HEALTH WEALTH CAREER

Attachment 3

OREGON PEBB BOARD MEETING

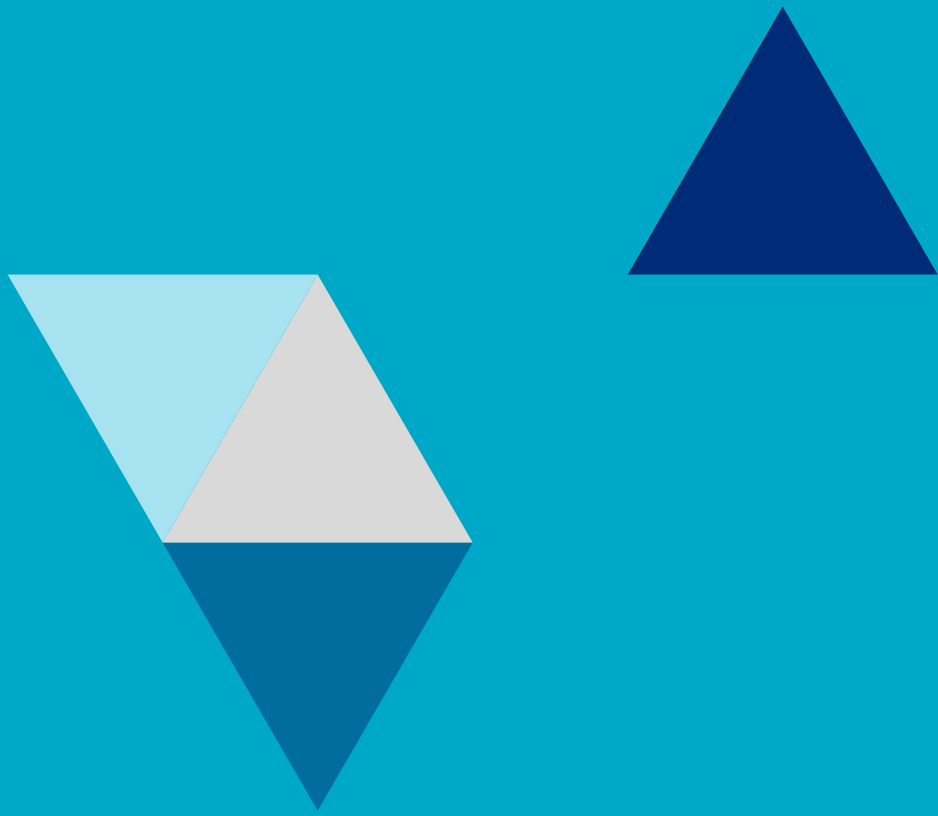
2020 RENEWAL RESULTS
ROUND 3 (BAFO)

APRIL 16, 2019

2020 RENEWAL DISCUSSION
OVERVIEW AND AGENDA

1. Composite Rate
2. Medical Renewals
   - Providence
   - Moda
   - Kaiser
   - All carriers
3. Non-Medical Renewals
4. Appendix

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)*	$1,533.65	1.3%		
2020 *(w/ Premium Tax)*	$1,562.44	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

RENEWAL OVERVIEW
SUMMARY OF COVERAGES

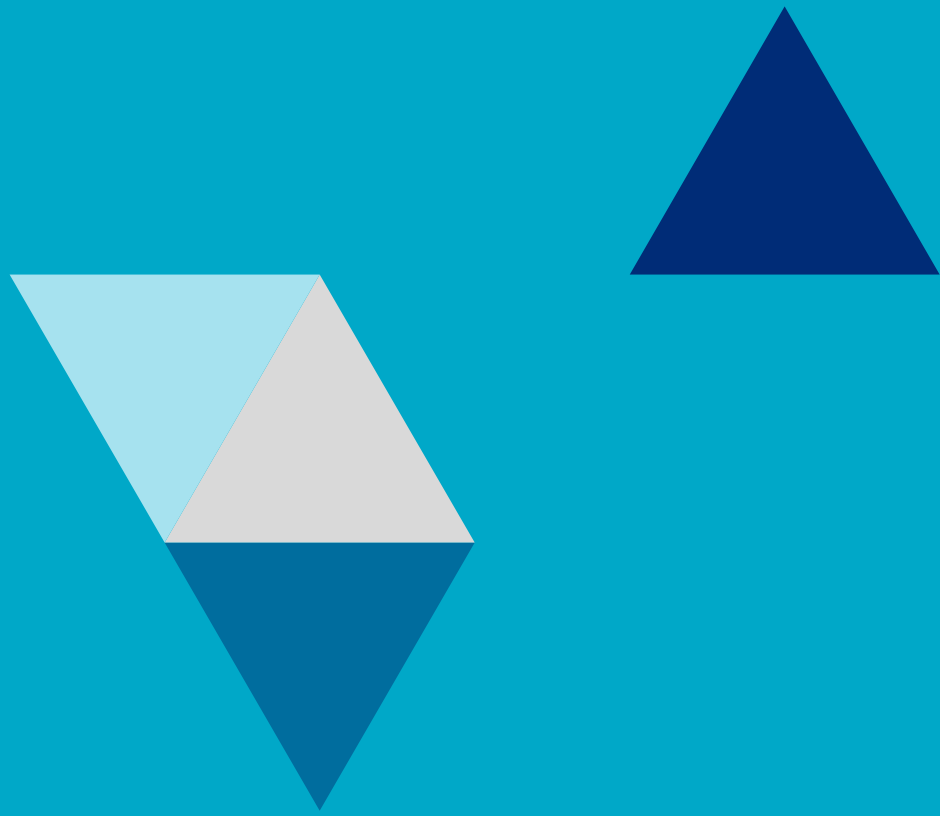
	2019 Final Increase	2020 Increase – no design changes	
Medical		*Without Premium Tax*	*With Premium Tax*
Providence Choice	5.4%	1.1%	3.1%
Providence Statewide	3.9%	6.5%	8.7%
Moda	4.0%	0.6%	2.6%
Kaiser HMO/Ded.	2.9%	2.6%	4.7%
Non-Medical			
Delta Dental OR (Moda Dental)	2.0%	4.3%	
Kaiser Dental	3.4%	1.5%	
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.

