Chair Shaun Parkman will convene a public meeting of the PEBB Board on Tuesday, February 19, 2019, at 9:30 a.m. The meeting will be held in the boardroom of the Health Licensing Office at 1430 Tandem Ave., Ne, Suite 180, Salem, Oregon.

PEBB BOARD AGENDA

I.	9:30 a.m. – 9:35 a.m. Attachment 1 **ACTION**	**Welcome & Approval of January 15, 2019 meeting minutes** *Shaun Parkman, Chair*
II.	9:35 a.m. – 9:40 a.m.	**Director's Report** *Ali Hassoun, Director*
III.	9:40 a.m. – 10:40 a.m. Attachment 2	**Strategic Planning** *Robert Valdez and Michael Garrett, Mercer Health & Benefits, LLC*
	10:40 a.m. – 10:55 a.m.	***BREAK***
IV.	10:55 a.m. – 11:55 a.m. Attachment 2 cont.	**Strategic Planning (continued)** *Robert Valdez and Michael Garrett, Mercer Health & Benefits, LLC*
	11:55 a.m. – 12:30 p.m.	***LUNCH***
V.	12:30 p.m. – 1:45 p.m. Attachment 3	**Renewal Responses** *Emery Chen, Nick Albert, and Robert Valdez, Mercer Health & Benefits, LLC*
	1:45 p.m. – 2:00 p.m.	***BREAK***
VI.	2:00 p.m. – 3:00 p.m.	**Renewal Responses (continued)** *Emery Chen, Nick Albert, and Robert Valdez, Mercer Health & Benefits, LLC*
VII.	3:00 p.m. – 3:05 p.m.	**Public Comment and Other Business** **Adjourn**

Public Employees' Benefit Board
Meeting Minutes
January 15, 2019

The Public Employees' Benefit Board held a regular meeting on January 15, 2009, at the DHS Health Licensing Office, Suite 180, 1430 Tandem Ave. Ne, Salem, Oregon 97301. Chair Shaun Parkman called the meeting to order at 10:30 a.m.

Attendees

Board Members:
Shaun Parkman, Chair
Kimberly Hendricks, Vice Chair
Bill Barr (via phone)
Dana Hargunani, MD
Siobhan Martin
Mark Perlman
Jeremy Vandehey

Board Members Excused/Absent:
Senator Betsy Johnson
Representative Mitch Greenlick
Kim Harman

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

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

View meeting agenda and attachments.
View the meeting recording

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I. Welcome and approval of December 18, 2018 meeting minutes – Attachment 1

Chair Shaun Parkman welcomed everyone and asked for a motion to approve the October 16, 2018 Board Meeting Minutes and November 15, 2018 PEBB Retreat Minutes.

MOTION

Bill Barr moved to approve the minutes of the December 18, 2018, Board meeting. Siobhan Martin seconded the motion. The motion carried 6 – 0.

II. PEBB Strategic Planning – Next Steps - Attachment 2

Robert Valdez and Michael Garrett, Mercer Health & Benefits, LLC presented strategic planning next steps and the Board entered into discussion.

III. Innovation Workgroup Update - Attachment 3

Shaun Park, IW Vice Chair and Dana Hargunani IW Member presented an update of the Innovation Workgroup.

IV. Other Business

V. Public Comment

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

HEALTH WEALTH CAREER

OREGON PEBB BOARD MEETING

STRATEGY DISCUSSION GUIDE

PB ATTACHMENT 2
FEBRUARY 19, 2019

TODAY'S AGENDA

01 WHERE WE LEFT OFF

02 ACO / CCM DISCUSSION

03 MEDICAL BRIDGE STRATEGIES

04 NEXT STEPS

WHERE WE LEFT OFF

TRANSFORMING INTO AN ACO/CCM+: RATIONALE

Triple Aim	**Improve the quality of care**		**Improve the patient experience**		**Deliver care more efficiently**	
OHA Guiding Principles	**Access**	**Innovation with accountability**	**Patient-centered**	**Health equity**	**Collaborative partnerships**	**Social determinants of health**
PEBB Vision	An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely	A focus on improving quality and outcomes, not just providing health care	Promotion of health and wellness through consumer education, healthy behaviors, and informed choices	Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place	Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making	Benefits that are affordable to employers and employees

Critical ACO Elements	**Articulate the goals**	**Evaluate the ACO Health Management Capabilities**	**Patient-Centered Care and Communication**	**Quality Management & Improvement**	**Supplier Collaboration**
	Conduct gap analysis and identify opportunities	**Establish the Financial Reconciliation Methodology**	**Benefit Plan Design**	**Information Sharing and Reporting**	**Attribution**

ACO Success Measure Areas

PATIENTS

PLAN SPONSOR

DELIVERY SYSTEM

ADMINISTRATOR

HOW IT TIES TOGETHER
DRAFT STRATEGIC PLACEMAT

ENVIRONMENT

- Labor-management board who contracts and administers benefits for eligible state employees
- 136,000 covered participants
- Individuals live and work in every county in Oregon
- Mix of self-funded and fully-insured benefit plans
- Remain within 3.4% annual cost growth cap

GUIDING PRINCIPLES

- An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely
- A focus on improving quality and outcomes, not just providing health care
- Promotion of health and wellness through consumer education, healthy behaviors, and informed choices
- Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place
- Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making
- Benefits that are affordable to employers and employees

STRATEGY

- Offer competitive plan design and employee contributions as appropriate
- Increase focus on value-based payment approaches rather than fee-for-service arrangements
- Encourage members to participate in wellness programs through incentives to help reduce overall medical cost trends
- Monitor and evaluate innovative solutions and “add-on” health plan services that help members effectively use their benefits and optimize their and PEBB’s healthcare investment
- Utilize vendor tools to educate and engage members
- Stay abreast of compliance requirements

ACTIONS

- Collaborate with vendors to offer best-in-class products, tools and services to PEBB and its members
- Monitor vendors’ capabilities and evaluate innovations (e.g., ACO) for PEBB’s consideration
- Encourage employees’ use of vendor tools to select quality providers, learn about the true cost of specific procedures and better manage their overall health
- Educate employees on high performing providers to steer usage
- Look for programs and incentives to have the highest impact on overall health risks
- Develop data collection and dashboard tools for ongoing program measurement

BARRIERS

- Tight labor market
- Carrier capabilities
- Developing wellness program
- Decentralized workforce
- Staffing, growth and leadership retirements
- Employees unaware of available programs and their value
- Geographic health habits and influences
- Procurement rules
- Administrative time and cost impact
- Data integration from multiple carriers

SUCCESS MEASURES

- Year-over-year health care cost increase below trend
- Annual movement in value based payments to LAN Categories 3 and 4
- High levels of program participation and engagement
- Employees value their benefits and understand the underlying costs
- Increased consumerism behavior (e.g., generic Rx utilization, urgent care vs. ER)
- Health improvements (e.g., preventive screenings, disease management participation)

ACO / CCM DISCUSSION

OVERALL COMPARISON BETWEEN CURRENT CCM AND ACO

	Healthcare Focus	Description	Financial Arrangement
Coordinated Care Model	Primary Care, some models include specialty care but others primarily focused on primary care	Care is coordinated and managed by primary care teams via patient-centered primary care homes	Variable financial risk arrangements depending on the provider, ranging from total cost of care to no financial risk
Accountable Care Organization (ACO)	Entire healthcare continuum of services	Primary care serves as the central coordinating focal (like current CCMs), and then also coordinates, information shares, and collaborates with other providers: • Specialists • Acute care • Long term care • Behavioral health • Ancillary services	• Fees at risk for the total cost of care • Graduated risk sharing over time • Exceptions may include high cost claimants, specialty pharmacy, etc.

KEY ELEMENTS OF VALUE-BASED CARE

ALIGNMENT WITH OHA'S KEY ELEMENTS OF COORDINATED CARE MODEL

OREGON COORDINATED CARE MODEL KEY ELEMENTS

Least Managed → Most Managed

	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Best practices to manage and coordinate care	Although there are reported quality measures, systematic implementation of evidence-based clinical guidelines across the entire PPO network is not required	The CCM model incorporates the primary care team as the focal for care coordination and referrals to specialists The financial arrangement depends on the provider – from no financial risk to total cost of care risk	ACOs have expectations for incorporating evidence-based clinical guidelines across the entire healthcare continuum	Evidence-based clinical guidelines are embedded into the electronic health record (EHR) for all providers
Transparency in price and quality	Limited implementation of a transparency tool by vendor	Some providers have vendor transparency tools include a healthcare cost estimator web tool for members to evaluate price Members can access information regarding the patient-centered primary care home (PCPCH) certification status	There is variability in ACOs providing cost and transparency tools to members ACOs are required to provide quality management of their in-network ACO providers Some ACOs are required to obtain and maintain primary care or patient centered medical home certification	Kaiser has an app that members can use in identifying providers within the Kaiser network Uncertain on the level of price and quality information in the Kaiser app Kaiser is an accredited health plan, so they publish their HEDIS scores which include quality metrics that are publicly available at the plan level, not the provider level
Shared responsibility for health	Not currently a requirement	Incorporated as one of the underlying principles for this model but unknown extent of dissemination Moda's programs for member engagement include the disease management programs as well as the C3 program and promote shared responsibility	Could be included as a requirement, including reporting out on the dissemination and outcomes (e.g., avoided procedures)	Typically included as a part of the Kaiser model, but not certain about reporting on the extent of the application

KEY ELEMENTS OF VALUE-BASED CARE
ALIGNMENT WITH OHA KEY ELEMENTS

OREGON COORDINATED CARE MODEL KEY ELEMENTS

Least Managed → Most Managed

	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Measuring performance	Some quality measures are required to be reported with financial impact for meeting or not meeting the target	Quality metrics for primary care performance are part of the contractual requirement with financial penalties and incentives Coordinated Care Governance model includes requirements for provider participation including regular review of financial reports, quality & costs measures, network changes/updates, etc.	Quality and outcome measures are a key component for the ACO, including primary care, specialty care, hospitalizations, member experience, etc.	Kaiser reports out its quality metrics for PEBB as well as for plan accreditation with their HEDIS scores for the overall plan, not for individual providers
Paying for outcomes and health	Payment is based on a traditional fee-for-service (FFS) model	Primary care quality is incorporated into those providers who have a total cost of care reimbursement model based on the identified quality metrics for primary care Outcomes from specialty care and acute care are not part of the proposed payment model for CCMs but vendor may incorporate in future years	Depending on the extent of the financial risk, ACOs are incented to proactively manage care across the continuum of care with financial consequences when outcomes are achieved or not achieved	Kaiser is under a total cost of care, complete at risk contract, so there is an inherent incentive to obtain healthy outcomes with the lowest costs
Sustainable rate of growth	Over the last three years, the claims growth rate has been 7%, annualized	Over the last three years, the claims growth rate has been 6%, annualized (Includes Choice and Moda)	The medical trend rate is typically outlined over the course of several years with increasing limits to the trend rate over time	Over the last three years, the claims growth rate has been 5%, annualized (Includes Deductible and HMO plans)

KEY ELEMENTS OF VALUE-BASED CARE
OTHER IMPORTANT CONSIDERATIONS

ADDITIONAL KEY COMPONENTS	Statewide PPO	Coordinated Care Model (CCM)	Accountable Care Organization (ACO)	Kaiser HMO
Benefit plan design	Members can access primary care or specialty care at will with no referrals required Prior authorizations are required for certain services such as hospitalizations	To receive In-Medical Home benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from providers referred by their medical home Otherwise, benefits typically have higher costs or may not be covered Usual benefit prior authorizations, e.g. hospitalizations, are required	Members are strongly encourage to select a primary care physician, and to allow the PCP to coordinate care and specialty referrals However, members can receive care from any provider within the ACO network with no referral If members go outside the ACO network, benefits have higher member cost share or may be not covered Usual benefit prior authorizations, e.g. hospitalizations, are required	Members must select a PCP who serves as the coordinator of care, including specialty care referrals required for certain services Co-pays and deductibles are lower than the statewide PPO when care is received from Kaiser providers and when referrals are obtained when required Except for emergency care, there is no coverage when seeking care outside the Kaiser network unless Kaiser has prior authorized the out of network services
Premium cost share	Highest premium cost share to the member	Lower than both Kaiser HMO plans and statewide PPO	Typically, the premium cost share is significantly lower than a PPO plan The comparison to HMO plans varies by plan	Traditional Kaiser plan is lower than the statewide PPO but higher than all of the other plans Kaiser deductible plan is lower than the traditional Kaiser plan and the statewide PPO plan
Financial reimbursement model	Traditional fee-for-service (FFS) reimbursement model	Primary care practices in the medical home network are reimbursed on FFS basis and with financial impact based on quality measures Limited capitated and foundational payments	Depending on the maturity of the ACO model, the financial reimbursement typically sits on a “FFS chassis” and then financial incentives and penalties are assessed based on quality metrics Some highly mature ACOs are fully at risk with some exceptions such as high cost claimants and specialty pharmaceuticals	Risk bearing, integrated delivery system combing coverage and cost of care Limited fee for service payments to contracted network hospitals
Information sharing, coordination, and integration with all benefit programs	No infrastructure or requirement for information sharing or care coordination	Primary care practices within the medical home network share information, and PCPs can make specialty referrals when the member seeks the coordination Uncertain if there is systematic information sharing between specialty practices and primary care practices	ACOs share information and provide care coordination through various means, including shared electronic health record (EHR), data intermediary, and other technologies	Kaiser providers share an integrated electronic health record (EHR), so that all providers (including primary care, specialty care, acute care, etc.) have access to all clinical information

MEDICAL

BRIDGE STRATEGIES

BRIDGE STRATEGIES
PLAN OF ACTION — FINALIZED IN DECEMBER

Strategies

Expert Medical Opinion

Concierge for Statewide

Bundled Payments with COE

Point Solutions

Approach

#1
Carriers build, buy, or align with the strategies

#2
PEBB procures

Process

Incorporate questions into renewal letters → Receive responses → PEBB decides if responses are adequate, and if the carriers are not able to do it, is the idea important enough to go out to procurement → Procurement process on ideas carriers cannot administer

