HEALTH WEALTH CAREER

Attachment 3

OREGON PEBB BOARD MEETING

2020 RENEWAL DECISIONS

MAY 21, 2019

2020 RENEWAL DISCUSSION
OVERVIEW AND AGENDA

1. Composite Rate
2. Summary of Decision Points
3. Details — Medical and Non-Medical Renewals
4. Appendix

OBJECTIVES

- Revisit 2020 composite rates as renewal decision “starting point”
- Review program renewal considerations, impact and rationale
- Consider applying funding assessment to medical rates
- Secure board’s decisions for 2020 program changes, for which final rates will be produced for approval at next meeting

2020 COMPOSITE RATE AND RENEWAL OVERVIEW

COMPOSITE RATES
HISTORICAL & 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	-1.1%
2016	$1,356.47	2.6%	$1,347.31	2.6%
2017	$1,416.93	4.5%	$1,405.13	4.3%
2018	$1,464.20	3.3%	$1,452.68	2.5%
2019	$1,513.98	3.4%	$1,495.83	2.2%
2020 *(w/o Premium tax)*	$1,533.29	1.3%		
2020 *(w/ Premium Tax)*	$1,562.08	3.2%		

- Composite rate, even including the premium tax, falls below 3.4% threshold
- Includes family subsidy, VSP Buy-up contributions, and adjustment for opt-outs and double coverage
- 2020 rates changed from April due to WW change, down from $1,533.65 and $1,562.44
- PEBB is **$20.8M** under budget compared to the 3.4% cap

RENEWAL OVERVIEW
SUMMARY OF COVERAGES

	2019 Final Increase	2020 Increase – no design changes	
Medical		*Without Premium Tax*	*With Premium Tax*
Providence Choice	5.4%	1.1%	3.1%
Providence Statewide	3.9%	6.5%	8.7%
Moda	4.0%	0.6%	2.6%
Kaiser HMO/Ded.	2.9%	2.4%	4.5%
Non-Medical			
Delta Dental OR (Moda Dental)	2.0%	4.3%	
Kaiser Dental	3.4%	1.5%	
Willamette Dental Group (WDG)	3.4%	6.9%	
VSP	2.9%	0.3%	
Composite Rate	**3.4%**		
Other Vendors			
The Standard	5.1%	0.0%	
ASI Flex	0.0%	0.0%	
Benefit Help Solutions (BHS)	0.0%	0.0%	
Cascade	0.0%	0.0%	

Assumptions

- Self-Funded rate accounts for both administrative and premium increases
- Excludes consultant commission (0.13%) and PEBB Admin.

SUMMARY OF DECISION POINTS

MEDICAL
ALL CHANGES AND IMPACTS

Plans	Consideration	Cost impact	Composite Rate Impact	Rationale	Mercer Recommendation	Board Decision
Choice	Physical / Occupational Therapy medical necessity review after the 12th visit	($800,000)	(0.1%)	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines coupled with specialized expert reviewers • Administered through eviCore	Accept	
Statewide		($800,000)	(0.1%)			
Choice	Chiropractic medical necessity review after the 12th visit	($700,000)	(0.1%)	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines • Administered through the individual carriers	Decline; monitor chiro utilization	
Statewide		($700,000)	0.0%			
Choice	Expand spinal manipulation to include massage therapy	$1,100,000	0.1%	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain • Would not include medical necessity review after the 12th visit; the benefit on Choice is limited to $1,000 which limits PEBB's exposure	Accept for Choice only	
Statewide		$3,800,000	0.4%			
Choice	Promote benefit differential between outpatient hospital and ASC • $25 copay for ASC • $100 copay for outpatient hospital	$0	0.0%	• Incentivize members towards lower-cost ambulatory surgical centers rather than outpatient hospitals, for their outpatient procedures and radiology services	Decline	
Statewide		$0	0.0%			
Choice	Medically necessary varicose vein surgery[1]	$0	0.0%	• Enhanced benefit • Help members experience pain, skin problems, and/or blood clots associated with varicose veins	Accept	
Statewide		$0	0.0%			

[1]Kaiser HMO and deductible plans currently cover medically necessary varicose vein surgery

MEDICAL
ALL CHANGES AND IMPACTS (CONTINUED)

Plans	Consideration	Cost impact	Composite Rate Impact	Rationale	Mercer Recommendation	Board Decision
Moda	**Alignment of medical and pharmacy benefit to 20% coinsurance**	($200,000)	0.0%	• Current benefit structure creates incentives for members to receive infusions in an office visit setting which runs drugs through the medical benefit ($10 copay compared to $100 specialty medication copay) • This change would eliminate that incentive by charging a higher cost share for infused drugs administered under the medical benefit	Decline	
	Alignment of medical and pharmacy benefit to $100 copay	($200,000)	0.0%		Decline	
	Alignment of medical and pharmacy benefit to $10 copay	($200,000)	0.0%		Accept	
	Pharmacy benefit optimization program	($200,000)	0.0%	• Shifting certain drugs from the medical to pharmacy benefit allows those drugs to be reimbursed on a fixed % of the AWP of a drug, which creates more predictable and significantly lower reimbursement level • Members could continue to see the same provider and receive their infusions at the same location, but the medication would be supplied via the specialty pharmacy	Accept	
	Change formulary tier structure	($200,000)	0.0%	• Incentivize members to use formulary medications • $30 copay for approved non-formulary generics, $50 for non-formulary brand	Accept	
	Expand spinal manipulation to include massage therapy • **No eviCore review** • **With eviCore review after 6th visit**	 $1,000,000 $600,000	 0.1% 0.1%	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain	Accept with eviCore review	
	Medically necessary varicose vein surgery[1]	$500,000	0.0%	• Enhanced benefit • Help members experience pain, skin problems, and/or blood clots associated with varicose veins	Accept	
	Promote benefit differential between outpatient hospital and ASC • **$25 copay for ASC** • **$100 copay for outpatient hospital**	($300,000)	0.0%	• Incentivize members towards lower-cost ambulatory surgical centers rather than outpatient hospitals, for their outpatient procedures and radiology services	Decline	

[1]Kaiser HMO and deductible plans currently cover medically necessary varicose vein surgery

MEDICAL
ALL CHANGES AND IMPACTS (CONTINUED)

Plans	Consideration	Cost impact	Composite Rate Impact	Rationale	Mercer Recommendation	Board Decision
Kaiser HMO	Change a subset of DME items that are currently $0 member cost share (CADD pumps, enteral pumps, etc.) to the DME cost share.	$0	0.0%	• Standardize benefits	Accept	
KP Deductible		$0	0.0%			
Kaiser HMO	Remove ophthalmology from services accessible without referral	$0	0.0%	• Standardize benefits	Accept	
KP Deductible		$0	0.0%			
Kaiser HMO	Expand spinal manipulation to include massage therapy • FT $250 Ded. • FT $350 Ded. • PT $250 Ded. (full Alt Care benefit would be added) • PT $350 Ded. (full Alt Care benefit would be added)	$800,000	0.1%	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain	Decline for HMO and Accept for Deductible (both FT and PT plans)	
KP Deductible		$0 $0 $0 $0	0.0% 0.0% 0.0% 0.0%			

NON-MEDICAL
DELTA DENTAL

Benefit	Former Benefit	New Benefit	Claims Impact	Mercer Recommendation	Board Decision
Space maintainer	The Plan allowed once per space. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 14 or over are not covered.	The Plan allows once per space per quadrant as a lifetime benefit. Space maintainers for primary anterior teeth or missing permanent teeth or for members age 19 or over are not covered.	Minor	Accept	
Restorative services – Basic	The Plan disallowed indirectly fabricated post and core in addition to crown. Participating providers write off the charges.	The Plan denies indirectly fabricated post and core in addition to a crown unless more than half of the coronal tooth structure is missing.	Minor	Accept	
Endodontic Services	Retrograde fillings were covered.	Retrograde fillings by the same dentists within a 2-year period of the initial retrograde filling is not covered.	Minor	Accept	
Oral surgical Services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Minor	Accept	
Oral surgical services	Bone replacement graft was covered subject to consultant review.	Bone replacement grafts are limited to once per single tooth or multiple teeth within a quadrant in any 3-year period.	Minor	Accept	
Oral surgical services	Oral and Maxillofacial surgery was covered subject to consultant review.	A separate charge for post- operative care done within 30 days following oral surgery is included in the charge of the original surgery.	-0.25% or 100,000 in claims savings	Accept	
Prosthodontic services	Re-cement or re-bond implant/abutment supported crown or fixed partial denture was covered.	Re-cement or re-bond implant/abutment supported crown or fixed partial denture is limited to once in any 12- month period.	Minor	Accept	

NON-MEDICAL
DELTA DENTAL (CONTINUED)

Benefit	Former Benefit	New Benefit	Claims Impact	Mercer Recommendation	Board Decision
Restorative services[1,2]	Composite restoration in posterior tooth was not covered. Member paid the difference between amalgam and composite. Inlays were considered an optional service and an alternate benefit of an amalgam filling was provided.	Composite restoration in posterior tooth is covered. Inlays are an optional service and the alternate benefit will now be composite filling.	+1% or $500,000 in additional claims spend	Accept	
Oral surgical Services	Brush biopsy was not covered	Brush biopsy is covered twice in a 12-month period.	Minor[3]	Accept	
Prosthodontic services	The final crown and implant abutment over a single implant were covered. This benefit was limited to once per tooth or tooth space in any 7-year period. The final implant-supported bridge retainer and implant abutment, or pontic were covered. The benefit was limited to once per tooth or tooth space in any 7-year period.	The final crown and implant abutment over a single implant are covered. This benefit is limited to once per tooth or tooth space over the lifetime of the implant. The final implant-supported bridge retainer and implant abutment, or pontic are covered. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.	Minor[3]	Accept	

[1] Kaiser: Amalgam filling and anterior composite filling material is covered at 100% after a $20 office visit fee; Posterior composite filling material is covered at 100% after a $20 OV charge up to the cost equivalent amalgam filling material. The member must pay the difference between the cost of an amalgam and composite filling when placed on a posterior tooth

[2] WDG: Covered under a $20 copay (2019) whether it is amalgam/ composite and does not distinguish by location (posterior costs the same)

[3] Combined claims impact is around $50K for these two services, limited impact in the PEBB budget