MEDICAL

2020 FINANCIAL OUTLOOK



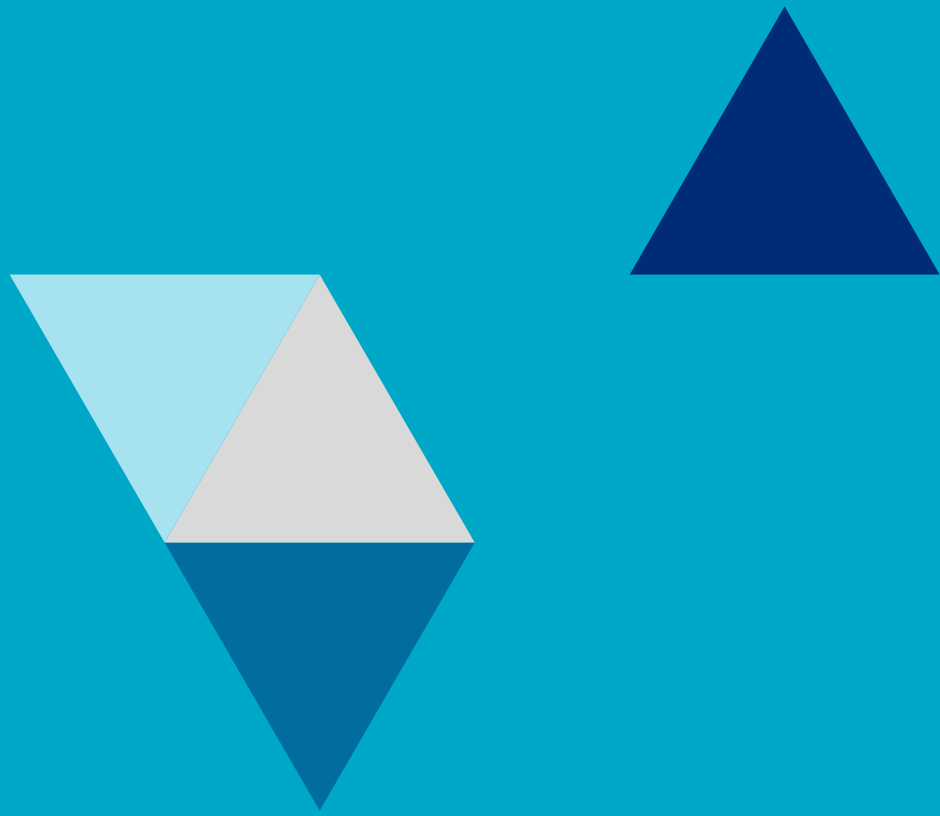
SUMMARY
IMPACT OF 2020 PLAN CHANGE SUGGESTIONS

Plan	2020 Status Quo Increase[1]	2020 Increase With All Changes[1]	$ Impact of changes
Providence Choice[2]	3.1%	+3.9%	+$2.5M
Providence Statewide[2]	8.7%	+9.6%	+$3.2M
Moda[3]	2.6%	+3.1%	+$0.4M
Kaiser HMO and Deductible	4.7%	+5.0%	+$0.5M
			+$6.6M

- PEBB is $20.5M under budget compared to the 3.4% cap

[1]Includes OR premium tax
[2]Does not include impact of ASC change or chiropractic medical necessity review
[3]Does not include impact of chiropractic medical necessity review

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
FUNDING INCREASES AND CHANGES

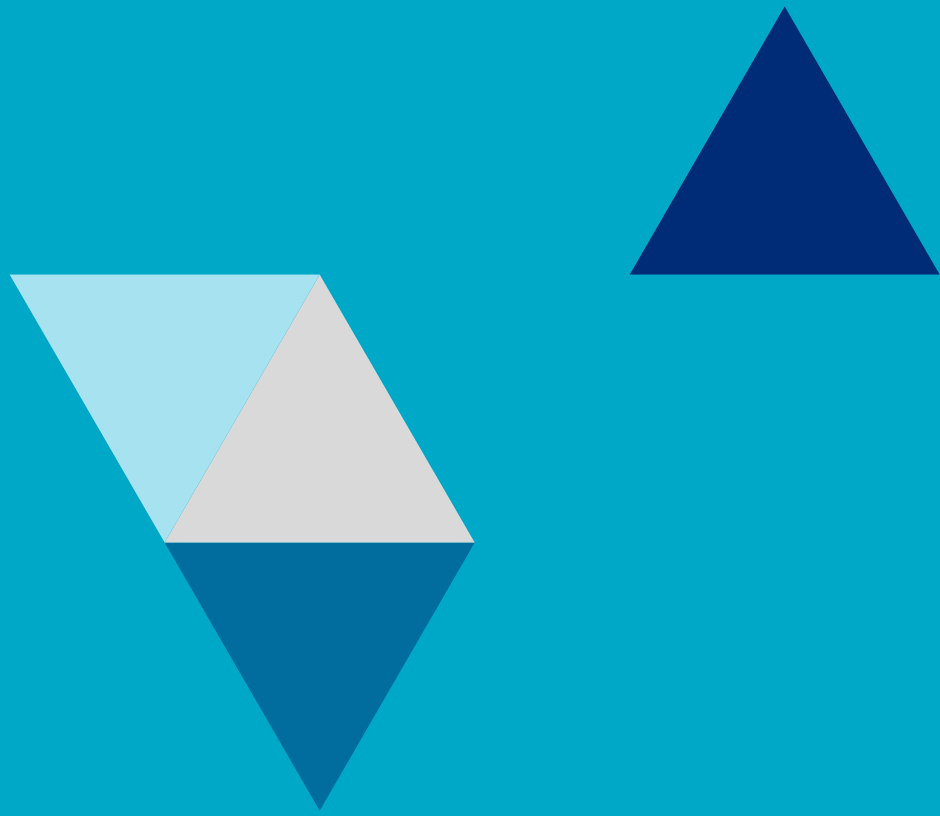
	Status Quo	With Changes
Choice	3.1%	4.0%
Statewide	8.7%	9.6%

Recommendations	Cost impact	Rationale
Medically necessary varicose vein surgery	• 0.1% • $700K	• Enhanced benefit • Help members experience pain, skin problems, and/or blood clots associated with varicose veins
Expand spinal manipulation to include massage therapy	• 1.0% • $7.0M	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain
Promote benefit differential between outpatient hospital and ASC	• TBD	• Incentivize members towards lower-cost ambulatory surgical centers rather than outpatient hospitals, for their outpatient procedures and radiology services
Chiropractic medical necessity review	• TBD	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines
Physical / Occupation Therapy medical necessity review after the 12th visit	• (0.3%) • ($2.0M)	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines coupled with specialized expert reviewers
Total – if all changes accepted	• +$5.7M	

PROVIDENCE
FOLLOW-UP SUMMARY

eviCore - PT/OT medical necessity review	• Providence's engagement with eviCore will begin effective 5/1/2019 for commercial lines of business • eviCore will use evidence-based clinical guidelines to complete these reviews • The medical necessity review will just cover physical and occupational therapy, would not cover speech, chiropractic, or massage therapy • Education happens on the member and provider level – eviCore uses data analytics to inform their efforts in outreaching directly to Providers. Providers with higher patient volume will get onsite and in-person visits to explain the medical necessity review – They also have a Provider Engagement Team that will onboard all providers – PHP's account team has an assigned Provider Engagement Director to collaborate with PHP's provider relations team to help assess the network and prioritize educational efforts in advance of the start of the program; will track trends and utilization
Ambulatory Surgical Centers – Benefit Differentials	• PEBB member materials will be update to explain the difference – PHP can separate on benefit summaries, modify online language, and send targeted email messages • Members will have ability to search for an ASC in the online directory, or call customer service for assistance • Provider education will take place via online provider portal, ProvLink, as well as targeted to major provider groups, particularly in the areas with a high concentration of PEBB members and ASCs • PHP would work with PEBB to determine the criteria used for this benefit as well as an exceptions process
Network changes – First Health / First Choice network in 2019	• No change to the fixed cost component in the network fees • Savings will be experienced in the travel wrap access fees – reducing the expense to Providence and clients from 15% of savings to 9% of savings

