

Double spousal surcharge

Cost shift to members –this applies even to members who have a spouse with skinny employer coverage (blunt instrument, not linked to system transformation). One view is this is a barrier, another viewpoint is that this illustrates the value proposition of PEBB benefits.

Poll results: A (would like to dig deeper as soon as feasibly possibly) - 33%; B (this sounds promising, but I am not entirely sure about it) -22%; C (the pros and cons seem equal to me) -9%; D (significant concerns; need further discussion) -18%; E (absolutely against considering this strategy further) -18%

CCM in efficient counties – Restrict counties where CCM plans are offered to those with demonstrated efficiencies and improved outcomes. A modified strategy would involve longer timeline and a warning/probationary period for plans found to be inefficient. The consideration is how this might play out in counties that only have Type A and/or B hospitals.

Poll results: A (would like to dig deeper as soon as feasibly possibly) -27%; B (this sounds promising, but I am not entirely sure about it) -64%; C(the pros and cons seem equal to me) -9%

Bundled Payments with Centers of Excellence (COE)

This strategy is generally used for surgical procedures. Fees at risk with a bundled payment and warranty is the gold standard (might be aspirational at present – phased in approach).

Early phase would be just for the procedure (professional and facility services) – pre-operative, operative, and post-operative care.

Greatest savings are from avoidance of unnecessary procedures. Washington state found that 35% of patients sent to COE for hip/knee replacements were inappropriate candidates for surgery.

Couple with travel benefit for members out of COE local area.

Added benefit of bundled payment is that it ensures all operative professional costs (i.e., anesthesiology, radiology) are included in the payment bundle

Currently Providence bundled payments are with 2 Providence hospitals in Portland and cover hip/knee, maternity, coronary artery bypass graft.

Good candidate for joint effort including both PEBB and OEBB.

Expert medical opinion for these services would not be needed – redundant

Point solutions – targeted service for a clinical condition

There is a need to identify the conditions that PEBB wants to make ground on - what aspects of the condition are most important to focus on; musculoskeletal, physical/rehab therapy, behavioral health is PEBB areas of opportunity

Look for vendors that will put fees at risk. Driving participation, and the right participants, is key.

Accountable Care Organizations;

- Community solution – truly transformative
- Some ACOs have fully capitated arrangements
- Aligns with statewide goals
- Focus on more densely populated counties first; leave rural areas for later phase

Next steps:

- Detailed comparison of requirements for Medicaid CCOs vs PEBB ACOs – analyze/understand differences
 - Agree on what 2023 looks like – define goal and then map out steps/phased in approach to get there
 - Summary of fees at risk and specific requirements of ASO contract
- A. We should dig deeper immediately to consider what it looks like to implement this strategy as soon as feasible
 - B. This sounds promising, but I am not entirely sure about it
 - C. The pros and cons seem equal to me
 - D. I'm concerned with an aspect of this and wouldn't recommend to explore this further without a discussion of the issues
 - E. I am absolutely against considering this strategy further

There being no further business to come before the Board, Chair Shaun Parkman adjourned the meeting at 3:00 p.m.

HEALTH WEALTH CAREER

PEBB DECEMBER BOARD MEETING

DECEMBER 18, 2018

Robert Valdez
Michael Garrett
Emery Chen
Nick Albert



MAKE TOMORROW, TODAY



TODAY'S OBJECTIVES

01

To recap the Board Retreat discussion

02

To compare PEBB's roadmap to CCO 2.0

03

To help distinguish between CCOs and ACOs

04

To outline options to move to ACO and Statewide bridge strategy

STRATEGIC ROADMAP BOARD RETREAT RECAP

DECISIONS AND TAKEAWAYS



TODAY:

- Timeline and design for ACO/CCO development
- Timeline and design for interim/bridge strategy

STRATEGIC ROADMAP

BOARD RETREAT RECAP

Criteria for evaluating plan management strategies:

- Amount of Savings: 35%
- Improved Health Outcomes: 28%
- Timeframe for Saving: 12%
- Ease of Implementation: 9%
- Improved Experience for Members: 7%

STRATEGY RANKINGS

Strategy	GPA ¹	
Expert Medical Opinion	4.50	} Strategies worth exploring
Concierge for Statewide PPO	4.45	
Bundled payments with Centers of Excellence	4.20	
CCM in Efficient Counties	4.18	
Point Solutions	4.10	
Double Spousal Premium Surcharge	3.24	} Long-term ACO / CCO development
Accountable Care Organizations (ACOs)	Poll not completed	

¹GPA calculated as follows:

- 5 points - We should dig deeper immediately to consider what it looks like to implement as soon as feasible
- 4 points - This sounds promising, but I am not entirely sure about it
- 3 points - The pros and cons seem equal to me
- 2 points - I'm concerned with an aspect of this and wouldn't recommend exploring this further without discussion
- 1 point - I am absolutely against considering this strategy further



BRIDGE STRATEGIES PLAN OF ACTION

Strategies



Expert Medical
Opinion



Concierge for
Statewide



Bundled Payments
with COE



Point Solutions

Approach

#1

Carriers build, buy, or align
with the strategies

#2

PEBB Procures

Process

Incorporate questions
into renewal letters

Receive responses

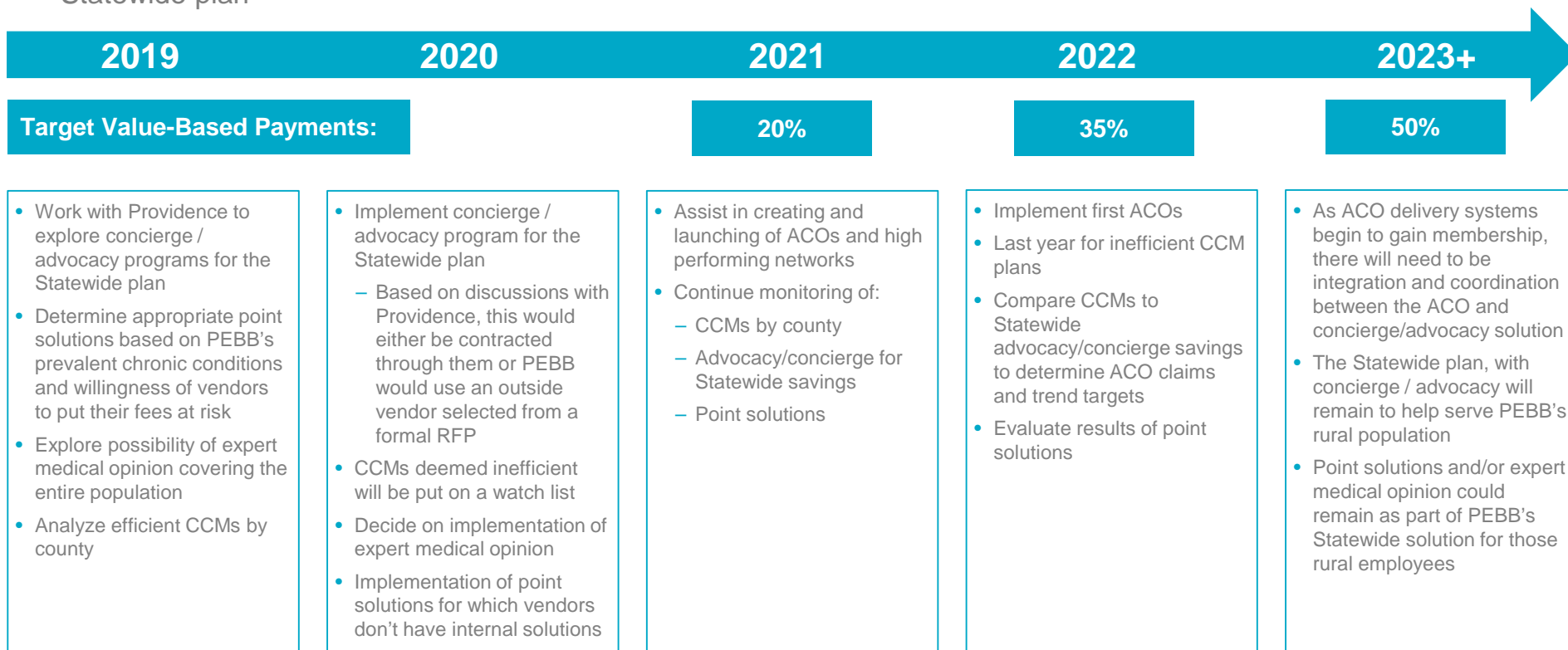
PEBB decides if responses are
adequate, and if the carriers are not
able to do it, is the idea important
enough to go out to procurement

Procurement process on
ideas carriers cannot administer

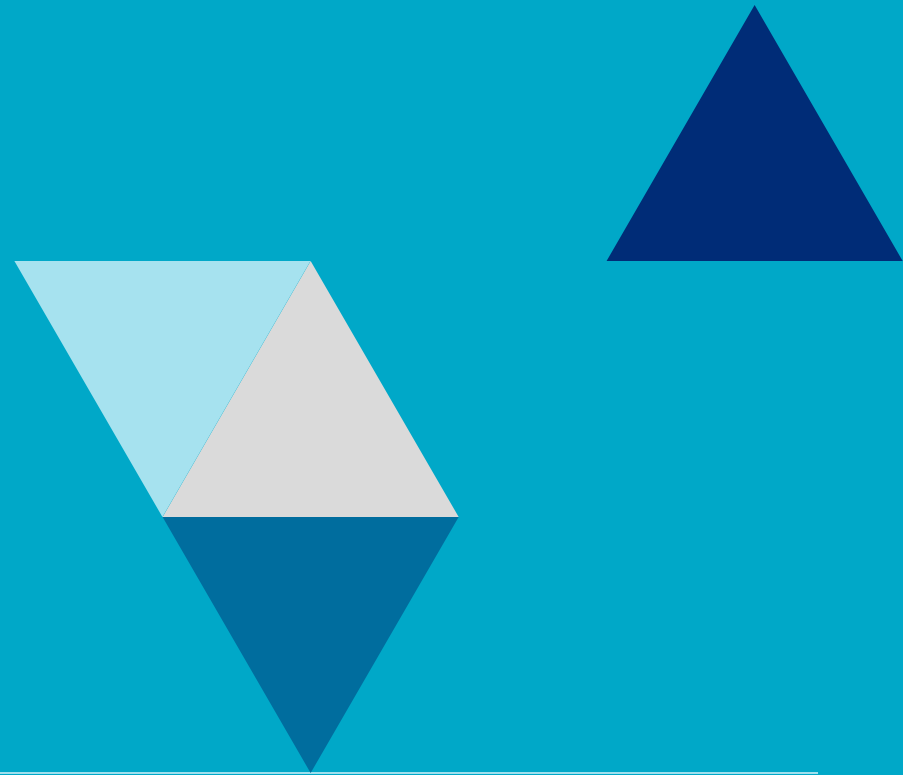
ROADMAP

LONG-TERM AND BRIDGE STRATEGIES

- Implementing high-performing ACOs will take five+ years
- PEBB will need strategies in the interim to generate cost savings in order to meet the 3.4% target
- Additionally, the ACOs will only replace the current CCMs, leaving the need for continued management on the Statewide plan

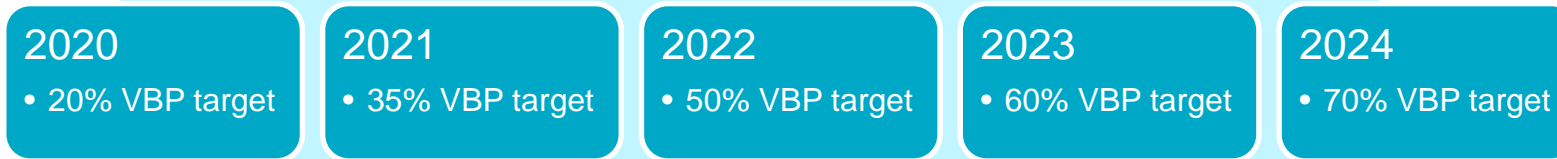


ACO / CCO DEVELOPMENT



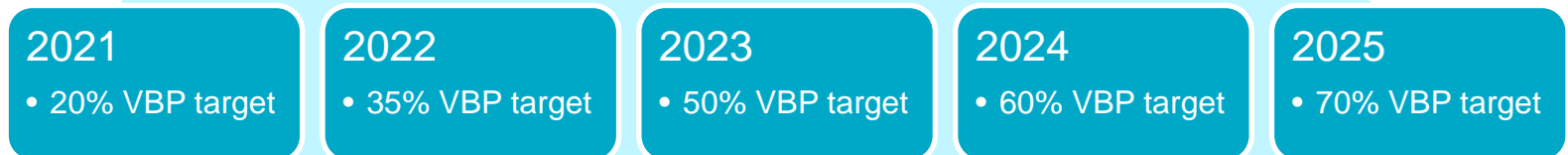


PEBB'S ROADMAP VS. OHA'S CCO 2.0 OHA ROADMAP



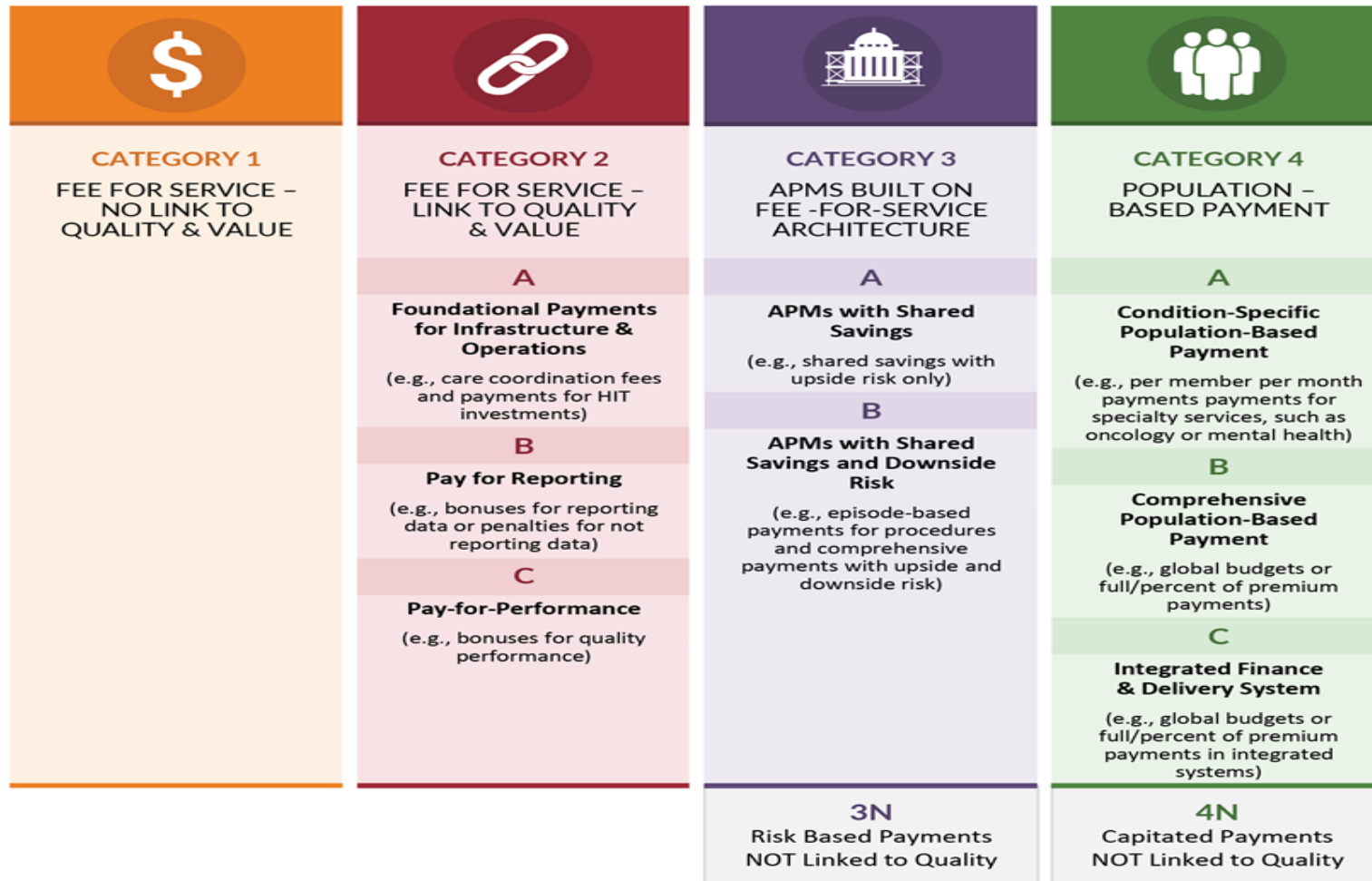
- OHA's CCO payments to providers must be in the form of a VBP and fall within LAN Category 2C (Pay for Performance) or higher

PEBB DRAFT ROADMAP



- Mercer recommends PEBB consider more aggressive Value-Based-Payment targets:
 - 2021-2024: Category 2C, transitioning to Category 3
 - By 2025: Category 3B (APMs with Shared Savings and Downside Risk)
 - ACO/CCO will be required to have a minimum Category 4 payment model after six years of development/implementation