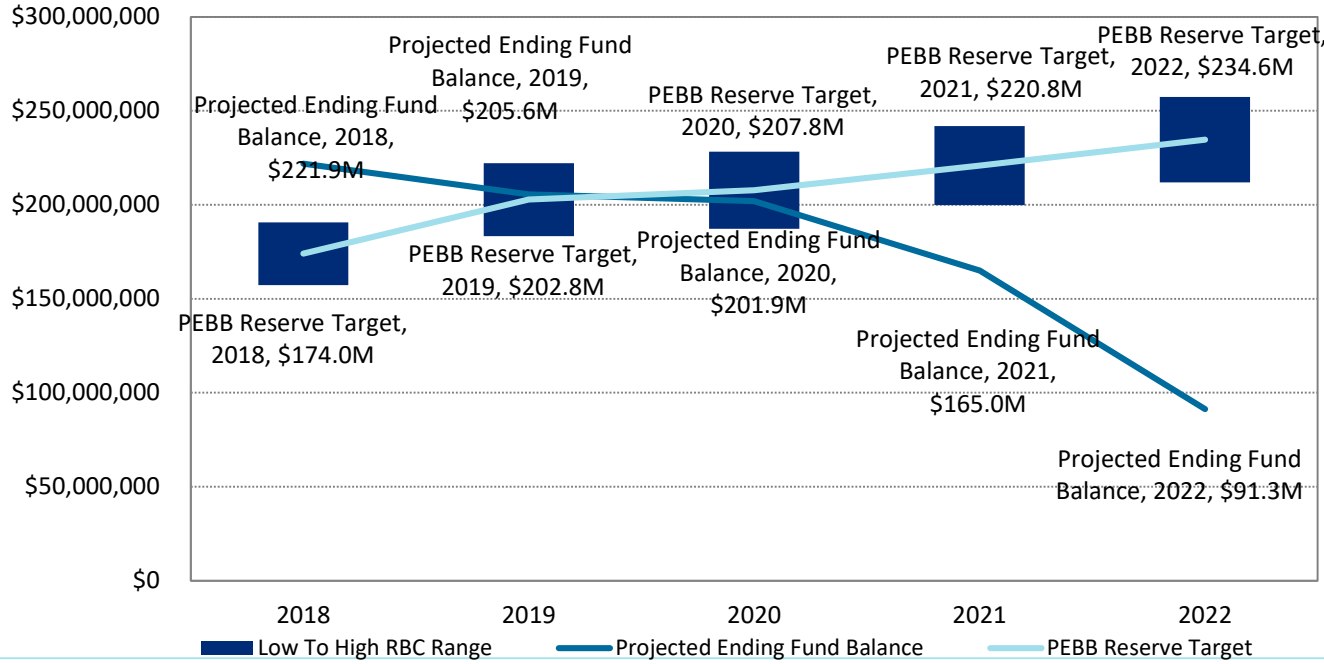
NON-MEDICAL
WILLAMETTE DENTAL, VISION, AND EAP

Carrier	Consideration	Cost impact	Composite Rate Impact	Change / Rationale	Mercer Recommendation	Board Decision
Willamette Dental	**Implant Surgery benefit copay changes**	• n/a – 1.35% claims impact but WDG already incorporated into premiums with rate concession	• n/a	• For 2020, WDG will require the following new implant benefit design: – Dental implant surgery will be covered up to an annual maximum of $1,500 with a limit of one tooth space per year – Current benefit: $2,745 copay for a single tooth, up to $5,060 copay for two teeth and $7,210 for three teeth – As of 2018, implants cost ~$4,900 per tooth	Accept – mandatory change on all WDG plans	
VSP	**Suncare**	• $300K for base/buy-up • $100K for buy-up only	• n/a	• Suncare: allows members to utilize their frame benefit for non-prescription ready-made sunwear in lieu of prescription eyewear • Dependent upon 3.4% target, but this would be a valuable benefit to members • Could just apply to the Buy-up plan to pass the benefit to members	Accept for Buy-Up	
VSP	**Plan Relativity Adjustments**	• Reduces VSP rates by 3% and increases VSP Plus rates by 3.5% • VSP costs decrease by $400,000 while VSP Plus increases by $400,000	• Decrease slightly	• Current rate relativities were set two years ago when VSP Plus plan was being implemented • Actual experience over past two years have resulted in a deficit for the VSP Plus plan and a surplus for the VSP plan – PEBB is subsidizing the VSP Plus members approximately $400,000 per year • Increased differential would result in VSP Plus premiums more closely covering the actual cost of care	Accept	
Cascade Centers	**WholeLife Directions**	• $120K, passed onto agencies	• n/a	• Complement existing EAP and wellbeing services • Provides proactive mental health engagement and instant connection to personalized programs	Accept	

COMPOSITE RATE WITH FUNDING ASSESSMENT

PEBB STABILIZATION RESERVE
FROM APRIL PRESENTATION

- As a reminder, the 2019 and 2020 ending fund balances are projected to near PEBB reserve targets
- 2021 and 2022 ending fund balance is projected to be below reserve targets
- Currently, the OR premium tax is being funded through the PEBB stabilization reserve without being passed on to agencies



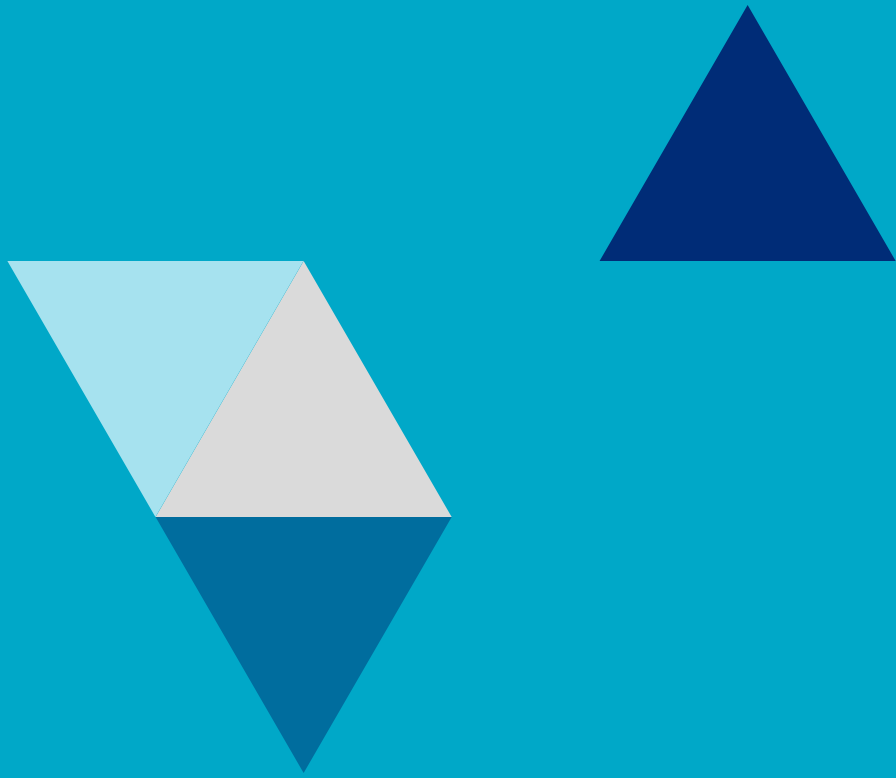
FUNDING ASSESSMENT
OUTLINE OF OPTIONS

- PEBB has the option of “loading” the composite rate in order to reach the 3.4% limitation (excluding premium tax)
  - Including the premium tax, the composite rate is a 3.2% increase
- Including a funding assessment to reach the 3.4% limitation would be an increase in funding of approximately $21 million per year (prior to any plan changes)

Option	Description	2019 Final Funding Rate (before switching)	2020 Funding Rate (excluding Premium Tax)	% Change	2020 Funding with Premium Tax	% Change
Baseline	• Without funding load • Without premium tax	$1,513.98	$1,533.29	1.3%	$1,562.08	3.2%
Baseline with funding assessment	• Without premium tax • With 2.29% funding assessment	$1,513.98	$1,565.44	3.4%	$1,594.88	5.3%

- Mercer’s recommendation is to add a funding load (2.29% prior to plan changes) to the rates and include the premium tax for a 5.3% increase to the composite rate
  - Final funding load would be determined after board decisions on plan changes

PROVIDENCE



PROVIDENCE
MEDICAL — ASO FEES

ASO PROPOSED FEES (PEPM)	2019	2020	% CHANGE
Statewide			
Base ASO	$40.92	$42.13	3.0%
Triple Aim Incentive (PEPM)	$13.63	$13.63	0.0%
Total Admin	**$54.55**	**$55.76**	**2.2%**
Choice			
One year rate guarantee	$58.44	$60.22	3.0%
Triple Aim Incentive (PEPM)	$13.20	$13.20	0.0%
Total Admin	**$71.64**	**$73.42**	**2.5%**

- Notes:
  - For the 2019 plan year, Providence reduced the Triple Aim incentive from $15 PEPM to the amounts shown above in order to get a rate pass on the total administration fee
  - For the 2020 renewal, Mercer requested Providence increase the Triple Aim Incentive back to $15 PEPM without increasing the total fees proposed. Due to the complexity and cost associated with administering the plans, Providence is unable to reduce the base fees to offset the increase in the Triple Aim Incentive
  - Fees above do not include PEBB fees (consultant and admin)

PROVIDENCE
FOLLOW-UP SUMMARY

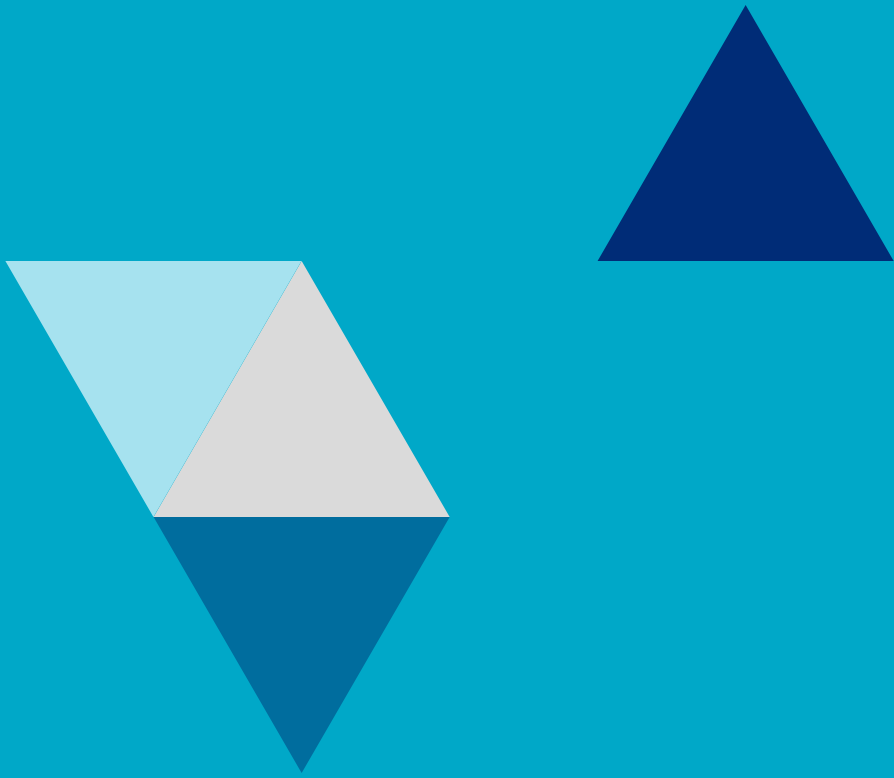
Medical vs. Pharmacy Distribution

- Mercer requested more information regarding drugs administered through the medical plan vs. the pharmacy plan, specifically, whether Providence is directing drugs to be run through the lower-cost pharmacy channel
  - PHP directs medications that are typically “medical” through the pharmacy channel for dispensing, however, the cost sharing for the member is based on established definitions of pharmacy vs. medical benefit drugs
  - Regarding channel management, PHP actively manages procurement site or the channel of dispense

WW (formerly Weight Watchers)

- The Board elected to accept WW’s pricing proposal to move from a fee paid per enrollment to a fixed population-based price of $1,374,660
- PHP confirmed there is **no impact** to the admin fee as WW claims are paid like any other medical claim and are auto-adjudicated

MODA



MODA
ASO FEE

ASO Fee	2019	2020	% Change
ASO	$75.97	$76.85	1.2%

WW (formerly Weight Watchers)

- The Board elected to accept WW's pricing proposal to move from a fee paid per enrollment to a fixed population-based price of $1,374,660
- Moda confirmed WW claims are currently being adjudicated through claims wires and will continue to do so under the new agreement
  - WW will be broken out as a line item on the claims bill

MODA
DETAILS ON CHANGES

Change #1: Medical Benefit Cost Share

- Large benefit differential for certain services under medical benefit versus via pharmacy
  - Provider administered infusions, injections, implants, etc. have a $10 copay
  - Self-administered orals, self-injections, patches, etc. have a $100 copay
- Creates incentive to utilize medical benefit drugs, which are almost always more expensive than similar Rx benefit drugs
- **Recommendation: decrease copay on self-administered orals, self-injections, patches, etc. to match the office visit copay of $10**
- Member impact
  - Members utilizing self-administered medications covered under the medical benefit are not impacted
  - Members will receive 60-day notice of change
  - Can continue the same provider-administered drug(s)
- Moda confirmed the program only includes six drugs, but they are currently reevaluating a number of other drugs for addition to the program
  - As more drugs get added, members may see their copay decrease from $100 to $10 based on the channel of distribution

MODA
DETAILS ON CHANGES

Change #2: Pharmacy Benefit Optimization Program

- Drugs billed through the medical benefit are reimbursed using a variety of methodologies
- Could be significant “markup” from hospitals
- Drugs billed through the pharmacy benefit have fixed methodologies without an ability to “markup”
- Recommendation: shift reimbursement of select infused medications to the pharmacy benefit
  - High cost drugs
  - Eliminate variability in reimbursement between benefits
  - Relatively low utilization
- Member impact:
  - Same drug, provider, and infusion location
  - Drug now billed to the member’s pharmacy benefit
  - Financially neutral only if accepted in conjunction with medical benefit cost share change (Change #1)
    - Otherwise $90 cost share increase, if first change not accepted (goes from $10 copay to $100 copay)
  - Members utilizing self-administered medications covered under the medical benefit are not impacted
  - Medication is supplied by specialty pharmacy and billed through the pharmacy benefit