MODA



MODA
FUNDING INCREASES AND CHANGES

Funding	Status Quo	With Changes
Moda	2.6%	3.5%

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

Recommendations	Cost impact	Rationale
Medically necessary varicose vein surgery	• 0.6% • $500K	• Enhanced benefit • Help members experience pain, skin problems, and/or blood clots associated with varicose veins
Expand spinal manipulation benefit to include massage therapy	• +1.0% • +$800K	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain
Changing the benefit for outpatient surgery in a hospital to $100 copay and $25 for an ASC	• (0.4%) • ($300K)	• Incentivize members towards lower-cost ambulatory surgical centers rather than outpatient hospitals, for their outpatient procedures and radiology services
Chiropractic medical necessity review	• TBD	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines
Alignment of medical and pharmacy benefit cost share Change specialty medications under medical benefit to be • 20% coinsurance, OR • $100 copay	• (0.2-0.3%) • ($200K)	• 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
Pharmacy Benefit Optimization Program Shift select medical infused medications to be covered under the pharmacy benefit only	• (0.3%) • ($200K)	• 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
Change formulary tier structure	• (0.3%) • ($200K)	• Incentivize members to use formulary medications • $30 copay for approved non-formulary generics, $50 for non-formulary brand
Total – if all changes accepted	• +0.5% • +$400K	

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 $5 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: increase medical benefit drug cost share to eliminate incentive to utilize more medications in a more expensive setting
  - 20% co-insurance aligns with other medical services
  - $100 copay aligns with specialty drug copay
- 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); coverage under medical benefit continues at the higher copay
- Recommendation: Change the benefit for outpatient surgery in a hospital to $100 copay and $25 for an Ambulatory Surgical Center
  - Incentives members to lower cost ASCs rather than outpatient centers

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: Creation of 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
CONNEXUS NETWORK CHANGE

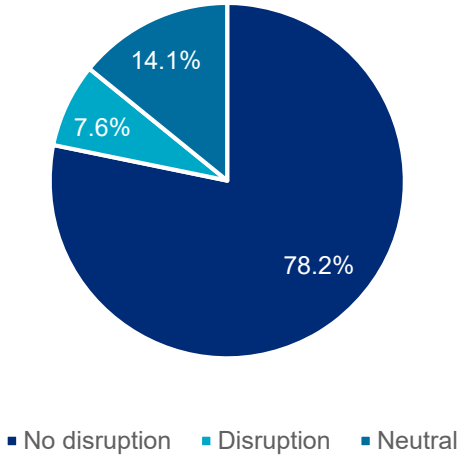
- Does PEBB have the ability to keep the current Synergy/Summit Network?
  - Yes, but PEBB will have to move to Moda's CCM 2.0 risk model
- Changes in the Risk Model
  - With the implementation of SB 1067 and the 200% of Medicare, the Synergy/Summit risk models are no longer viable since the hospitals were an important component of that risk model
  - Moda's CCM 2.0 uses a new risk model that is focused on primary care with bonuses provided if total cost of care is below 3.4%
- While PEBB doesn't have control over the risk model changing, PEBB has control over the provider network:
  - Move to Connexus network
    - Connexus network would give PEBB members access to more hospitals and providers
    - Current medical homes that are not PCPCH or CPC+ members would no longer be available
    - CCM 2.0 risk model with bonuses to primary care providers keeping total cost of care at 3.4% or lower would be in implemented
  - Keep Synergy/Summit network
    - Network of hospital and specialist providers and hospitals would remain the same, but the prior risk model would no longer be in place
    - Primary care providers who are not PCPCH or CPC+ certified would not be in the network
    - CCM 2.0 risk model would be in place for all primary care providers, however, there would be some PCPs who would no longer be in the network (non-PCPCH or CPC+)

MODA
CONNEXUS NETWORK CHANGE

Plan	Network	Risk Model
Current	**Synergy/Summit** Primary care medical home providers may or may not have PCPCH and CPC+ designation with OHA	**CCM "1.0"** Aspects of the risk model focused on hospital reimbursements and agreements
Proposed	**Connexus** Primary care medical home providers must have a PCPCH and/or CPC+ designation with OHA	**CCM "2.0"** Main aspect of risk model is primary care and uses a total cost of care set at 3.4%

MODA
CONNEXUS NETWORK CHANGE

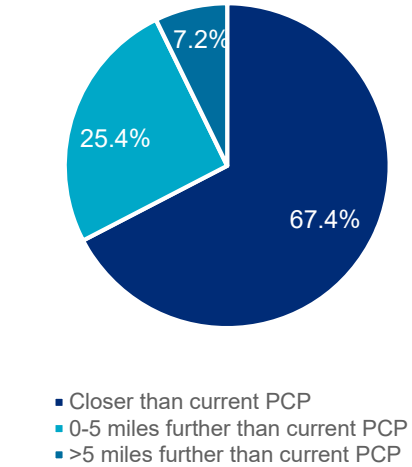
Overall Disruption	Members
Total Members	12,688
No Disruption • Members can keep current PCP	9,924
Disruption • Members will have to find a new PCP	969
Neutral • Members do not currently have a PCP	1,795



Top Counties

County	Members	# Disrupted	% Disrupted
Marion	1944	64	3.3%
Multnomah	1225	158	12.9%
Jackson	962	60	6.2%
Lane	739	24	3.2%
Linn	732	40	5.5%

Out of the total disrupted members…	Members
Total Disrupted Members	969
Disrupted members with CCM PCP closer than their current PCP	653
Disrupted members with CCM PCP between 0-5 miles further than current PCP	246
Disrupted members with CCM PCP greater than 5 miles further than current PCP	70



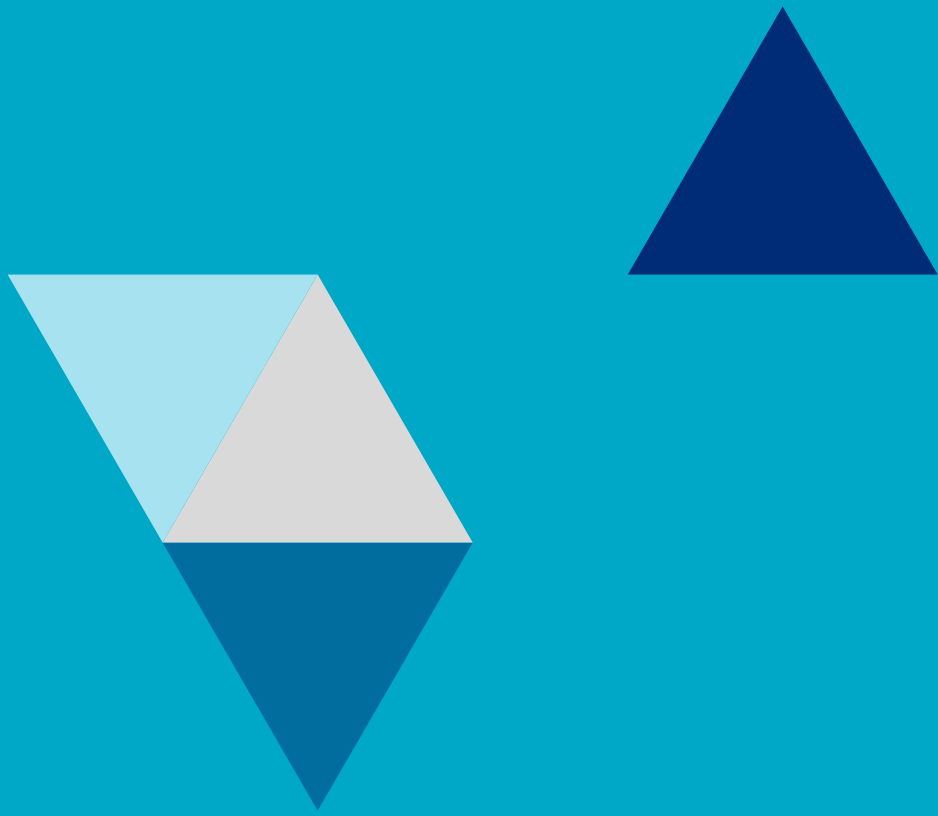
Of those being disrupted…

County	Closer than current PCP	0-5 miles further	>5 miles further
Marion	85.9%	14.1%	0.0%
Multnomah	93.0%	7.0%	0.0%
Jackson	81.7%	16.7%	1.7%
Lane	95.8%	4.2%	0.0%
Linn	62.5%	37.5%	0.0%
Total	**86.4%**	**13.3%**	**0.3%**