PEBB'S ROADMAP VS. OHA'S CCO 2.0 FINANCIAL ROADMAP



Source: APM Framework, HCP-LAN,2017

OHSU STUDY

MCO, ACO, AND CCO COMPARISON

MCOs (Managed Care Organizations)

- MCOs receive capitated payments from a state Medicaid program to manage benefits for Medicaid members
- Typically contract with and manage a network of health care providers
- As in Oregon before 2012, separate MCOs typically manage physical, behavioral, and oral health benefits
- MCOs may work with providers in their networks to improve care coordination, implement APMs, and improve other aspects of health care delivery and payment systems, although they usually lack an explicit directive to transform health care broadly

ACOs (Accountable Care Organizations)

- ACOs are groups of providers that assume responsibility for health care access and quality among a defined population of members
- At minimum, they consist of a group of doctors and a hospital
- ACOs typically receive financial incentives if they meet quality goals
- The federal Medicare program recognizes multiple kinds of ACOs, and states are beginning to experiment with Medicaid ACOs

CCOs (Coordinated Care Organizations)

- CCOs shared aspects of MCOs and ACOs but resemble MCOs more closely
- Like MCOs, CCOs contracted with and managed networks of providers, although some CCOs were organized as partnerships between MCOs and providers
- Like ACOs, CCOs were accountable for the health care of a defined population and could receive financial incentives for performance
- Unlike MCOs and ACOs, CCOs integrated funding and payment for behavioral and oral health care, and were directed to transform health care delivery and payment more broadly

Source: "Evaluation of Oregon's 2012-2017 Medicaid Waiver" – OHSU Center for Healthy System Effectiveness

TRANSFORMING THE CCM INTO AN ACO

CRITICAL ELEMENTS

Element	Questions to Consider
Articulate the goals	<ul style="list-style-type: none"> • What are we trying to achieve through the VBC/ACO? • How do we define success? • How will we measure success?
Conduct gap analysis and identify opportunities	<ul style="list-style-type: none"> • What elements of the delivery system are impacted by our measures of success? • Where are the CCMs currently rated on these measures of success? • How and where can the delivery system make improvements to achieve the goals?
Evaluate the ACO Health Management Capabilities	<p>For organizations that want to partner and become a high functioning ACO, perform a readiness assessment of the delivery system to see if the requisite population health management capabilities with the necessary tools, resources, staff, methodologies, etc. are in place in order to achieve the desired goals.</p> <ul style="list-style-type: none"> • How do we know that the delivery system can perform as an ACO and a patient-centered medical home (PCMH)? • What accreditations or recognition can be or are obtained by the delivery system in order to ensure that it will be a highly functioning ACO? • Where there are gaps, what action plans are in place to eliminate those gaps?
Establish the Financial Reconciliation Methodology	<ul style="list-style-type: none"> • Adapt the financial measures of success to performance guarantees including upside and downside risk • Clearly articulate the financial reconciliation methodology, including outlier exclusions (if any), attribution methodology, risk corridors (if any), etc.
Patient-Centered Care and Communication	<p>The VBC/ACO model needs to be patient-centered with tailored and customized communications in order to support patient enrollment and engagement</p> <ul style="list-style-type: none"> • Determine gaps between current patient experience and engagement (open enrollment, standardized messaging, concierge call center, patient decision aids, etc.) and definition of success for the VBC/ACO • Document action steps to address gaps • Create metrics for success and methodology for calculating those metrics
Benefit Plan Design	<p>The benefit design needs demonstrate the value to the patient in enrolling in the VBC/ACO</p> <ul style="list-style-type: none"> • Is the VBC/ACO replacing the CCM or offered as an option? • Determine if the benefit design or contributions need to be adjusted to encourage enrollment into the VBC/ACO • Create process for obtaining a waiver to go outside the ACO • Will a primary care physician (PCP) designation be required?
Quality Management & Improvement	<p>The ACO delivery system needs to clearly articulate how it is engaged in an on-going, systematic quality management and improvement program that delivers improved outcomes and better patient satisfaction/engagement</p> <ul style="list-style-type: none"> • Clearly define success to the delivery system • Document action steps to address gaps in quality • Determine key metrics that define success and methodology for calculating those metrics
Information Sharing and Reporting	<p>The ACO needs timely, accurate, meaningful, standardized, and actionable information and data in order to support proactive population health management.</p> <ul style="list-style-type: none"> • Determine key stakeholders (providers, facilities, care managers, etc.) and the data required by each stakeholder • Assess current reporting capabilities and gaps • Create project plan for delivering and reviewing data with key stakeholders with timeframes for evaluating success and reassessing needs
Supplier Collaboration	<p>There are usually a number of services and suppliers involved with an employer's overall benefit plan. There needs to be awareness and collaboration between all of the benefit suppliers when an ACO/VBC is launched.</p> <ul style="list-style-type: none"> • How will the suppliers interact and collaborate in order to support a highly functional, integrated system?
Attribution	<ul style="list-style-type: none"> • What kind of providers are considered primary care providers (e.g., MDs, ARNPs, PAs, etc.)? • What type and what kind of office visits are counted (e.g., two office visits of any kind)? • What is the look-back period for counting visits (e.g., one year, two years, etc.)? • How and when would specialist visits be considered?

TRANSFORMING THE CCM INTO AN ACO

SAMPLE SUCCESS MEASURES

PATIENTS



- Clear relationship with the care team and the delivery system
- Receives concierge services
- Experiences low hassle factor with administrative (e.g., eligibility, benefits, etc.) and clinical (e.g., accessing care, interacting with the care team, etc.)
- Feels “delighted” with the delivery system
- Has accessible multiple channels to care (e.g., telemedicine, nurse line, emailing, texting, app, etc.)
- Receives education and support from care team that is understandable and actionable
- Uses tools and resources for self-care (e.g., patient decision aids)

PLAN SPONSOR



- Plan design that demonstrates value and facilitates enrollment into the ACO/VBC
- Communicates and reinforces the model to its population
- Supports supplier integration and collaboration
- Ensures timely and accurate information and data sharing routinely occurs
- Negotiates meaningful performance guarantees (financial, clinical, and administrative)

DELIVERY SYSTEM



- Commitment from leadership with appropriate dedicated resources
- Consolidates, curates, and distributes actionable data
- Staffs primary care teams with the appropriate qualifications and infrastructure to perform proactive population health management
- Implements empowered electronic health record (EHR) that provides efficient communication, information sharing, and incorporates evidence-based guidelines
- Controls care delivery pathways and protocols
- Understands and commits to meet the needs of the patient, including service delivery and clinical delivery
- Reports measures of quality rigorously and transparently with improvement activities to address gaps

ADMINISTRATOR



- Administers value based payment methodologies
- Provides timely and accurate data between suppliers
- Vets high quality provider groups
- Establishes clear administrative processes for the ACO/VBC plan design
- Reinforces the communication regarding the ACO/VBC value proposition
- Provides meaningful performance guarantees (financial, clinical, and administrative)
- Transfers certain functions (e.g., catastrophic case management and utilization management) when the delivery system proves it has the capabilities to perform

OPTIONS FOR ACHIEVING CCO / ACO



1. Piggyback on existing OHA CCO arrangements

2. PEBB executes direct contracts with health systems for graduated risk-bearing ACOs

- Administrator will have to pay providers according to terms based on PEBB's contract

Examples: Boeing, Washington HCA

3. Contract through carriers with health systems for graduated risk-bearing ACOs

- PEBB provides contractual requirements for ACO arrangements, carriers will need to customize any existing ACO arrangements

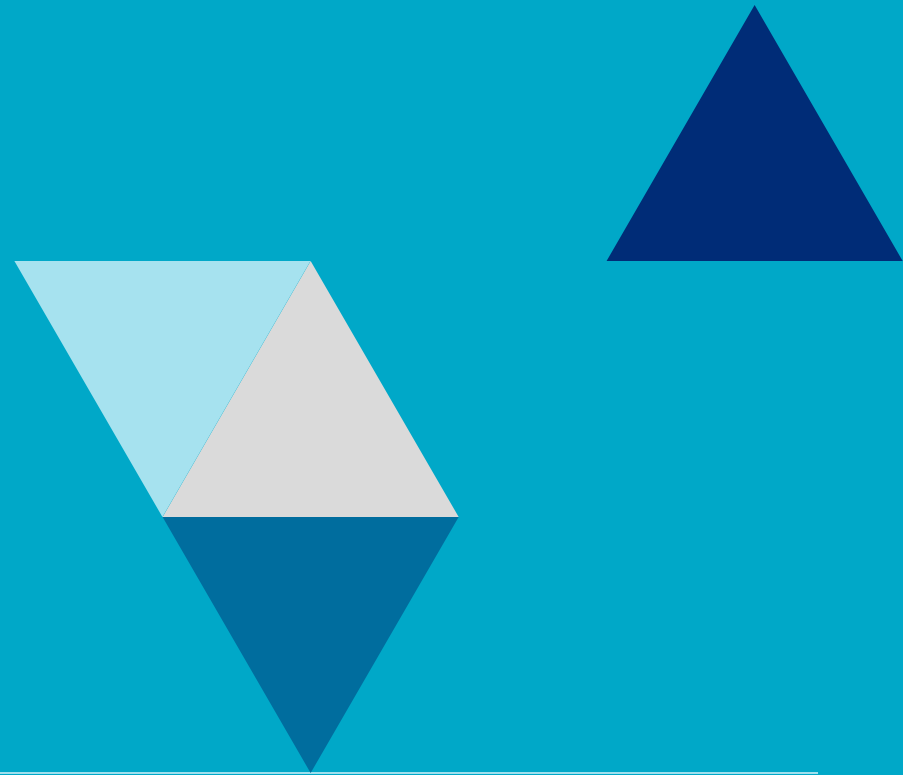
Example: Microsoft

4. Require carrier to develop and administer full risk-bearing arrangement with health system

2020 RENEWAL OVERVIEW AND TIMELINE

2019 DATE	ACTION ITEM	RESPONSIBLE PARTY
Jan. 4	Round One renewal letters sent to carriers	PEBB and Mercer
Jan. 25	Carriers responses to Round One renewal letters due	Carriers
Feb. 13	Final Materials of Round One responses due to PEBB	Mercer
Feb. 19	Board Meeting – Overview of Round One Responses	PEBB and Mercer
Feb. 22	Round Two renewal letters sent to carriers	PEBB and Mercer
March 6	Carriers responses to Round Two renewal letters due	Carriers
March 13	Final Materials of Round Two responses due to PEBB	Mercer
March 19	Board meeting — Overview of Round Two responses	PEBB and Mercer
March 22	Best and Final renewal requests sent to carriers	PEBB and Mercer
April 3	Carrier responses to Best and final letters due	PEBB and Mercer
April 10	Best and Final responses/materials due to PEBB	Mercer
April 16	Board meeting — Review of Best and Final Offers	PEBB and Mercer
May 15	Final materials for approval of best and final offers and final rates due to PEBB Board	Mercer
May 21	Board meeting – Approval of Best and Final offers and final rates	PEBB and Mercer
May 24	Final 2018 renewal letters sent to carriers for signature	PEBB and Mercer
May 31	Signed final renewal letters returned to PEBB and Mercer	Carriers

APPENDIX



SAMPLE GAP ANALYSIS AND ACTION PLAN BASED ON TYPICAL ACO TIMELINE

COMPETENCY EXPECTATIONS	CURRENT Years 1 to 3	INTERMEDIATE YEARS 2 to 5	SUCCESS YEARS 4+
Clinical Governance			
Provider Responsibility	Providers approve clinical and operational goals and plans	PCPs and specialists oversee quality and patient experience	Accountable for achieving sustained high performance
Network			
Primary Care (PCP)	Established	Add high-value PCPs	Optimized and refine network
Hospitals and Specialists	Identified and recruit	Add high-value hospitals and specialists	Optimized and refine network
Care Model			
Medical Home	Implementing	Established, integrating behavioral health	Optimized and complete
Risk Stratification	High-risk patients targeted	Expanded to include moderate-risk patients	All consumers targeted
Clinical Guidelines	Established for high-risk patients	EMR-based, expanded use across conditions	Complete guidelines across ACO
Quality	Siloed quality efforts	Coordinated quality efforts	Continuous quality improvement
Care Coordination	Through health plan or ACO	Shifting ACO	ACO-driven
Site of Care	Adding low-cost sites of care	Refer efficient sites of care	Integrated into care model
Medication	Polypharmacy and reconciliations	Evidence-based use, adherence and efficiency	Value-based, efficient across sites
Consumer Experience			
Access	24/7 access	Expanded 24/7 and same-day urgent access	Consistent 24/7 and urgent access
Proactive Outreach	Limited to high-risk patients	Expanded for moderate-risk patients	Consistent outreach tall consumers
Satisfaction	Measured for high-risk patients	Improving for high-moderate-risk patients	Concierge model for all consumers
Portal	Basic, includes records and messaging	Addition of care plans and content	Comprehensive and mobile-enabled
Technology & Analytics			
Electronic Medical Record (EMR)	Multiple and separate EMRs	Limited data exchange between EMRs	Complete EMR interoperability
Predictive Analytics/Registries	Primary care registries only	Primary and specialty care registries	Integrated registries
Data Analytics	Limited to EMR data	Multiple data sources to identify opportunities	Use comprehensive clinical/claims data
Finance Model			
ACO Risk	Gain-sharing tied to quality and cost	Gain- and loss-sharing tied to quality and cost	At risk for total cost of care
Physician Incentives	Small incentive, limited ACO panel	Increased incentive, expanded ACO panel, introduce downside risk	Compensation with incentives tied to performance

STRATEGY: CONCIERGE FOR STATEWIDE

Overlay digital navigation and advocacy services to the PPO plan and create steerage by offering the highest level of benefits when receiving care through a concierge care management vendor

Projected Potential Savings

<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>
\$7M	\$11M	\$16M	\$17M

How this stacks up with key criteria

- Demonstrated savings with guaranteed ROI from some vendors
- Some vendors provide reduced trend guarantees with first year savings if implemented on a total replacement basis
- Increased care coordination and improves the member experience at the expense of current plan administrators
- Maximum savings requires extreme disruption by outsourcing all customer service and care management to third party vendor

How this could make people happy

- High quality, high touch guidance through the health care system improves the experience
- Concierge service could help guide members and increase utilization of relevant point solutions

How this could frustrate people

- Change from current customer service and care management to a new administrator



TIMING
MEDIUM



CARRIER/VENDOR
NEW



COMMUNICATION
CONTINUOUS



IMPLEMENTATION
HIGH

STRATEGY: EXPERT MEDICAL OPINION

Enables employees struggling with a medical decision to have their medical case reviewed by experts to confirm the diagnosis and treatment plan, or to offer an alternative diagnosis and/or treatment approach

Projected Potential Savings

<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>
\$1 M	\$1 M	\$1 M	\$1 M

How this stacks up with key criteria

- Potentially improves outcomes with members facing complex or rare diagnoses
- Demonstrated savings per utilization but program costs are \$2 to \$5 PEPM
- Utilization of the program may be low unless highly communicated
- Supports Triple Aim but could fragment care
- Program requires a third party administrator
- Can be implemented in a short time frame

How this could make people happy

- Reassurance on diagnosis or treatment plan
- Concierge customer service
- Availability of top providers for rural members
- Service can be extended to non-covered family members

How this could frustrate people

- May result in a conflicting opinion with a different treatment plan than original doctor's
- Program understanding/awareness may be low unless well-communicated



TIMING
SHORT



CARRIER/VENDOR
NEW



COMMUNICATION
HIGH FOR
UTILIZATION



IMPLEMENTATION
MEDIUM

STRATEGY: DOUBLE SPOUSAL SURCHARGE

Increase monthly spousal surcharge from \$50 to \$100 for working spouses

Projected Potential Savings

<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>
\$2.5 M	\$2.5 M	\$2.5 M	\$2.5 M

How this stacks up with key criteria

- Saves PEBB money by partially recouping cost of spouses with coverage available at another employer
- 1st year savings estimated at \$3 million
- Savings is immediate on a per paycheck basis
- Does not align with OHA
- Disruptive by \$600/yr to impacted families
- No special administrative requirements other than employee communications
- No implementation concerns: available as early as Jan. 1, 2020

How this could make people happy

- Reduces inequity with how employees with coverage available via other employers are treated vis-à-vis state employees

How this could frustrate people

- Financial burden to impacted employees



TIMING
SHORT



CARRIER/VENDOR
N/A



COMMUNICATION
AT ANNUAL
ENROLLMENT



IMPLEMENTATION
EASY

STRATEGY: CCM IN EFFICIENT COUNTIES

Restrict the counties where CCM plans are offered to those with demonstrated efficiencies and improved outcomes

Projected Potential Savings

<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>
N/A	\$2M	\$3M	\$3M

How this stacks up with key criteria

- Reduces costs by eliminating less efficient plans
- Savings dependent on **how** restrictive the approach is
- Recommended that inefficient plans have a couple of years to improve or face elimination
- Action plan for inefficient plans to improve may result in closer alignment with CCO 2.0 principles
- Eliminating plans may be very disruptive