MODA
DETAILS ON CHANGES

Change #3: Create Non-preferred Cost Share Tier

- Current formulary tiers:
  - Value: no cost share
  - Generic: $10 copay
  - Brand: $30 copay
- Members with non-formulary exceptions currently have the same copayment levels as those using formulary medications
- Recommendation: ensure members utilizing the formulary medications receive the best value
  - New tiers:
    - Value: no cost share
    - Formulary Generic - $10 copay
    - Non-Formulary Generic - $30 copay, when approved
    - Formulary Brand - $30 copay
    - Non-Formulary Generic - $50 copay, when approved
- 1,570 members would be impacted, with 4,200 claims and approximately $2M in paid claims

MODA
NETWORK CHANGE

- As of May 15th, Moda is NOT proposing the Connexus network for the PEBB population due in part to Providence's decision to not contract as in-network providers/facilities
- Moda is still moving forward with the CCM 2.0 risk model which focuses on primary care and only includes PCPCH and CPC+ providers
- Due to the risk model changing, there will still be some disruption for PEBB members as the providers who are not PCPCH or CPC+ certified will be considered out-of-network
  - See the following slide for disruption

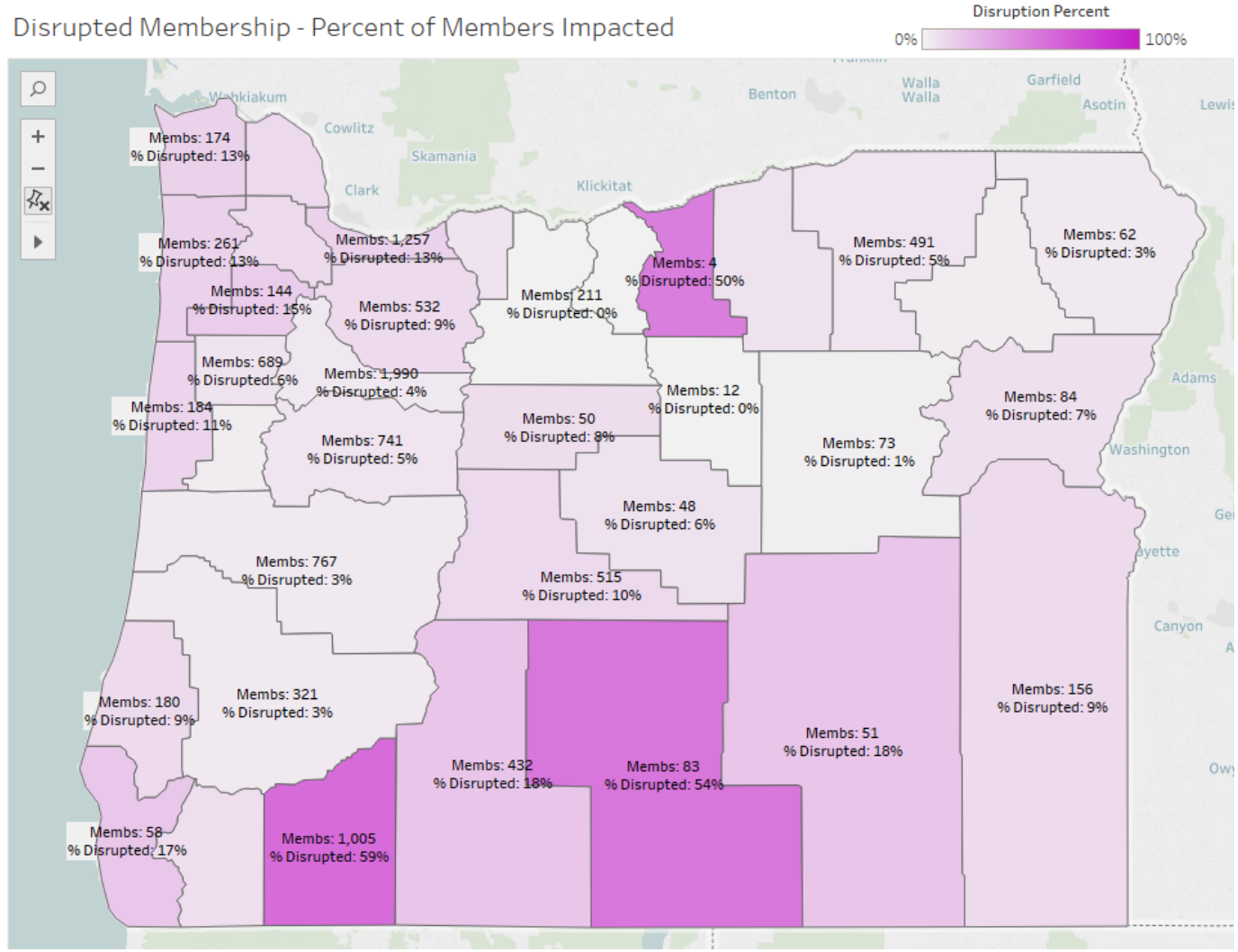
Plan	Risk Model
Current	**CCM "1.0"** Aspects of the risk model focused on hospital reimbursements and agreements
Proposed	**CCM "2.0"** Main aspect of risk model is primary care and uses a total cost of care set at 3.4%

MODA
NETWORK CHANGE

Overall Disruption	Members
Total Members	12,444
No Disruption	
• Members can keep current PCP	9,561
• Members not utilizing any PCP	1,430
Disruption	
• New PCP is closer than current PCP	1,209
• New PCP is less than five miles farther than current	239
• New PCP is greater than five miles farther than current	5

- Disruption has been updated based on the fact that Providence primary care providers will not be available as a Coordinated PCP
- Moda also updated the disruption algorithm to better attribute members to PCP clinics, rather than clinics that actually specialize in urgent care
- Only five members are more than five miles from their current PCP; the distances for those five members are:
  - One at 10 miles
  - Three at 20 miles
  - One at 21 miles

MODA
NETWORK CHANGE



KAISER

KAISER
2020 PREMIUM RATES

KAISER	2019	2020	2020 W/ TAX
FULL-TIME HEM HMO RATES (PEPM)			
Employee	$775.67	$794.53	$810.77
Employee & Spouse/Partner	$1,551.35	$1,589.07	$1,621.55
Employee & Children	$1,318.64	$1,350.70	$1,378.31
Employee & Family	$2,094.32	$2,145.25	$2,189.09
FULL-TIME HEM DEDUCTIBLE RATES (PEPM)			
Employee	$708.54	$725.77	$740.60
Employee & Spouse/Partner	$1,417.09	$1,451.55	$1,481.21
Employee & Children	$1,204.53	$1,233.82	$1,259.03
Employee & Family	$1,913.08	$1,959.60	$1,999.65
		+2.4%	+4.5%

- Factors Include:
  - 3.6% medical and pharmacy annual trend
  - The following fees:
    - $83.07 PEPM ($32.55 PMPM) medical retention, $14.22 PEPM ($5.57 PMPM) HIP fee, $24.32 PEPM ($9.53 PMPM) other benefits, $2.55 PEPM ($1.00 PMPM) group specific charges (Weight Watchers, flu shot clinic, commercial driver's exam). The Premium Tax increases rates $30.91 PEPM ($12.11 PMPM)
  - $525,000 pooling point

KAISER
FOLLOW-UP SUMMARY

Medical vs. Pharmacy Distribution

- All medications, whether dispensed through Kaiser pharmacies, mail order, or clinically administered, are purchased on a National scale for all of Kaiser's members
- Due to the integrated model, there are no incentives to dispense via the pharmacy channel or the medical channel

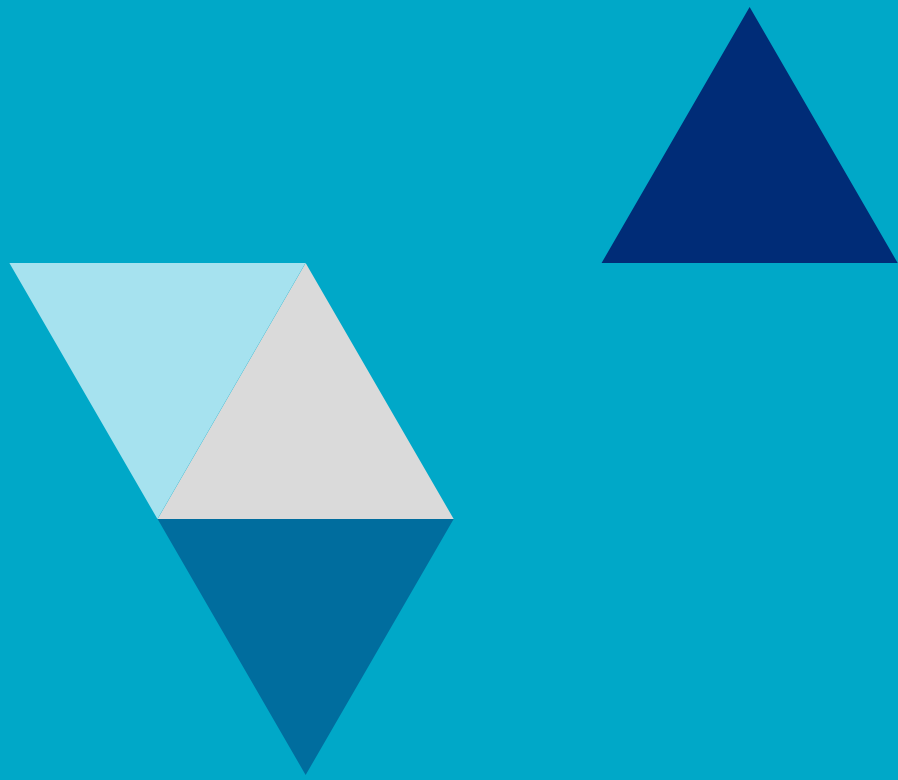
DME Benefit Change

- Kaiser is proposing changing the following subset of DME services to have the same cost share as other DME services: enteral pumps and supplies; CADD pumps; osteogenic bone stimulators; osteogenic spine stimulators; ventilators
- The change will affect both the FT and PT plans:

FULL-TIME PLANS	HMO	DEDUCTIBLE
Current benefit	$0 cost share	$0 cost share
New benefit	$0 cost share	15% coinsurance; $0 for diabetic supplies

PART-TIME PLANS	HMO	DEDUCTIBLE
Current benefit	$0 cost share	$0 cost share
New benefit	50% coinsurance; $0 for diabetic supplies	50% coinsurance; $0 for diabetic supplies

NON-MEDICAL



DELTA DENTAL OF OREGON
FINANCIALS

2020 COMPOSITE BUDGET RATES

Delta Dental of Oregon	2019	2020	Increase % / $	
Traditional	$111.32	$116.10	4.3%	$1,107,000
Preferred	$100.61	$104.93	4.3%	$788,000
Part-Time	$74.63	$77.84	4.3%	$14,000
Combined	$106.28	$110.84	4.3%	$1,909,000

Assumptions

- Claims through December 2018
- 3.0% Trend
- Excludes consultant commission (0.13%) and PEBB Admin.
- March 2019 Enrollment

ADMINISTRATION

Year	PEPM Fee	Rate Increase
2018	$6.10	Rate Hold
2019	$6.20	1.5%
2020	$6.30	1.5%

- 2020 is the final year of a three-year rate guarantee
- Note: the admin fee includes $0.20 for the Oral Health Initiative

KAISER DENTAL FINANCIALS

2020 COMPOSITE BUDGET RATES

Kaiser	2019	2020	Increase % / $	
Full Time Rates	**$118.12**	**$119.95**	1.5%	$127,000
• EE Only	$63.45	$64.43		
• EE + SP	$126.90	$128.86		
• EE + CH	$107.87	$109.54		
• EE+ FAM	$171.32	$173.91		
• CH Only	$51.14	$51.93		
Part Time Rates	**$83.14**	**$84.12**	1.5%	$1,000
• EE Only	$47.32	$48.05		
• EE + SP	$94.64	$96.10		
• EE + CH	$80.45	$81.69		
• EE + FAM	$127.77	$129.74		
• CH Only	$38.09	$38.68		
Combined	**$117.73**	**$119.55**	**1.5%**	**$128,000**

Assumptions

- Status Quo Plan Design
- 5.5% trend being used, with data through December 2018
- $4.75 PMPM retention
- Composite calculated with March 2019 Enrollment

2020 PLAN DESIGN CONSIDERATIONS

• Board Consideration	Financial Impact	Mercer Comments
• None	• n/a	• n/a

WILLAMETTE DENTAL GROUP (WDG) FINANCIALS

2020 / 2021 TIERED RATES

Willamette	2019	2020	2021
Employee	$52.25	$55.85	$57.75
Employee & Spouse	$104.50	$111.70	$115.50
Employee & Child(ren)	$88.85	$95.00	$98.23
Employee & Family	$141.10	$150.85	$155.98
Child Only	$44.40	$47.45	$49.06
% Increases		**6.9%**	**3.4% (maximum)**

In the spirit of long-term partnership, WDG has proposed a two-year agreement, with rates in 2021 to not exceed 3.4%.