We are here

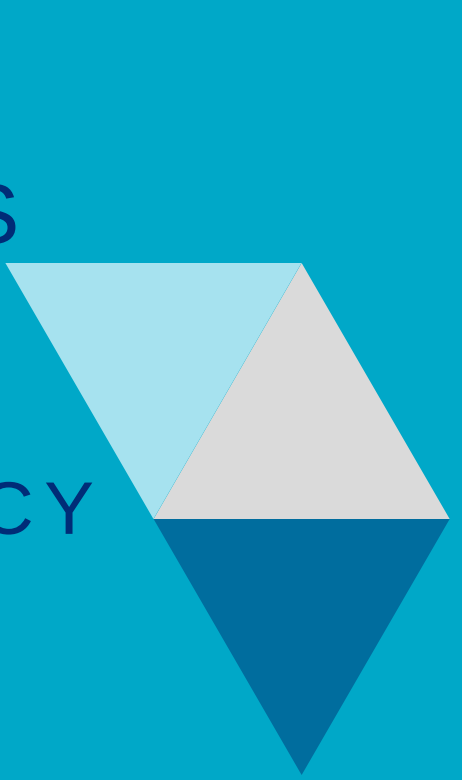
BRIDGE STRATEGIES
ALIGNMENT WITH OHA'S COORDINATED CARE MODEL KEY ELEMENTS

	CONCIERGE AND ADVOCACY SERVICES	BUNDLED PAYMENTS AND CENTERS OF EXCELLENCE	DIGITAL HEALTH POINT SOLUTIONS	EXPERT MEDICAL OPINION (EMO)
Best practices to manage and coordinate care	Provides navigation to clinical services and benefit programs based on the identified needs of the members	COE contracts typically require vetted clinical teams and use of evidence-based clinical guidelines	Provides digital navigation, education, and support for members with clinical conditions	Incorporates evidence-based clinical guidelines in evaluating treatment options
Transparency in price and quality	May provide navigation to price and quality data if the plan includes that as a benefit program	May include information about the qualifications of the clinical teams, and the bundled payment amount is transparent	May incorporate data on cost and quality depending on the solution	May include information regarding quality providers
Shared responsibility for health	Should be included as a part of the requirements for this service, so that patients are given information about treatment options	Should be included as a part of the service, since the health system should be screening for the appropriateness of the proposed procedure	These solutions are aimed at providing education and support for patients with chronic conditions to accelerate self-care	Should be a part of this service, so that when the proposed procedure is being evaluated, the patients are also given information about treatment options
Measuring performance	Primary measure is active and sustainable engagement with the service	COE contracts typically include quality metrics, including performance guarantees, such as warranties and screening out members who are not appropriate for services	Primary measure is sustainable engagement with the digital health solution	Primary measure is based on avoidance of unnecessary services
Paying for outcomes and health	Potential array of performance guarantees related to member experience and engagement, referrals to clinical services, and improved health outcomes	Potential performance guarantees based on clinical outcomes, return to function, and member experience	Potential performance guarantees related to percent of members engaged with the digital health solution	Potential performance guarantees related to member experience, timeliness, and case outcomes
Sustainable rate of growth	Some vendors are willing to tie fees to overall trend growth depending on the overall structure of the program	Not directly tied to total cost of care but should result in reductions in unnecessary healthcare services	Not directly tied to total cost of care but could contribute to reduce costs with better managed conditions	Not directly tied to total cost of care but could result in avoidance of unnecessary services

MEDICAL

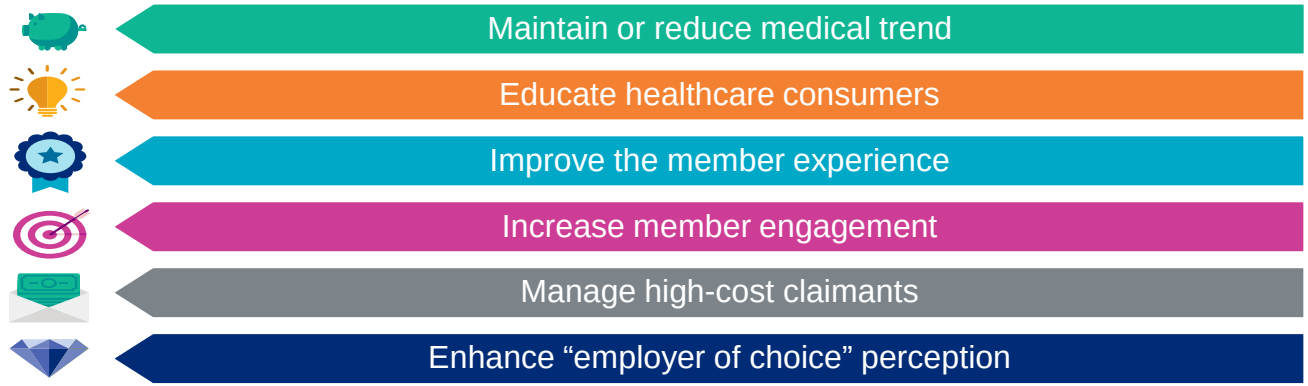
BRIDGE STRATEGIES

CONCIERGE / ADVOCACY



CONCIERGE / ADVOCACY
OVERVIEW AND PROBLEMS ADDRESSED

- **Enhanced customer service** staffed by highly qualified associates who seek to connect the dots between the caller's question and the underlying root-cause in an effort to **simplify the member's healthcare journey**
- Advocacy solutions have the potential to impact the following strategic goals:



- **The paradigm shift:**

Transactional, volume-driven service

- Customer service functions measured on call volume, call times – the shorter the better
- Clinical support teams viewed as a cost-center; emphasis on "making do" with resources at hand, without needing to invest more
- Limited integration between functions

Traditional carrier-led model

Transformative, outcome-focused service

- Customer service measured on referrals to relevant services/programs, identifying and resolving members' underlying questions
- Clinical teams seen as key in achieving proactive population health management
- Enhanced integration between functions; single point of contact where possible

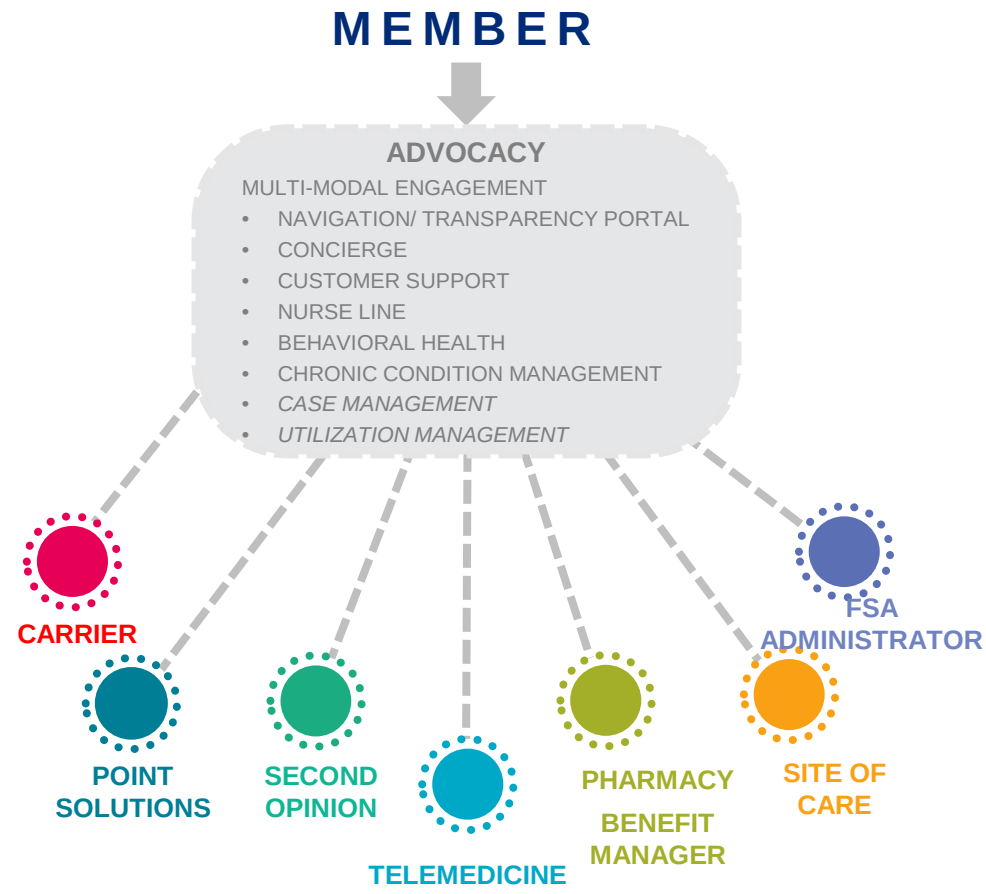
Began as the carve-out niche, but carriers are adapting

CONCIERGE / ADVOCACY
OVERVIEW AND PROBLEMS ADDRESSED

Problems being solved:

- Medical trend growth?
- Improved customer service?
- Enhanced clinical programs?
  - Targeting chronic conditions?
  - Targeting high-cost claimants?
- Engagement in healthcare and benefit programs?
- Return on program investment?
- Drive to quality in-network providers?
- Reduce administrative burden (for organization and/or member)?
- Provide assistance with navigating benefits and health system?

"Front door" for the member



CONCIERGE / ADVOCACY
FROM BOARD RETREAT

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

Projected Potential Savings

2020	2021	2022	2023
$7M	$11M	$16M	$17M

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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

TIMING
MEDIUM

CARRIER/VENDOR
NEW

COMMUNICATION
CONTINUOUS

IMPLEMENTATION
HIGH

CONCIERGE / ADVOCACY SERVICES (CAS)
PROVIDENCE RESPONSE

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

Providence Proposal:

- Providence is willing to redesign the features of their existing customer service to identify member needs and provide an enhanced, personalized service experience
- **Service Delivery:**
  - Team-based structure by geography which will include clinical support, member support, whole person care management professionals, and ancillary Providence experts.
  - The team will manage all member inquiries, including claims/eligibility, coordination of care, provider access, and care plan coordination
  - Providence will also establish onsite resources at key locations throughout Oregon on a monthly or quarterly basis for face-to-face interactions
- **Experience / Training:** CAS teams will be selected from existing service and clinical caregivers
- **Quality / Metrics**:
  - Providence expects decreased utilization, decrease in avoidable costs, increase in number of members engaged in care management, decrease in complaints, and an increase in PCP / Express Care
  - Out of network costs will likely decrease
- **Marketing / Member Communication**:
  - Marketing campaigns throughout 2019 leading to full implementation in 2020
  - Existing PEBB microsite will be enhanced to direct Statewide members to the CAS program for navigation assistance
  - myProvidence portal will display geographically-based messaging to push relevant information, including direct contact information for the CAS team serving the member's location
  - Real-time web chat and email
- **Pricing**: Providence's goal is to have final pricing in alignment with the best-in-class concierge vendor

Questions / Concerns

- Providence is keenly interested in providing this service model for PEBB, however, it is completely new and many of the details are still in development
- The best-in-class vendors do not typically hire people with call center backgrounds, as the "retraining" is extremely challenging. The Providence CAS teams will be selected from the most seasoned among their existing customer service teams
- Providence will charge market rates for the service, but will not be placing fees at risk or proposing trend guarantees
  - According to Providence, the trend / PGs would not align with PEBB's goals of accelerating value based payment methodologies
- Procurement issues with going to an outside vendor, or even building it within Providence if the service deviates too far from original RFP

CAS = Concierge/Advocacy Services

MEDICAL

BRIDGE STRATEGIES

BUNDLED PAYMENTS / CENTERS OF EXCELLENCE

CENTERS OF EXCELLENCE
OVERVIEW AND PROBLEMS ADDRESSED

What is the problem?

- Lack of transparency with cost of major surgeries
- Extreme variation in cost and quality across the US and within markets
- Lack of consumer awareness about their options

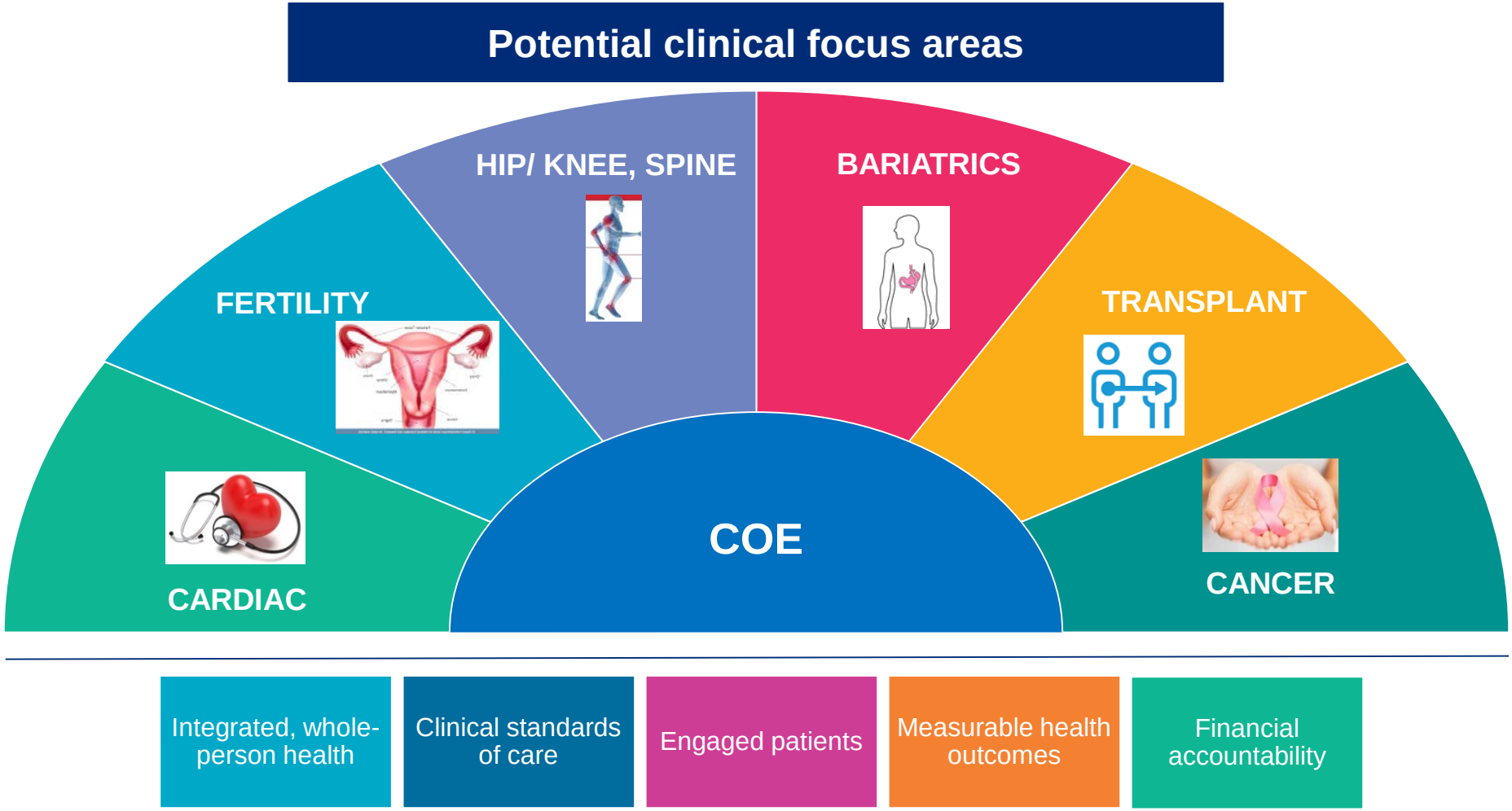
What is a COE?