How this could make people happy

- Lower overall costs

How this could frustrate people

- Reduces choice of health plans
- Will force some employees to switch plans



TIMING
MEDIUM



CARRIER/VENDOR
CURRENT



COMMUNICATION
AT ANNUAL
ENROLLMENT



IMPLEMENTATION
EASY

STRATEGY: BUNDLED PAYMENT WITH COES

Select and implement bundled payments for high volume services with high cost variances, along with an enhanced travel benefit and Centers of Excellence

Projected Potential Savings

<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>
\$2M	\$2M	\$2M	\$2M

How this stacks up with key criteria

- Programs would be priced to provide savings off of current costs
- RFP to create bundles and determine centers of excellence would take at least a year
- Rewards providers of high quality care but potentially fragments health care delivery
- Uneven capabilities for current plans to administer
- Shifts costs from fee for service to pay for value
- Program can be disruptive but could be developed in conjunction with OEBC

How this could make people happy

- Improved benefits with warranties on outcomes of members' surgeries
- Concierge service for the member's case
- Engages members in their own treatment decisions

How this could frustrate people

- Additional requirements, including shared decision making, to access higher level of benefits
- Centers of excellence locations may require travel



TIMING
MEDIUM



CARRIER/VENDOR
CURRENT/NEW



COMMUNICATION
HIGH



IMPLEMENTATION
MEDIUM

STRATEGY: ACCOUNTABLE CARE ORGANIZATION

Work with provider groups and hospital organizations to create a closed network of coordinated providers with lower reimbursement, risk sharing, and performance guarantees based on quality metrics and trend guarantees

Projected Potential Savings

2020
N/A

2021
\$2 M

2022
\$4 M

2023
\$7 M

How this stacks up with key criteria

- Potential for large savings if trend guarantees and negotiated discounts are contracted
- The Triple Aim is the paradigm for ACOs
- Development and implementation of ACOs may take multiple years with true care coordination realistically achieved over a long time frame
- Aligns directly with CCO 2.0
- Disruption is dependent on which provider systems are willing to form an ACO

How this could make people happy

- Better care and better health outcomes along with lower cost
- Typically members are incented to join ACOs via reduced cost sharing

How this could frustrate people

- Provider network could be greatly reduced in size depending on the provider systems willing to form the financial and clinical ties
- Financial and clinical improvements may take years to achieve



TIMING
LONG



CARRIER/VENDOR
NEW



COMMUNICATION
HIGH



IMPLEMENTATION
VERY DIFFICULT

STRATEGY: POINT SOLUTIONS

Condition/risk-specific programs to improve the health outcomes of impacted individuals

Projected Potential Savings

2020
TBD

2021
TBD

2022
TBD

2023
TBD

How this stacks up with key criteria

- Individual programs typically provide return on investment guarantees
- Each solution would likely save under \$1 million per year
- Programs attempt to achieve the Triple Aim but would segment care away from current providers and vendors
- Utilization and engagement requires high level of communication
- Point solutions are delivered by outside vendors

How this could make people happy

- Targeted solutions for the members' specific conditions
- Improved care, health outcomes, and/or lower member costs

How this could frustrate people

- Care is fragmented and members and their doctors will need to interact with an outside vendor
- Solutions may be disruptive to members



TIMING
SHORT



CARRIER/VENDOR
NEW



COMMUNICATION
DIRECTED AND
CONTINUOUS



IMPLEMENTATION
MEDIUM

MICROSOFT

THE HEALTH CONNECT PLAN

From Microsoft media release and employee newsletter:

- The Health Connect Plan, offered through Premera, provides personalized, coordinated care and cost predictability to help simplify managing your health
- Key details:
 - **The Health Connect network:** The Health Connect Plan is built around a select group of providers on the Eastside—the Eastside Health Network, which includes dozens of independent practices, EvergreenHealth, and Overlake Medical Center and Clinics; Allegro Pediatrics; and the Living Well Health Center—who share Microsoft's vision to deliver a personalized health care experience and help you achieve improved health outcomes over time.
 - **A personalized and coordinated approach to your health care:** In the Health Connect Plan, you are encouraged to work closely with a Health Connect network primary care provider (PCP) of your choice. Your PCP gets to know you and your dependents' health care needs and goals and helps coordinate your care.
 - **Predictable out-of-pocket costs and simplified administration:** You pay a convenient copay for many basic services, such as office visits and prescription medications, when you see providers in the Health Connect network, making your out-of-pocket costs predictable and potentially reducing the time you spend reviewing claims and paying bills. You also have access to Premera network providers outside the Health Connect network, although a deductible may apply and your out-of-pocket costs will generally be higher.
 - **A dedicated service center for all of your questions:** The Health Connect Navigator provides personalized help, such as finding providers, making appointments, answering plan questions, and much more

<https://www.premera.com/mshealthconnectplan/>

BOEING PREFERRED PARTNERSHIP

For eligible employees in the Puget Sound region

From Boeing's Preferred Partnership website for employees:

- Overview:
 - Boeing has partnered with a leading healthcare system in the Puget Sound region — UW Medicine Accountable Care Network — to change the way healthcare is delivered. This arrangement is called the Preferred Partnership and is designed to improve quality, provide a better experience for you and your family, and be more affordable
- How the Preferred Partnership Option Works:
 - The Preferred Partnership option has a broad provider network — with primary care providers (PCPs), specialists, urgent care facilities and hospitals located throughout the Puget Sound region. To receive network benefits, generally you and your family need to use only providers in the UW Medicine Accountable Care Network. Urgent care and emergency care, however, are covered at the network level, even if the provider is not in the UW Medicine Accountable Care Network, or if you are traveling outside the Puget Sound region
 - If you otherwise receive medical services from providers not in the UW Medicine Accountable Care Network, and the services are not for urgent care or emergency care, those services would be covered at the non-network level in the Traditional Medical Plan and the Advantage+ health plan. In the Select Network Plan, non-network, nonemergency care is not covered.
 - If you cover a child under the plan who lives outside the Puget Sound region, the standard option may be a better choice for your family.
- Features:
 - **Enhanced Services**
 - Quicker access to network PCPs and specialists, and more after-hours care availability.
 - More personalized and coordinated care, especially for individuals with complex medical situations such as diabetes or a heart condition.
 - Greater use of electronic messaging with providers, and access to your electronic medical record.
 - **Affordable Coverage**
 - Lower paycheck contributions
 - Increased company contributions to the HSA if applicable

http://www.healthpartnershipoptions.com/SiteAssets/pub/fact_sheet_emp_ps.html

WASHINGTON HEALTHCARE AUTHORITY

UNIFORM MEDICAL PLAN (UMP)

From WA State HCA website

- **UMP Plus:**

- UMP Plus has a lower deductible and monthly premiums than UMP Classic while offering most of the same benefits. The plan has no prescription drug deductible, and you pay nothing for primary care office visits with your network primary care provider. Other services received at the visit, like x-rays and labs, are covered the same as they are with UMP Classic. And all your UMP Plus network providers work together to give you the right care at the right time.

- **Employees choose between two ACO networks:**

- UW Medicine Accountable Care Network
- Puget Sound High Value Network

- **Advantages:**

- Lower premiums than many other PEBB Program health plans.
- Lower medical deductible than many other PEBB Program health plans.
- No prescription drug deductible.
- Lower out-of-pocket costs when using network providers.
- Office visits with primary care providers at no charge.
- Quick access to primary and specialty care.
- Focus on wellness, such as screenings and preventive care.
- Coordinated care between your providers for chronic conditions such as diabetes.
- Providers with extended office hours.

<https://www.hca.wa.gov/ump/plan-ump-plus>



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MAKE TOMORROW, TODAY

HEALTH WEALTH CAREER

**OREGON PUBLIC
EMPLOYEES' BENEFITS
BOARD**

RISK BASED CAPITAL

DECEMBER 18, 2018
ATTACHMENT 3

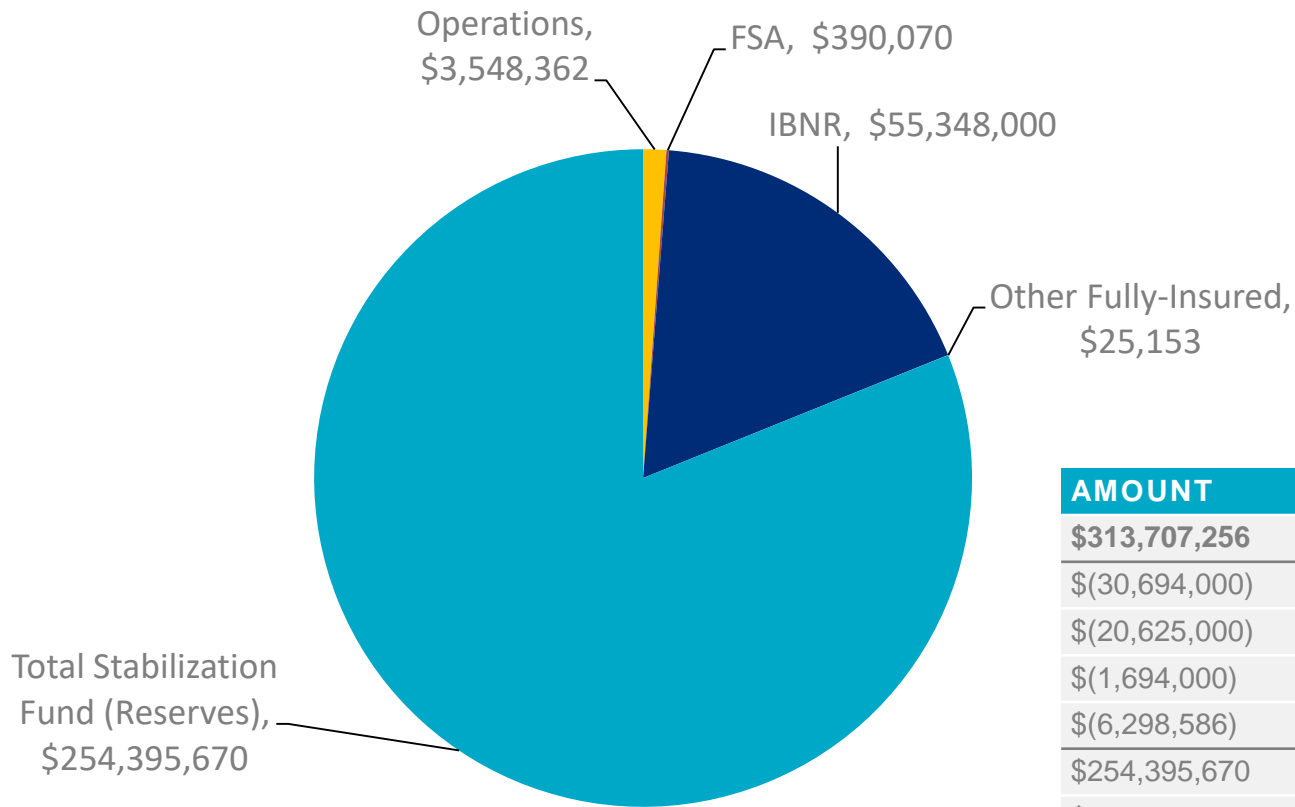
Emery Chen, ASA MAAA



WHAT IS RISK BASED CAPITAL?

- From the National Association of Insurance Commissioners (NAIC)
 - ***Risk Based Capital*** (RBC) is a method of measuring the minimum amount of ***capital*** appropriate for a reporting entity to support its overall business operations in consideration of its size and ***risk*** profile. RBC limits the amount of ***risk*** a company can take.
- NAIC created RBC to determine the minimum amounts of capital appropriate for insurance companies
 - The capital provides a cushion against insolvency
- Formulas focus on various areas of risk; for PEBB, underwriting risk is the main exposure

PEBB GENERAL LEDGER ACCOUNT FUND BALANCES AS OF DECEMBER 31, 2017

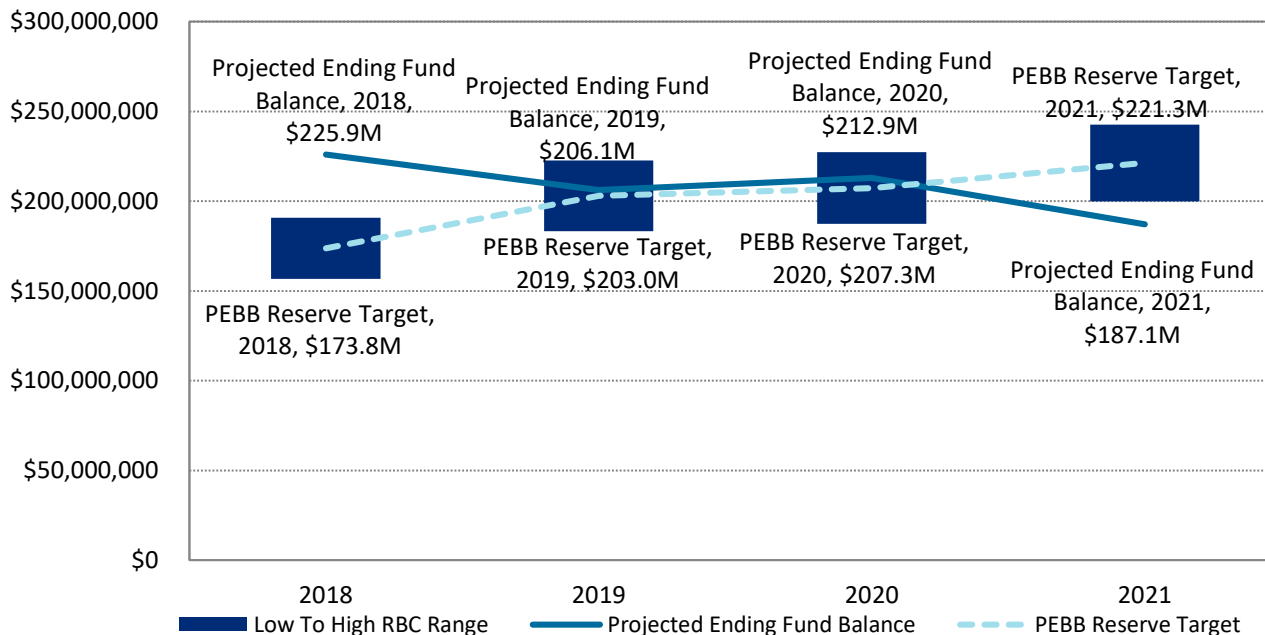


AMOUNT	COMPONENT
\$313,707,256	Dec 31, 2017 Fund Balance
\$(30,694,000)	Statewide IBNR
\$(20,625,000)	Providence Choice IBNR
\$(1,694,000)	AllCare Risk Share
\$(6,298,586)	Moda Dental, VSP IBNR, and Other
\$254,395,670	Dec 31, 2017 Balance after IBNR
\$165,400,000	2017 RBC Target
\$88,995,670	Net Difference

Plan fund balances (e.g. Statewide) include required funding to pay for claims

2018 TO 2021 FUND BALANCE MERCER TREND RATES

- Costs are set based on claims through October and November 2018 depending on plan
 - Mercer projected trend rates for plans eliminating the provider tax in 2020 and \$35M in savings from SB 1067
 - Impact of opt out and double coverage provisions listed as cost neutral
- Funding for 2019 is based on renewal results and the September 2018 census
 - Includes reduction for family tier contribution subsidy
- 2020 and 2021 funding increased by 3.4% from 2019 funding rate set during renewal and March 2018 census
- Chart below shows projected ending fund balance and the recommended RBC range
- PEBB Reserve Target is middle of High and Low RBC