2020 underwriting called for a 19.58% premium increase

2020 PLAN DESIGN CONSIDERATIONS

Board Consideration	Financial Impact	Mercer Comments
• For 2020, WDG will require the following new implant benefit design: – Dental implant surgery will be covered up to an annual maximum of $1,500 with a limit of one tooth space per year – Current benefit: $2,745 copay for a single tooth, up to $5,060 copay for two teeth and $7,210 for three teeth	• n/a – change would have a 1.35% claims impact but WDG already incorporated into premiums via rate concessions	• Required by WDG-underwritten plans

Note:
- WDG does not recommend any copay changes for the 2020 renewal, apart from implants, as there is not enough data at this time to support changes

VISION SERVICE PLAN (VSP)
FINANCIALS

2020 COMPOSITE BUDGET RATES

VSP	2019	2020	Increase % / $	
Base	$17.43	$17.48	0.3%	$19,000
Buy-Up	$26.09	$26.18	0.3%	$16,000
Combined	$20.53	$20.60	0.3%	$35,000

Assumptions
- Claims through December 2018
- 2.0% Trend
- Excludes consultant commission (0.13%) and PEBB Admin.
- March 2019 Enrollment

ADMINISTRATION

Year	PEPM Fee	Rate Increase
2019 - 2021	$1.19	0.0%

- Second year of three-year rate guarantee

2020 PLAN DESIGN CONSIDERATIONS

Board Consideration	Financial Impact	Mercer Comments
• Suncare: allows members to utilize their frame benefit for non-prescription ready-made sunwear in lieu of prescription eyewear	• +3.0% of 2020 premium – $300,000 for all Base + Buy-up – $100,000 if just applied to the Buy-up (no impact to composite rate as members pay the cost difference)	• Dependent upon 3.4% target, but this would be a valuable benefit to members • Could just apply to the Buy-up plan to pass the benefit to members

VISION SERVICE PLAN (VSP)
PROPOSED CHANGE TO RATE RELATIVITIES

2020 STATUS QUO RATES

VSP	2019	2020	% Increase
Employee	$8.87	$8.90	0.3%
Employee & Spouse	$17.74	$17.80	0.3%
Employee & Child(ren)	$15.08	$15.13	0.3%
Employee & Family	$23.95	$24.03	0.3%
VSP Plus	**2019**	**2020**	**% Increase**
Employee	$13.31	$13.35	0.3%
Employee & Spouse	$26.61	$26.70	0.3%
Employee & Child(ren)	$22.62	$22.70	0.3%
Employee & Family	$35.92	$36.05	0.3%

2020 PROPOSED RATES

VSP	2019	2020	% Increase
Employee	$8.87	$8.27	-6.8%
Employee & Spouse	$17.74	$16.54	-6.8%
Employee & Child(ren)	$15.08	$14.06	-6.8%
Employee & Family	$23.95	$22.33	-6.8%
VSP Plus	**2019**	**2020**	**% Increase**
Employee	$13.31	$14.47	8.8%
Employee & Spouse	$26.61	$28.95	8.8%
Employee & Child(ren)	$22.62	$24.60	8.8%
Employee & Family	$35.92	$39.08	8.8%

REASONING

PLAN CHANGE	Financial Impact	Mercer Comments
• Current rate relativities were set two years ago when VSP Plus plan was being implemented • Actual experience over past two years have resulted in a deficit for the VSP Plus plan and a surplus for the VSP plan – PEBB is subsidizing the VSP Plus members approximately $400,000 per year	• Reduces VSP rates by 6.8% and increases VSP Plus rates by 8.8% • VSP costs decrease by $400,000 while VSP Plus increases by $400,000 • PEBB composite rate would slightly decrease	• Increased differential would result in VSP Plus premiums more closely covering the actual cost of care

VISION SERVICE PLAN (VSP)
VSP® SUNCARE ENHANCEMENT

While 79% of people know the sun's ultraviolet (UV) rays cause skin cancer, only 6% know it can harm the eyes.[1] UV exposure can lead to the development of serious eye diseases, including tumors, cataracts, and macular degeneration. These diseases can result in increased medical costs, lost productivity, and drastic impacts to quality of life.

VSP Suncare Enhancement Summary	
Eyewear	• Members can use their frame allowance toward non-prescription sunglasses from their VSP Provider's frame board, exhausting both their lens and frame eligibility. • Encourages members without a prescription to visit their VSP provider and get an annual eye exam.
Suncare Facts	
Cataracts	• Annual mean medical costs associated with cataracts in the U.S. are approximately $11,743 per person (18-65 years old).[2]
Macular Degeneration	• Wearing the proper sunglasses may reduce the risk of macular degeneration. • People who spent 5 or more hours a day outdoors as teenagers or in their thirties had twice the risk of developing early macular degeneration than those who reported spending less than 2 hours a day outdoors.[3]
Tumors and Growths	• Without proper eyewear, excessive UV exposure can cause tumors (cancerous and non-cancerous), tissue growths, or yellowish, slightly raised lesions to form over the white part of your eye.
Sunburn	• UV rays can burn the cornea, which can cause tearing, pain, redness, swollen eyelids, headache, a gritty feeling in the eyes, halos around lights, hazy vision, and temporary loss of vision.
Children and Suncare	• Children's eyes are more susceptible to UV rays because the lenses inside their eyes are less capable of filtering the rays. • Children receive 3 times the annual UV exposure of an adult.[5]

VSP® Suncare Enhancement

20%

of all cataracts are caused by extended exposure to UV rays.[6]

1.8 million

Americans age 40 and older have macular degeneration and an additional

7.3 million

are at substantial risk of developing it.[4]

80%

of our lifetime exposure to UV rays occurs by age 18.[1]

[1] *Source: Eye Didn't Know That! Site, Transitions Optical, Inc, accessed April 2010*
[2] *Source: U.S. Department of Health and Human Services Medical Expenditure Panel Survey, 2006* [3]*Source: Cruickshanks KJ, Klein R, Klein BE. Sunlight and age-related macular degeneration: the Beaver Dam Eye Study. Arch Ophthalmol. 1993: 111(4): 514-518.*
[4] *Source: Improving The Nation's Vision Health: A Coordinated Public Health Approach, Center for Disease Control and Prevention, 2006.*
[5] *Source: Improve Your Vision Improve Your Game, Transitions Optical, Inc, accessed April 2010*
[6] *Source: World Health Organization*

CASCADE CENTERS

Rates:

VISITS	2019	2020	INCREASE
Three Visits	$1.04	$1.04	Rate Pass
Five Visits	$1.33	$1.33	Rate Pass

Utilization

	2017	2018
Individual EAP services	4,503	4,940
• *In Person visits*	*2,426*	*2,568*
• *Work/Family/Life*	*1,332*	*1,424*
Group services	3,328	5,040

Proposed Plan Changes/Enhancements:

Overview

- WholeLife Directions (WLD) is a complement to Cascade's existing EAP and wellbeing services
- It provides proactive mental health engagement and instant connection to personalized programs

CASCADE CENTERS
WHOLELIFE DIRECTIONS

WholeLifeDirections
Journey to the Best You

TWO LEVELS OF INTERVENTION

Individual User Level

Includes the WholeLife Scale (WLS) assessment, ongoing self-use cognitive behavioral programs, and educational outreach to sustain engagement

Organizational Level

Includes supervisor training, materials for employee engagement, and targeted intervention programs based on unique employer needs identified through the WLS

FEATURES

- **Complete Mental Health Appraisal** – Nine domains of mental health are evaluated. Can be completed within 8-10 minutes
- **Individual Summary** – Each participant receives immediate confidential feedback about their results including high risk areas, suggested actions, next steps, and resources
- **Immediate In-Assessment feedback** – Participants receive immediate prompts for action based on their answers
- **Participation Reports** – Ability to view who took the WLS to provide incentives for participating
- **Employer Aggregate Report** – Overall snapshot of the assessed population
- **WholeLife Directions; Total Wellness Campaign** – The WLD campaign promotes overall wellbeing and is based on the outcomes of each company's aggregate WholeLife
- **Online Cognitive Behavioral / Mindfulness Tool** e Scale results evidence based online/app based mental treatment

STUDY RESULTS

Since 2017, several independent research studies were conducted to collect data to investigate the effect the WLD program had on mental health in the workplace:

- The WLD program was found to provide an effective intervention for employees experiencing distress:
  - Pre and post measures of absenteeism show that participants experience an 18% improvement in absenteeism following the WLD assessment and intervention
  - After participation in the WLD self-use programs, participants were found to have a 48% symptom reduction for anxiety
  - A 59% reduction for symptoms of depression was found for participants after receiving intervention through the WLD app programs
  - WLD sessions were demonstrated to significantly reduce social anxiety for participants
  - 91% of participants reported the WLS program engaged them positively
- The 2016 PEBB pilot exceeded expectations in both utilization rate and outcomes

PEBB PILOT OUTCOMES

For PEBB members the results showed statistically significant improvement in the (4) areas below post EAP intervention:
Notes. *Lower scores are a better outcome; **Higher scores are a better outcome.

	PRE EAP	POST EAP	DIFFERENCE
Absenteeism*	9.259	7.732	16% Improvement
Presenteeism*	3.619	2.751	24% Improvement
Life Satisfaction**	2.911	3.49	20% Improvement
Work Distress*	2.459	2.206	10% Improvement

COST

- $0.18 PEPM
- One-time implementation fee of $1,200 across all of PEBB (not per agency)
- Total cost approximately $120K
- *See PMAC WLD recommendation for additional cost information*

THE STANDARD
LIFE & DISABILITY FINANCIALS

- 2020 is the 2nd year of a two-year rate guarantee

	COVERED LIVES	2018 RATES	CURRENT RATES Effective 1/1/2019	CHANGE % FROM 2018	RATE GUARANTEE
Basic Life					
• Active	52,464	$0.200	$0.180	-10%	2 years
• Judicial	512	$0.330	$0.280	-15%	2 years
• Dependent	29,894	$1.290	$1.290	0%	2 years
Optional Life	45,910	Step Rates	Step Rates	5%	2 years
Voluntary AD&D					
• Employee	11,230	$0.020	$0.020	0%	2 years
• Family	14,691	$0.034	$0.034	0%	2 years
Disability					
Short Term Disability*	26,735	$0.690*	$0.690**	0%	2 years
LTD 1 (60% 90 EP)	12,737	$0.510	$0.537	5%	2 years
LTD 2 (60% 180 EP)	4,988	$0.180	$0.190	6%	2 years
LTD 3 (66 2/3% 90 EP)	4,911	$1.060	$1.115	5%	2 years
LTD 4 (66 2/3% 180 EP)	3,742	$0.270	$0.284	5%	2 years

* STD: 0.05% of this rate is withdrawn from the PDA under 606814 on a monthly basis. Policyholder remits premium based on .64% of Volume.
** Beginning January 1, 2019, PDA funds will not be used to subsidize the STD rate. Policyholder will remit premium based on .69% of Volume.