- A concentration of expertise and resources in a specific medical area
- Delivered in a comprehensive, interdisciplinary fashion
- Yielding an exceptionally high level of care

A bundled episode of care and payment

- A set of services to treat a condition or perform a procedure
- Expected total costs for a clinically defined episode of services
- Discourages unnecessary care
- Encourages coordination across providers
- Potentially improves quality and outcomes

CENTERS OF EXCELLENCE
OVERVIEW AND PROBLEMS ADDRESSED



STRATEGY: BUNDLED PAYMENT WITH COES

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

Projected Potential Savings

2020	2021	2022	2023
$2M	$2M	$2M	$2M

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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

TIMING
MEDIUM

CARRIER/VENDOR
CURRENT/NEW

COMMUNICATION
HIGH

IMPLEMENTATION
MEDIUM

BUNDLED PAYMENTS / CENTERS OF EXCELLENCE (COE)

	Providence	Moda	Kaiser
Existing Bundles and Savings	• **Total Joint Replacement (TJR)** – Two options: Providence Portland Medical Center or Providence St. Vincent Medical Center – Many patients receive the TJR surgery in the outpatient setting – Better experience for member, return to normal quicker – In 2017, 5% of the PEBB claims for major hip and knee joint replacement were included in the Joint Bundle program	• COE providers are available for the following: – Adult and pediatric transplants – Specialized cancer care – Congenital heart disease – Neonatal intensive care unit – Bariatric surgery – Ventricular assist device • Partnership with OHSU – OHSU's advanced certification for stroke care, palliative care, heart failure, and ventricular assist devices	• COEs are part of Kaiser's integrated network • For members requiring specialized care, Kaiser offers internal COEs regionally and external COEs perform transplants and other specialized procedures • Services include: cancer treatment, cardiac, spinal, transplants, bariatric, joint, hemophilia, rheumatoid arthritis, HIV, MS, and transgender services • Kaiser is willing to discuss performance guarantees associated with their COE services
On the roadmap	• Expansion of the Total Joint Replacement in an outpatient setting model that will further reduce costs and increase patient satisfaction	• Joint replacement • Hemophilia • Expansion of cancer care program options with the Knight Cancer Center, the only National Cancer Institute Designated Cancer Center in Oregon • Certain pharmaceuticals, such as gene therapy	• Future COEs are determined by examining community needs, clinical research, and leveraging the knowledge collected by their electronic health record

MEDICAL

BRIDGE STRATEGIES

POINT SOLUTIONS

POINT SOLUTIONS
OVERVIEW AND PROBLEMS ADDRESSED

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

Emerging point solutions are being developed across the healthcare continuum:

ACROSS CONDITIONS:

Behavioral Health	Sleep	Pregnancy
Cancer	Musculoskeletal	Cardiovascular
Diabetes	Senior Care	Provider quality
Financial wellness	Pharmacy	Chronic Disease and Asthma

ACROSS GENERATIONS:

- Millennials
- Generation X
- Baby Boomers
- Traditionalists

POINT SOLUTIONS
OVERVIEW AND PROBLEMS ADDRESSED

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

Projected Potential Savings

2020	2021	2022	2023
TBD	TBD	TBD	TBD

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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

TIMING
SHORT

CARRIER/VENDOR
NEW

COMMUNICATION
DIRECTED AND
CONTINUOUS

IMPLEMENTATION
MEDIUM

POINT SOLUTIONS

Note: each of the carriers' responses were geared towards their care management or disease management programs; there were only a few instances Mercer found where the carriers used app-based digital technology platform

Overview

PROVIDENCE

- **Providence Ventures**
  - Investment arm of Providence has invested in a number of health innovation companies
- Many of the digital technology investments are tailored to hospitals / providers, but a few are member facing:
  - **Lyra Health –** Transformative Technologies in Behavioral Health
  - **Omada Health –** Digital Therapeutics for Chronic Disease Prevention
  - **SQORD –** Children's Wearable and Activity Platform
  - **Wildflower –** Mobile Family Health Platform
- Providence is working on a pilot partnership with **98.6**, which is on-demand primary care using a text-based mobile platform

MODA

- **eDoc** – Provides members with professional clinical online advice with timely personal responses, typically arriving in less than two hours. eDoc helps members understand their symptoms and make informed health decisions. It also encourages PCP follow-up as needed
- **Health Shelf** – Includes articles, mini-quizzes, self-checks, how-to-guides, worksheets, and recipes for healthy meals
  Moda is able to offer other programs such as VLM through **Canary**
    - Moda offers Canary for another large Statewide public group
- **Health & Wellness** –
  - Online health assessment (HA) tool where members receive a wellness score on a scale from 1 to 100.
  - Once the HA is completed, members can visit the Health Shelf, an online toolkit of health and wellness information

KAISER

- One of Kaiser's core strategies is the increased use of telehealth solutions, in all formats. Kaiser is making investments to ensure more members are steered towards these telehealth opportunities
- Kaiser's integrated system and electronic medical record (EMR) helps to identify at-risk members early through screenings, disease registries, hospital and outpatient visits, pharmacy records, and laboratory results
- Live coaching is available in several formats – in group settings, one-on-one sessions, online, or by phone
- Monthly, high-priority measures and other HEDIS measures are reported to all KP providers and staff. Kaiser can also capture long-term (up to 6 years) performance trends in most clinical areas
- Clinical data, engagement data, overview reports, and various utilization reports can be requested regarding all of Kaiser's disease management efforts

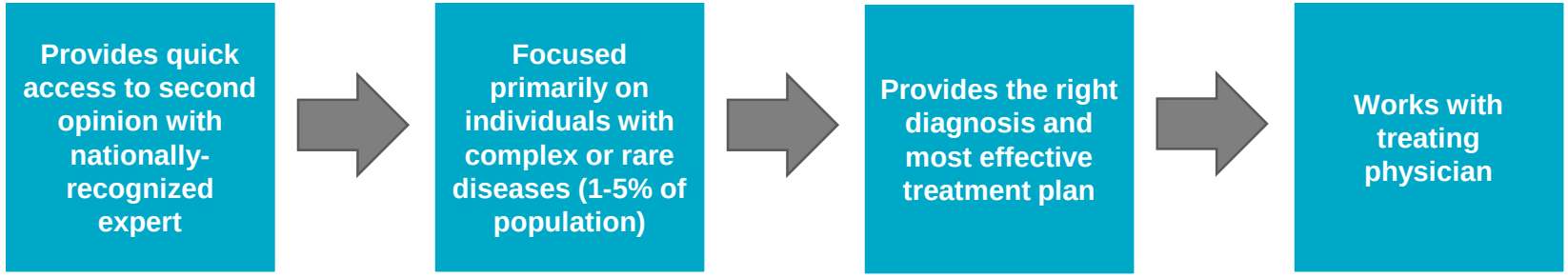
MEDICAL

BRIDGE STRATEGIES

EXPERT MEDICAL OPINION

EXPERT MEDICAL OPINION
OVERVIEW AND PROBLEMS ADDRESSED

- **What is the problem?**
  - Expert Medical Opinion (EMO) vendor data suggests over 30% of diagnoses and over 60% of treatment plans are incorrect
  - Employers and members may pay more than needed for excess and inappropriate testing and care, often with less than optimal outcomes
  - Patients and families feel overwhelmed by a diagnosis of a serious or rare medical condition
  - Health plan support is limited to in-network “experts” and health plans are cautious about the appearance of favoritism in selecting a limited group of experts
- **What is the solution?**



EXPERT MEDICAL OPINION
OVERVIEW AND PROBLEMS ADDRESSED

- **Why should Expert Medical Opinion be considered?**

Better outcomes	Value to employees	Value to PEBB
• **Prevent unnecessary** testing and procedures • Reduce medical errors and optimize **quality of care** • Provides **more intensive** care management for high cost claimants	• Direct **access to top experts** without travel or out-of-pocket expenses • **Empowers** patient to make **informed** decisions • **Peace of mind** that diagnosis and treatment plan are correct	• **Potential to lower** health care costs and reduce absenteeism • **Enhances** benefit offering and integration with case management and other health management programs • **Global** Solution (limited to certain vendors)

STRATEGY: EXPERT MEDICAL OPINION

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

Projected Potential Savings

2020	2021	2022	2023
$1M	$1M	$1M	$1M

How this stacks up with key criteria

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

How this could make people happy

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

How this could frustrate people

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

TIMING
SHORT

CARRIER/VENDOR
NEW

COMMUNICATION
HIGH FOR
UTILIZATION

IMPLEMENTATION
MEDIUM

EXPERT MEDICAL OPINION (EMO)

Overview

PROVIDENCE

- Providence Care Management Nurses assist members in starting a second opinion process
- Third opinions are available if the opinions of the first and second differ
- Utilization Management - Licensed clinical staff includes nurses, registered dietitians, and pharmacists responsible for clinical review in prior authorization, concurrent review, and discharge planning, etc.
- Providence has a number of Health System programs:
  - AskProv – connects providers with specialists, who can provide advice in near real-time
  - Spine Care Continuum (SCC) – supports managing patients with back and neck pain by reviewing MRI and clinical history
- Providence is willing to expand on their existing second opinion for PEBB
  - Phone # would be set up for members to call
  - Service could be used for various institutes – cardiology cancer, etc.
  - Willing to discuss reporting and data
  - Condition specific pricing may be paid on a case rate for EMO services

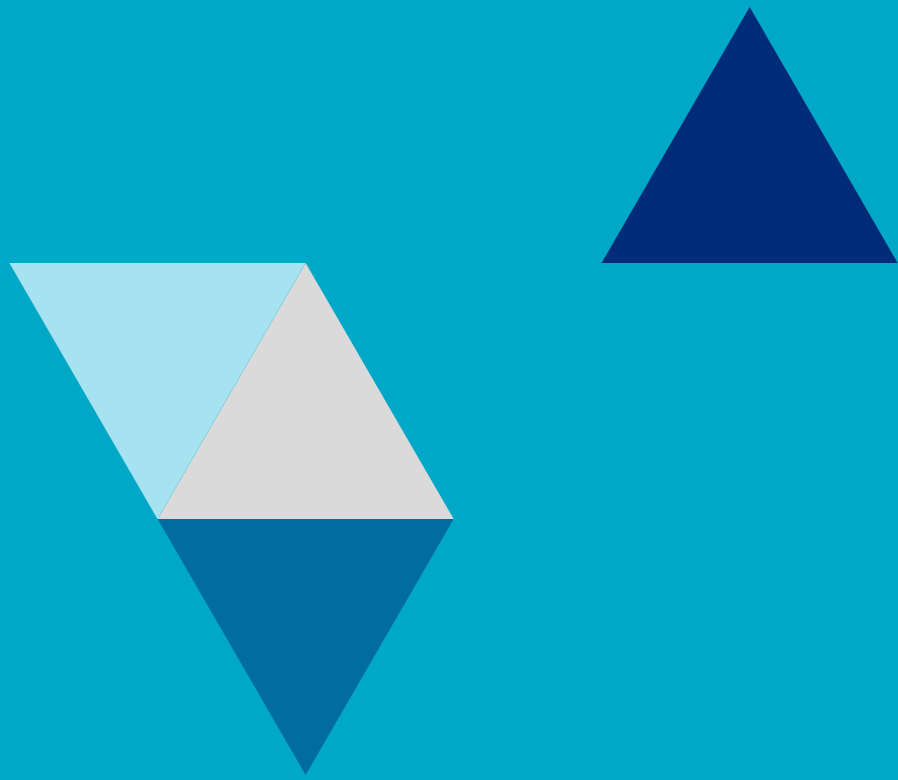
MODA

- Moda has a partnership with Magellan Rx Management for consultations on complex medication requests.
  - Particularly beneficial for rare and orphan diseases where there are a limited number of providers in the country
- Key Opinion Leaders provide second-opinion services during the prior authorization process and are also available for peer-to-peer conversations with treating providers
  - Reviews are initiated at the request of the provider or member, or a Moda clinical reviewer

KAISER

- Members may received a second medical opinion upon request, via in-person, telephone, or KP.org
- Physicians may also refer members to physicians outside KP for a 2nd opinion when medical expertise relevant to a condition isn't available within Kaiser
- Kaiser's Care Management Institute (CMI) develops and refines approaches to providing better health care and clinical performance
- All medical specialties are represented in Kaiser's EMO network
- Kaiser monitors compliance with clinical practice guidelines and clinical protocols, conducting quality assurance audits at least quarterly to measure variations in care
  - Deviations from guidelines are addressed at the system level and at the individual clinician level
- Behavioral health and chemical dependency are included
- Kaiser is open to discussing performance guarantees associated with reporting

NEXT STEPS



SUMMARY AND NEXT STEPS

ACO / CCM Development

Summary

- What is the summary of the Board's shared description and goals of this approach?
- What is the Board's shared vision of the number, location, and structure for the ACO (e.g., direct contracting, customizing the carrier/administrator ACO, etc.)?
- What are the Board's success measures (including clinical, financial, and member experience metrics) for the ACO?
- What are the Board's commitment of resources from itself and from staff for the ACO?