CONNEXUS NETWORK
POLICY CONSIDERATIONS

- During the 2015 RFP, the Board made a policy decision to select only one Statewide PPO for the PEBB population
  - The Board elected to have Providence administer the Statewide PPO
  - Having only one vendor administer the plan was thought to enhance plan efficiencies and allow stronger provider negotiation leverage
  - The Connexus network is the rebranded Moda network that the PEBB board declined to contract with during the 2015 RFP
- The Board is not legally bound to have only one Statewide Plan, meaning the Connexus network change from Moda would be allowed under DOJ regulations, but adding another Statewide plan would be a change in policy
- If the Board does not want to offer the Connexus network, potential options are:
  - Offer Moda with a status quo renewal in a self-funded arrangement
  - Offer Moda and move the funding back to fully-insured to place the risk back on Moda for managing the cost of care
  - Decline to offer Moda for the 2020 plan year

KAISER



KAISER
2020 PREMIUM RATES

KAISER	2019	2020	2020 W/ TAX
FULL-TIME HEM HMO RATES (PEPM)			
Employee	$775.67	$795.62	$811.85
Employee & Spouse/Partner	$1,551.35	$1,591.24	$1,623.72
Employee & Children	$1,318.64	$1,352.55	$1,380.15
Employee & Family	$2,094.32	$2,148.18	$2,192.02
FULL-TIME HEM DEDUCTIBLE RATES (PEPM)			
Employee	$708.54	$726.76	$741.59
Employee & Spouse/Partner	$1,417.09	$1,453.53	$1,483.20
Employee & Children	$1,204.53	$1,235.51	$1,260.72
Employee & Family	$1,913.08	$1,962.28	$2,002.32
		+2.6%	+4.7%

- 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, $4.62 PEPM ($1.81 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
FUNDING INCREASES AND CHANGES

	Status Quo	With Changes
Kaiser	4.7%	5.0%

Recommendations	Cost impact	Rationale
Medically necessary varicose vein surgery	• n/a	• Already covered
Expand spinal manipulation to include massage therapy	• +0.5% • $900K	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain
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%	• Standardize benefits • Minimal member impact – less than 130 members in a 12 month period
Change oral chemo drugs from $0 member cost share to the lesser of Clinically Administered Medication cost share or RX cost share.	• (0.2%) • ($400K)	• Standardize benefits
Remove ophthalmology from services accessible without referral	• 0.0%	• Standardize benefits
Total – if all changes accepted	• 0.3% • +$500K	

MEDICAL

OTHER RESPONSES

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

ALTERNATIVE CARE BENEFITS
MERCER RECOMMENDATIONS

Item	Mercer Recommendation	Rationale
eviCore medically necessity review	• Keep current 60 visits for Providence and Moda, but implement medical necessity review for both carriers	• Moda already uses eviCore to review after the 6th visit, with a denial rate of 7.46% • Recommend that all carriers conduct medical necessity review – Moda would remain at the 6-visit review due to their entire book of business being at that level – Providence would implement review at the 12th visit limit per their recommendation
Physician Prescription Requirement	• Should be required for Physical, Occupational and Speech therapies	• This would be a change for Providence and Moda as prescriptions are not required for those services today; Kaiser requires a prescription
Massage Therapy	• Do not add	• Benefit is cost prohibitive in light of 3.4% cap
Chiropractic	• No prescription but medical necessity review after the 12th visit	• Do not require MD/DO physician prescription • Conduct medical necessity review after the 12th visit to monitor utilization – **This could cause provider and member dissatisfaction and/or noise**

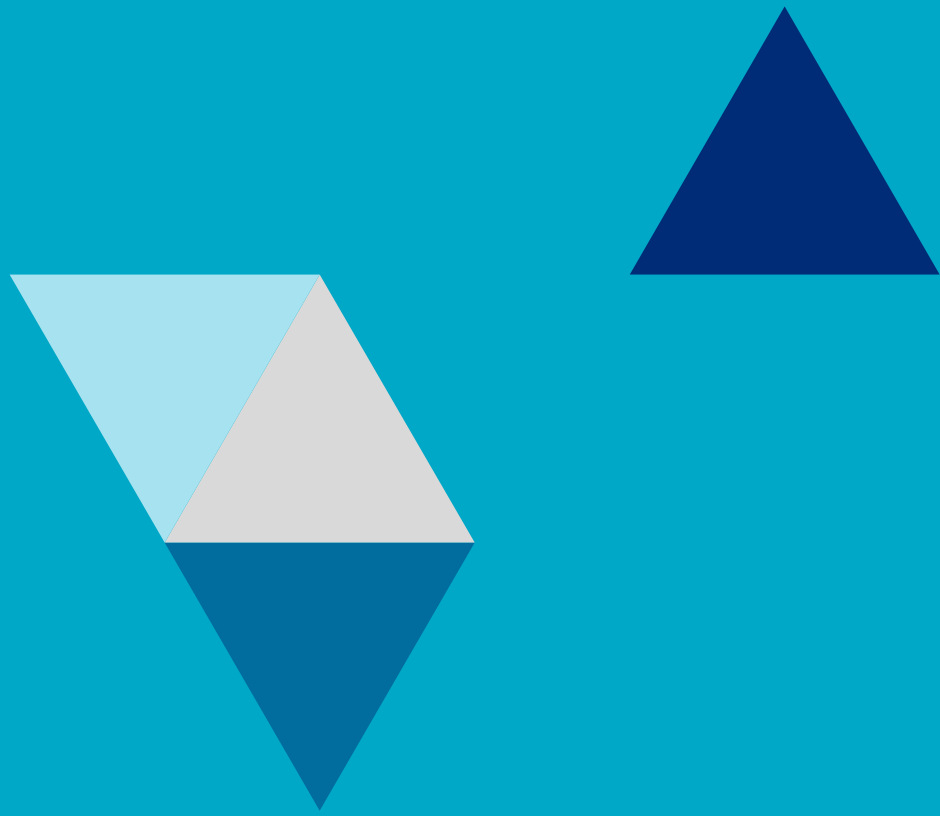
CARRIER FEES AT RISK
QUALITY PERFORMANCE MEASURES

- At the direction of PEBB Staff, Mercer included a question in the Round 3 renewals requesting more significant fees at risk associated with each of the carrier's contracts.