ASI FLEX
FSA AND COMMUTER

	RATE INCREASE
FSA and Commuter Administration	Rate Pass

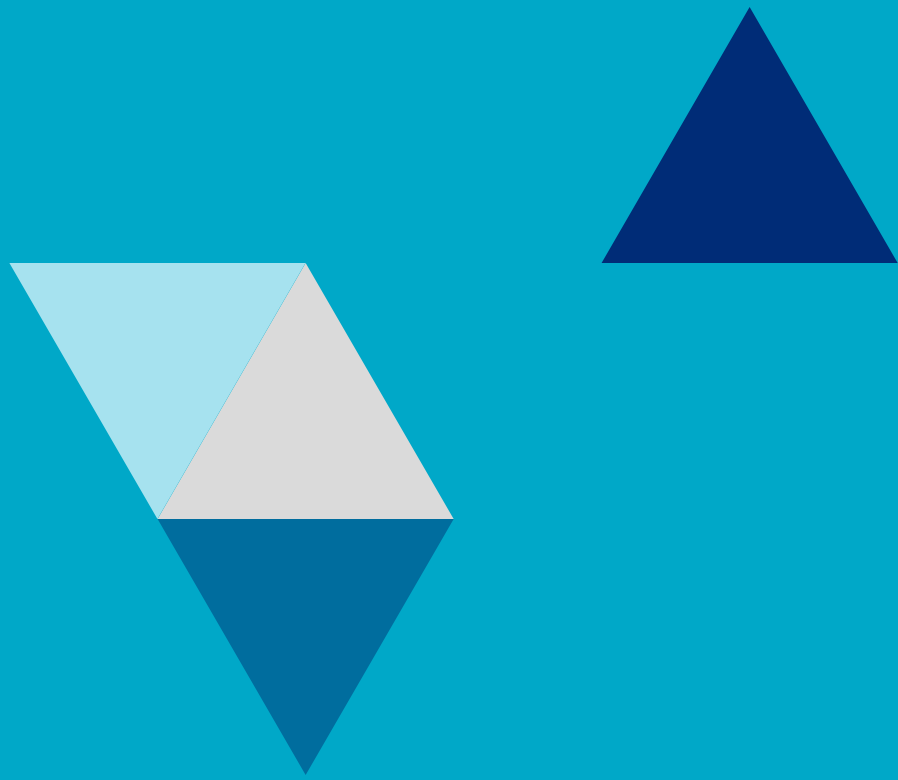
ITEM	FEE
Set Up Fee • Initial Plan Year • Renewal Plan Year	Waived
Monthly Administration PPPM	$2.95
Optional ASIFlex Card PPPM • Replacement or additional card sets	Included • $5.00 billed to participant FSA
Employee Communication • PDF documents • WebEx group meetings • Onsite Enrollment Meetings	 • No Charge • No Charge • $250 per day, plus travel expenses

BENEFIT HELP SOLUTIONS (BHS)
COBRA & SELF-PAY

	RATE INCREASE
COBRA, Retiree, Semi-Independent & Self-Pay Administration	Rate Pass

BOARD CONSIDERATION	DESIGN IMPACT	FINANCIAL IMPACT	
Continue with all BHS services (COBRA, Retiree, Semi-Independent & Self-Pay)		Per Service Option • Service Representative: $1,000 per month ($750 COBRA; $250 Retiree) • Qualifying Event Letter: $4.00 per letter • Per COBRA Continuant: $7.25 per month • Per Retiree: $7.25 per month • Open Enrollment Questionnaire: $3.15 per letter	
COBRA and Semi-Independent only services	• Service rep eliminated • Implements an annual set-up fee	• Annual Set Up Fee:$1,000 per month – (Service Rep $1,000 a month (goes away)) • Qualifying Event Letter: $10.00 per letter • Per COBRA continuant: $10.50 per month • Open Enrollment Questionnaire: $6.50 per letter	
COBRA only services	• Service rep eliminated • Implements an annual set-up fee	Per Service Option The per service rate is higher for COBRA administration: • Annual Set Up Fee: – $1,000 per month – (Service Rep $1,000 a month (goes away)) • Qualifying Event Letter: $10.00 per letter • Per COBRA continuant: $10.50 per month • Open Enrollment Questionnaire: $6.50 per letter	Per Employee Per Month Option – $0.20 PEPM

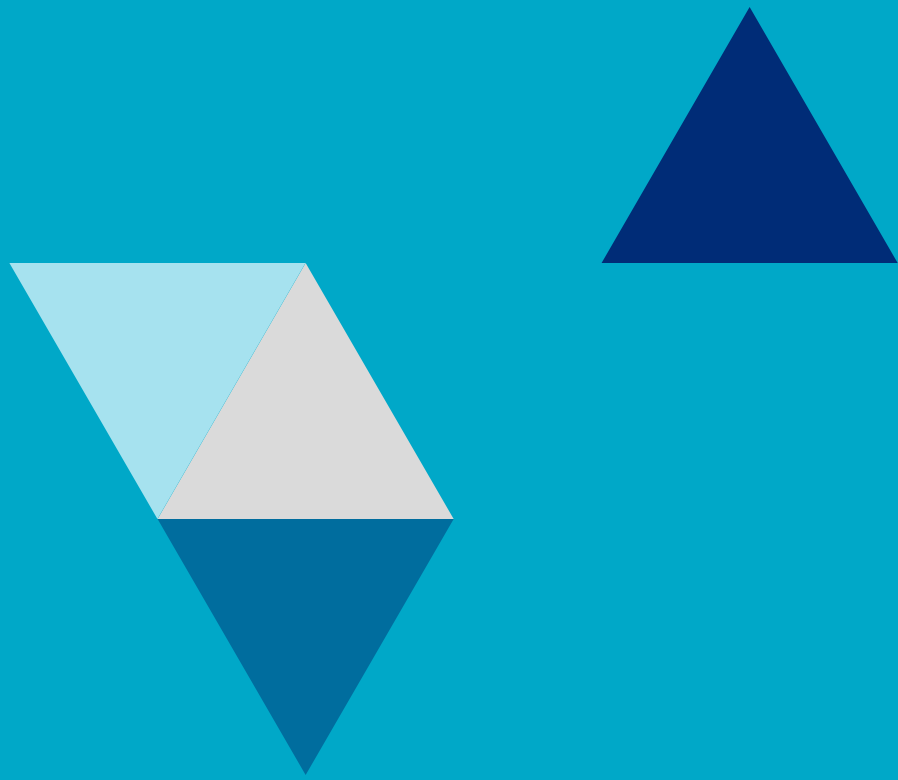
NEXT STEPS



NEXT STEPS
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**	**PEBB and Mercer**
	June TBD	**Board meeting – Approval of final rates**	**PEBB and Mercer**
	June 24	Final 2020 renewal letters sent to carriers for signature	PEBB and Mercer
	July 1	Signed final renewal letters returned to PEBB and Mercer	Carriers

APPENDIX



BENEFIT PLAN DESIGNS AND RATES

MEDICAL

Plan Provider Status	Kaiser Deductible	Kaiser HMO	Moda Summit/Synergy Coordinated Care Plan		PEBB Statewide PPO		Providence Choice (Medical Home)	
Benefit Plans	Kaiser Network	Kaiser Network	Care Home	Out of Network	In Network	Out of Network	Medical Home	Out of Network
Standard Deductible	$250/individual, $750/family	$0	$250/individual, $750/family	$500/individual, $1500/family	$250/individual, $750/family	$500/individual, $1500/family	$250/individual $750/family,	$500/individual $1500/family
Additional non-HEM participant deductible[3]	$100/individual, $300/family	$100/individual, $300	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max.	$1500/individual $4500/family	$600/individual $1200/family	$1500/individual $4500/family	$4000/individual $12,000/family	$1900/individual $5700 family	$4800/individual $14,400/family	$1500/ individual, $4500/family	$4000/ individual, $12,000/family
Primary care visit	$5, deductible waived	$5	$10, first four visits deductible waived	30%	15% or 10%[4] first four visits, deductible waived	30%	$10, first four visits deductible waived	30%
Specialty care visit	$5 w/referral, deductible waived	$5, with referral	$10	30%	15%	30%	$10, with referral	30%
Outpatient mental health / Substance abuse care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10, deductible waived	30%
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Inpatient hospital per admission	$50/day up to $250 max	$50/day, up to $250 max	$50/day to $250 max	$500 + 40%	15%	$500 + 40%	$50/day to $250 max	$500 + 40%
Outpatient surgery in a hospital setting	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25
Emergency department	$75	$75	$150	$150	$150 + 15%	$150 + 15%	$150	$150

PRESCRIPTION DRUGS

Plan Provider Status	Kaiser Deductible	Kaiser HMO	Moda Summit/Synergy Coordinated Care Plan		PEBB Statewide PPO		Providence Choice (Medical Home)	
Benefit Plans	Kaiser Network	Kaiser Network	Care Home[1]	Out of Network[1]	In Network	Out of Network	Medical Home	Out of Network[1]
Prescription Deductible	N/A	N/A	$50/Individual / $150/Family		$50/Individual / $150/Family		$50 Individual / $150/Family	
Prescription Out of Pocket Max	N/A	N/A	$1000/Individual / $3000/Family		$1000/Individual / $3000/Family		$1000/Individual	
Prescription drugs	• $5 generic • $25 brand • 50% up to $100 max non-formulary brand • $50 Specialty • Mail order (31-90 day), $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• $1 generic • $15 brand • $50 Specialty • Mail order (31-90 day), $1 generic, $15 brand	• $10 generic • $30 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• $10 generic • $30 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in network rate and billed amount	• $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Reimbursed as if filled in network; member pays difference between network rate & billed amount	• $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Reimbursed as if filled in network; member pays difference between in network rate and billed amount

DENTAL

Plan	Kaiser Dental	Delta Dental (Moda) PPO		Delta Dental (Moda) Premier	Willamette Dental Group
Provider	Kaiser	In-Network	Out-of-Network	Participating	Willamette
Deductible: individual/family	None	$50/$150	$50/$150	$50/$150	None
Annual max coverage	$1,750	$1,750	$1,750	$1,250	None
Diagnostic & preventive services	$0 copay, not applied to annual max coverage	0%, no deductible	10%, no deductible	0%	$10 copay
Basic & maintenance services	$5 copay + 20%, not applied to annual max coverage	20% year 1 10% year 2 0% year 3	30%	50%	$20 copay for fillings, other basic services covered with OV copay
Crowns	$5 copay + 25%	50%	50%	50%	$250 copay
Implants	$5 copay + 50%	50%	50%	Not covered	Varies
Dentures	$5 copay + 50%	50%	50%	50%	$290 copay
Orthodontia	$5 copay + 50% to $1500	50% to $1500	50% to $1500	Not covered	$2500 copay

CURRENT RATES

2019 Medical Rates — Actives

	Employee	Employee and Spouse/Partner	Employee & Child(ren)	Employee and Family
Kaiser	$767.75	$1,535.51	$1,305.16	$2,072.92
Kaiser Deductible	$701.30	$1,402.62	$1,192.23	$1,893.54
Moda Summit, Synergy	$698.37	$1,396.75	$1,187.23	$1,885.62
PEBB Statewide	$786.53	$1,573.09	$1,337.12	$2,123.66
Providence Choice	$682.07	$1,364.12	$1,159.51	$1,841.57

2019 Dental Rates — Actives

	Employee	Employee and Spouse/Partner	Employee & Children	Employee & Family
Kaiser Permanente	$63.75	$127.50	$108.39	$172.14
ODS (Moda) Premier	$55.52	$111.05	$94.39	$149.91
ODS (Moda) PPO	$51.31	$102.61	$87.21	$138.52
Willamette Dental Group	$52.50	$105.01	$89.28	$141.77

FINAL DECISIONS

2019

MEDICAL
FINAL DECISIONS FOR 2019

ALL CARRIERS' PREMIUMS INCLUDE THE HB2391 1.5% HEALTH PLAN ASSESSMENT

KAISER

- Expanded service area to Lane County
- Changed dependent coverage to terminate at end of month after turning age 26
- Initial proposal of 5.9%, reduced to 2.9%

MODA

- Self-insured effective 1/1/2019
- Increase Emergency Room copay from $100 to $150
- Changed dependent coverage to terminate at end of month after turning age 26
- Fully-insured renewal of 8.1%, reduced to 4.0% by self-funding and increasing ER copay