Next Steps:

- Discuss with the carrier/administrator their capabilities in developing the ACO
- Identify the Board, staff, consultants, carrier/administrator, and stakeholders for all of the ACO workgroups
- Determine any coordination or information sharing with other entities
- Develop a work plan for all workgroups
- Identify the communication format and reporting cadence for ACO project updates

Bridge Strategies

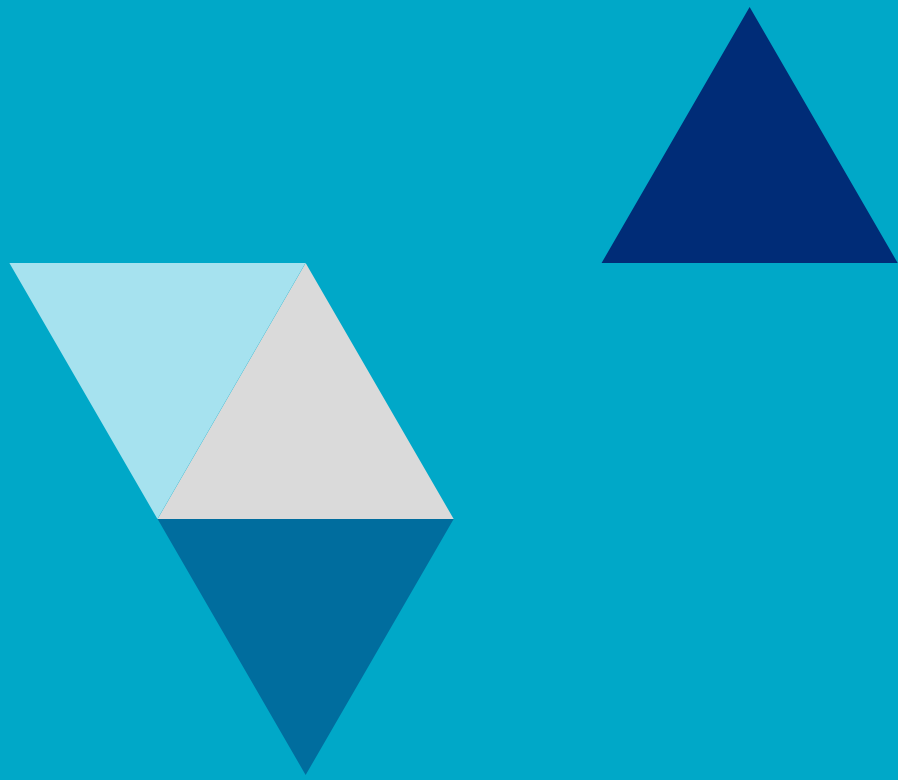
Next Steps:

- Determine whether or not the Board needs additional information/clarification from the carriers on the Bridge Strategies
- If no additional information is needed and carrier responses meet Board expectations, explore developing the solution with the respective carriers
- If the Board feels the carriers are not capable of administering a solution, PEBB Staff and Mercer will work together to develop a formal RFI for the solution to source from a 3rd party vendor

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



APPENDIX

ALIGNING WITH OREGON HEALTHCARE STRATEGIES

OREGON PEBB VISION

- Vision Statement
  - We seek optimal health for our members through a system of care that is patient-centered, focused on wellness, coordinated, efficient, effective, accessible, and affordable. The system emphasizes the relationship between patients, providers, and their community; is focused on primary care; and takes an integrated approach to health by treating the whole person.
- Key Components
  - An innovative delivery system in communities statewide that uses evidence-based medicine to maximize health and use dollars wisely
  - A focus on improving quality and outcomes, not just providing health care
  - Promotion of health and wellness through consumer education, healthy behaviors, and informed choices
  - Appropriate provider, health plan and consumer incentives that encourage the right care at the right time and place
  - Accessible and understandable information about costs, outcomes, and other health data that is available for informed decision-making
  - Benefits that are affordable to employers and employees

GOVERNOR BROWN'S AREAS FOR HEALTH CARE TRANSFORMATION

ADDRESSING SOCIAL DETERMINANTS OF HEALTH AND EQUITY

INCREASING VALUE AND PAY FOR PERFORMANCE

IMPROVING THE BEHAVIORAL HEALTH SYSTEM

MAINTAINING A SUSTAINABLE COST GROWTH

ALIGNING PEBB WITH CCO 2.0 GOALS

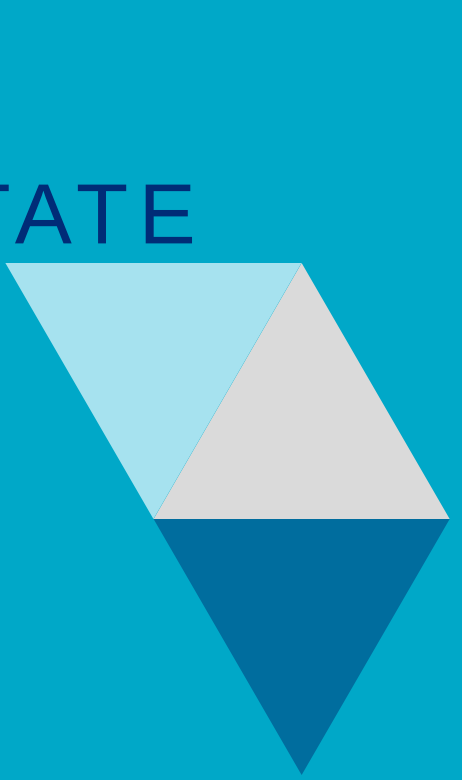
- **Increase Value Based Payments**
- **Support the triple aim: better care, better health and lower health care**
- **Reward providers'delivery of patient-centered, high-quality care**
- **Ensure health disparities & members with complex needs are considered**
- **Align payment reforms with state and federal efforts, where appropriate, for maximum impact and to streamline implementation for providers**
- **Reward CCO and provider performance**

CCO 2.0 STRATEGIES FOR PAYING FOR VALUE

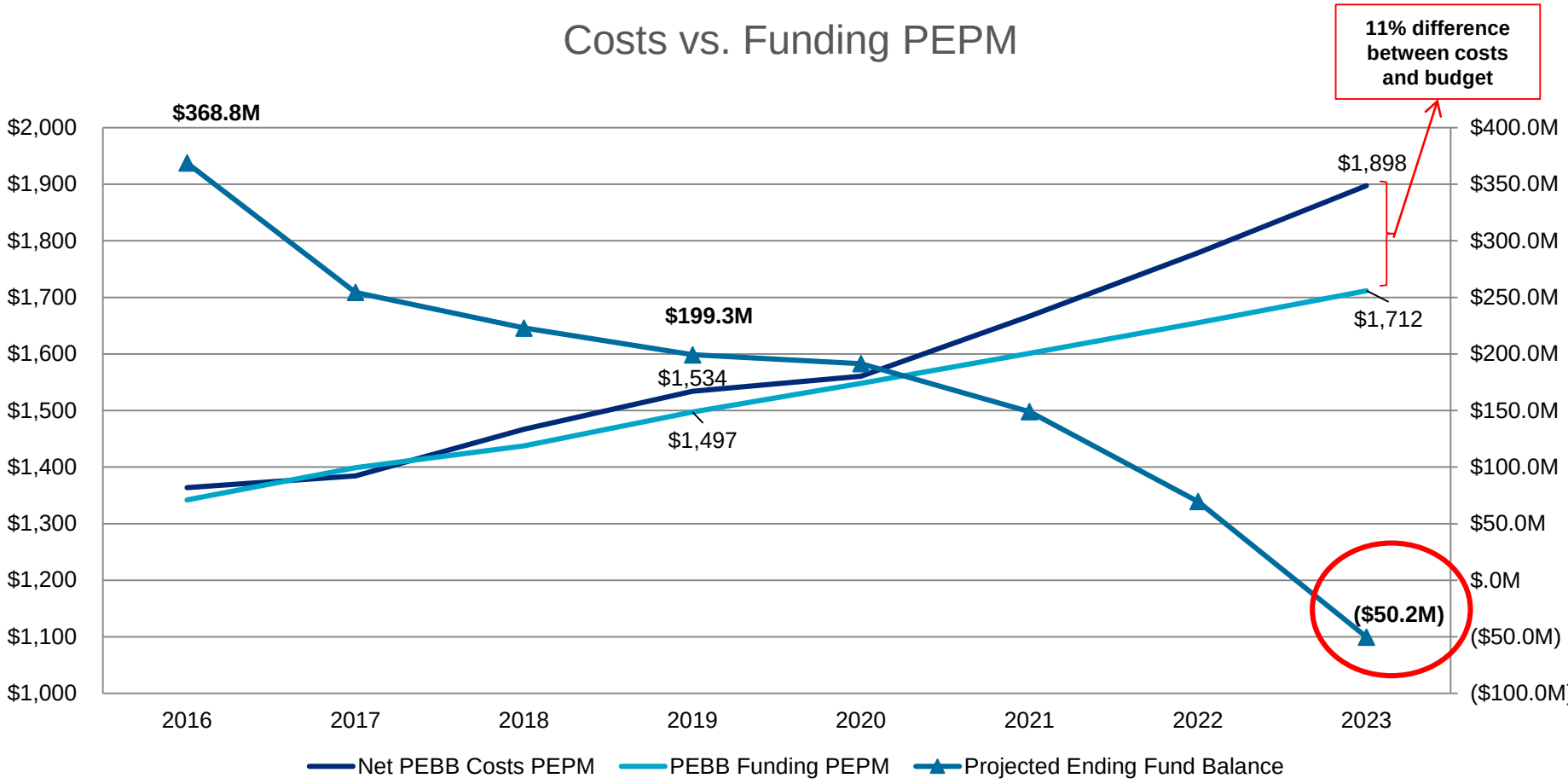
- Pay for outcome and value
- Shift focus upstream
- Improve health equity
- Increase access to healthcare
- Enhance care coordination
- Engage stakeholders and community partners
- Measure progress

APPENDIX

PEBB'S CURRENT STATE

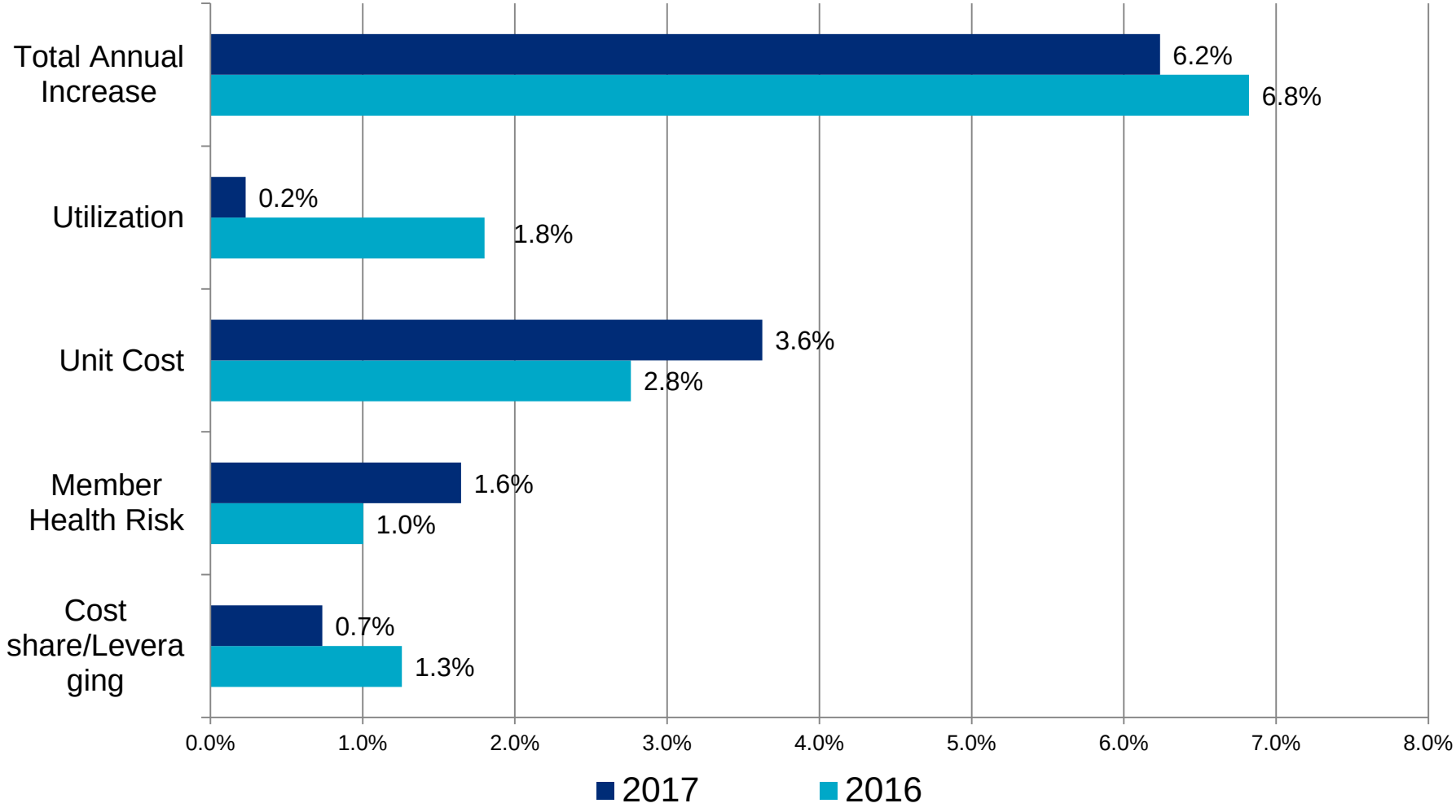


THE 3.4% FUNDING CAP
FUND BALANCE TURNS NEGATIVE BY 2023



Affecting positive impacts on health status, behavior change and costs can take several years

CHALLENGES OF 3.4% FUNDING CAP
HISTORICAL TRENDS REMAIN HIGH



Unit cost increases include impact of technology and service mix

PEBB CHRONIC CONDITIONS

- PEBB's Chronic Condition Prevalence suggests an opportunity for specific "point solutions" aimed at improving the management of a member's condition, and ultimately saving costs