Carrier	Current Contractual Limit	Proposed 2020 Contractual Limit	Carrier Response
Providence	2.5% of ASO fee with $375,000 annual cap for each Choice and Statewide; $750,000 total annual cap	5.0% of ASO fee with $625,000 annual cap for each Choice and Statewide; $1,250,000 total annual cap	At this time, Providence is unable to agree to an increase in fees at risk related to the quality performance measures as they have not yet established what the measurement targets will be.
Moda	3.75% of ASO fee with a $250,000 annual cap	5.0% of ASO fee with a $500,000 annual cap	Moda does not have concerns with the percentage of fees at risk, but the $500,000 cap causes concerns. Moda is concerned the % is increasing 33% but the cap is increasing by 50%. The $500,000 is over 10% of the total admin fees Moda collects. Instead, Moda would propose a $300,000 cap.
Kaiser	0.25% of premium with a $500,000 annual cap	0.50% of premium with a $750,000 annual cap	Confirmed

MEDICAL

IMPACT OF ALL CHANGES



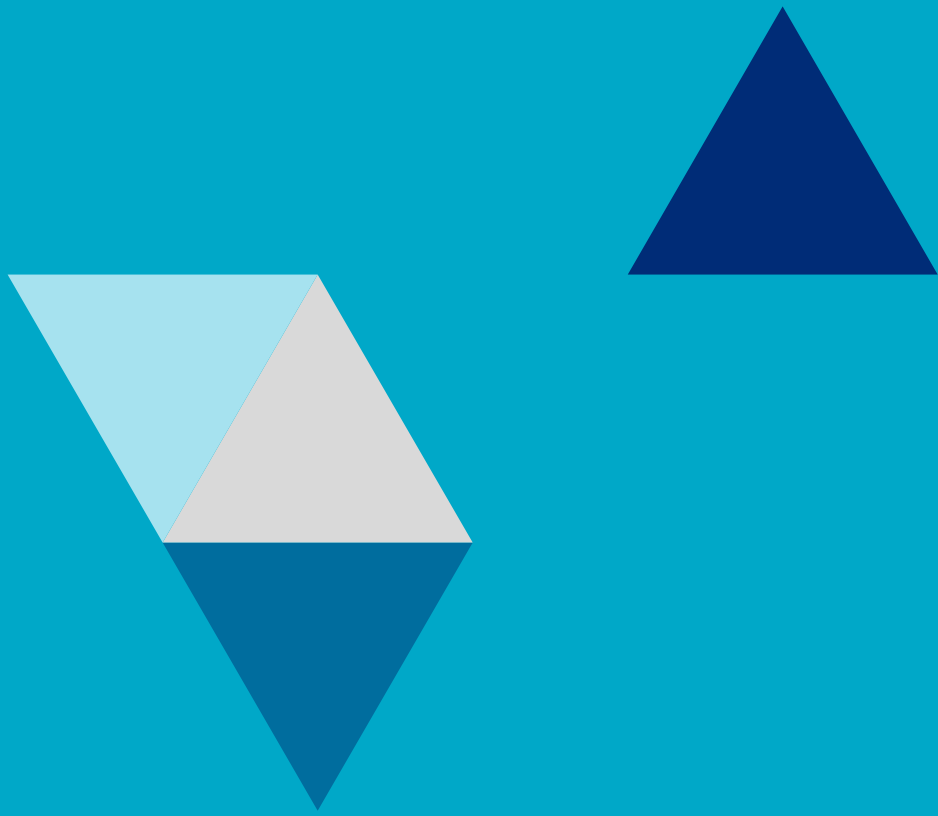
MEDICAL
ALL CHANGES AND IMPACTS

Recommendation	Carriers	Cost impact	Rationale
Medically necessary varicose vein surgery	• Providence • Moda	• $1,200,000	• Enhanced benefit • Help members experience pain, skin problems, and/or blood clots associated with varicose veins
Expand spinal manipulation to include massage therapy	• Providence • Moda • Kaiser	• $8,700,000	• Adding massage as a benefit may encourage members to seek lower-cost treatment for addressing anxiety, stress, and pain
Promote benefit differential between outpatient hospital and ASC • **$25 copay for ASC** • **$100 copay for outpatient hospital**	• Providence • Moda	• ($300,000)	• Incentivize members towards lower-cost ambulatory surgical centers rather than outpatient hospitals, for their outpatient procedures and radiology services
Chiropractic medical necessity review after the 12th visit	• Providence • Moda	TBD	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines • Administered through the individual carriers
Physical / Occupational Therapy medical necessity review after the 12th visit	• Providence	• ($2,000,000)	• Reduce cost and increase quality of care • Leverage clinical evidence-based guidelines coupled with specialized expert reviewers • Administered through eviCore
Alignment of medical and pharmacy benefit to $100 copay	• Moda	• ($200,000)	• 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

MEDICAL
ALL CHANGES AND IMPACTS (continued)

Recommendation	Carriers	Cost impact	Rationale
Pharmacy benefit optimization program	• Moda	• ($200,000)	• 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
Change formulary tier structure	• Moda	• ($200,000)	• Incentivize members to use formulary medications • $30 copay for approved non-formulary generics, $50 for non-formulary brand
Change a subset of DME items that are currently $0 member cost share (CADD pumps, enteral pumps, etc.) to the DME cost share.	• Kaiser	• n/a	• Standardize benefits • Minimal member impact – less than 130 members in a 12 month period
Change oral chemo drugs from $0 member cost share to the lesser of Clinically Administered Medication cost share or RX cost share.	• Kaiser	• ($400K)	• Standardize benefits
Remove ophthalmology from services accessible without referral	• Kaiser	• n/a	• Standardize benefits
Total – if all changes accepted	• $6,600,000		

NON-MEDICAL



SUMMARY
IMPACT OF 2020 PLAN CHANGE SUGGESTIONS

Plan	Coverage	2020 Status Quo Increase	2020 Changes	$ (Savings)/Cost
Delta Dental of Oregon	Dental	4.3%	+0.7%	$400K
Kaiser	Dental	1.5%	-	-
Willamette Dental Group	Dental	6.9%	-	-
VSP	Vision	0.3%	+3.0%[1]	$300K[1]
The Standard	Life / Disability	0.0%	-	-
ASI Flex	FSA / Commuter	0.0%	-	-
Benefit Help Solutions	COBRA / Self-pay	0.0%	-	-
Cascade	EAP	0.0%	-	-
				+$700K

[1] Assumes PEBB elects the SunCare Benefit for both plans; PEBB has the option to add SunCare to just the Buy-up, which would not increase composite rate

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

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

DELTA DENTAL OF OREGON
FINAL PROPOSED CHANGES

Benefit	Former Benefit	New Benefit	Claims Impact
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
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
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
Oral surgical Services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Minor
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
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
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

DELTA DENTAL OF OREGON
FINAL PROPOSED CHANGES (CONT.)