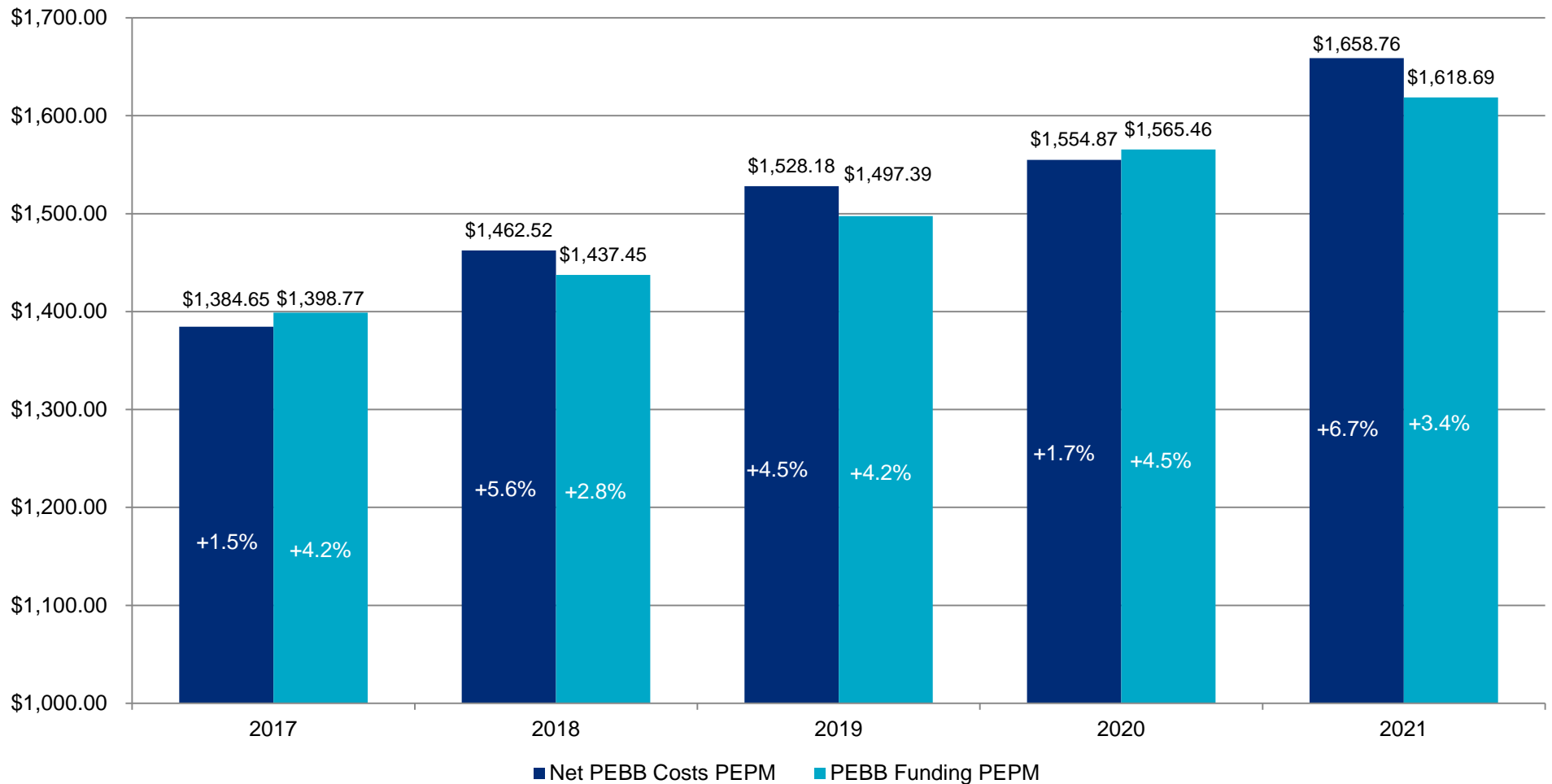


Key Takeaways

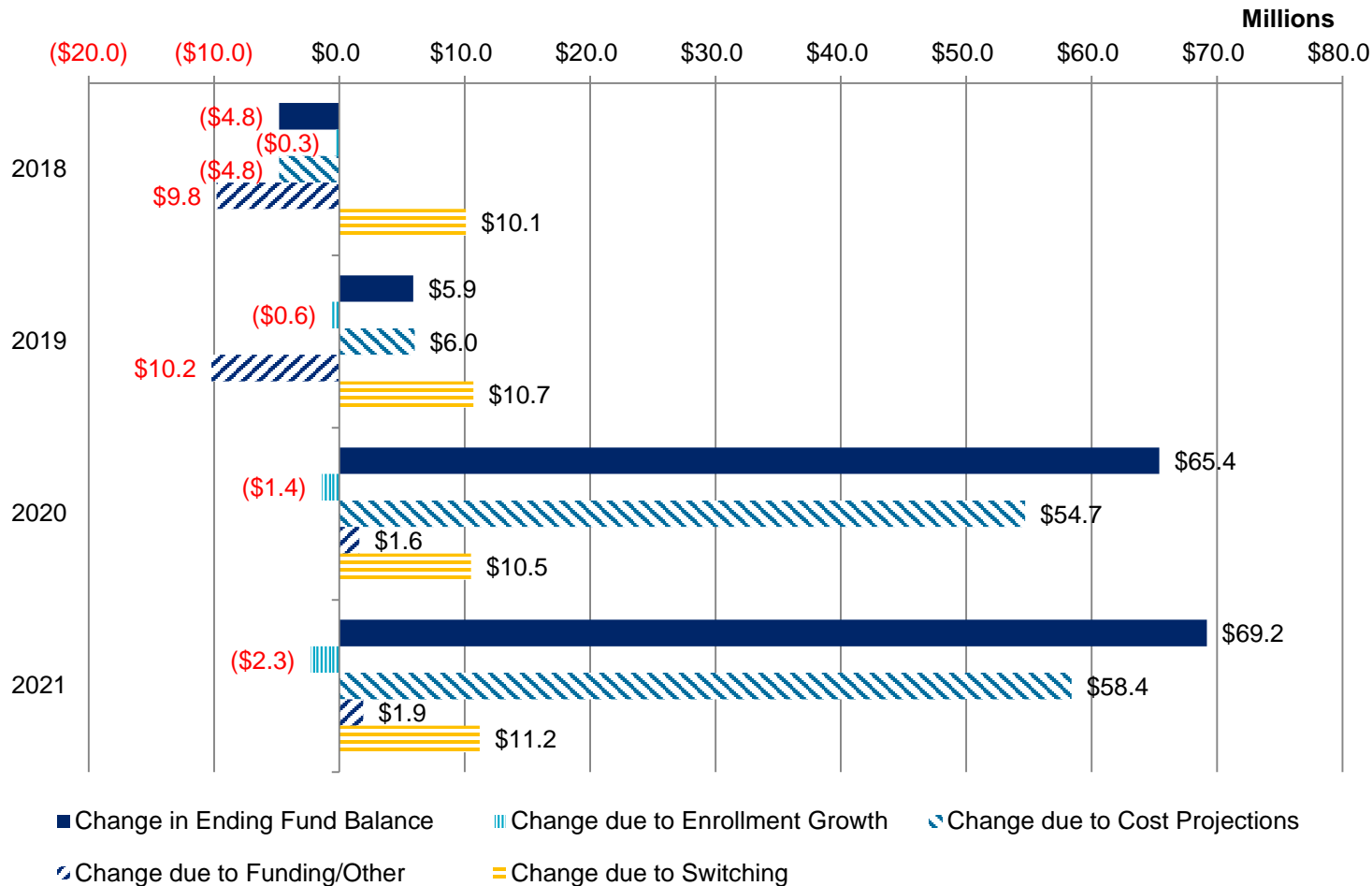
- 2019 ending fund balance is projected to near PEBB reserve target
- 2020 ending fund balance is projected to be near PEBB reserve target due to savings from SB 1067 and eliminating the 1.5% provider tax
- 2021 projected ending fund balance is \$34 million below reserve target



2018 TO 2021 FUND BALANCE COSTS VERSUS FUNDING — MERCER TREND RATES



COMPONENTS OF CHANGE FROM DECEMBER MERCER TREND RATES



Largest components of change include:

- Switching to lower cost plans
- Renewal results
- SB 1067
- Provider Tax

FUND BALANCE DETAIL

MERCER TREND

- PEBB projected cost PEPM increases based on Mercer trend rates are
 - 5.6% for 2018, 4.5% for 2019, 1.8% for 2020, and 6.7% for 2021
 - Self-insured trend rates are 6.5% for medical, 10% for Rx, 3% for dental, 2% for vision
- Funding increase for 2019 is 4.2% from 2018 funding after contribution subsidy
 - Increase for 2020 is 4.5% (3.4% from 2019 renewal funding rate) and 2021 is 3.4%

	1/1/2018 - 12/31/2018	1/1/2019 - 12/31/2019	1/1/2020 - 12/31/2020	1/1/2021 - 12/31/2021
PEBB Projected Costs*	\$938,000,000	\$980,300,000	\$997,500,000	\$1,064,425,000
PEBB Projected Costs* (PEPM)	\$1,456.00	\$1,521.66	\$1,548.36	\$1,652.24
Surcharges Payments from Employees	\$4,500,000	\$4,500,000	\$4,500,000	\$4,500,000
HEM Refunds	(\$8,700,000)	(\$8,700,000)	(\$8,700,000)	(\$8,700,000)
Net PEBB Costs	\$942,200,000	\$984,500,000	\$1,001,700,000	\$1,068,625,000
Net PEBB Costs (PEPM)	\$1,462.52	\$1,528.18	\$1,554.87	\$1,658.76
Funding	\$926,000,000	\$964,700,000	\$1,008,500,000	\$1,042,800,000
Funding (PEPM) (2018-19 Actual, 2020-21 based on 3.4% increases from 2019 Renewal)	\$1,437.45	\$1,497.39	\$1,565.46	\$1,618.69
Funding as % of Net PEBB Costs	98%	98%	101%	98%
Proj Surplus/(Deficit) for PY**	(\$16,200,000)	(\$19,800,000)	\$6,800,000	(\$25,825,000)
Beginning Risk Stabilization Fund	\$254,400,000	\$225,900,000	\$206,100,000	\$212,900,000
SB 501 Transfer (Estimated \$12.3M Penalty)	(\$12,300,000)			
Ending PY Risk Stabilization Fund	\$225,900,000	\$206,100,000	\$212,900,000	\$187,075,000
PEBB Reserve Target	\$173,750,000	\$203,000,000	\$207,250,000	\$221,300,000
Difference between Ending Balance and Target	\$52,150,000	\$3,100,000	\$5,650,000	(\$34,225,000)
% Difference	30%	2%	3%	-15%

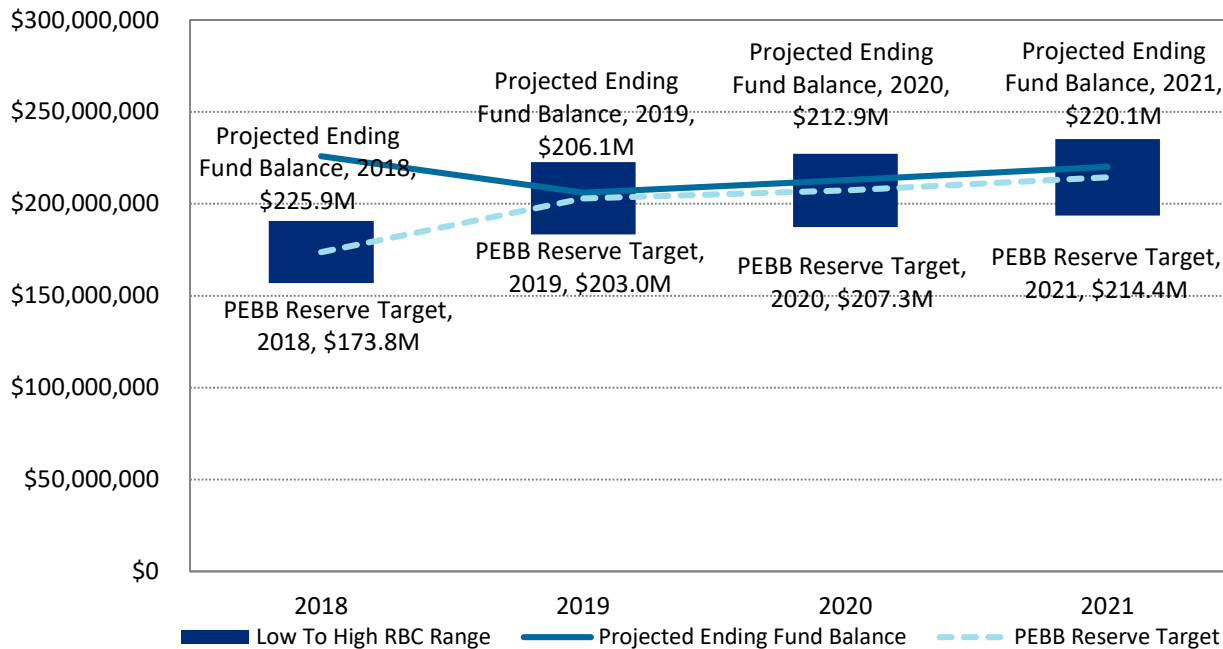
* Using Sept 2018 enrollment of 53,686 and Oct/Nov 2018 claims experience

** Surplus/(Deficit) = Agency Payments + Surcharges - PEBB Projected Costs

2018 TO 2021 FUND BALANCE

3.4% EXPENDITURE GROWTH

- 2018 Costs are set based on claims through October/November 2018 data
 - 2019 based on projected
 - 2020 based on projected due to being below 3.4% mandate
 - Due to SB 1067 hospital savings, expiration of the Provider Tax, and savings from switching
 - 2021 based on 3.4% from 2020
- PEBB Reserve Target is middle of High and Low RBC



Key Takeaways

- 2020 projected PEBB costs are below the 3.4% mandate
- Claims savings required for 2021 to achieve 3.4% increase from 2020 is \$32 million
- 2019 to 2021 ending fund balance remains above reserve range

FUND BALANCE DETAIL

3.4% EXPENDITURE GROWTH

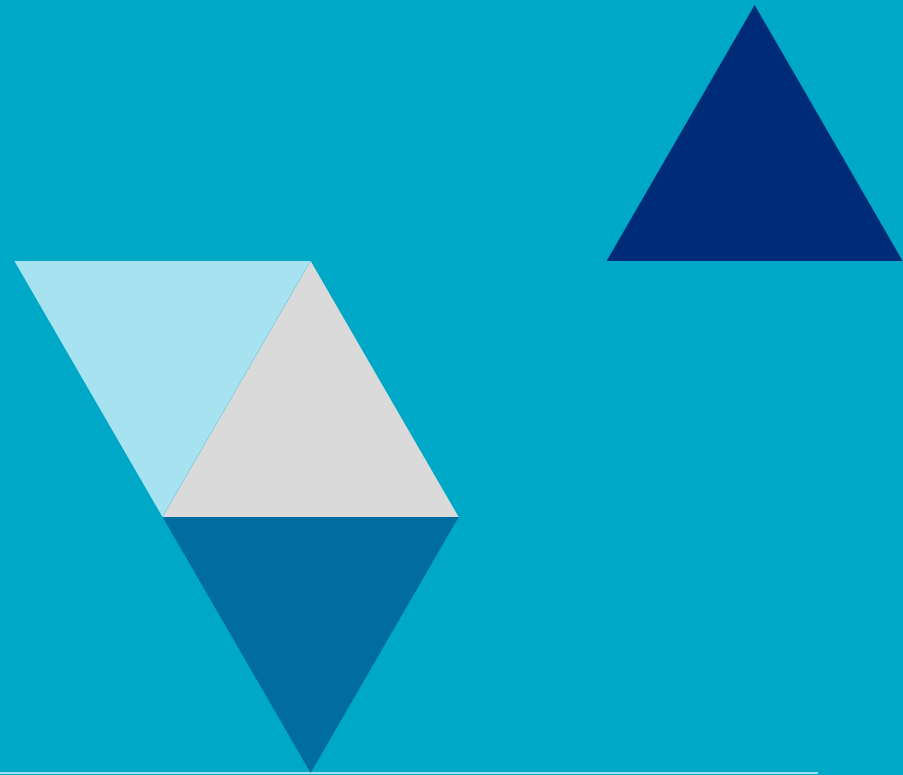
- PEBB projected cost PEPM increases are
 - 5.6% for 2018, 4.5% for 2019, 1.8% for 2020, and 3.4% for 2021
- Funding increase for 2020 and 2021 is 3.4% per year from 2019 renewal composite rate after contribution subsidy

	1/1/2018 - 12/31/2018	1/1/2019 - 12/31/2019	1/1/2020 - 12/31/2020	1/1/2021 - 12/31/2021
PEBB Projected Costs*	\$938,000,000	\$980,300,000	\$997,500,000	\$1,031,400,000
PEBB Projected Costs* (PEPM)	\$1,456.00	\$1,521.66	\$1,548.36	\$1,600.98
Surcharges Payments from Employees	\$4,500,000	\$4,500,000	\$4,500,000	\$4,500,000
HEM Refunds	(\$8,700,000)	(\$8,700,000)	(\$8,700,000)	(\$8,700,000)
Net PEBB Costs	\$942,200,000	\$984,500,000	\$1,001,700,000	\$1,035,600,000
Net PEBB Costs (PEPM)	\$1,462.52	\$1,528.18	\$1,554.87	\$1,607.50
Funding	\$926,000,000	\$964,700,000	\$1,008,500,000	\$1,042,800,000
Funding (PEPM) (2018-19 Actual, 2020-21 based on 3.4% increases from 2019 Renewal)	\$1,437.45	\$1,497.39	\$1,565.46	\$1,618.69
Funding as % of Net PEBB Costs	98%	98%	101%	101%
Proj Surplus/(Deficit) for PY**	(\$16,200,000)	(\$19,800,000)	\$6,800,000	\$7,200,000
Beginning Risk Stabilization Fund	\$254,400,000	\$225,900,000	\$206,100,000	\$212,900,000
SB 501 Transfer (Estimated \$12.3M Penalty)	(\$12,300,000)			
Ending PY Risk Stabilization Fund	\$225,900,000	\$206,100,000	\$212,900,000	\$220,100,000
PEBB Reserve Target	\$173,750,000	\$203,000,000	\$207,300,000	\$214,400,000
Difference between Ending Balance and Target	\$52,150,000	\$3,100,000	\$5,600,000	\$5,700,000
% Difference	30%	2%	3%	3%