		Previous	Current	Allow Amt Med + Rx Cost Per Pat (Episode Based)
Asthma	Prevalence per 1000			$1,147 $1,164 $1,806
	Prevalence per 1000 Benchmark [4]	25.4	27.7	
	Visits per 1000 ER	N/A	21.1	
	Visits per 1000 ER Benchmark [4]	1.7	1.9	
		N/A	2.6	
	% of Total Allowed Cost	0.8%	0.6%	
Diabetes	Prevalence per 1000	59.7	63.3	$2,559 $2,894 $4,631
	Prevalence per 1000 Benchmark [4]	N/A	51.2	
	Visits Per 1000 ER	1.0	1.8	
	Visits per 1000 ER Benchmark [4]	N/A	1.7	
	% of Total Allowed Cost	3.5%	2.5%	
CAD	Prevalence per 1000	7.4	7.8	$7,578 $9,154 $10,581
	Prevalence per 1000 Benchmark [4]	N/A	9.9	
	Visits Per 1000 ER	1.2	1.2	
	Visits per 1000 ER Benchmark [4]	N/A	1.4	
	% of Total Allowed Cost	1.7%	1.6%	
Depression	Prevalence per 1000	82.9	89.6	$1,072 $1,139 $1,670
	Prevalence per 1000 Benchmark [4]	N/A	38.4	
	Visits Per 1000 ER	2.9	3.4	
	Visits per 1000 ER Benchmark [4]	N/A	2.1	
	% of Total Allowed Cost	2.1%	1.8%	
Lower Back	Prevalence per 1000	91.1	88.5	$1,405 $1,562 $1,932
	Prevalence per 1000 Benchmark [4]	N/A	64.6	
	Visits Per 1000 ER	N/A	N/A	
	Visits per 1000 ER Benchmark [4]	N/A	N/A	
	% of Total Allowed Cost	2.6%	2.2%	
Hypertension	Prevalence per 1000	62.7	61.4	$850 $1,000 $1,281
	Prevalence per 1000 Benchmark [4]	N/A	76.9	
	Visits Per 1000 ER	1.1	1.6	
	Visits per 1000 ER Benchmark [4]	N/A	1.9	
	% of Total Allowed Cost	1.1%	0.9%	

Previous Current Benchmark [3]

Previous Period: Jun 1, 2016 - May 31, 2017 (Incurred)
Current Period: Jun 1, 2017 - May 31, 2018 (Incurred)
Paid Through: Aug 31, 2018

APPENDIX

POTENTIAL STRATEGIES AND ESTIMATED COST SAVINGS

HOW DO WE HELP PEBB SOLVE FOR 3.4%?
EXPLORING THE POSSIBILITIES

CONTINUUM OF STRATEGIES TO IMPACT COSTS

Unit Prices

- Directly negotiate rural fee schedule prices
- Contract with efficient CCMs by county
- Reference based pricing
- Exclusive specialty drug vendor
- High cost claim management

Benefit Coverage

- Advocacy care management
- Stricter medical and benefit policies
- Adjust plan values to benchmark
- Risk adjust premiums for contributions
- Point solutions

Delivery and Associated Payments

- Bundled payments
- Centers of Excellence
- Health alliance to influence how providers operate
- Better integration of behavioral health and EAP with medical
- Single electronic health record provider

Payment Model with Risk Sharing

- Upside and downside risk
- Create ACO
- Changing in-network to only include risk bearing providers

Patient Behavior

- Concierge vendor
- Transparency tool
- Require use of shared decision support tool
- Single telemedicine solution
- Consumer directed medical plan
- Expert medical opinion vendor
- Address social determinants of health

STRATEGY
ILLUSTRATIVE SAVINGS

	2020	2021	2022	2023	Total
Needed Savings per Year	$8 Million	$35 Million	$37 Million	$41 Million	$120 Million
Savings Opportunities					
• Concierge for Statewide	$7 Million	$11 Million	$16 Million	$17 Million	$51 Million
• Expert Medical Opinion	$1 Million	$1 Million	$1 Million	$1 Million	$4 Million
• Double Spousal Surcharge	$2 Million	$3 Million	$2 Million	$3 Million	$10 Million
• CCMs In Efficient Counties		$2 Million	$3 Million	$3 Million	$8 Million
• Bundled Payments	$2 Million	$2 Million	$2 Million	$2 Million	$9 Million
• Accountable Care Organization		$2 Million	$4 Million	$7 Million	$13 Million
Total Savings	$12 Million	$22 Million	$28 Million	$33 Million	$94 Million
Remaining Gap	None	($13 Million)	($9 Million)	($8 Million)	($25 Million)

Annual savings from members selecting CCM plans has historically been between $4M and $7M

APPENDIX

ACO / CCO DEVELOPMENT

OHSU STUDY
MCO, ACO, AND CCO COMPARISON

MCOs (Managed Care Organizations)	• MCOs receive capitated payments from a state Medicaid program to manage benefits for Medicaid members • Typically contract with and manage a network of health care providers • As in Oregon before 2012, separate MCOs typically manage physical, behavioral, and oral health benefits • MCOs may work with providers in their networks to improve care coordination, implement APMs, and improve other aspects of health care delivery and payment systems, although they usually lack an explicit directive to transform health care broadly
ACOs (Accountable Care Organizations)	• ACOs are groups of providers that assume responsibility for health care access and quality among a defined population of members • At minimum, they consist of a group of doctors and a hospital • ACOs typically receive financial incentives if they meet quality goals • The federal Medicare program recognizes multiple kinds of ACOs, and states are beginning to experiment with Medicaid ACOs
CCOs (Coordinated Care Organizations)	• CCOs shared aspects of MCOs and ACOs but resemble MCOs more closely • Like MCOs, CCOs contracted with and managed networks of providers, although some CCOs were organized as partnerships between MCOs and providers • Like ACOs, CCOs were accountable for the health care of a defined population and could receive financial incentives for performance • Unlike MCOs and ACOs, CCOs integrated funding and payment for behavioral and oral health care, and were directed to transform health care delivery and payment more broadly

Source: “Evaluation of Oregon’s 2012-2017 Medicaid Waiver” – OHSU Center for Healthy System Effectiveness

TRANSFORMING THE CCM INTO AN ACO
CRITICAL ELEMENTS

Element	Questions to Consider
Articulate the goals	• What are we trying to achieve through the VBC/ACO? • How do we define success? • How will we measure success?
Conduct gap analysis and identify opportunities	• What elements of the delivery system are impacted by our measures of success? • Where are the CCMs currently rated on these measures of success? • How and where can the delivery system make improvements to achieve the goals?
Evaluate the ACO Health Management Capabilities	For organizations that want to partner and become a high functioning ACO, perform a readiness assessment of the delivery system to see if the requisite population health management capabilities with the necessary tools, resources, staff, methodologies, etc. are in place in order to achieve the desired goals. • How do we know that the delivery system can perform as an ACO and a patient-centered medical home (PCMH)? • What accreditations or recognition can be or are obtained by the delivery system in order to ensure that it will be a highly functioning ACO? • Where there are gaps, what action plans are in place to eliminate those gaps?
Establish the Financial Reconciliation Methodology	• Adapt the financial measures of success to performance guarantees including upside and downside risk • Clearly articulate the financial reconciliation methodology, including outlier exclusions (if any), attribution methodology, risk corridors (if any), etc.
Patient-Centered Care and Communication	The VBC/ACO model needs to be patient-centered with tailored and customized communications in order to support patient enrollment and engagement • Determine gaps between current patient experience and engagement (open enrollment, standardized messaging, concierge call center, patient decision aids, etc.) and definition of success for the VBC/ACO • Document action steps to address gaps • Create metrics for success and methodology for calculating those metrics
Benefit Plan Design	The benefit design needs demonstrate the value to the patient in enrolling in the VBC/ACO • Is the VBC/ACO replacing the CCM or offered as an option? • Determine if the benefit design or contributions need to be adjusted to encourage enrollment into the VBC/ACO • Create process for obtaining a waiver to go outside the ACO • Will a primary care physician (PCP) designation be required?
Quality Management & Improvement	The ACO delivery system needs to clearly articulate how it is engaged in an on-going, systematic quality management and improvement program that delivers improved outcomes and better patient satisfaction/engagement • Clearly define success to the delivery system • Document action steps to address gaps in quality • Determine key metrics that define success and methodology for calculating those metrics
Information Sharing and Reporting	The ACO needs timely, accurate, meaningful, standardized, and actionable information and data in order to support proactive population health management. • Determine key stakeholders (providers, facilities, care managers, etc.) and the data required by each stakeholder • Assess current reporting capabilities and gaps • Create project plan for delivering and reviewing data with key stakeholders with timeframes for evaluating success and reassessing needs
Supplier Collaboration	There are usually a number of services and suppliers involved with an employer's overall benefit plan. There needs to be awareness and collaboration between all of the benefit suppliers when an ACO/VBC is launched. • How will the suppliers interact and collaborate in order to support a highly functional, integrated system?
Attribution	• What kind of providers are considered primary care providers (e.g., MDs, ARNPs, PAs, etc.)? • What type and what kind of office visits are counted (e.g., two office visits of any kind)? • What is the look-back period for counting visits (e.g., one year, two years, etc.)? • How and when would specialist visits be considered?

TRANSFORMING THE CCM INTO AN ACO
SAMPLE SUCCESS MEASURES

PATIENTS

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

PLAN SPONSOR

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

DELIVERY SYSTEM

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

ADMINISTRATOR

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

OPTIONS FOR ACHIEVING CCO / ACO

1. Piggyback on existing OHA CCO arrangements

2. PEBB executes direct contracts with health systems for graduated risk-bearing ACOs
   - Administrator will have to pay providers according to terms based on PEBB's contract

Examples: Boeing, Washington HCA

3. Contract through carriers with health systems for graduated risk-bearing ACOs
   - PEBB provides contractual requirements for ACO arrangements, carriers will need to customize any existing ACO arrangements

Example: Microsoft

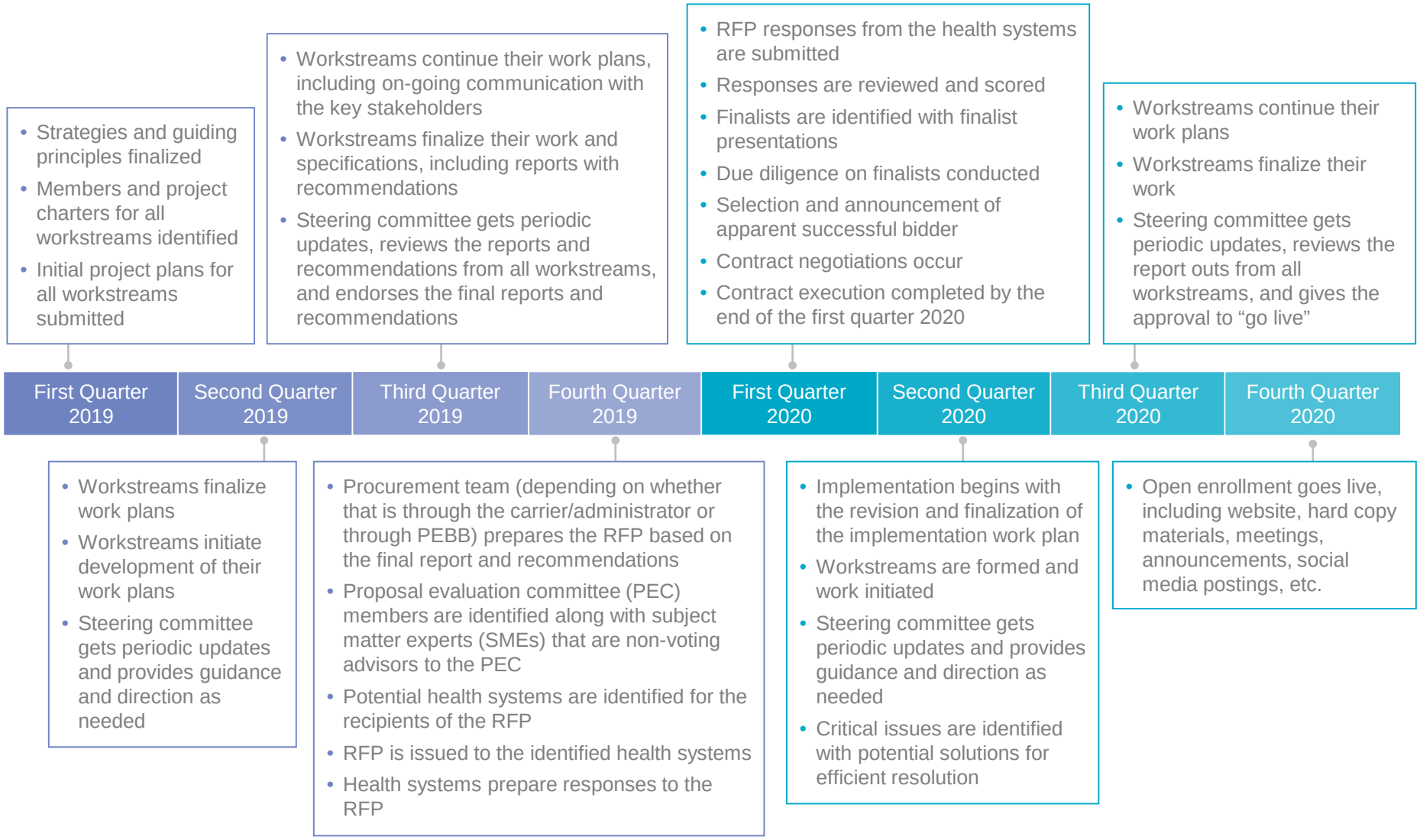
4. Require carrier to develop and administer full risk-bearing arrangement with health system

SUGGESTED STRUCTURE FOR ACO DEVELOPMENT

Steering Committee	• Provides leadership guidance for the developers of the ACO • Includes Board members, PEBB staff members, carrier/administrator, consultants, and other stakeholder leaders

Member Experience	Clinical, Quality, and Care Transformation	Integration, Data, and Operations
• Develops the communications strategies (e.g., website, open enrollment materials, etc.), benefit design, and other guiding principles for enhancing the member experience • Includes PEBB staff members, carrier/administrator, consumer representatives, consultants, and other stakeholders as necessary	• Develops the requirements for the clinical, care transformation, and quality measurements for the ACO • Includes PEBB staff members, carrier/administrator, medical leaders, quality directors, consultants, and other stakeholders as necessary	• Develops the protocols for integrating benefit vendors with the ACO, designs information sharing arrangements, and other operational aspects • Includes PEBB staff members, carrier/ administrator, information technology experts, consultants, and other stakeholders as necessary