Benefit	Former Benefit	New Benefit	Claims Impact
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
Oral surgical services	Brush biopsy was not covered	Brush biopsy is covered twice in a 12-month period.	Minor[3]
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]

[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

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
- 3.0% trend being used, with data through December 2018
- +1.6% increase in administration
- 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

Willamette Dental Group

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

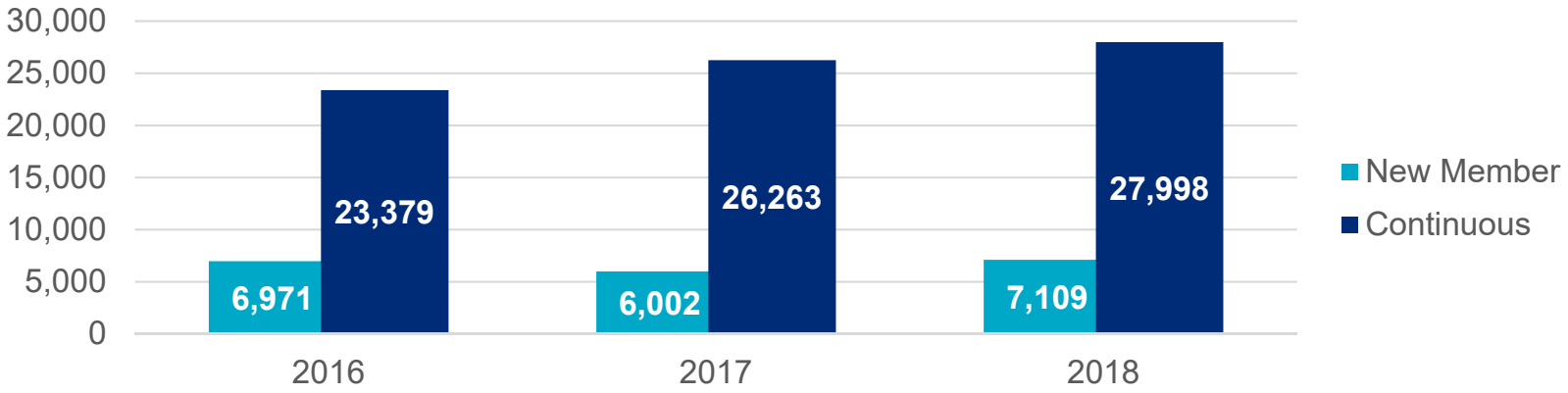
Board Consideration	Financial Impact	Mercer Comments
• For 2020, WDG will require the following new implant benefit design: – Dental implant surgery will be covered up to an annual maximum of $1,500 with a limit of one tooth space per year – Current benefit: $2,745 copay for a single tooth, up to $5,060 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

WILLAMETTE DENTAL FOLLOW-UPS

Willamette Dental Group

Change in Membership



Cost / Utilization

Implants			
Year	Implant Surgery Service Count	Unique Patients per Implant	Average Cost per Implant
2016	55	36	$4,589
2017	76	52	$4,710
2018	149	93	$4,902

Orthodontia		
Year	Ortho Service Count	Average Cost
2016	254	$6,912
2017	299	$7,197
2018	447	$6,577

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 3% and increases VSP Plus rates by 3.5% • 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

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

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

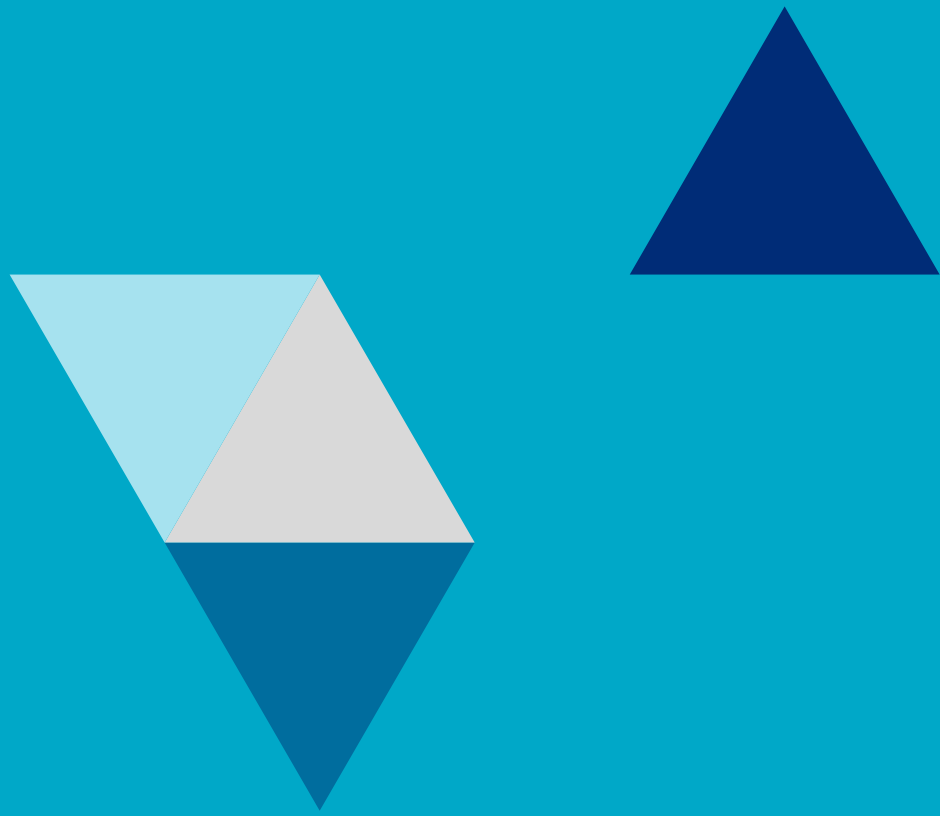
ITEM	FEE
Set Up Fee • Initial Plan Year • Renewal Plan Year	Waived
Monthly Administration PPPM	$2.95
Optional ASIFlex Card PPPM • Replacement or additional card sets	Included • $5.00 billed to participant FSA
Employee Communication • PDF documents • WebEx group meetings • Onsite Enrollment Meetings	 • 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