* Using Sept 2018 enrollment of 53,686 and Oct/Nov 2018 claims experience

** Surplus/(Deficit) = Agency Payments + Surcharges - PEBB Projected Costs

APPENDIX



RISK BASED CAPITAL — 2018 AND 2019

DECEMBER 2018 — MERCER PROJECTED COSTS

- Based on claims from October/November 2018 and September 2018 enrollment

Recommended Rate Stabilization Reserve Range								
	1/1/2018 - 12/31/2018				1/1/2019 - 12/31/2019			
	Low	Mid-Point Low/Middle	Middle	High	Low	Mid-Point Low/Middle	Middle	High
Stabilization Fund for Self-Insured Plans								
Statewide Plan	\$84,000,000	\$88,250,000	\$92,500,000	\$101,000,000	\$88,000,000	\$92,500,000	\$97,000,000	\$106,000,000
% of RBC	250%	263%	275%	300%	250%	263%	275%	300%
Providence	\$65,000,000	\$68,250,000	\$71,500,000	\$78,000,000	\$69,000,000	\$72,500,000	\$76,000,000	\$83,000,000
% of RBC	250%	263%	275%	300%	250%	263%	275%	300%
Moda					\$18,000,000	\$19,000,000	\$20,000,000	\$22,000,000
% of RBC					250%	263%	275%	300%
DDOR	\$6,500,000	\$7,375,000	\$8,250,000	\$10,000,000	\$7,000,000	\$7,750,000	\$8,500,000	\$10,000,000
% of RBC	200%	225%	250%	300%	200%	225%	250%	300%
VSP	\$1,300,000	\$1,400,000	\$1,500,000	\$1,700,000	\$1,300,000	\$1,400,000	\$1,500,000	\$1,700,000
% of RBC	150%	163%	175%	200%	150%	163%	175%	200%
Total	\$156,800,000	\$165,275,000	\$173,750,000	\$190,700,000	\$183,300,000	\$193,150,000	\$203,000,000	\$222,700,000

RISK BASED CAPITAL — 2020 AND 2021

DECEMBER 2018 — MERCER PROJECTED COSTS

- Based on claims from October/November 2018 and September 2018 enrollment

Recommended Rate Stabilization Reserve Range								
	1/1/2020 - 12/31/2020				1/1/2021 - 12/31/2021			
	Low	Mid-Point Low/Middle	Middle	High	Low	Mid-Point Low/Middle	Middle	High
Stabilization Fund for Self-Insured Plans								
Statewide Plan	\$90,000,000	\$94,500,000	\$99,000,000	\$108,000,000	\$96,000,000	\$101,000,000	\$106,000,000	\$116,000,000
% of RBC	250%	263%	275%	300%	250%	263%	275%	300%
Providence	\$70,000,000	\$73,500,000	\$77,000,000	\$84,000,000	\$75,000,000	\$78,750,000	\$82,500,000	\$90,000,000
% of RBC	250%	263%	275%	300%	250%	263%	275%	300%
Moda	\$19,000,000	\$20,000,000	\$21,000,000	\$23,000,000	\$20,000,000	\$21,000,000	\$22,000,000	\$24,000,000
% of RBC	250%	263%	275%	300%	250%	263%	275%	300%
DDOR	\$7,000,000	\$7,875,000	\$8,750,000	\$10,500,000	\$7,500,000	\$8,375,000	\$9,250,000	\$11,000,000
% of RBC	200%	225%	250%	300%	200%	225%	250%	300%
VSP	\$1,300,000	\$1,400,000	\$1,500,000	\$1,700,000	\$1,300,000	\$1,425,000	\$1,550,000	\$1,800,000
% of RBC	150%	163%	175%	200%	150%	163%	175%	200%
Total	\$187,300,000	\$197,275,000	\$207,250,000	\$227,200,000	\$199,800,000	\$210,550,000	\$221,300,000	\$242,800,000



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HEALTH WEALTH CAREER

OREGON'S PUBLIC
EMPLOYEES' BENEFITS
BOARD
UTILIZATION REPORT

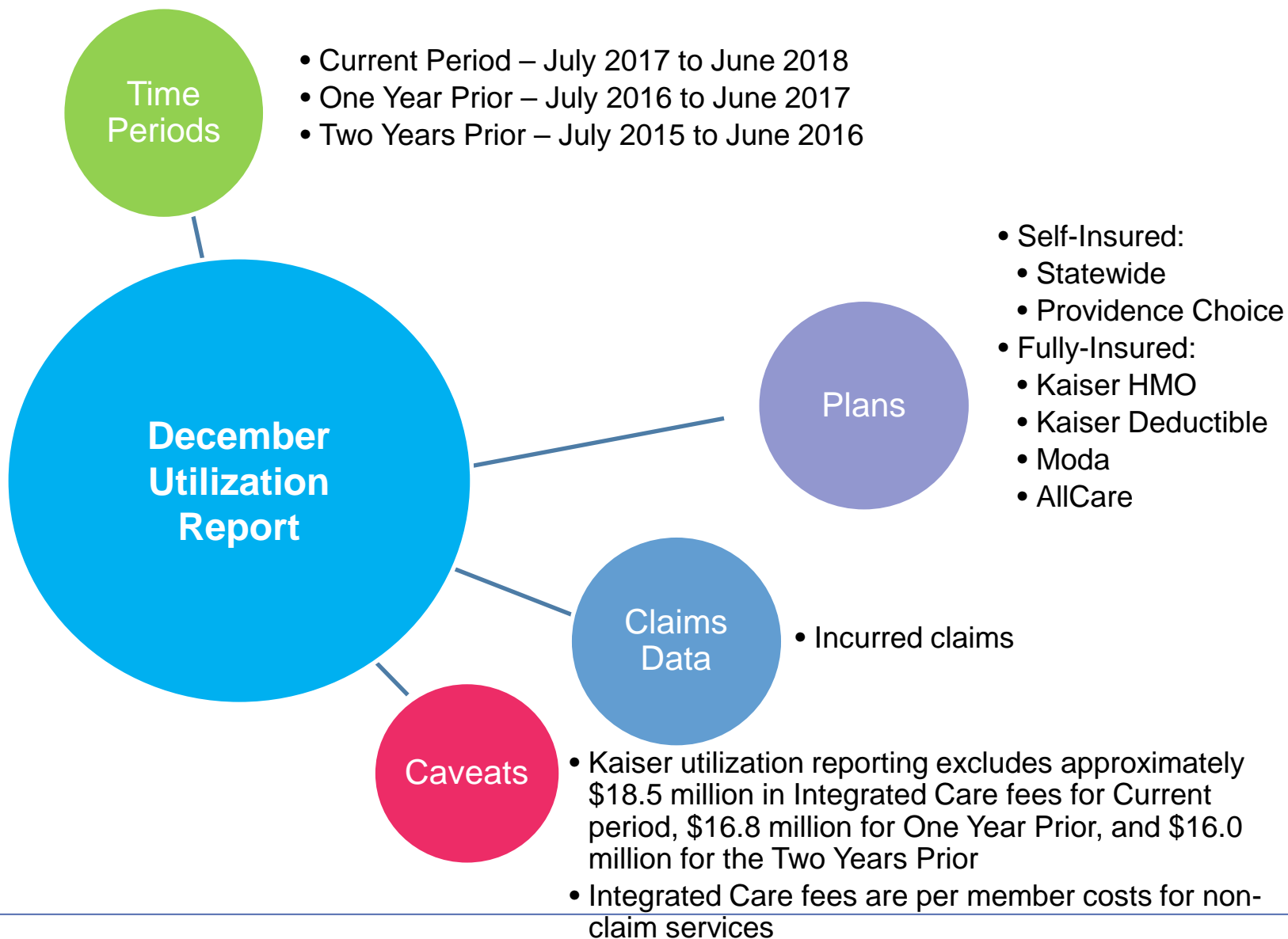
December 18, 2018
Attachment 4

Emery Chen, ASA, MAAA

CONTENT

- 1 AGGREGATE COSTS
- 2 BY TYPE OF SERVICE
- 3 RISK SCORES
- 4 COMPONENTS OF TREND
- 5 UTILIZATION

DATA AND ASSUMPTIONS



EXECUTIVE SUMMARY

AGGREGATE COSTS

Self-insured per employee costs increasing at a higher rate than fully-insured costs

BY TYPE OF SERVICE

Statewide remains the outlier with higher per employee costs in multiple service categories

RISK SCORES

Statewide and Moda continue to have the highest risk scores

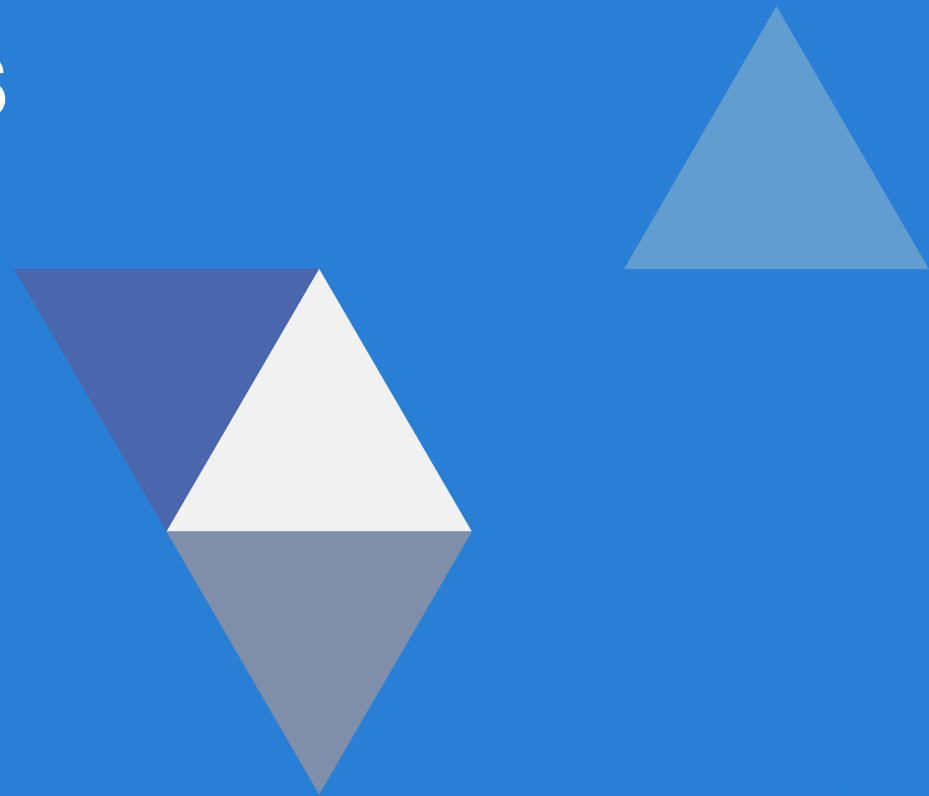
COMPONENTS OF TREND

Unit Cost (cost per service) continues to be the biggest driver of trend with *Member Health Risk* and *Leveraging* also increasing PEBB costs

UTILIZATION

Unit Cost increases are highest in specialty drug, radiology, and emergency room, while changes in *Utilization* is moderate for most services, with the exception of office visits

AGGREGATE COSTS



ANNUAL COSTS SELF-INSURED

	TWO YEARS PRIOR	ONE YEAR PRIOR	% CHANGE	CURRENT	% CHANGE
AGGREGATE					
Medical	\$462,558,282	\$491,637,533	6.3%	\$517,097,864	5.2%
Prescription Drug	\$74,762,115	\$76,413,748	2.2%	\$78,711,457	3.0%
Total	\$537,320,397	\$568,051,281	5.7%	\$595,809,321	4.9%
PER EMPLOYEE PER MONTH					
Medical	\$11,722	\$12,586	7.4%	\$13,478	7.1%
Prescription Drug	\$1,895	\$1,956	3.3%	\$2,052	4.9%
Total	\$13,617	\$14,543	6.8%	\$15,529	6.8%
AVERAGE ANNUAL MEMBERSHIP					
Employees	39,460	39,061	-1.0%	38,367	-1.8%
Members	104,997	103,827	-1.1%	101,592	-2.2%

- SELF-INSURED COSTS HAVE INCREASED AT A CONSISTENT RATE OVER THE PAST TWO YEARS
- BOTH MEDICAL AND PRESCRIPTION DRUG COSTS INCLUDE IMPACT OF REBATES

ANNUAL COSTS FULLY-INSURED

	TWO YEARS PRIOR	ONE YEAR PRIOR	% CHANGE	CURRENT	% CHANGE
AGGREGATE					
Medical	\$124,273,429	\$142,915,161	15.0%	\$155,972,697	9.1%
Prescription Drug	\$22,284,102	\$24,112,425	8.2%	\$26,615,445	10.4%
Total	\$146,557,531	\$167,027,587	14.0%	\$182,588,142	9.3%
PER EMPLOYEE PER MONTH					
Medical	\$11,332	\$11,827	4.4%	\$12,201	3.2%
Prescription Drug	\$2,032	\$1,995	-1.8%	\$2,082	4.3%
Total	\$13,365	\$13,822	3.4%	\$14,283	3.3%
AVERAGE ANNUAL MEMBERSHIP					
Employees	10,966	12,084	10.2%	12,784	5.8%
Members	28,486	31,435	10.4%	33,442	6.4%

- GROWTH IN FULLY-INSURED COSTS HAVE MODERATED
- ALLCARE WAS REMOVED AS A PEBB HEALTH PLAN STARTING 1/1/18
- KAISER INTEGRATED CARE FEES ARE INCLUDED



ANNUAL COSTS

TOTAL PEBB

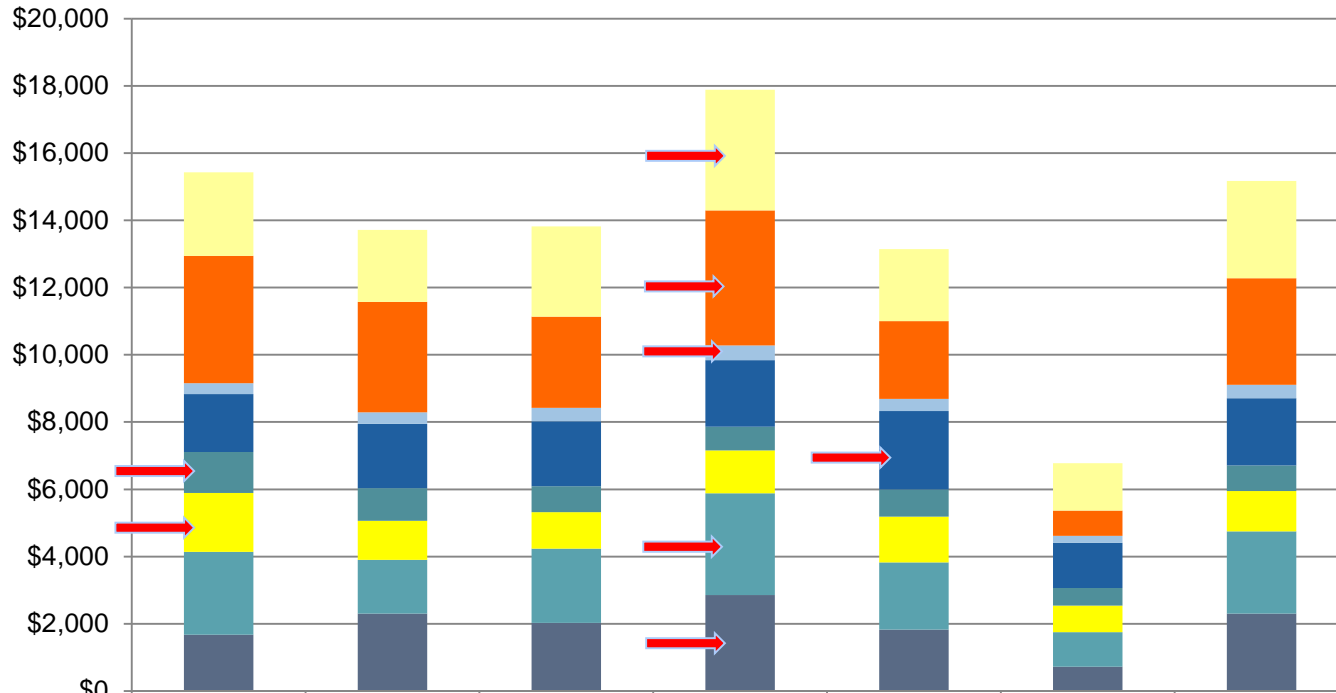
	TWO YEARS PRIOR	ONE YEAR PRIOR	% CHANGE	CURRENT	% CHANGE
AGGREGATE					
Medical	\$586,831,711	\$634,552,694	8.1%	\$673,070,561	6.1%
Prescription Drug	\$97,046,216	\$100,526,173	3.6%	\$105,326,902	4.8%
Total	\$683,877,928	\$735,078,867	7.5%	\$778,397,464	5.9%
PER EMPLOYEE PER MONTH					
Medical	\$11,638	\$12,407	6.6%	\$13,159	6.1%
Prescription Drug	\$1,925	\$1,966	2.1%	\$2,059	4.8%
Total	\$13,562	\$14,373	6.0%	\$15,218	5.9%
AVERAGE ANNUAL MEMBERSHIP					
Employees	50,426	51,145	1.4%	51,150	0.0%
Members	133,483	135,262	1.3%	135,034	-0.2%