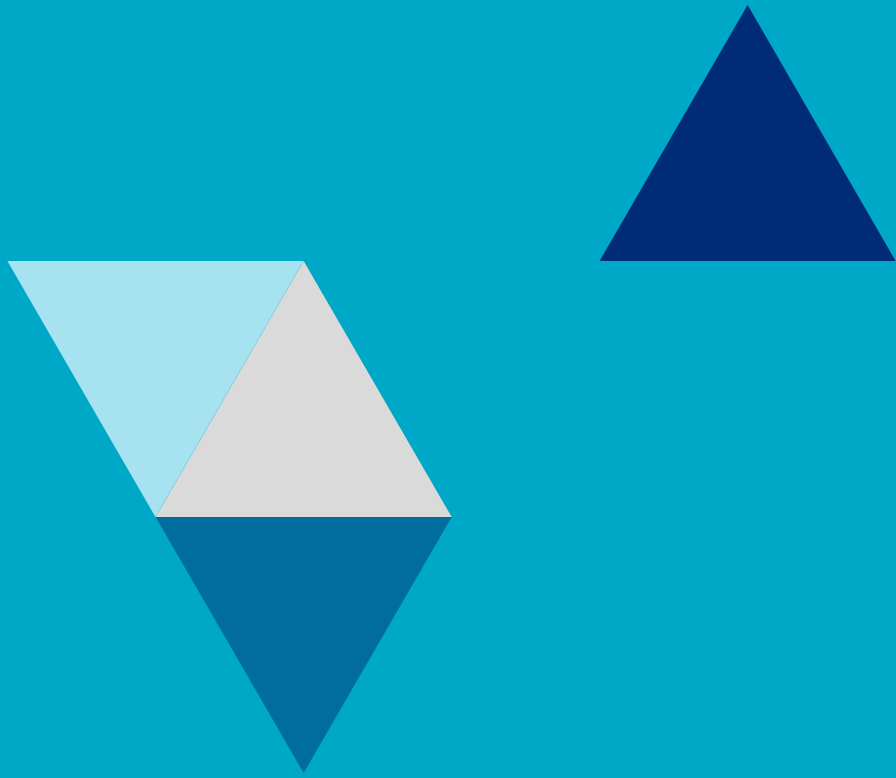
PROVIDENCE

- Increase Emergency Room copay from $100 to $150 on Choice and Statewide
- Statewide out-of-pocket maximum changes to…
  - $1,900 / $5,700 FT IN
  - $4,800 / $14,400 FT OON
  - $3,200 / $9,600 PT IN
  - $7,500 / $22,500 PT OON
- Reduced triple aim incentive from $15 PEPM to $13.63 (Statewide) and $13.20 (Choice)
- Statewide: accrual increase of 3.9%, no admin increase
- Choice: accrual increase of 5.4%, no admin increase

NON-MEDICAL
FINAL DECISIONS FOR 2019

LINE OF COVERAGE	CARRIER	FINAL DECISIONS
Dental	Delta Dental (Moda)	• Simplified the Athletic / Occlusal Guard Benefit • Adding coverage for nitrous oxide
	Willamette	• Various copay changes: • Office Visit Copay from $5 to $10 • Fillings from $0 to $20 • Crowns & Bridges from $190 to $250 • Dentures from $190 to $290 • Root Canals from $0 to $150 • Surgical Extractions from $0 to $40 • Orthodontia from $1,500 to $2,500
	Kaiser	• Simplified the Athletic / Occlusal Guard Benefit
Vision	VSP	• Broke out the fitting and evaluation fee from the contact lens total allowance • Cover standard progressive / ethos lenses
Life / Disability	The Standard	• Reduced Basic rates 10-15% • Increased Optional Life rates by 5% • Held the STD rate • Increased the LTD rates overall by 5.3% (negotiated)
Other	Cascade Centers – EAP	• Status quo, no changes
	ASI – Flex	• Status quo, no changes
	BHS – COBRA / Self-pay	• Status quo, no changes

MEDICAL



MEDICAL
HISTORICAL RATE INCREASES

	2015	2016	2017	2018	2019	2020 (BEFORE PREMIUM TAX)
Kaiser HMO	0.0%	4.4%	3.3%	5.0%	2.9%	2.4%
Kaiser Deductible	0.0%	4.4%	3.3%	5.0%	2.9%	2.4%
Moda	n/a	2.4%	3.5%	FT: 7.2% PT: 7.7%	4.0%	0.6%
Providence Choice	-0.8%	3.3%	3.2%	7.0%	5.4%	1.1%
Providence Statewide	0.2%	3.9%	8.2%	5.9%	3.9%	6.5%

Red font indicates above 3.4%

- Increases prior to PEBB admin, commissions, and funding assessment; includes plan changes
  - 2019 rate increases include 1.5% provider tax
- Providence has proposed one-year 2.2% increase to administrative fees for Statewide and a one-year 2.5% increase for Choice
  - Includes no change to Triple Aim Incentive
- Moda proposed an increase of 1.2% to administrative fees

LAN VALUE-BASED-PAYMENTS

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

CATEGORY	SUB-CATEGORY	DESCRIPTION	PROVIDENCE	MODA	KAISER
Fee for Service – No link to quality & Value	1	n/a		$14,095,620 (32%)	$15,315,368 (11.2%)
Fee for Service – Link to quality & value	2A	Foundational payments for infrastructure & operations	$2,790,000 (0.5%)	$900 (0%)	
	2B	Pay for reporting			
	2C	Pay for performance	$23,550,000 (3.9%)		
APMs built on Fee-For-Service architecture	3A	APMs with shared savings	$20,550,000 (3.4%)	$1,236,308 (3%)	
	3B	APMs with shared savings and downside risk	$138,630,000 (22.8%)	$27,961,778 (63%)	
Population – based payment	4A	Condition-specific population-based payment	$20,000 (0.0%)	$959,588 (2%)	
	4B	Comprehensive Population-Based payment			
	4C	Integrated finance & delivery system			$121,611,968 (88.8%)
		Total	$185,540,000 (30.5%)	$44,254,194	$136,927,337

- Value based payments are self-reported by the vendors
- See next slides for important caveats

LAN VALUE-BASED-PAYMENTS
CARRIER CAVEATS AND NOTES

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

		WHAT'S INCLUDED?		
Category	**Sub-Category**	**Providence**	**Moda**	**Kaiser**
Fee for Service – No link to quality & Value	1			Contracted hospitals / facilities
Fee for Service – Link to quality & value	2A	CPC+ PCPCH Cap	PCPs not participating in the Synergy/Summit shared savings model, but receiving PCPCH capitation (e.g., payments for Connexus members in the C3 program)	
	2B			
	2C	Pay-for-performance		
APMs built on Fee-For-Service architecture	3A	PMG total cost of care	CPC+ Track 1 Providers CPC+ Track 2 providers not participating in the APM portion of the Track 2 model Synergy/Summit PCP providers participating in shared savings, without co-owned specialty practices or facilities (e.g., hospitals)	
	3B	3.4% target	Multi-specialty clinics and hospitals participating in the Synergy/Summit shared risk / shared savings model	
Population – based payment	4A	Joint bundle	CPC+ Track 2 providers participating in the APM portion of the Track 2 model	
	4B			
	4C			
Data Based on:		January – September 2018, annualized	Incurred in 2018; paid through December 2018	2017

LAN VALUE-BASED-PAYMENTS
CARRIER CAVEATS AND NOTES

Question: *What is the dollar amount and percent of overall PEBB payments in each of the LAN Value-Based Payment categories?*

- **Providence:**
  - The percentages shown are representative of the percentage of payments that fall into LAN categories out of the entire medical, Rx, and Behavioral Health paid amounts
- **Moda:**
  - If a provider contract contains multiple elements that fall into different categories, all dollars are assigned to the highest payment category
  - In cases where a health system has multiple TINs, the dollars may be allocated to different categories by TIN (for example, OHSU has separate TINs for its hospital services and physician services)
    - As payment models evolve and as more experience is gained with categorizing dollars, Moda may decide to alter their allocation decisions
  - Dollars were categorized according to the contract terms of the entity billing the claim
    - For example, Moda's primary care physicians, specialists, and hospitals are held financially accountable for pharmacy costs; however, Moda's interpretation of the LAN framework is that actual pharmacy claims are fee-for-service that fall into Category 1 since the pharmacy billing the claims does not have any APM in its contract that bears no risk over quality and utilization

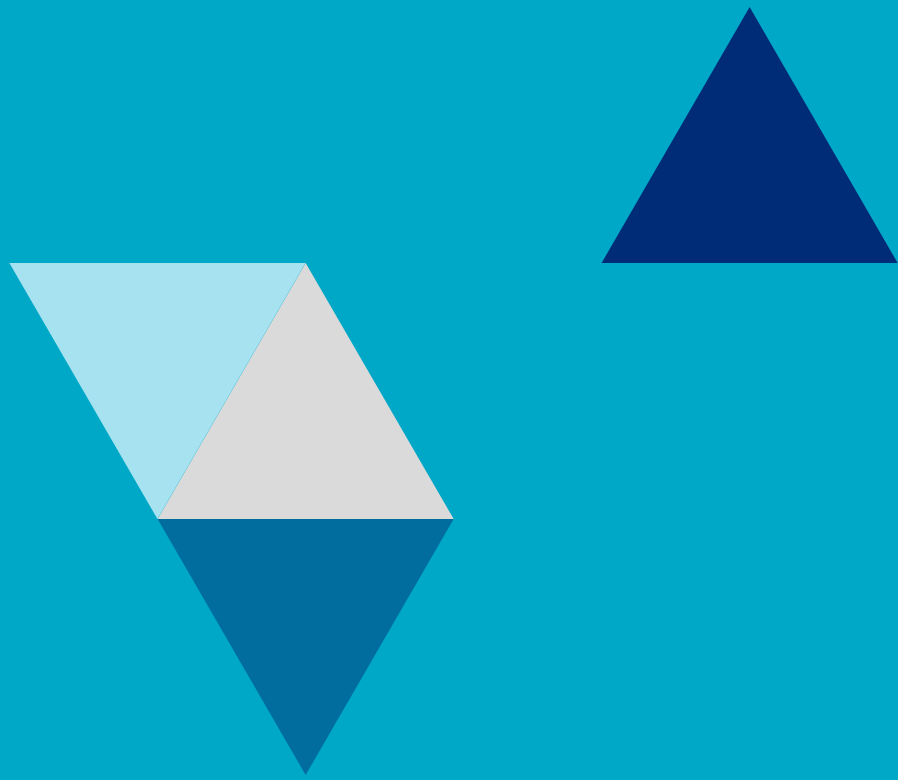
ALTERNATIVE CARE BENEFITS

Question: *PEBB would like to further explore physical, occupational, speech therapies, chiropractic care, and massage benefits. Carriers were asked to fill out the table below for each of those services*

	Visit Limits			Physician Prescription Required?			Prior authorization or concurrent review?			Other Benefit Plan Provisions		
	Prov	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**	**Prov**	**Moda**	**Kaiser**
Physical / Occupational / Speech Therapy	60	60	20	eviCore does not require PA; but can add provider attestation if required by health plan	No	Yes	Both – eviCore recommends the initial evaluation/visit occurred to collect required clinical information; requests for ongoing care may be submitted as early as 7 days prior to requested start date	Yes, registered at initial visit, then PA required after 6th visit	No	N/A	Additional visits may be approved following acute head or spinal cord injury	
Chiropractic	SW: 60 CH: No visit limit (annual max of $1,000)	No visit limit (annual max of $1,000)	No visit limits	No On CH, if medical home is not on record with PHP, benefit will apply to OON	No	No	No	No	UM program satisfies NCQA standards	Additional visits may be approved following certain injuries	Additional visits may be approved following acute head or spinal cord injury	$1000 max per year. Max includes chiro, naturopath, and acupuncture
Massage Therapy	Not covered	Not a covered benefit	Not currently covered, would have 12-visit limit	Not covered	Not a covered benefit	No	Not covered	Not a covered benefit	UM program satisfies NCQA standards	Not covered	Additional visits may be approved following acute head or spinal cord injury	