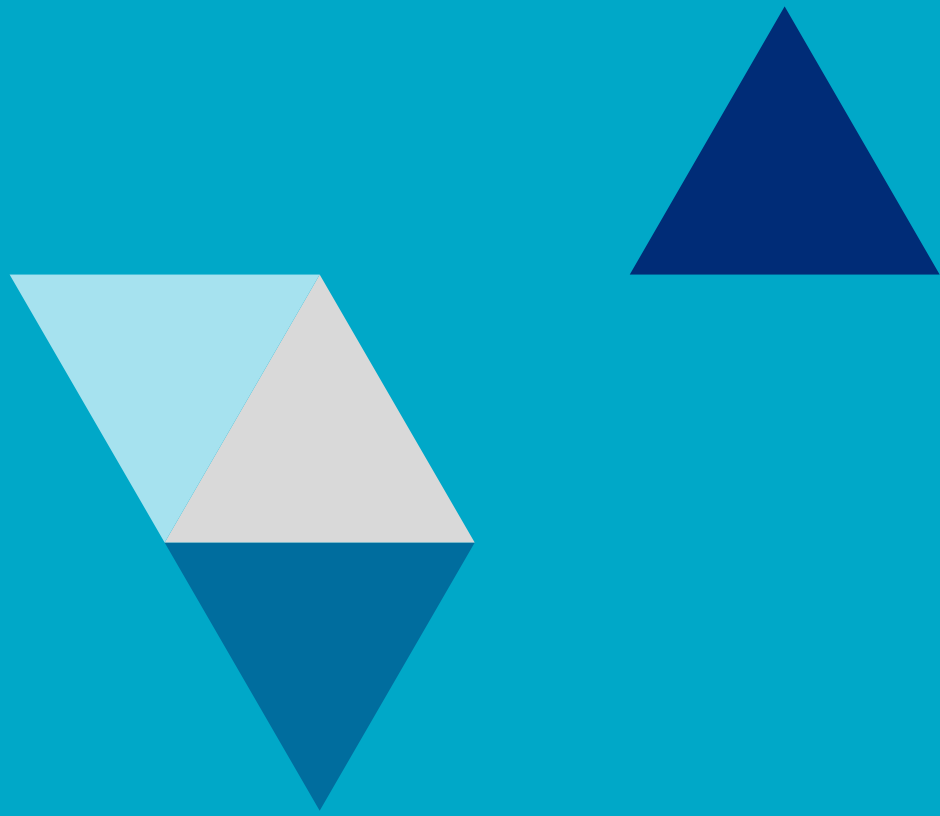
NEXT STEPS

- Additional data will be used to develop the final 2020 composite rate
- Finalize projections / premiums for all carriers, based on current plan designs
- Request final follow-ups for vendor proposed changes for 2020
- During May Board meeting:
  - Review final composite rate and finalize plan changes
  - Finalize plan changes or request additional changes based on composite rate projection
  - Continue strategy discussion

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



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

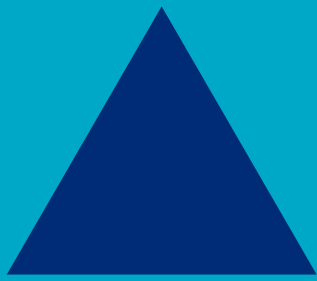
	Employee	Employee and Spouse/Partner	Employee & Child(ren)	Employee and Family
Kaiser	$767.75	$1,535.51	$1,305.16	$2,072.92
Kaiser Deductible	$701.30	$1,402.62	$1,192.23	$1,893.54
Moda Summit, Synergy	$698.37	$1,396.75	$1,187.23	$1,885.62
PEBB Statewide	$786.53	$1,573.09	$1,337.12	$2,123.66
Providence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

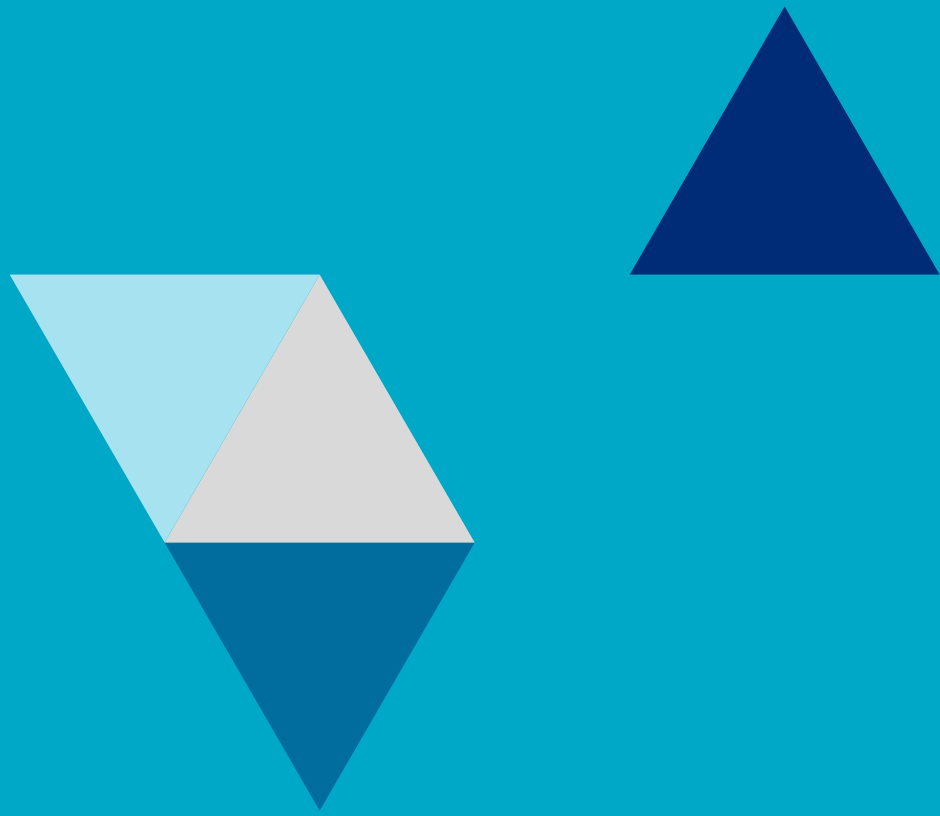
PROVIDENCE

- 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 (ROUND 1)
Kaiser HMO	0.0%	4.4%	3.3%	5.0%	2.9%	4.6%
Kaiser Deductible	0.0%	4.4%	3.3%	5.0%	2.9%	4.6%
Moda	n/a	2.4%	3.5%	FT: 7.2% PT: 7.7%	4.0%	0.0%
Providence Choice	-0.8%	3.3%	3.2%	7.0%	5.4%	1.3%
Providence Statewide	0.2%	3.9%	8.2%	5.9%	3.9%	5.8%

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?*

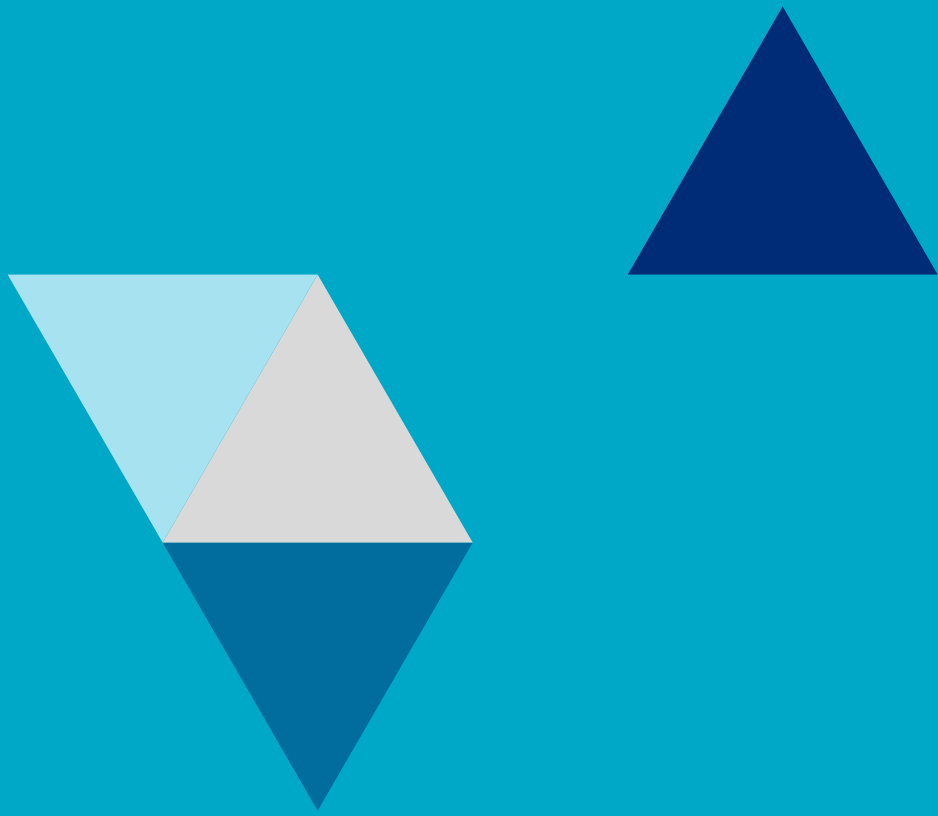
		WHAT'S INCLUDED?		
Category	**Sub-Category**	**Providence**	**Moda**	**Kaiser**
Fee for Service – No link to quality & Value	1			Contracted hospitals / facilities
Fee for Service – Link to quality & value	2A	CPC+ PCPCH Cap	PCPs not participating in the Synergy/Summit shared savings model, but receiving 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