ILLUSTRATIVE TIMELINE FOR ACO DEVELOPMENT



SAMPLE GAP ANALYSIS AND ACTION PLAN
BASED ON TYPICAL ACO TIMELINE

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

ACO BOARD INPUT
MEMBER SUCCESS MEASURES FOR AN ACO

Board was asked to rank order its top five from the following success measures from the *Member* perspective:

	POINTS
Receives comprehensive care for all physical and behavioral health needs	8.80
Less administrative hassle	8.25
Lower premium costs	8.00
Lower cost shares, such as lower co-pays, deductibles, and co-insurance	8.00
Has navigator support throughout the healthcare system	7.67
Easier access to healthcare providers	7.25
Feels respected and honored for personal preferences and values	6.75
Feels empowered and educated for self-care	5.00
Has multiple channel access to healthcare services and education	4.75
Gets whatever medication or healthcare service/procedure that is asked for	2.33
Other:	

*One abstention

ACO BOARD INPUT
PEBB'S SUCCESS MEASURES FOR AN ACO

Board was asked to rank order the following success measures from the *PEBB Board and Staff* perspective

	POINTS
Comprehensive reporting demonstrating the positive financial, clinical, and member/patient experience outcomes	4.80
Has all performance guarantees met by the ACO	4.67
Meets or exceeds financial targets	4.20
Minimal or no member complaints	3.40
Able to clearly articulate the value proposition of the ACO to all stakeholders resulting in achieving the desired ACO enrollment	3.00
Other:	

ACO BOARD INPUT

HEALTHCARE DELIVERY SYSTEM SUCCESS MEASURES FOR AN ACO

Board was asked to rank order the following success measures from the *PEBB Healthcare Delivery System* perspective

	POINTS
Demonstrated improvements in the clinical, financial, and member/patient experience outcomes	5.50
Able to meet or exceed all quality metrics and other targets while receiving the maximum financial rewards for performance	4.17
Incorporates systematic shared decision making (including patient decision aids) with patients resulting in improved clinical outcomes, empowered patients, and lower costs	4.00
Able to redesign clinical workflows with care teams and electronic health records (EHRs) to deliver efficient, effective, comprehensive, patient-centered, team-based care	3.80
Able to leverage the work with PEBB for other contracts and products with other plan sponsors	2.20
Increase volume of patients	1.75

ACO BOARD INPUT
CARRIER/ADMINISTRATOR SUCCESS MEASURES

Board was asked to rank order the following success measures from the *Carrier/Administrator* perspective

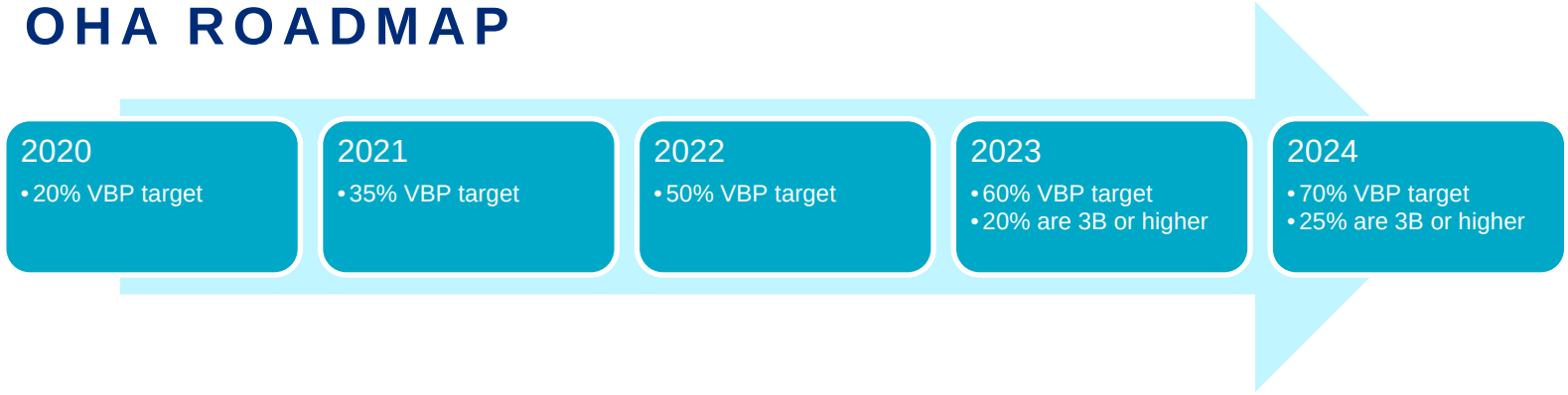
	POINTS
Able to meet or exceed all performance guarantees	4.83
Provides accurate, timely, and meaningful data with the ACO and all benefit vendors	4.40
Able to administer accurate, efficient, and timely value-based payments	4.25
Able to coordinate and integrate with the ACO for optimal and non-duplicative clinical management services	3.60
Able to leverage the ACO work with PEBB for other contracts and products with other plan sponsors	3.00
Provides timely and meaningful data on critical metrics	2.40

APPENDIX

ROADMAP FOR PEBB'S VALUE-BASED-PAYMENT STRATEGY

PEBB'S ROADMAP VS. OHA'S CCO 2.0

OHA ROADMAP

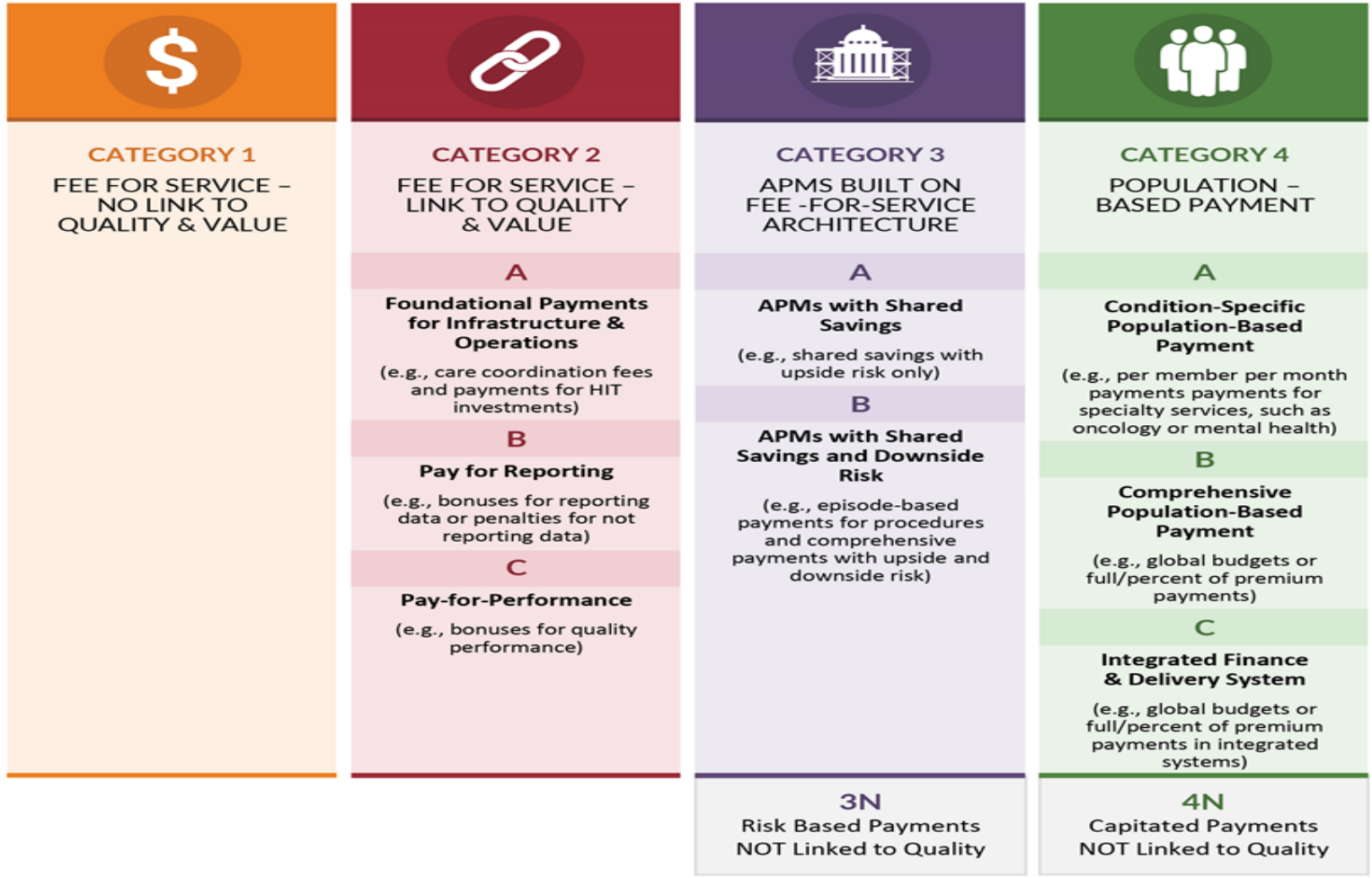


- OHA's CCO payments to providers must be in the form of a Value-Based-Payment (VBP) and fall within LAN Category 2C (Pay for Performance) or higher

PEBB DRAFT ROADMAP

- Mercer recommends PEBB consider more aggressive VBP targets:
  - 2021-2024: Minimum of Category 2C, transitioning to Category 3
  - By 2025: Category 3B or higher (APMs with Shared Savings and Downside Risk)
  - ACO/CCO will be required to have a minimum Category 4 payment model as soon as possible

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



Source: APM Framework, HCP-LAN,2017

APPENDIX

EXAMPLES OF ACO NETWORKS

MICROSOFT
THE HEALTH CONNECT PLAN

From Microsoft media release and employee newsletter:

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

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

BOEING
PREFERRED PARTNERSHIP

For eligible employees in the Puget Sound region

From Boeing's Preferred Partnership website for employees:

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

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

WASHINGTON HEALTHCARE AUTHORITY
UNIFORM MEDICAL PLAN (UMP)

From WA State HCA website

- **UMP Plus:**
  - UMP Plus has a lower deductible and monthly premiums than UMP Classic while offering most of the same benefits. The plan has no prescription drug deductible, and you pay nothing for primary care office visits with your network primary care provider. Other services received at the visit, like x-rays and labs, are covered the same as they are with UMP Classic. And all your UMP Plus network providers work together to give you the right care at the right time.
- **Employees choose between two ACO networks:**
  - UW Medicine Accountable Care Network
  - Puget Sound High Value Network
- **Advantages:**
  - Lower premiums than many other PEBB Program health plans.
  - Lower medical deductible than many other PEBB Program health plans.
  - No prescription drug deductible.
  - Lower out-of-pocket costs when using network providers.
  - Office visits with primary care providers at no charge.
  - Quick access to primary and specialty care.
  - Focus on wellness, such as screenings and preventive care.
  - Coordinated care between your providers for chronic conditions such as diabetes.
  - Providers with extended office hours.

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

APPENDIX

EXAMPLES OF OTHER STATE INITIATIVES

STRATEGY FOR ACTION
WHAT IS WASHINGTON DOING?
ACO AND BUNDLED PAYMENTS

	Targets / Enhances	Demonstrating Value
ACO	• Shared Risk Model • Member experience • Care transformation • Timely data • Incentives with benefit designs	• 17,000 members in 9 counties representing 52% growth between 2016 and 2017 • Both networks received 100% credit in 2016 for clinical quality improvement • 19,281 PCP visits • Range of member annual savings: Premium $300-$828; deductible up to $375 • 44% premium differential for 2018 • 89% member retention
Bundled Payment	• Concierge experience for members with total joint replacements • Virginia Mason designated COE through competitive procurement • Based on Bree Collaborative recommendations	• 10-15% cost savings first year of COE • About $1,000 out of pocket cost savings to member • 100% of members would use COE again and recommend it • 23 more members currently pursuing surgeries at COE • Expansion of COE to spinal fusions

STRATEGY FOR ACTION
RURAL PAYMENT STRATEGY

Vermont ACO Model	• Limits per capita health care growth to 3.5% annually • Focuses on outcomes and quality, specifically on access to care, substance abuse disorder, suicides, and chronic conditions
Pennsylvania	• Prospectively sets global budget for participating rural hospitals, based on historical revenue • Rural hospitals will redesign delivery of care to improve quality and meet health needs of local communities
Washington State	• Patient centered solutions to reward rural providers for value of care and incent based on improved outcomes • Address access and sustainability concerns along with community needs • Integrated delivery systems and redefine primary care for rural populations • Ensure that members are engaged with local health delivery systems • Create payments based on total cost of care with encounter-based payments

APPENDIX

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).