SW = Statewide Plan
CH = Choice Plan

NON-MEDICAL



2020 NON-MEDICAL RENEWALS
HISTORICAL RATE INCREASES

	2016	2017	2018	2019	2020 (ROUND 1)
Self-Funded Vendors					
Delta Dental of Oregon (ODS)	-1.1%	1.0%	1.9%	2.0%	4.8%
Vision Service Plan (VSP)	3.5%	-1.4%	0.7%	2.9%	(0.1%)
Fully-Insured Vendors					
Kaiser Dental	7.7%	4.5%	0.0%	3.4%	1.1%
Willamette Dental Group (WDG)	0.0%	5.4%	2.5%	3.4%	7.9%
The Standard	0.0%	0.0%	0.0%	5.1%	0.0%
Contract Vendors					
ASI Flex	-9.2%	0.0%	0.0%	0.0%	0.0%
Benefit Help Solutions (BHS)	0.0%	0.0%	0.0%	0.0%	0.0%
Cascade	0.0%	0.0%	0.0%	0.0%	0.0%

Red font indicates above 3.4%

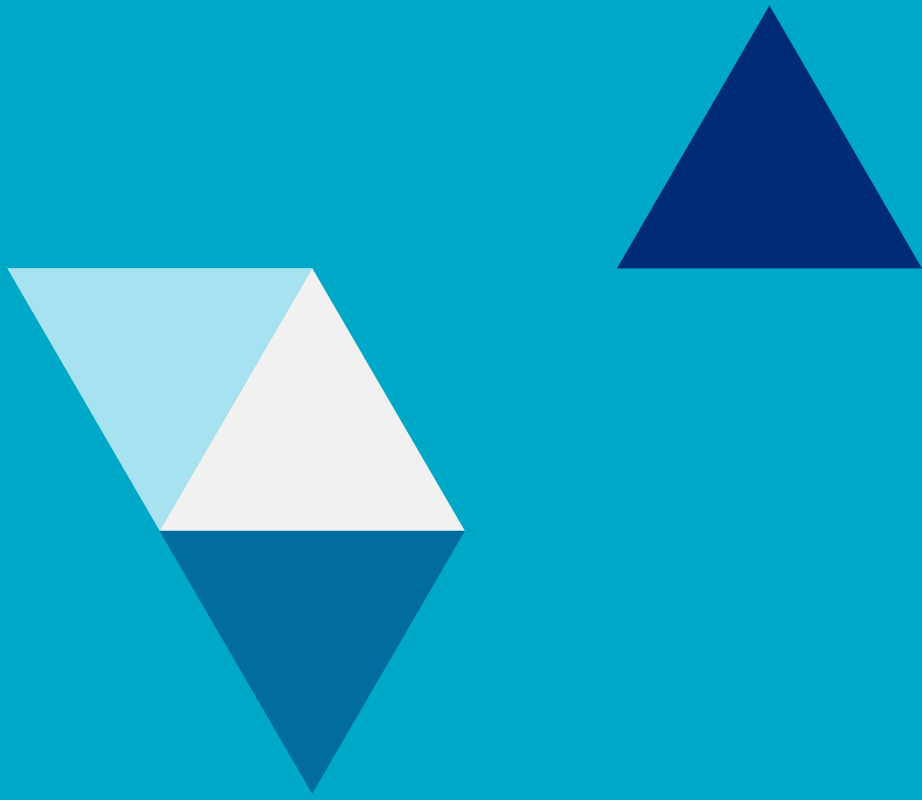
- Self- Funded rate accounts for both administrative and premium increases

DENTAL COVERAGE
COMPARISON OF PREMIUM RATES

- While WDG's proposed increase is higher than the other carriers, the premium rates are similar to the other carriers, even with a richer benefit design

Tier	DDOR – Preferred	DDOR - Traditional	Kaiser Dental	WDG
Employee	$53.25	$57.63	$64.43	$55.85
Employee + Spouse	$106.50	$115.26	$128.86	$111.70
Employee + Child	$90.52	$97.97	$109.54	$95.00
Employee + Family	$143.77	$155.60	$173.97	$150.85

SELF-FUNDING



SELF-FUNDING GROUP HEALTH PLANS
FULLY-INSURED VS. SELF-FUNDED

FULLY-INSURED

- Fully-insured provides monthly funding stability
- Transfers risk to the insurer
  - Reduces the need for RBC
  - Margin to pay for the risk is typically included via explicit margin or higher trend
- Fully-insured plans must pay ACA Health Insurance Fees which are around 3%
- Some insurers prefer to be fully-insured

SELF-FUNDED

- Higher monthly fluctuation in expenses due to claims costs
  - Reduction in fluctuation can be achieved via reinsurance (i.e. stop loss)
- PEBB is responsible for risk and reserves (RBC and IBNP)
- More control over the health plan
- PEBB saved $60 million in 2010 going self-insured and $10+ million per year since due to lower fees

PEBB has reserves to cover potential fluctuations and self-insurance has saved PEBB money since 2010

SELF-FUNDING GROUP HEALTH PLANS
FULLY-INSURED VS. SELF-FUNDED

	Fully-Insured	Self-Funded
Claims Liability/Risk	Insurer	Employer – can be reduced through stop loss
Non-Claims Costs	• ACA fees (fully insured, PCORI) • Retention, risk and profit • Premium tax	• ACA fees (PCORI) • Third Party Administration fees • Internal staffing time
Plan Design	Must comply with state and federal mandates	More flexible, comply with federal mandates only, however, non-discrimination rules apply
Monthly Employer Cash Flow	Predictable premiums paid monthly	Claims payments fluctuate weekly or more frequently, with fees and stop loss premiums paid monthly
Reserves	Funded by premium, held by insurer	Held by employer.
Financial Administration by Employer	Minimal	Additional banking and accounting functions
Plan Management	Primarily on insurer	Employer – Design, governance, documentation, communications, fiduciary obligations

SELF-FUNDING GROUP HEALTH PLANS
FINANCIAL PROS AND CONS

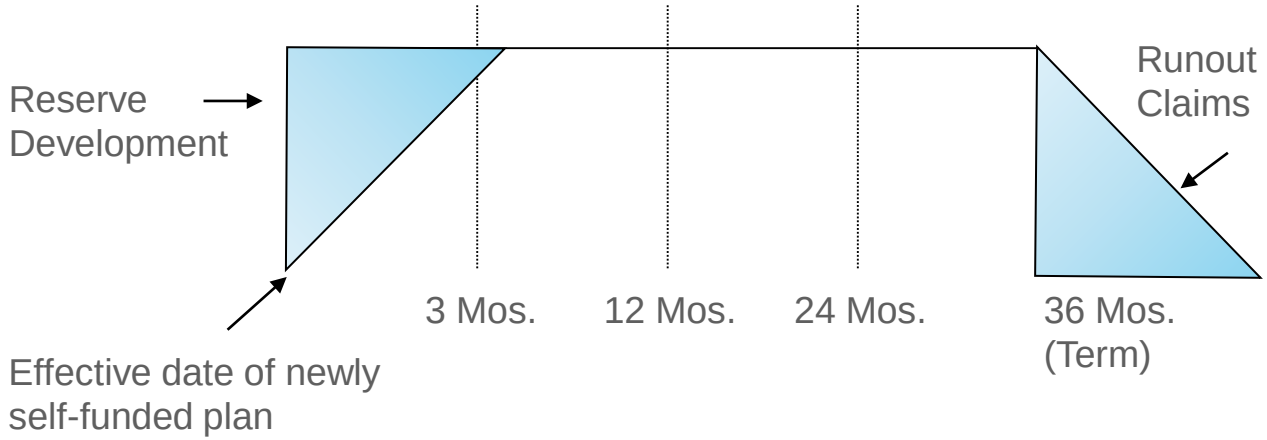
	Pros of Self-Funding	Cons of Self-Funding
Cash Flow	• Employer benefits from good experience • Claims are funded as paid • Employer holds reserves • Employer gains float (claims dollars still in employer's account between the time a claim is paid by carrier and the time the carrier draws the employer's account)	• If claims are worse than projected, employer pays full difference immediately • Inconsistent costs each week/month
Cost Savings	• Eliminate carrier profit and risk charge • Avoid state and ACA premium taxes • Avoid state mandated benefits • Typically able to expect savings over time, versus fully insured approach • Self-funded trend rates can be lower than those for fully insured	• Transfer of insurance risk from carrier to employer • Monthly claims fluctuations • If claims exceed projections, cost difference borne by employer

SELF-FUNDING GROUP HEALTH PLAN
NON-FINANCIAL PROS AND CONS

	Pros	Cons
Flexibility	• Employer has full control over plan designs • Able to avoid costly state mandated benefits • Employer can outsource components of plan administration to third party vendors	• More decisions required of employer • Exercise prudence in the selection and monitoring of vendors
Administration	• Self funded employers have ability for exceptions, claim determination overrides and more control, in general • Generally more utilization and cost driver data available to plan sponsor	• Additional administrative requirements (banking, vendor interface) • Additional compliance responsibilities, including discrimination testing • Internal staffing needs; external resources

SELF-FUNDING GROUP HEALTH PLANS
CASH FLOW TIMING AT BEGINNING AND END

- First year costs are “immature” due to lag in claim payments (first year medical costs may be 18% to 20% lower than a mature year) resulting in approximately 10 months of mature incurred and paid claims
  - Reduction in first year expense will help “fund” reserves (Incurred But Not Reported claims – IBNR)
  - Self funded plan sponsors must book this liability
- Employer gains benefit of float (weekly/monthly funding and IBNR)
- Second year costs are mature (i.e., twelve months of paid claims and expenses)



SELF-FUNDING GROUP HEALTH PLANS
COMPLIANCE CONSIDERATIONS

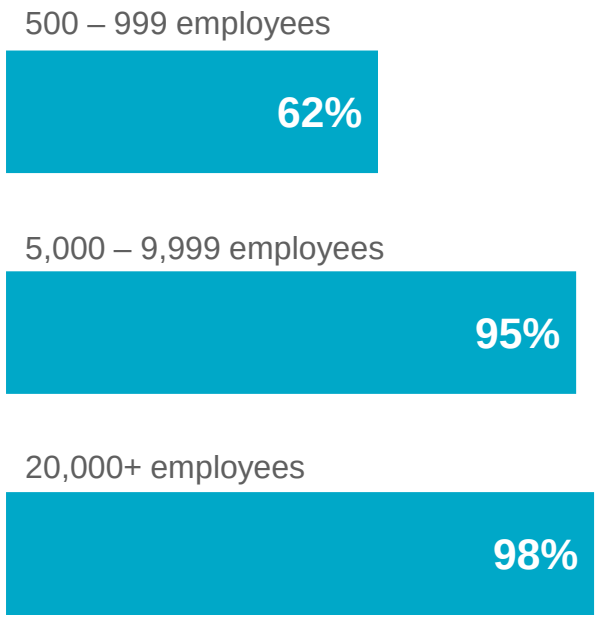
General Compliance Considerations	Communications	HIPAA Compliance	Other State and Federal Laws	Exposure
Fiduciary designations	Summary Plan Descriptions	HIPAA Privacy	Hawaii Prepaid Health Care Act	Increased exposure to claims litigation
H&W and Cafeteria Plan Documents	Summary of Benefits and Coverages	HIPAA Security	Vermont Pay or Play	Fiduciaries can be named as defendants
Claims and Appeals processes and fiduciary delegations	Summary of Material Modifications	HIPAA Training	New York Surcharge	Privacy and security of PHI
Federal mandates: ACA, Mental Health Parity	Summary of Material Reductions in Benefits	Business Associate Agreements	Massachusetts Form 1099-HC reporting	Opportunity to authorize claim payment
Government reporting (Annual Report ; ACA Reporting; W-2 reporting)	Summary Annual Reports	HIPAA Breach Analysis and Reporting	Medicare Primary and Secondary Payer	Assistance to employees
Taxation Nondiscrimination testing	Open Enrollment Materials		Service Contract Act and Governmental Contracting limitations	Plan asset regulations: misuse of assets, reversion of trust assets
Trust obligations if funded	Required Notices			

SELF-FUNDING GROUP HEALTH PLANS
RISK MODERATION — STOP LOSS

- To reduce claims liability, employers frequently purchase stop-loss insurance: aggregate, specific or both
  - Specific stop-loss
    - Limits employer's claim exposure for benefits paid on behalf of any covered claimant during the year
      - Plan eligibility provisions and definition of covered participants is important!
    - Deductibles will vary based upon the size of the group and expected claims projections
    - To minimize risks further, individual deductibles can be low ($75,000 – $150,000 per person per year)
  - Aggregate stop-loss
    - Limits employer's overall liability for total claims within the term of the contract (12 months)
    - Based upon expected claims plus a corridor (typically expected claims x 1.25)