NON-MEDICAL



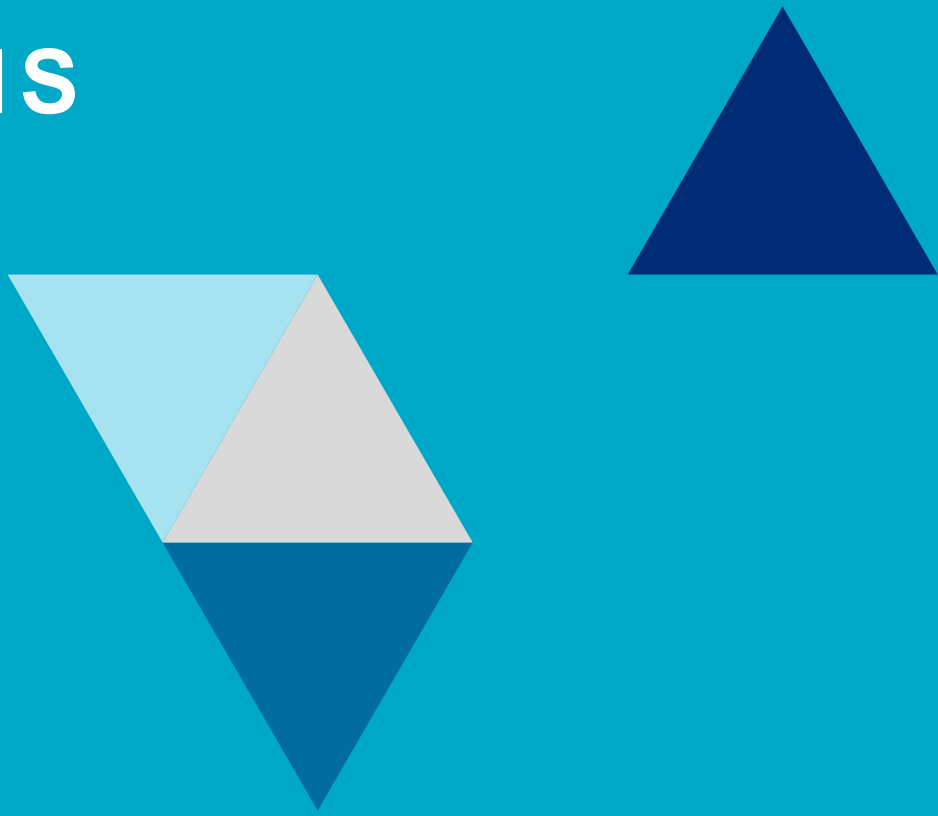
2020 NON-MEDICAL RENEWALS
HISTORICAL RATE INCREASES

	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

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+.

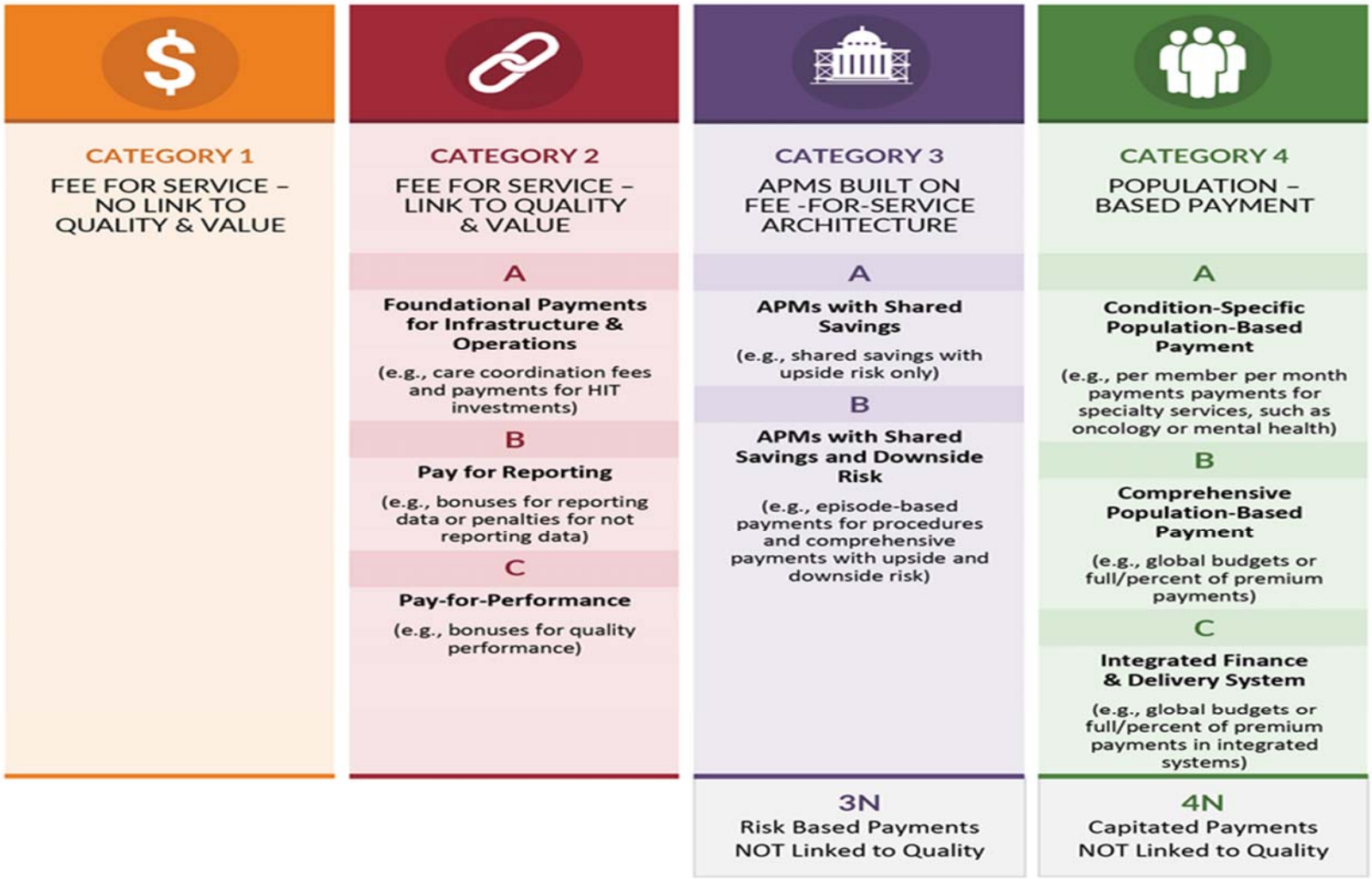
GLOSSARY OF TERMS

- **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