MERCER

MAKE TOMORROW, TODAY

OREGON PEBB BOARD MEETING

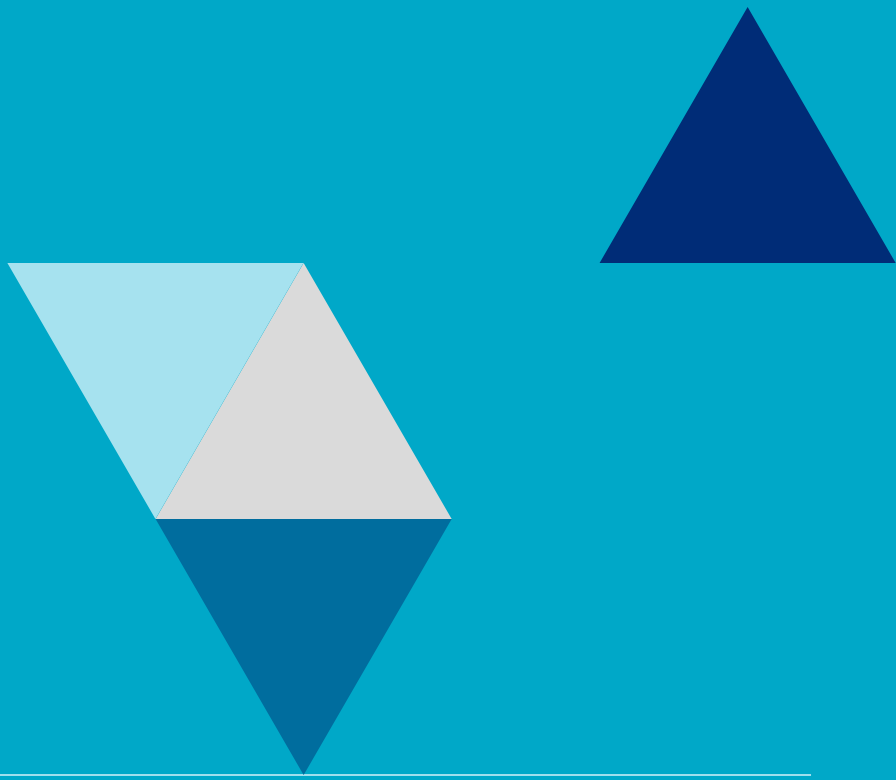
2020 RENEWAL RESULTS
ROUND 1

PB ATTACHMENT 3
FEBRUARY 19, 2019

2020 RENEWAL DISCUSSION
OVERVIEW AND AGENDA

1. Plan background
2. Medical Renewals
   - 2020 Financial Outlook
   - Renewal questions
3. Non-Medical Renewals
4. Next Steps
5. Appendix – Detailed Responses

PLAN BACKGROUND



BACKGROUND
OVERVIEW OF COVERAGE

CARRIER	LINE OF COVERAGE	FUNDING	2019 INCREASE	2020 INITIAL INCREASE
Kaiser Permanente	HMO	Fully-insured	2.9%	4.6%
Kaiser Permanente	Deductible	Fully-insured	2.9%	4.6%
Moda	Medical / Rx	Self-insured	4.0%	0.0%
Providence Choice	Medical / Rx	Self-insured	5.4%	1.3%
Providence Statewide	Medical / Rx	Self-insured	3.9%	5.8%
Delta Dental of Oregon	Dental	Self-insured	2.0%	4.8%
Kaiser Dental	Dental	Fully-insured	3.4%	1.1%
Willamette Dental Group	Dental	Fully-insured	3.4%	7.9%
Vision Service Plan	Vision	Self-insured	2.9%	-0.1%
The Standard	Life and Disability	Various	5.1%	0.0%
ASI Flex	FSA, Commuter	Service contract	0.0%	0.0%
Benefit Help Solutions	COBRA Administration	Service contract	0.0%	0.0%
Cascade	Employee Assistance Plan (EAP)	Service contract	0.0%	0.0%

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

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

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

2020 FINANCIAL OUTLOOK

KAISER MEDICAL

FULL-TIME HEM HMO RATES (PEPM)	2019	2020	% INCREASE
Employee	$775.67	$811.00	4.56%
Employee & Spouse/Partner	$1,551.35	$1,622.02	
Employee & Children	$1,318.64	$1,378.71	
Employee & Family	$2,094.32	$2,189.72	

FULL-TIME HEM DEDUCTIBLE RATES (PEPM)	2019	2020	% INCREASE
Employee	$708.54	$740.81	4.56%
Employee & Spouse/Partner	$1,417.09	$1,481.64	
Employee & Children	$1,204.53	$1,259.40	
Employee & Family	$1,913.08	$2,000.22	

- Factors Include:
  - Preliminary quote
  - 4.25% medical and pharmacy annual trend
  - The following fees:
    - $100.25 PEPM ($38.56 PMPM) medical retention, $24.75 PEPM ($9.52 PMPM) other benefits, $4.71 PEPM ($1.81 PMPM) group specific charges (Weight Watchers, flu shot clinic, commercial driver's exam), and assumes 1.5% OR State premium tax remains in place
  - $500,000 pooling point

MODA
SELF-FUNDED MEDICAL

Fees and Rates:

ASO PROPOSED FEES (PEPM)	2019	2020	% CHANGE
Moda	$75.97	$76.85	1.2%

Trend Assumptions:

6.5% **Medical Annual Trend**

10.0% **Rx Annual Trend**

Annualized Trend (Jan 2015 to Dec 2018):

5.5% **Medical Annual Trend**

9.7% **Rx Annual Trend**

PEPM Administration Fees:

• Base administration	$55.35
• Utilization Management	$7.12
• Disease Management	$1.10
• Health Coaching	$3.69
• Tobacco cessation services	$0.95
• Nurse line	$1.25
• Weight Management Program	$1.15
• Access Fees	$5.30
• Injectable Benefits Management	$0.94

MODA
MEDICAL — PRELIMINARY FULL-TIME RATES

PRELIMINARY PREMIUM RATES	2019	2020	% CHANGE
Employee	$705.58	$705.77	0.0%
Employee & Spouse/Partner	$1,411.16	$1,411.54	0.0%
Employee & Children	$1,199.49	$1,199.81	0.0%
Employee & Family	$1,905.07	$1,905.58	0.0%
Composite	$1,372.53	$1,372.91	0.0%

- Notes:
  - Rates do not include PEBB fees (consultant and admin)

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
  - Fees above do not include PEBB fees (consultant and admin)

PROVIDENCE
SELF-FUNDED MEDICAL

PRELIMINARY ESTIMATED RENEWAL	2019	2020	% CHANGE
Choice	$1,314	$1,331	1.3%
Statewide	$1,550	$1,641	5.8%

Projected Trend:

6.5% **Medical Annual Trend**

10.0% **Rx Annual Trend**

Annualized Trend (July 2014 – Dec. 2018):

CHOICE	STATEWIDE	
5.4%	7.0%	Medical
9.3%	10.1%	Rx

KEY COST DRIVERS

1

Risk scores continue to increase

- Choice increased 1.0% from 2013 to June 2018 on an annualized basis and 1.3% in the most recent 12 month period
- Statewide have increased 2.1% from 2013 to June 2018 on an annualized basis and 1.5% in the most recent period

2

Inpatient Costs

- Allowed costs per inpatient admission increased approximately 13% for Choice and 9% for Statewide
- Admits per 1000 decreased 8.5% and 1.9% for Choice and Statewide respectively

Trends continue to outpace 3.4% cap

- Providence's average PPO and EPO combined medical trend is 8.3%; pharmacy trend is 10.3%
- Trends for CDHP combined medical and pharmacy is 10.3%

PROVIDENCE
MEDICAL — PRELIMINARY FULL-TIME RATES

PRELIMINARY PREMIUM RATES (PEPM)	2019	2020	% CHANGE
Statewide			
Employee	$794.66	$840.90	5.8%
Employee & Spouse/Partner	$1,589.32	$1,681.80	5.8%
Employee & Children	$1,350.92	$1,429.52	5.8%
Employee & Family	$2,145.58	$2,270.42	5.8%
Choice			
Employee	$689.10	$697.73	1.3%
Employee & Spouse/Partner	$1,378.20	$1,395.46	1.3%
Employee & Children	$1,171.47	$1,186.14	1.3%
Employee & Family	$1,860.57	$1,883.87	1.3%

- Notes:
  - Rates do not include PEBB fees (consultant and admin)

MEDICAL

RENEWAL QUESTIONS

CARRIER RECOMMENDATIONS

PROVIDENCE Health Plan

- Implement PT/OT medical necessity review after the 12th visit
- Expand spinal manipulation benefit to include massage therapy
- Emphasize value-based payment contracting strategies
- Promote benefit differential between outpatient hospital services and ASCs

moda HEALTH

- Continue to mature and align its efforts on value-based-care
- Increased quality of care with services delivered through recognized medical homes (PCPCHs) and implementing CPC+
- Change specialty medications under medical benefit to be 20% coinsurance
- Shift medical infused medications to be under the pharmacy benefit

KAISER PERMANENTE®

- Expansion of telehealth services:
  - Virtual urgent care
  - Video consults
  - Text messaging capabilities
  - Mobile health partners
  - Development of AI
- Utilization Management
  - Reducing practice variability
  - Decreasing rates for inpatient and ER
  - Optimizing pharmacy

CARRIER TOP RECOMMENDATIONS DETAILS

PROVIDENCE Health Plan

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1	• For their commercial book of business, Providence is partnering with eviCore to implement PT/OT medical necessity and treatment appropriateness review for services after the 12th visit. Goal is to reduce costs and increase the quality of care by leveraging clinical evidence based guidelines coupled with specialized professional expert reviewers. – PEBB members would still have access to the 60 visits, but after the 12th visit, the treatment would be reviewed by eviCore – **Cost: +$0.35 PEPM to the administrative fee** – **Estimated Savings: -0.3% or $2 million prior to administrative fee**
Recommendation and/or Observation #2	• Expand spinal manipulation benefit to include massage therapy subject to the existing benefit limitations. – PEBB's alternative care benefit includes coverage for spinal manipulation and acupuncture but excludes massage therapy – PEBB's benefits only allow for minimal units of massage when submitted in conjunction with spinal manipulation – Adding massage therapy as a benefit may encourage members to seek this lower-cost treatment for addressing anxiety, stress, and pain – **Estimated cost: +1% or $7 million**
Recommendation and/or Observation #3	• Emphasize value-based payment contracting strategies that align targets with CCO 2.0 metrics, Patient-Centered Primary Care Home (PCPCH) standards, and other multi-payer initiatives. – PEBB can support provider participation in community collaboratives such as the initiative in Salem where an incentive around Total Cost of Care is tied to meeting a 3.4% year-over-year total cost of care target coupled with an incentive around quality metrics
Recommendation and/or Observation #4	• Promote benefit differential between outpatient hospital services and ASCs allowing outpatient procedures to be delivered in lower cost settings. – This differential should be considered for radiology services as well – Hospitals participating in community collaboratives with risk tied to 3.4% would be covered at the same benefit level as free standing radiology centers

CARRIER TOP RECOMMENDATIONS DETAILS

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1	• Value-Based Care (VBC) – Moda will continue to mature and align its efforts on value based care – Currently, all Moda PEBB members are in a VBC model of care, which includes elements of shared risk, quality payments, and care management fees – As PEBB and OHA develop goals for the percentage of payments to be made under a VBC arrangement and any categorization of these payments using the LAN VBC framework, Moda will work with PEBB to align its efforts
Recommendation and/or Observation #2	• Primary Care Focus – Moda has seen success in terms of cost savings and increased quality of care with services delivered through recognized medical homes (PCPCHs) – Included in Moda's contract with PEBB are quality metrics related to the number of members served by a PCPCH – Based on these elements, Moda would like to engage more members with recognized PCPCH's – This can happen through a combination of benefit design and member outreach in partnership with PEBB
Recommendation and/or Observation #3	• Pharmacy: Change specialty medications under medical benefit to be 20% coinsurance – PEBB's current benefit design incentivizes members to utilize infused, provider-administered medications under the medical benefit, which are almost always more costly than self-administered medications covered under the pharmacy benefit – The current copay is $5 for infusion drugs, which represents a 0.12% cost share. – Nearly all of the medial benefit drug spend is for specialty drugs, which also have a $5 copay, however, specialty medications covered under the pharmacy benefit have a $100 copay – This creates an incentive for members to seek treatment with a more costly infused medication than an oral or self-injectable medication that has lower cost, yet comparable safety and efficacy – The 20% coinsurance would result in a -0.3% claims impact
Recommendation and/or Observation #4	• Pharmacy: Shift medical infused medications under the pharmacy benefit – Moda recommends PEBB opt into the Pharmacy Benefit Optimization program, which shifts the reimbursement of select infused specialty medications from the medical benefit to the pharmacy benefit – By doing this, reimbursement becomes a fixed percentage of the average wholesale price (AWP) of a drug, so drug cost is predictable and significantly lower than when paid under the medical benefit – Members could continue to see the same provider and receive their infusion at the same location, but the medication would be supplied to the infusion location by a specialty pharmacy rather than the provider going through their own process – The program would result in a -0.28% claims impact

CARRIER TOP RECOMMENDATIONS DETAILS

Question: *Based on what you know about the PEBB membership, where do the biggest opportunities lie and what are the top three to five strategies your organization recommends PEBB pursue in partnership with you to advance quality, care experience, and cost goals?*

Recommendation and/or Observation #1

Telehealth

- Telehealth services allow KP members to access services conveniently and cost effectively
- Contrary to typical plan telehealth deployments, every encounter – phone, email, video – is completed with KP's e-portal and documented in the members' electronic medical record (EMR), so KP clinicians have a complete picture of members' health, deliver a better member experience, and resolve issues more efficiently
- Telephonic care and video visits are less expensive and can satisfy member needs without defaulting to more expensive face-to-face visits
- Kaiser is making investments in these areas:
  - Expansion of Virtual Urgent Care
  - Implementing Video consults in specialty departments including Palliative Care, Ophthalmology, Oncology, and Orthopedic Cast Room
  - Providing telehealth options for Inpatient and Continuing Care Services
  - Text messaging for appointment reminders and cancer screening care gap scheduling reminders
  - Mobile Health Partners (MHP) paramedic services offering select appointment services at member's home or offices
  - Adoption of new programs in 2019: Deployment of AI supported virtual-urgent care visit and "Chat with a Doc" program to augment real time telehealth services

VISIT TYPE	OUTPATIENT VISITS	TOTAL PAID CLAIMS PMPM	COST PER OUTPATIENT VISIT
Office Visit	74,141	$54.46	$209.91
Virtual Care Visit	14,078	$2.06	$41.76
Total	88,214	$56.52	$183.09

Recommendation and/or Observation #2

Utilization Management

- Kaiser is focusing on the following elements from their operating plan:
  - Reducing practice variability
  - Decreasing day rate (days/1000) of inpatient care and ER use
  - Optimizing pharmacy cost via use of mail order pharmacy; optimizing use of specialty and infused medications; and optimizing site of service for medication delivery as clinically appropriate, convenient, and cost efficient for KP members
  - Reduce cost per service by increasing virtual care while reducing outpatient utilization
- Kaiser is seeing movement with virtual dermatology, outpatient total joint replacement, reducing length of stay in KP hospitals, and reducing readmissions

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

IMPORTANT NETWORK CHANGES FOR 2020

NETWORK CHANGES

Question: *Describe any changes to your network and intended partners for 2020. Detail new providers and financial implications of these proposed changes. Please also provide any major hospital or physician groups with open contracts or those that are up for negotiation*

PROVIDENCE Health Plan

- Effective January 1, 2019, First Health replaced PHCS/Multiplan as Providence's national wrap network and First Choice Health Network (FCHN) replaced BrightPath in Idaho, Montana, Alaska outside of Providence's domestic facilities
- Benefits include
  - 17% more in-network hospital
  - 22,000 more ancillary facilities
  - Access to 873,000 providers and facilities nationwide

moda HEALTH

- Effective January 1, 2020, Moda is proposing to use its broadest network, Connexus
- Connexus includes more PCPCH and CPC+ providers
  - Moda's approach will be to focus on high performing primary care clinics
- Connexus will add Providence Health System and its associated providers, pending further conversations with Providence
- The effect for PEBB members will be that some existing primary care clinics will no longer be available for members to select their primary care medical home

