2018

SB 1067 Executive Committee Report








Oregon Health Authority

oebb

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

Contents

1.0 Executive summary

This Executive Summary and full report is submitted in response to Senate Bill 1067 (2017 legislative session), which directed the Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB) to develop a report that plans for the orderly merger of the functions and operations of the two boards, for submission and presentation at the 2018 February legislative session. OEBB and PEBB staff worked with the boards to establish and appoint a joint "SB 1067 Committee" per the direction in the bill, comprised of equal representation of OEBB and PEBB board members as well as management and labor representation. The SB 1067 Committee was charged with the study, deliberation and creation of a report that met the intent of the legislation of "merging the functions and operations" of the two boards, "to avoid duplication of effort and to promote efficiency" across both programs.

PEBB and OEBB are similar in many aspects, but different in just as many. The PEBB and OEBB boards both serve populations and constituencies providing public service to the taxpayers of Oregon. Both offer medical, dental, vision, life, disability and accidental death and dismemberment benefit plans. However, PEBB is a Section 125 Cafeteria Plan benefits program that is required to offer the same benefits to all members. OEBB offers a multitude of different benefit plan options that each educational entity can select from and offer to their employees. OEBB resembles an "exchange" of plan offerings rather than a Cafeteria Plan.

The challenges in merging two very complex, self-directed boards are immense. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk. The committee considered a number of board models and frameworks, reviewed qualitative and quantitative input and data, and considered each option carefully. Eventually, the committee chose three board structure models that fit the criteria they were looking for while maintaining stakeholder representation with varying levels of program "disruption." All three board model options are similar in the amount of cost savings they could potentially generate. The committee embarked on a thorough analysis and discussion of each board model option, identifying important factors that would either aid or impede achieving the desired outcome:

Board Model Option 1: A full merger of the OEBB and PEBB boards into one combined board. The legal and governance structures of the OEBB and PEBB boards would sunset and new statutory authority would be required to establish the new joint board legal and governance structure. All contracts, rules, policies and business processes would need to be re-done. High rate of disruption.

Board Model Option 2: Create a merged "oversight" board while maintaining OEBB and PEBB boards as "subgroups." A merged oversight board would be the new legal and governance structure over the OEBB and PEBB board subgroups. All contracts, rules, policies and business processes would need to be re-done. High rate of disruption.

Board Model Option 3 (see Appendix A): A hybrid merger of the OEBB and PEBB boards. The boards maintain their separate legal structure and governance, and create a combined "innovation" subgroup of the OEBB and PEBB boards and a "shared services" subgroup for administrative efficiencies. Most contracts, rules, policies and business processes would remain, focus could be on reducing claims and utilization. Low rate of disruption, most efficient model.

After much deliberation, the SB 1067 Committee unanimously adopted Board Model Option 3 as the joint board model that meets the intent of the legislation and sets both boards on a path of "joint" strategic collaboration in meeting the challenges of controlling the costs of health care, improving quality of care, and becoming more efficient. Throughout the deliberation and analysis process, staff and consultants were able to identify several areas where efficiencies could be gained and savings could be generated. They noted from a benefits plan cost perspective that any assumed savings in costs, simply by combining two uniquely different risk pools of 150,000 lives into one pool of 300,000 lives, is quite low relative to the total combined benefit plan costs for OEBB and PEBB. In summary, the expected claims costs of the combined risk pool—with no other changes—would not decrease from what the separate pools generate. The finding was the largest opportunity for savings would be generated by increasing efficiencies of claims and utilization through benefit plan design, choice of plan offerings, utilization and disease management efforts, provider and pharmacy reimbursement models and advancement of organized systems of care. These combined efforts to increase efficiencies in claims and utilization would require coordination between the boards. Therefore, the SB 1067 committee adopted the concept of a new joint collaborative subgroup referred to as the OEBB and PEBB "Joint Innovation Subgroup."

The Joint Innovation Subgroup would be created as a joint OEBB and PEBB subcommittee that will exist as a platform of exploration for the OEBB and PEBB boards, their carrier partners and other stakeholders. The platform would explore initiatives for measuring and improving quality of care, encouraging the development of efficient models of care and driving efforts to ensure cost-effective care treatment protocols are followed. The Joint Innovation Subgroup will foster creativity and innovation in solving many health-care-related challenges, including the triple aim goals of improving population health, improving the patient experience of care and reducing the cost of healthcare.