• OVERALL PEBB CLAIMS GROWTH ON A PER EMPLOYEE BASIS HAS BEEN CONSISTENT OVER THE PAST THREE YEARS BUT ABOVE 3.4%

BY TYPE OF SERVICE



COSTS BY TYPE OF SERVICE PEPY BY PLAN



	AllCare \$15,436	Moda \$13,715	Providence \$13,817	Statewide \$17,885	Kaiser HMO \$13,148	Kaiser Ded \$6,772	PEBB \$15,171
Facility Inpatient	\$2,492	\$2,137	\$2,683	\$3,587	\$2,148	\$1,409	\$2,891
Facility Outpatient	\$3,783	\$3,290	\$2,709	\$4,016	\$2,311	\$750	\$3,166
Physician Inpatient	\$326	\$343	\$401	\$439	\$366	\$207	\$402
Physician Outpatient	\$1,729	\$1,916	\$1,931	\$1,983	\$2,331	\$1,348	\$1,999
MHSA	\$1,218	\$967	\$776	\$703	\$807	\$522	\$763
Laboratory and Radiology	\$1,751	\$1,160	\$1,079	\$1,275	\$1,361	\$789	\$1,205
Other Professional Services	\$2,462	\$1,605	\$2,216	\$3,030	\$2,004	\$1,024	\$2,440
Prescription Drugs	\$1,675	\$2,297	\$2,021	\$2,852	\$1,821	\$724	\$2,305

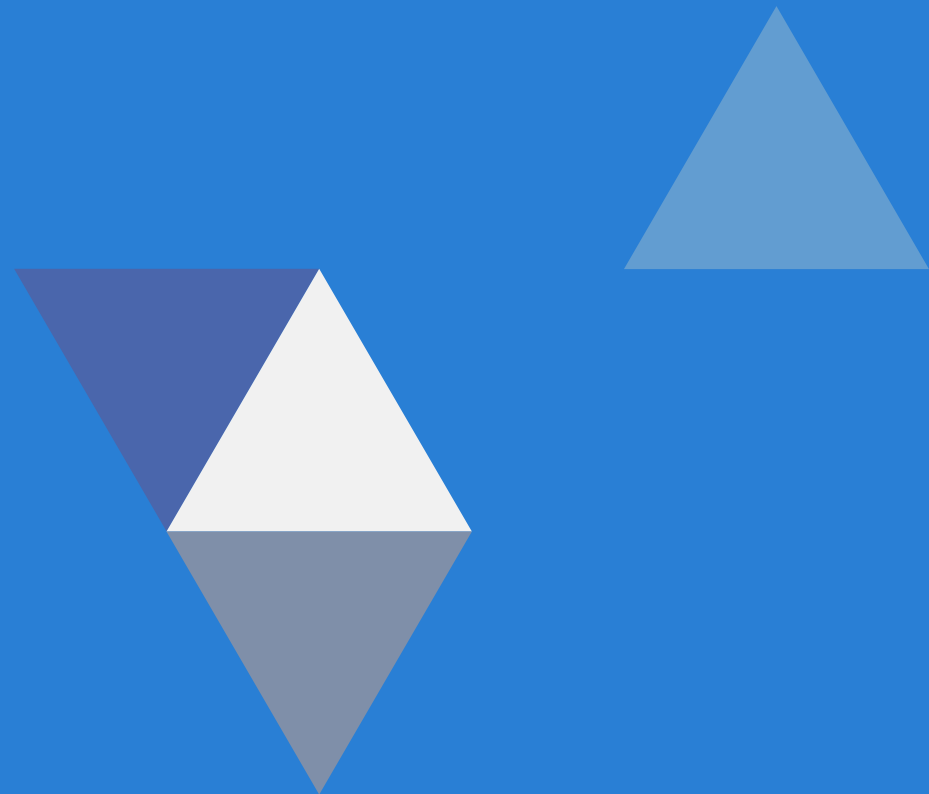
- Statewide plan has highest PEPY costs of all plans
- AllCare has second highest PEPY costs

- Statewide has highest cost in five categories; Facility IP, Facility OP, Phys IP, Other Prof, Rx (red arrows)
- Kaiser has the highest cost in for Phys OP
- AllCare has highest MHSA and Lab costs

- Kaiser costs do not include \$789 PEPY in integrated care fees
- PEPY Rebates for Statewide and Choice were \$483 and \$348 respectively

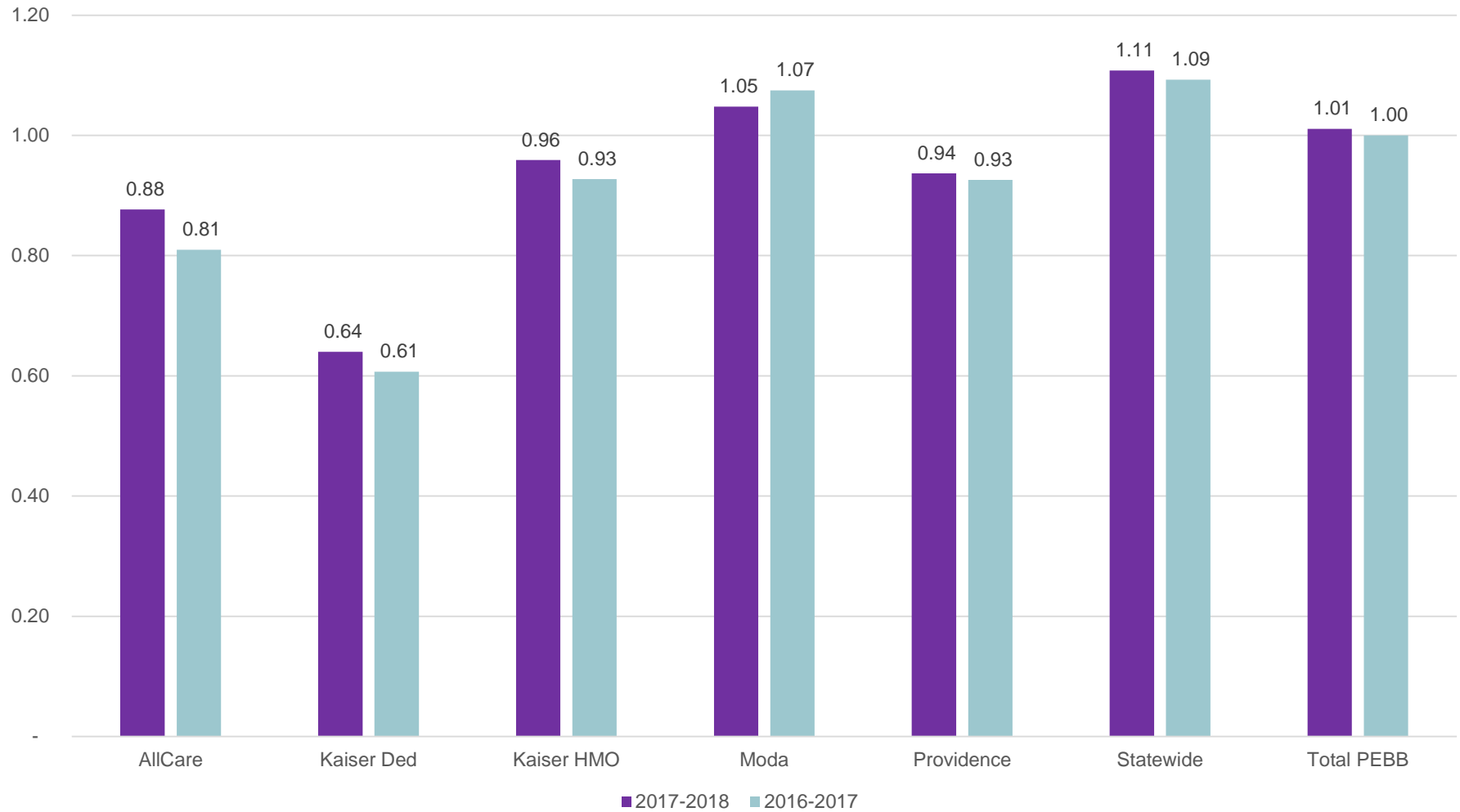
Costs shown above are not risk adjusted

RISK SCORES





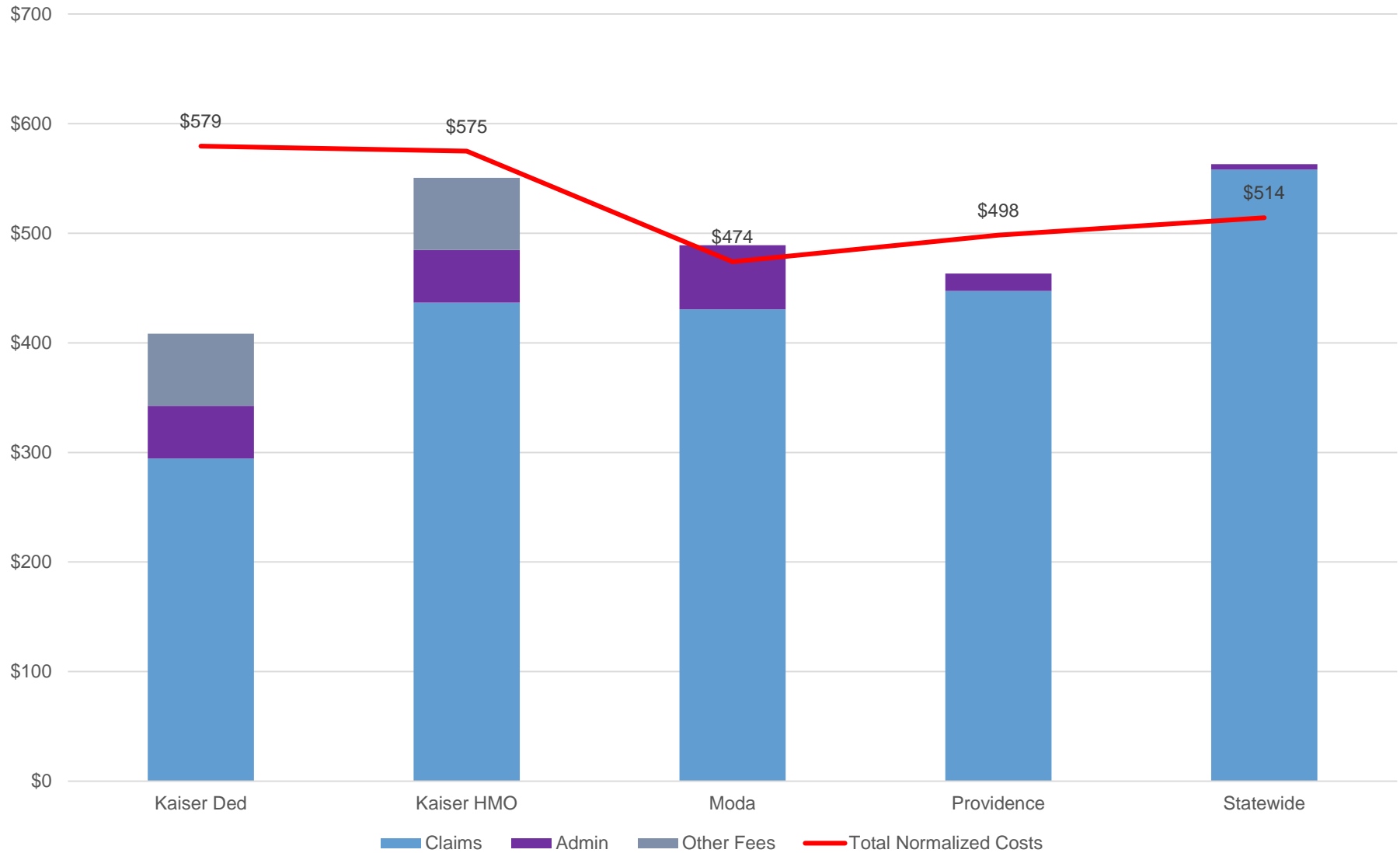
RISK SCORES BY PLAN



Risk scores are the relative cost of a member determined by the underlying illness burden based on age, sex, and diagnosis data. Scores are normalized to an average 2016/2017 PEBB member.