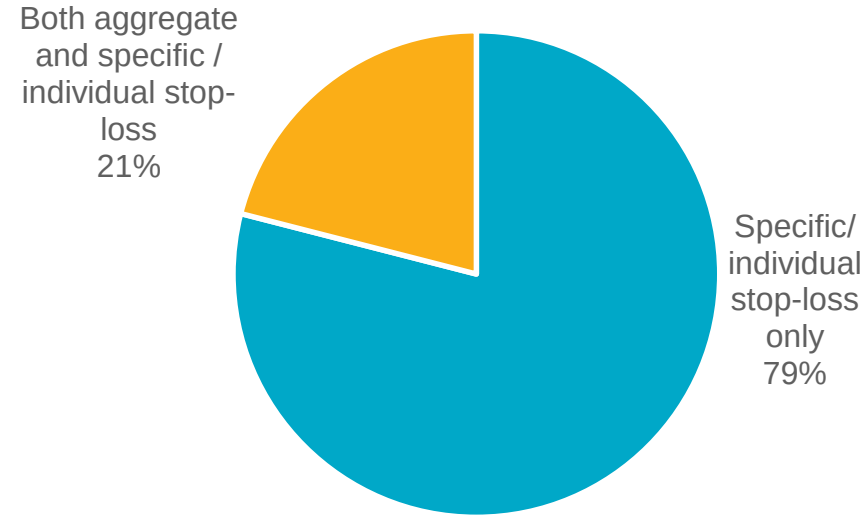
ALTERNATE MEDICAL/RX APPROACH
SELF-FUNDING BENCHMARKS

Self-fund Largest Medical of any Type, by Employer Size



38% of Jumbo Employers (20,000+) Purchase Stop Loss

Type of Stop Loss Coverage Used by Jumbo Employers with Stop Loss Coverage



Median per-person stop loss deductible: $750,000

MERCER NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS-2018

GLOSSARY OF TERMS

GLOSSARY OF TERMS

- **Accountable Care Organization (ACO):** This is a group of health care providers, potentially including doctors, hospitals, health plans and other health care constituents, who voluntarily come together to provide coordinated high-quality care to populations of patients. The goal of coordinated care provided by an ACO is to ensure that patients and populations — especially the chronically ill — get the right care, at the right time and without harm, while avoiding care that has no proven benefit or represents an unnecessary duplication of services.
- **Alternative Payment Model (APM):** This is a payment approach that gives added incentive payment to provide high-quality and cost effective care. APMs can apply to a specific clinical condition, a care episode, or a population. The APM framework began as a payment model classification system originally presented by the Centers for Medicare & Medicaid Services (CMS) and later modified by the HCP LAN workgroup, and it tracks progress toward payment reform and provides a pathway for the delivery of person-centered care.
- **Bundled payment**: a model that pays multiple providers across multiple settings for healthcare services associated with a defined “episode of care” under a single payment rate. Bundled payment is sometimes called “episode-based payment.”
- **Care coordination:** This is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.
- **Capitation:** The per capita (per patient or beneficiary) payment arrangement for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the payer. This payment is the same regardless of the amount of service rendered by the provider.
- **Case management (CM):** This is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.
- **Centers of excellence (COE):** These are specialized programs within healthcare institutions which supply exceptionally high concentrations of expertise and related resources centered on particular medical areas and delivered in a comprehensive, interdisciplinary fashion.
- **Clinically integrated network**: This is defined as a collection of health providers, such as physicians, hospitals, and post-acute specialists that join together to improve care and reduce costs. Such networks generally share record systems, track data, and rely on evidence-based guidelines to provide high-quality care across participating providers.
- **Comprehensive Primary Care Plus (CPC+):** This is program from the Centers for Medicare & Medicaid Services (CMS) this is a regionally based, multi-payer advanced medical home model offering an innovative payment structure to improve healthcare quality and delivery. It is a five year federal program beginning in January 2017. Over 150 practices in Oregon have been selected to participate in CPC+.

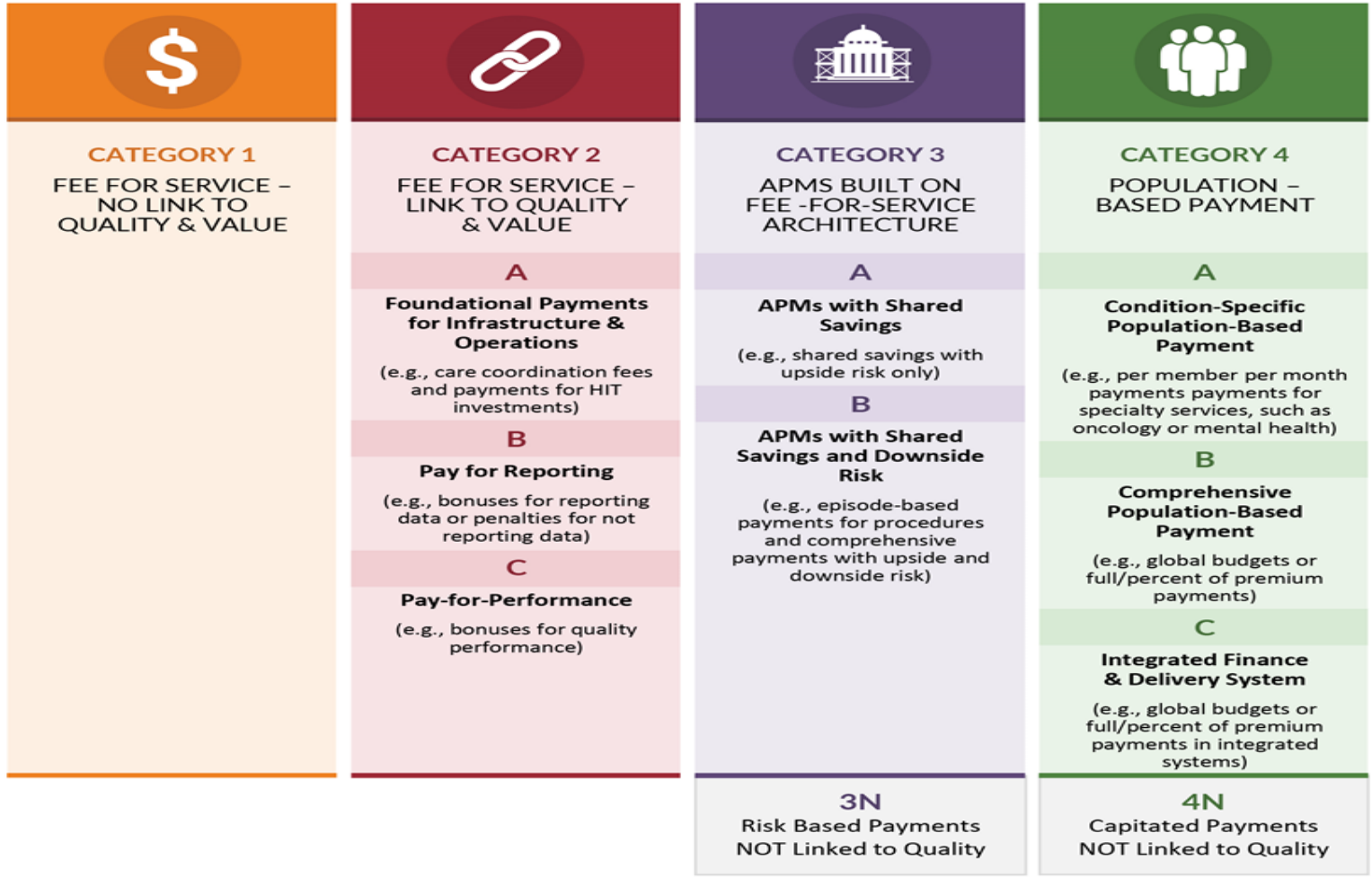
GLOSSARY OF TERMS

- **Coordinated Care Organization (CCO)**: This is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid).
- **Fee-for-service**: a model in which providers are reimbursed by payers at negotiated rates for individual services delivered to patients without financial responsibility for the total cost for specified episodes of care or for a population of patients. This category also includes pay-for-performance incentives that accompany fee-for-service payments.
- **Full Continuum of Care**: All aspects of care delivery, spanning preventive to end-of-life services in all settings.
- **Global payment**: a model that establishes spending targets to cover all of the expected costs for healthcare services to be delivered to a specified population during a stated time period. Global payment is called by other names, including “total-cost-of-care payment” and “population-based payment.”
- **Health Care Payment Learning & Action Network (HCP LAN):** This is a public-private partnership established to accelerate transition in the healthcare system from a fee-for-service payment model to those that pay providers for quality care, improved health, and lower costs.
- **Narrow Networks:** A strategy employed by health insurance companies (payers) that limit the number and types of physicians that are included in their network. In return, those physicians “in the network” typically extend greater discounts to the payer and receive greater numbers of patients. This arrangement may be primarily be based on deep discounts and not necessarily on quality metrics.
- **Patient Attribution:** The method used to determine which provider group is responsible for a patient’s care and costs.
- **Patient-Centered Primary Care Home (PCPCH), also called Patient-Centered Medical Home (PCMH):** This is an approach to providing comprehensive primary care for children, youth, and adults. This is a health care setting that facilitates partnerships between individual patients, and their person physicians, and when appropriate, the patient’s family.
- **Pay for performance (PFP or P4P):** An incentive system offered by some payers to healthcare providers based on their quality practices and/or outcomes or other factors. P4P programs come in a variety of forms based on the payer. Examples include Medicare’s Quality Payment Program (QPP). Some other programs offer financial incentives to providers who can meet evidence-based standards of care for particular conditions, such as heart disease, asthma and breast cancer screening that may exist both in government and private health plans or programs.
- **Population-Based Payment Model (PBM):** A payment model in which a provider organization is given a population-based global budget or payment and accepts accountability for managing the total cost of care, quality, and outcomes for a defined patient population across the full continuum of care.
- **Population Health:** The health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

GLOSSARY OF TERMS

- **Population health management:** An approach to health care delivery that aims to improve the overall health outcomes of a defined population of individuals, based on the preservation of health, prevention of disease, and management of acute and chronic disease among members of the group. It typically relies on the aggregation of patient data across multiple health information resources, and analysis of data and actions through which care providers can improve both clinical and financial outcomes.
- **Risk adjustment:** A statistical process that attempts to take into account the known and latent comorbid conditions of a patient cohort when comparing health care outcomes or health care costs.
- **Risk Scoring:** A numeric value assigned to a particular patient in a risk adjustment system that indicates the relative level of spending that is expected for that patient and/or the relative level of quality or outcomes that can be expected in the delivery of care to that patient relative to other patients.
- **Risk Stratification:** A process of identifying, predicting, and separating patient populations into high-risk, low-risk, and likely to be at high risk (or rising-risk group) to assist in population health management activities.
- **Shared risk**: a model that holds the provider financially responsible for a negotiated portion of costs that exceed a predetermined budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget. Shared-risk arrangements can be applied to global or bundled payments.
- **Shared savings:** a model that allows the provider to share in a portion of any savings generated below a predetermined budget. Shared-savings arrangements can be applied to global or bundled payments.
- **Total Cost of Care (TCOC):** A broad indicator of spending for a given population (i.e., payment form payer to provider organizations). In the context of PBM models, in which provider accountability spans the full continuum of care, TCOC includes all spending associated with caring for a defined population, including provider and facility fees, inpatient, and ambulatory care, pharmacy, behavioral health, laboratory, imaging, and other ancillary services (e.g., home health, hospice, durable medical equipment, supplies, etc.)
- **Value-based Care**: This is about empowering and rewarding providers to provide the right care, at the right time, in the right setting.
- **Value-based insurance design (VBID):** This is an insurance benefit design strategy that encourages use of high-value clinical services by aligning consumer spending with high-quality and beneficial health services and medications.
- **Value-based Payment:** This is a new payment method for healthcare services to providers aimed at rewarding value (quality of care), not volume (fee-for-service), so that providers assume more accountability for the quality and cost of care, incentivizing higher-value care, by health plans or purchasers.
- **Value-based Purchasing:** Purchasers, plan sponsors, and employers use to incent higher value care (i.e., quality metrics in contracts, payment based on quality and outcomes).

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



Source: APM Framework, HCP-LAN,2017