KAISER PERMANENTE®

- Kaiser does not anticipate any changes to KPNW's contracted network as of January 1, 2020
- Salem hospital is up for renewal 10/1/2020, but Kaiser fully-expects a long-term renewal
- Expanding behavioral health network and anticipate new contracts effective January 1, 2020

IMPORTANT NETWORK CHANGES FOR 2020
SERVICE AREA CHANGES

Question: *Describe any service area changes PEBB should consider for the 2020 plan year*

PROVIDENCE Health Plan

- Providence is not proposing any service area changes for Choice or Statewide at this time

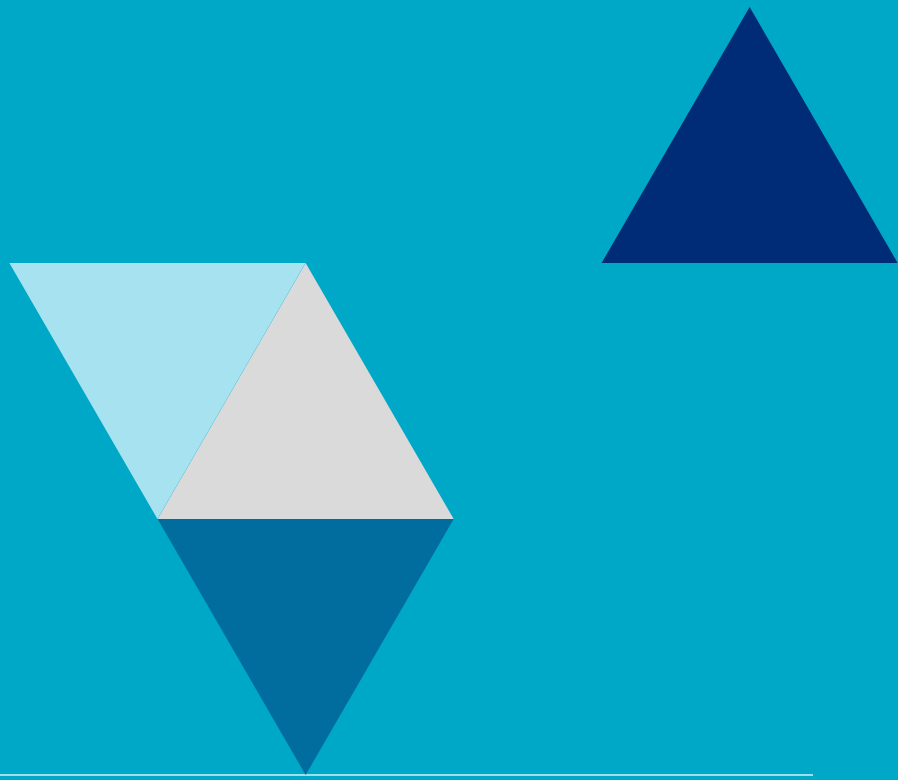
moda HEALTH

- Moda is not proposing any service area changes for the 2020 plan year at this time

KAISER PERMANENTE®

- Kaiser is not planning on service area expansion, but they are adding to their current service area:
  - Newberg – KP PCP is providing primary care access at Newberg Urgent Care. KP members will also have access to Newberg Urgent Care
  - McMinnville – KP will provide access to KP Primary Care Providers and other specialty care services through KP, Willamette Valley Eye Clinic, Salem Health, and Doernbecher Children's Hospital.
  - Beaverton MRI Expansion – New unit will improve region wide access later in 2019

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

2020 DENTAL RENEWAL PROPOSAL
DELTA DENTAL OF OREGON

2020 COMPOSITE BUDGET RATES

Delta Dental of Oregon	2019	2020	Increase % / $	
Traditional	$111.93	$117.31	4.8%	$1,249,000
Preferred	$101.18	$106.05	4.8%	$884,000
Part-Time	$74.28	$77.86	4.8%	$15,000
Combined	$106.87	$112.02	4.8%	$2,148,000

Assumptions

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

2020 PLAN DESIGN CONSIDERATIONS

Former Benefit	New Benefit	Financial Impact	Mercer Comments
• 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**	• +1.0% of premium or $468,000	• Recommend, depending on composite rate
• 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% of premium or ($117,000)	• Recommend
• Brush biopsy was not covered	• Brush biopsy **covered twice in a 12-month period**	• +0.06% of premium or $28,000	• Recommend
• 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. This was limited to once every 7 years	• 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 were covered. This is limited to **once per lifetime**	• -0.1% of premium or ($47,000)	• Recommend

For a complete list of plan design considerations, refer to the Appendix. The rest of the changes have negligible claims impact

2020 DENTAL RENEWAL PROPOSAL
KAISER DENTAL

2020 COMPOSITE BUDGET RATES

Kaiser	2019	2020	Increase % / $	
Full Time Rates • EE Only • EE + SP • EE + CH • EE+ FAM • CH Only	**$118.43** • $63.45 • $126.90 • $107.87 • $171.32 • $51.14	**$119.77** • $64.17 • $128.34 • $109.09 • $173.26 • $51.72	1.1%	$92,000
Part Time Rates • EE Only • EE + SP • EE + CH • EE + FAM • CH Only	**$90.20** • $47.32 • $94.64 • $80.45 • $127.77 • $38.09	**$91.23** • $47.86 • $95.72 • $81.37 • $129.23 • $38.52	1.1%	$1,000
Combined	**$118.11**	**$119.44**	**1.1%**	**$93,000**

Assumptions

- Status Quo Plan Design
- 5.5% trend being used, with data through October 2018
- No change in retention costs (administration)
- Composite calculated with January 2019 Enrollment

2020 PLAN DESIGN CONSIDERATIONS

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

2020 DENTAL RENEWAL PROPOSAL
WILLAMETTE DENTAL GROUP (WDG)

Willamette Dental Group

2020 COMPOSITE BUDGET RATES

Willamette	2019	2020	Increase % / $
Full Time and Part Time	$100.78	$108.75	7.9% / $1,151,000

Note:
- Large increases will continue until population stabilizes, or new members are offset by those enrolled over time

Notes and Assumptions

Willamette's preliminary status quo 2020 renewal offer represents a **7.9%** increase based on the following:
- Increase of over 2,500 new members between January 2018 and December 2018; new members cost 197% more in Year 1 versus Year 2
- Utilization for orthodontia increased 54%; crowns up 22%; fillings up 19%
- Underwriting calculation calls for a 20.2% increase
- 5.9% trend being used, with data through December 2018
- Underwriting was provided with and without the ACA tax of 1.9%; due to the rate concession, the $2.21 PEPM for 2020 does not impact the renewal

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	• -1.4% of premium or $207,000	• Required by WDG-underwritten plans
• Chronic Condition Dental Management Program	• No demonstrated ROI	• Not recommended

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

2020 VISION RENEWAL PROPOSAL
VISION SERVICE PLAN (VSP)

2020 COMPOSITE BUDGET RATES

VSP	2019	2020	Increase % / $	
Base	$17.56	$17.54	-0.1%	($8,000)
Buy-Up	$26.34	$26.32	-0.1%	($3,000)
Combined	$20.12	$19.72	-0.1%	($11,000)

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

ADMINISTRATION

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

- Second year of three-year rate guarantee

2019 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
	  • $298,000 for all Base + Buy-up
	  • $102,000 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

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

2020 EAP RENEWAL PROPOSAL
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:

WholeLifeDirections
Journey to the Best You

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

LIFE & DISABILITY
THE STANDARD

- 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.

FLEXIBLE SPENDING ACCOUNT AND COMMUTER BENEFITS ADMINISTRATION

ASIFLEX

	RATE INCREASE
FSA and Commuter Administration	Rate Pass

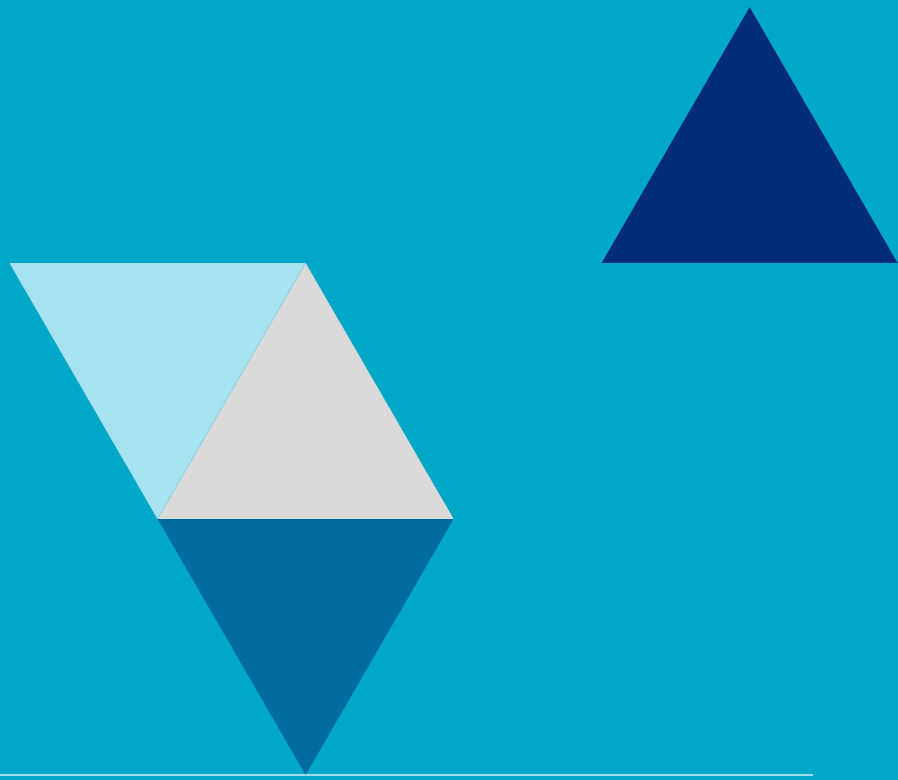
ITEM	FEE
Set Up Fee • Initial Plan Year • Renewal Plan Year	Waived
Monthly Administration PPPM	$2.95
Optional ASIFlex Card PPPM • Replacement or additional card sets	Included • $5.00 billed to participant FSA
Employee Communication • PDF documents • WebEx group meetings • Onsite Enrollment Meetings	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

COBRA ADMINISTRATION
BENEFIT HEALTH SOLUTIONS (BHS)

	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

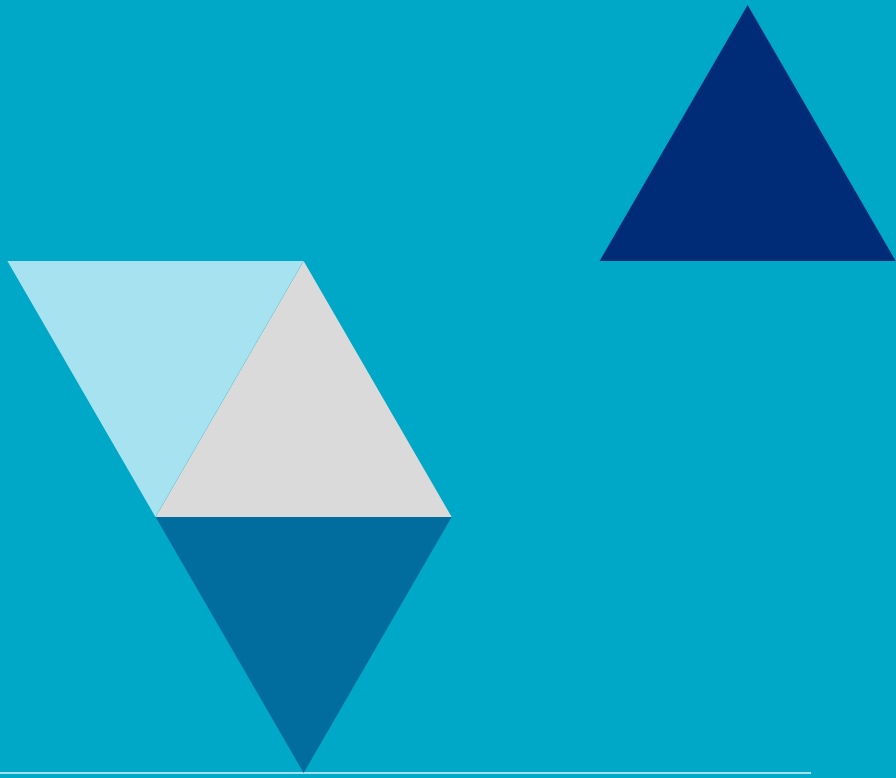
NEXT STEPS



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 CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations 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.	Delta Dental processing policy.	negligible
Benefits and Limitations 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.	Delta Dental processing policy.	negligible
Benefits and Limitations 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.	The retreatment is included in the charge for the original care.	negligible
Benefits and Limitations Oral surgical services	Osseous surgery was covered subject to consultant review.	Osseous surgery is limited to 2 quadrants per date of service.	Delta Dental processing policy.	negligible

BENEFIT CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations 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. Benefits for bone replacement grafts are not covered when submitted with apicoectomy sites, implants, mucogingival/soft tissue grafts, periradicular surgery, ridge augmentation or preservation procedures, sinus elevation, defects from cyst removal, hemisections or with extractions.	Delta Dental processing policy. This procedure does not occur often.	negligible
Benefits and Limitations 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.	Delta Dental processing policy.	-0.25%
Benefits and Limitations 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.	Delta Dental processing policy. Usually there are underlying issues with the implant or abutment if additional re-cementing or re-bonding is made.	negligible

BENEFIT CHANGES
DELTA DENTAL PROCESSING GUIDELINES

REFERENCE	FORMER BENEFIT	NEW BENEFIT	EXPLANATION	CLAIMS IMPACT*
Benefits and Limitations Restorative services	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.	Composite fillings on posterior teeth is standard dental practice.	+1%
Benefits and Limitations Oral surgical services	Brush biopsy was not covered	Brush biopsy is covered twice in a 12-month period.	This procedure plays a role in the early detection of oral pre-cancers and cancers.	0.06%
Benefits and Limitations Prosthodontal 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.	With more data and implant designs more advanced, the frequency for final crown and abutment can be per lifetime with continual maintenance.	-0.1%

MERCER

MAKE TOMORROW, TODAY