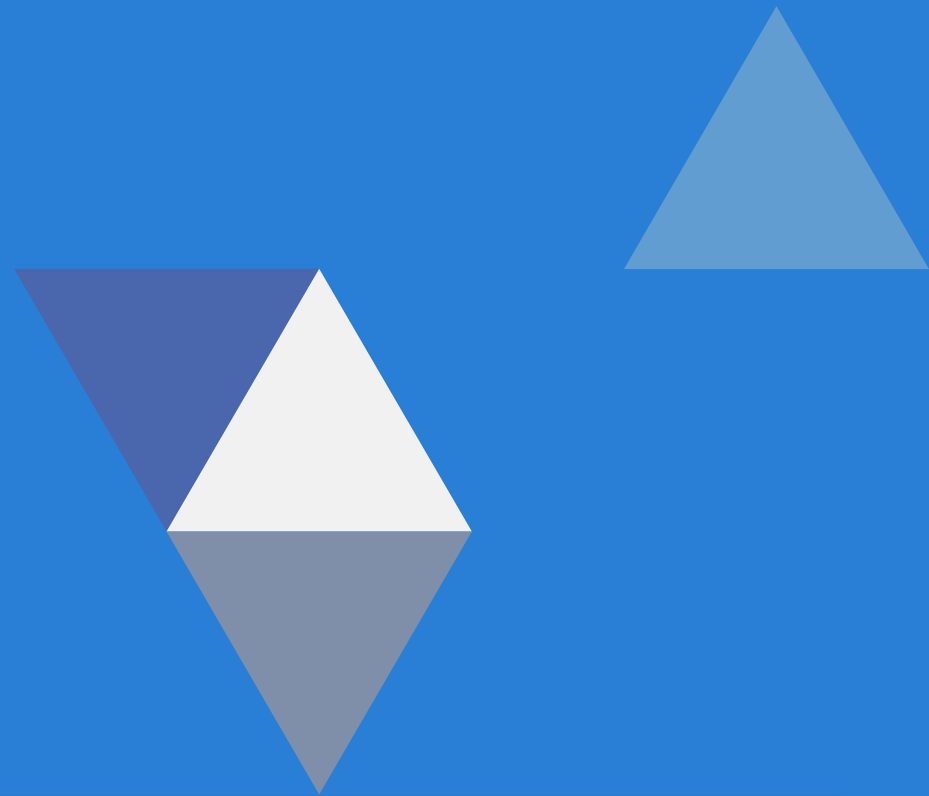
NORMALIZED COSTS BY PLAN



ADMINISTRATION BASED ON COSTS FROM 2018 RENEWAL

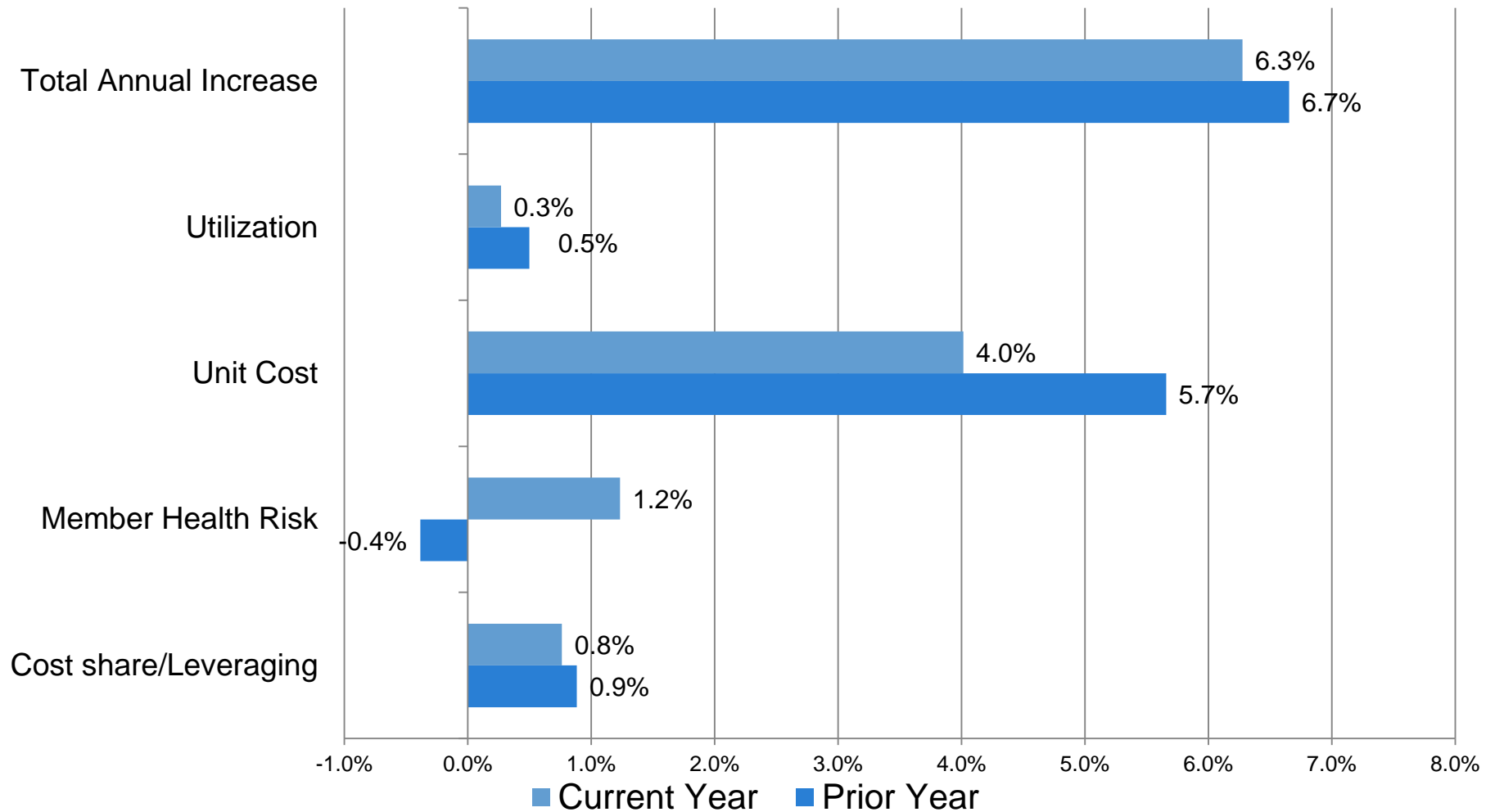
STATEWIDE AND CHOICE ADMINISTRATION OFFSET BY REBATES

COMPONENTS OF TREND





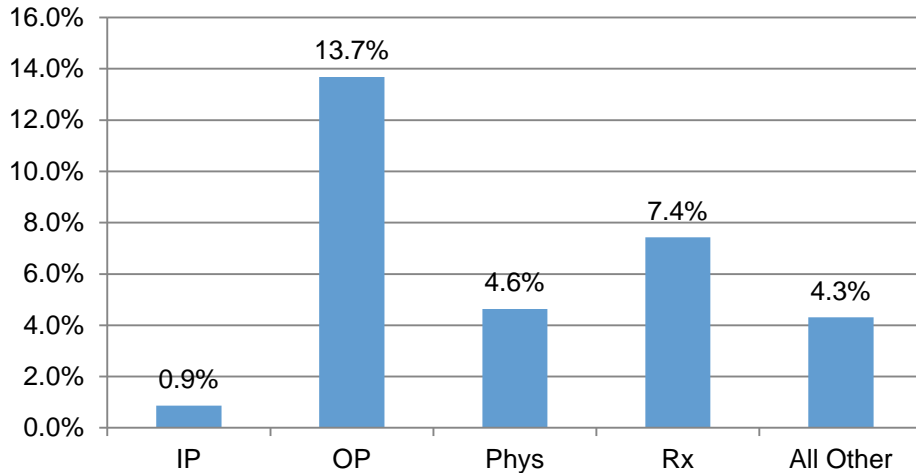
COMPONENTS OF TREND



- LARGEST CONTRIBUTORS TO UNIT COST INCREASES FOR CURRENT PERIOD ARE: OP FACILITY SURGERY, IP FACILITY MEDICAL, AND OP FACILITY SPECIALTY DRUGS
- UNIT COST INCLUDES REIMBURSEMENT RATES, MIX OF SERVICES, AND INTENSITY

FACTORS IMPACTING TREND

2017-2018 % Increase by Category



CATEGORY	IMPACT ON TREND	MAIN DRIVER
Facility OP Surgery	1.7%	Unit cost increases (13%)
Prescription Specialty Drug	1.2%	Unit cost (7%) and utilization increases (9%)
Facility IP Medical	0.7%	Unit Cost (18%)
Other Mental Health OP	0.6%	Utilization increase (22%)

KEY INSIGHTS

1

FACILITY OP SURGERY INCREASES

- \$4.6 million for Spinal Muscular Atrophy
- \$600,000 colonoscopies (+16% utilization)
- \$500,000 for endometriosis of uterus (+73% utilization, +43% cost)

2

SPECIALTY DRUG

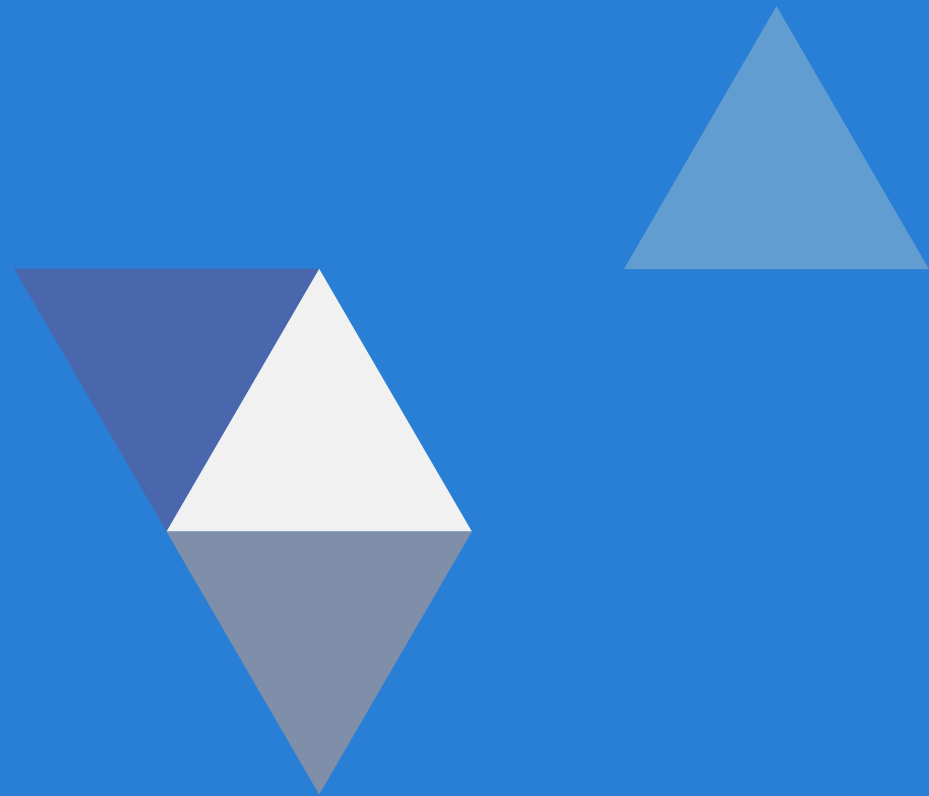
- Paid per script increased 7.7%
- Utilization increased 5.5%

3

FACILITY IP MEDICAL INCREASES

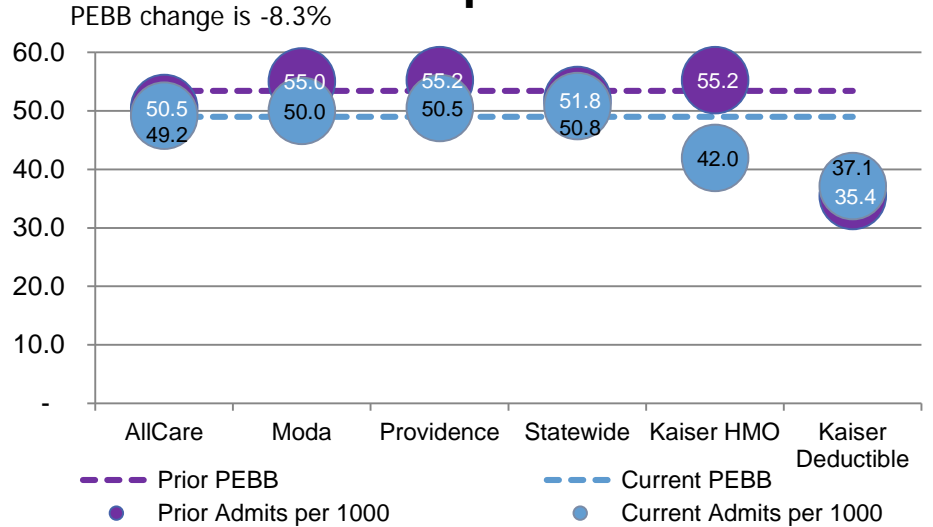
- \$1.8 million for leukemia patients

UTILIZATION

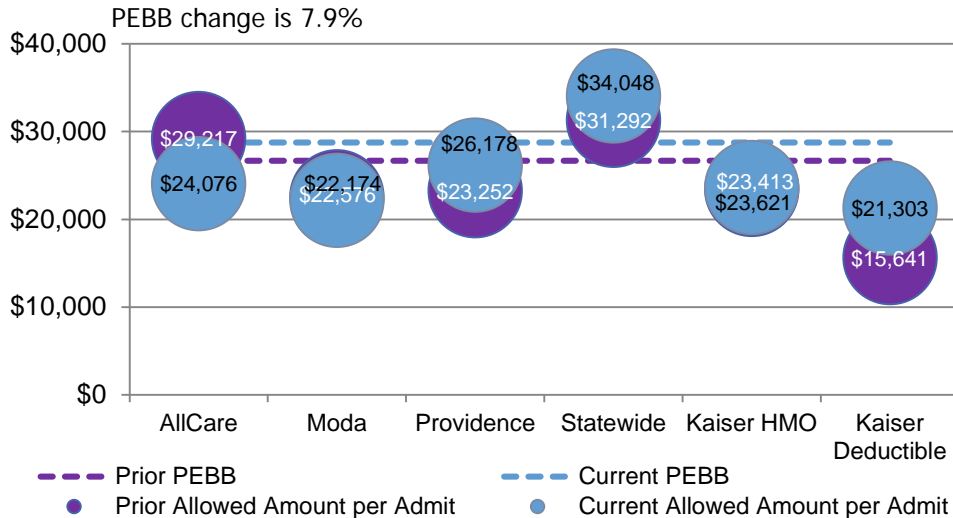


INPATIENT FACILITY

Admits per 1000



Allowed Amount per Admit



KEY INSIGHTS

1

- Admits per 1000 decreased for all plans with the exception of Kaiser Deductible

2

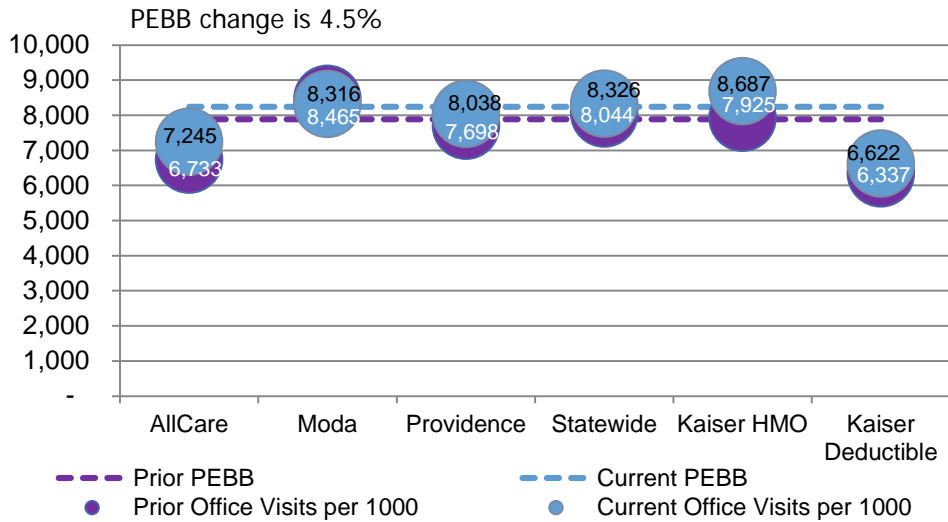
- Allowed per admit increased 36.2% for Kaiser Deductible and 12.6% for Providence Choice

3

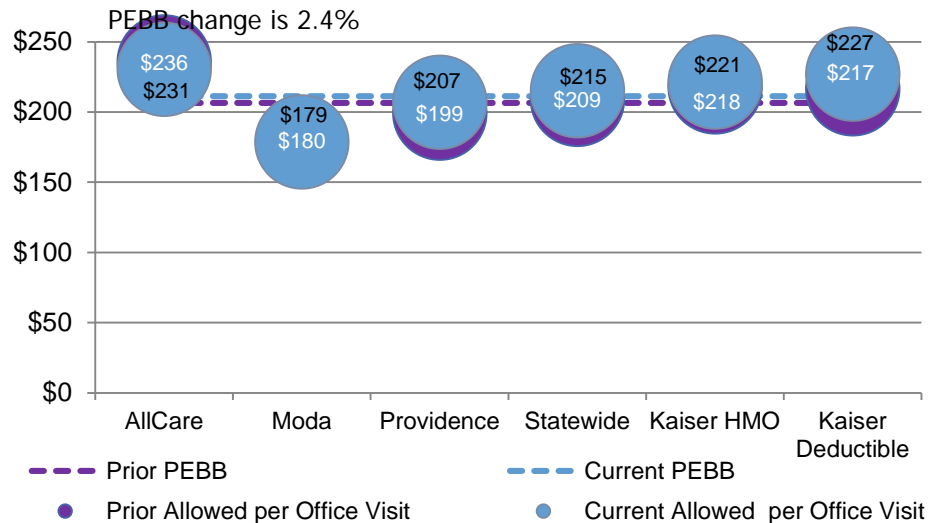
- Net result is a 1.1% decrease in IP facility costs across all of PEBB

OUTPATIENT OFFICE VISITS

Office Visits per 1000



Allowed per Office Visit



KEY INSIGHTS

1

- Both utilization per 1000 and cost per visit increased during the current period

2

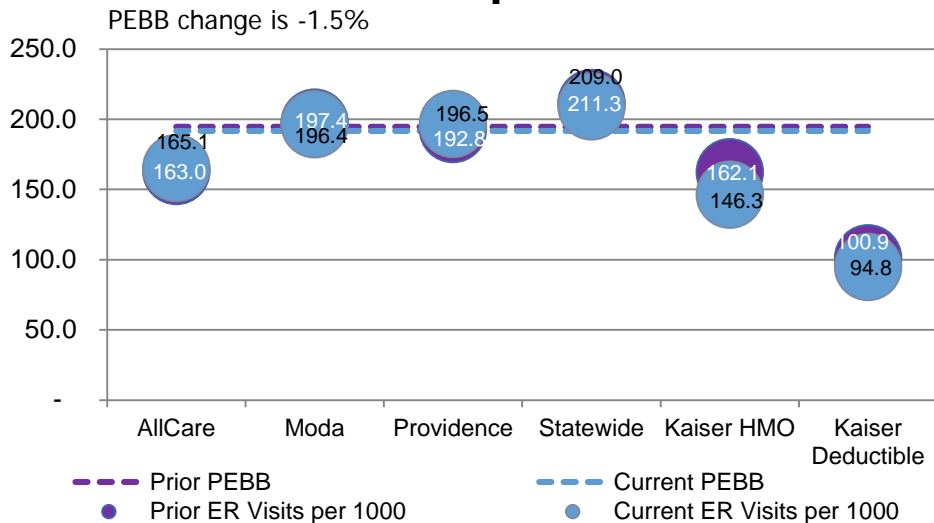
- The increase in Kaiser office visits is driven by a substantial increase in mental health visits

3

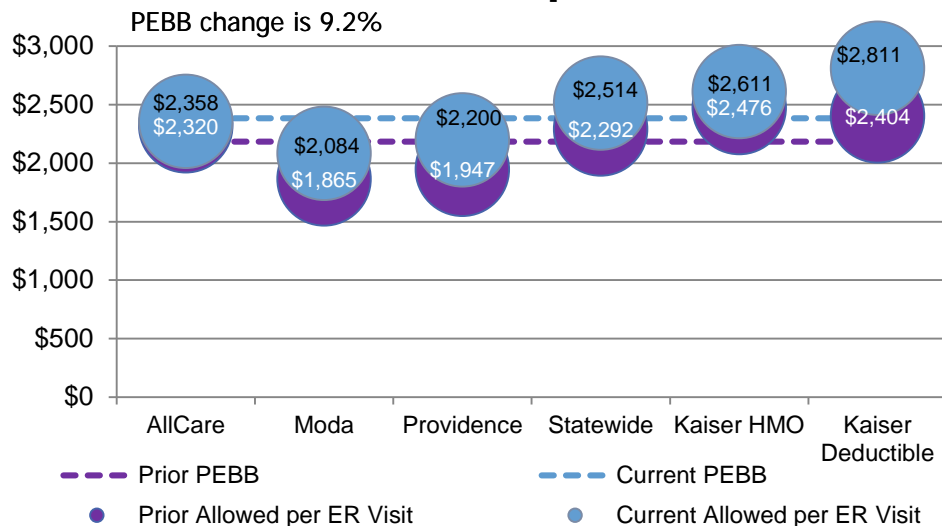
- Despite a reduction in allowed per visit, AllCare had the highest cost per visit of all plans

EMERGENCY ROOM

ER Visits per 1000



Allowed Amount per ER Visit



KEY INSIGHTS

1

- Cost per emergency room visit continues to increase with Choice (13.0%) and Kaiser Deductible (16.9%) having the largest increases
- Moda cost per ER visit increased 11.8%

2

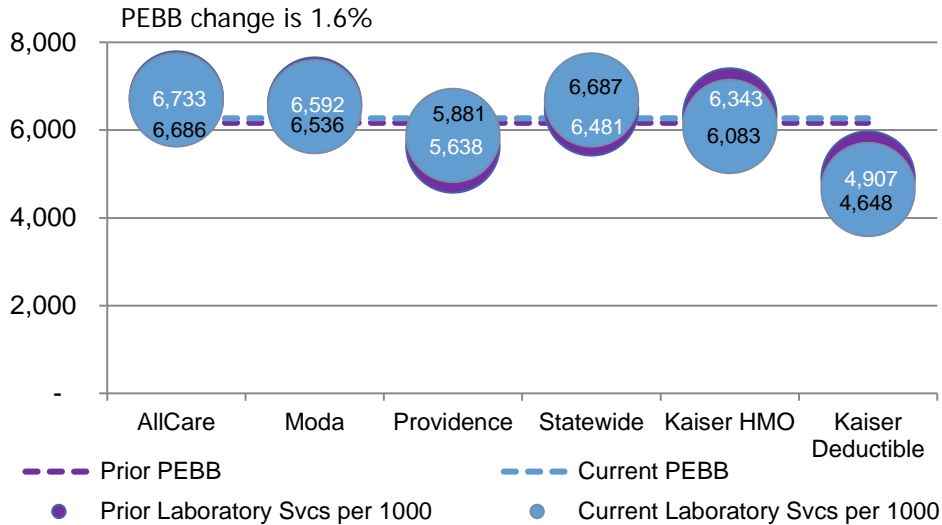
- Kaiser HMO and Kaiser Deductible had the fewest visits per 1000

3

- Percentage of ER visits coded as category 4 or 5 increased for both Kaiser Deductible (35% to 49%) and Providence Choice (46% to 51%)

LABORATORY SERVICES

Laboratory Svcs per 1000



KEY INSIGHTS

1

- Statewide had the highest utilization of laboratory services, with AllCare close behind
- Choice had the highest utilization increase at 4.3%

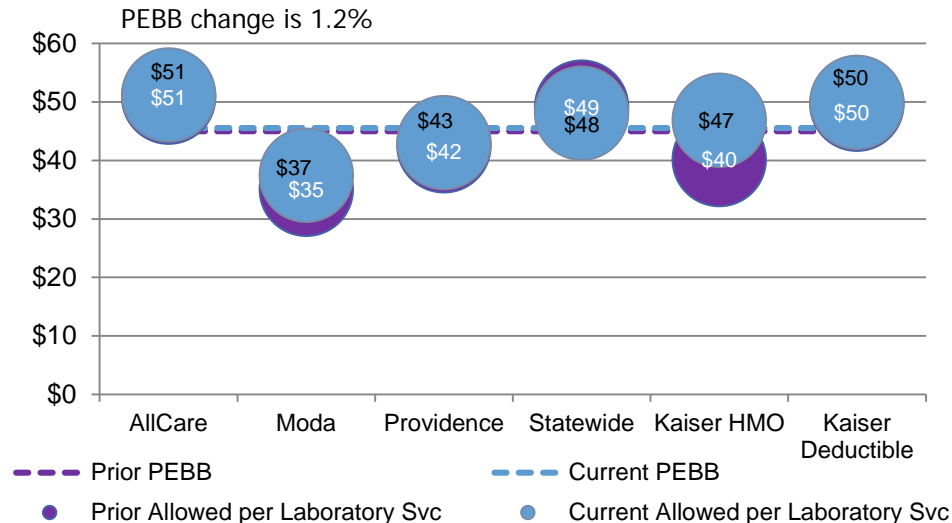
2

- Kaiser HMO cost per service increased 16.6% and Moda increased 6.9% over the prior period

3

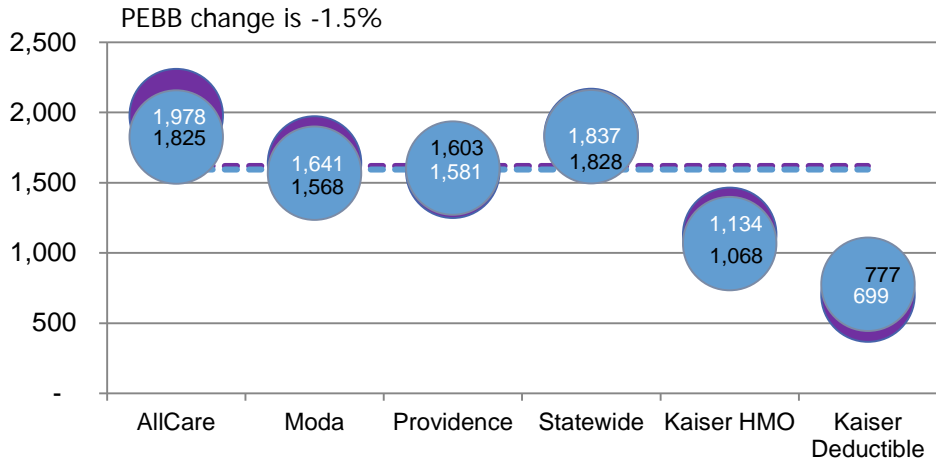
- Increased usage of DNA tests including BRCA contributed to Kaiser HMO increases

Allowed Amount per Laboratory Svc

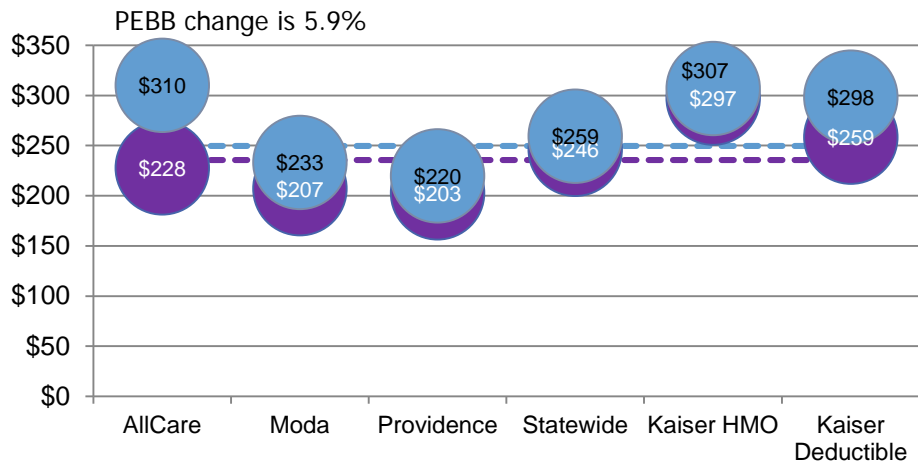


RADIOLOGY SERVICES

Radiology Svcs per 1000



Allowed Amount per Radiology Svc



KEY INSIGHTS

1

- AllCare had the highest utilization of radiology services, however both Choice and Kaiser Deductible saw increases

2

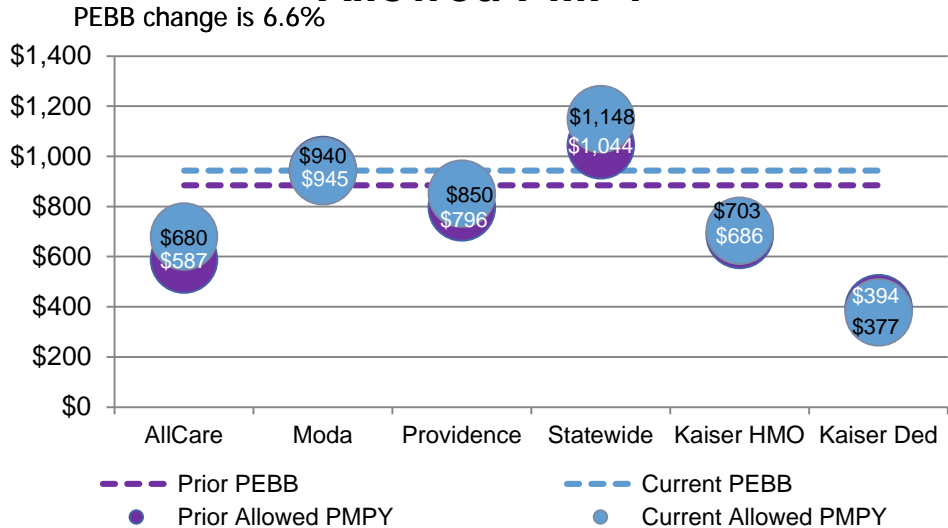
- Kaiser Deductible and Moda cost per service increased 15.4% and 12.6% respectively over the prior period

3

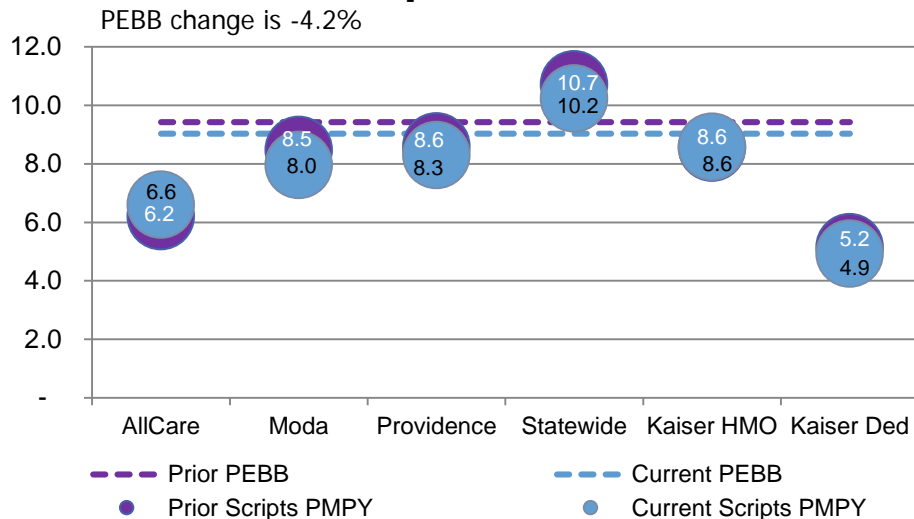
- MRIs as a percentage of overall radiology increase for both Kaiser Deductible and Moda
- Therapeutic (radiation/cancer treatments), which are higher cost services, also increased

PRESCRIPTION DRUGS

Allowed PMPY



Scripts PMPY



KEY INSIGHTS

1

- Allowed costs per member for prescription drugs increased by 6.6% for PEBB despite a decrease in scripts per member of 4.2%

2

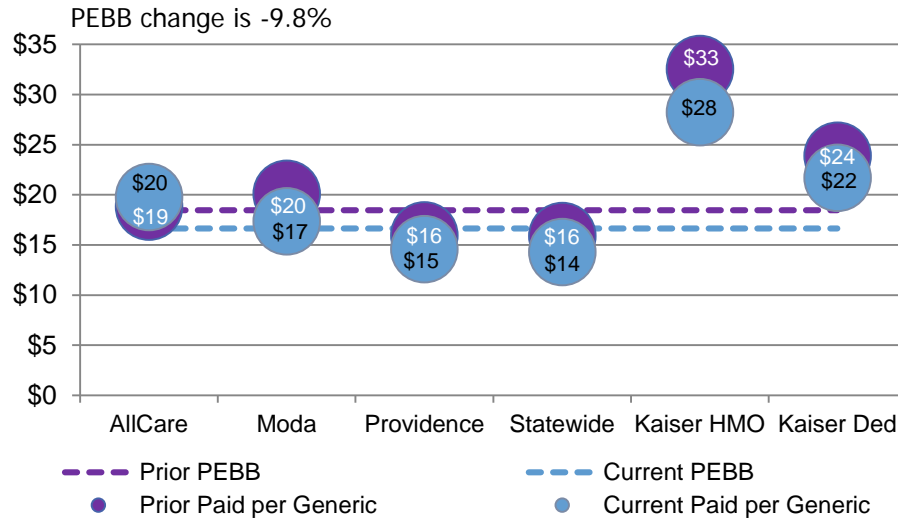
- The paid per member increased 7.6%, indicating a decrease in members' cost share

3

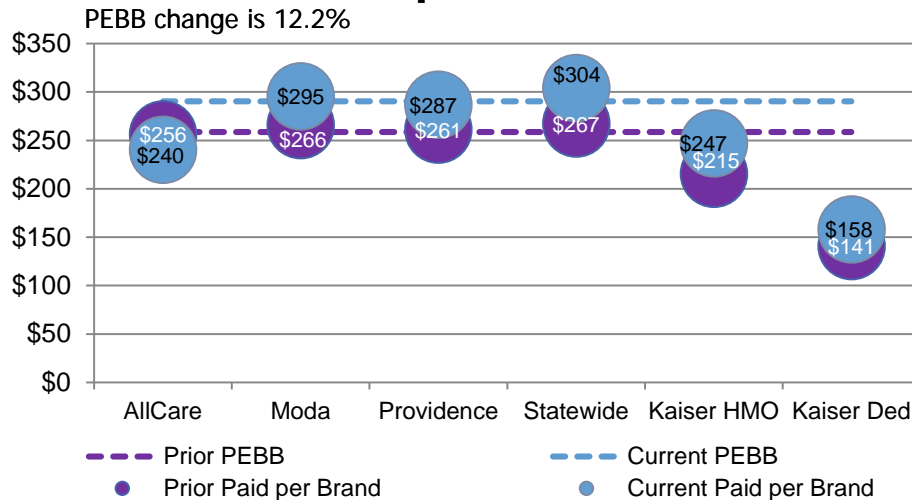
- The paid per script increased 12.3% for PEBB overall

PRESCRIPTION DRUGS

Paid per Generic



Paid per Brand



KEY INSIGHTS

1

- Paid per generic script saw a decrease for all plans with the exception of AllCare

2

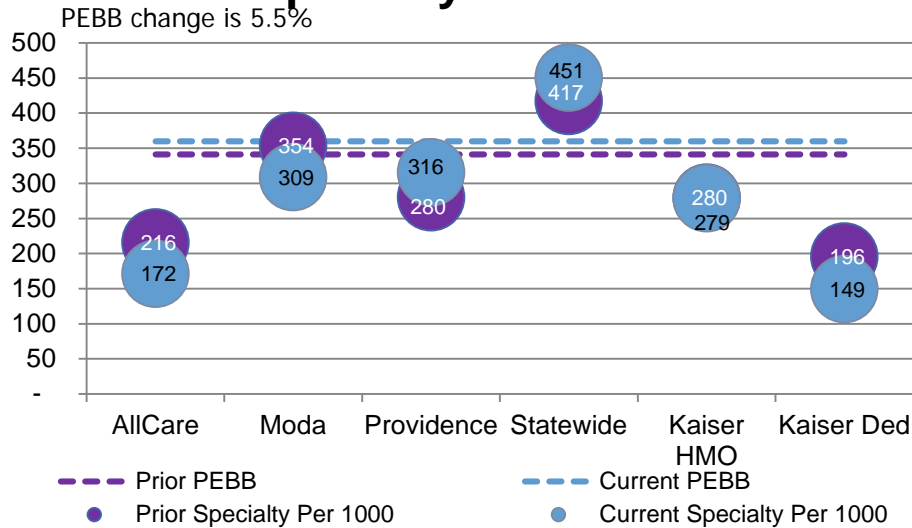
- Paid per brand saw an increase for all plans with the exception of AllCare
- Costs exclude specialty drugs and Rx rebates

3

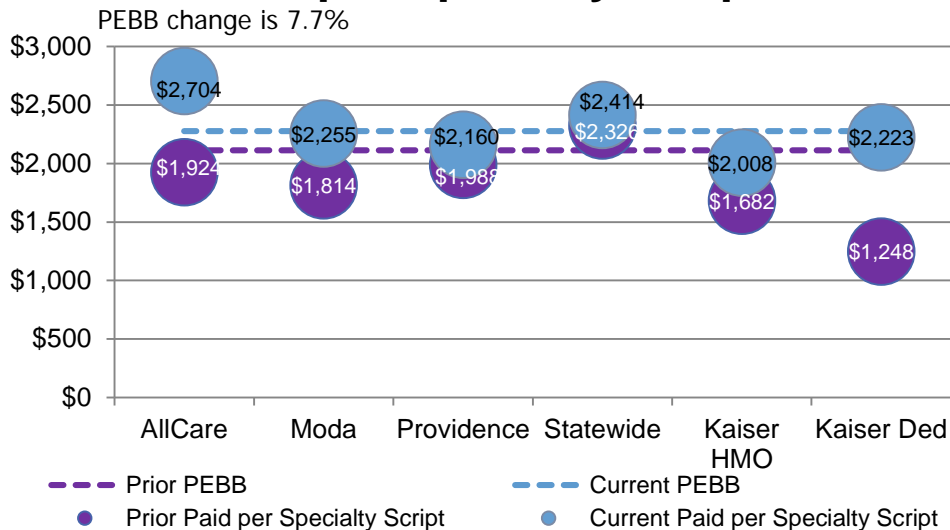
- Generic utilization for PEBB decreased by 0.4% to 84.7%

SPECIALTY DRUGS

Specialty Per 1000



Paid per Specialty Script



KEY INSIGHTS

1

- Utilization of specialty drugs increased 13% for Choice and 8% for Statewide
- Costs per script increased for all plans with Kaiser Deductible up 78% and Moda up 24%
 - Increased usage of cancer drugs

2

- Specialty drug costs now represent 14.3% of total PEBB claims and 16.4% of Statewide
- This is an increase from 13.4% and 15.9% respectively

3

- Excluding specialty drugs, the PEBB cost increase of 6.4% would have been 5.3%



MERCER