The Joint Innovation Subgroup will conduct various levels of analysis focused on exploring opportunities in the areas of provider and pharmacy contracting, innovative payment methodologies, clinical management programs, plan design and plan offerings, funding options, risk management strategies and so on. The concept will be a "win-win" initiative for both programs.

From an administrative perspective, the merger of OEBB and PEBB staff members has already started, so it does not result in a fundamental shift in the values or culture that currently exists in the programs. Merging administrations offers an opportunity to review the mix of staff and administrative knowledge, skills and abilities. It would not reduce the size of the populations served nor resolve their disparate needs. The OEBB and PEBB director has already developed a work plan to reorganize OEBB and PEBB staff into one functional division instead of two separate programs. This consists of merging and cross-training operational teams that are not already merged. Currently each program has its own member services, communications, systems and program administration staff. Per SB 1067, the OEBB and PEBB director will report annually to the Ways and Means Committee on the progress of merging the functions and operations of the boards.

This report also contains an analysis of the separate issue of merging of OEBB and PEBB risk pools. The analysis shows minimal savings and significant challenges for this possibility. See section 6.0 Fiscal Analysis.

2.0 Overview

Senate Bill 1067 (SB 1067) was enacted by the Oregon Legislature in the 2017 legislative session. SB 1067 is referred to as the "cost containment" bill whose purpose is to reduce and control costs across state government. SB 1067 includes cost containment measures directed at several state agencies. It directs several measures at the Oregon Educators Benefit Board (OEBB) and Public Employees' Benefit Board (PEBB), which this report will address in detail. OEBB and PEBB are programs under the Oregon Health Authority.

SB 1067's main deliverable for OEBB and PEBB requires them to create a joint executive committee comprising equal members from each board. The joint committee is charged with developing a report with a plan for the orderly merger of the "functions and operations" of the two boards. The report must be accompanied by a fiscal analysis and shall be presented to the Joint Committee on Ways and Means by February 1, 2018. The intent behind merging the functions and operations of the two boards is "to avoid duplication of effort and to promote efficiency" across both programs.

SB 1067 has several other provisions that will have a significant impact on OEBB and PEBB programs in the coming years. For example, the bill's following directives are to be implemented by October 1, 2019, for OEBB and January 1, 2020, for PEBB:

- Appointing the PEBB executive director to also serve as the OEBB executive director in a permanent capacity. Note: this has been completed.
- The OEBB/PEBB executive director to combine administrative and operational functions of the boards and report to the Legislature annually on the progress.
- A dependent eligibility audit must be performed by a third-party administrator every year.
- A request for proposals (RFP) for actuarial services must be completed every three years.
- The adoption of policies and procedures that limit annual premium increases and per member per month costs to a 3.4 percent cap.
- Limiting in-network hospital reimbursements to 200 percent of Medicare and out-of-network hospital reimbursements to 185 percent of Medicare (with certain exceptions).

- Prohibits "opt-out" for full cash incentives in lieu of coverage for OEBB or PEBB employees enrolled as a dependent on another OEBB or PEBB plan.
- Prohibits "double-coverage" for OEBB or PEBB employees who enroll as a subscriber on an OEBB or PEBB plan when already enrolled as a dependent on another OEBB or PEBB plan.

Executive committee composition

SB 1067 Committee Member	Committee Representation	OEBB/PEBB Representation
Shaun Parkman	Chair	PEBB Vice-Chair
Geoff Brown	Vice-Chair	OEBB Chair
Cherie Maas-Anderson	Committee Member	OEBB Vice-Chair
Ron Gallinat	Committee Member	OEBB Board Member
John Larson	Committee Member	OEBB Board Member
Mark Perlman	Committee Member	PEBB Board Member
Bill Barr	Committee Member	PEBB Board Member
Senator Betsy Johnson	Committee Member	PEBB ex officio (non-voting)

The SB 1067 Committee was designed and implemented with transparency in mind. The committee served as a primary vehicle for engaging and empowering a wide range of stakeholder interests. Staff and the committee worked closely with labor unions, the Executive Branch agencies, universities and educational entities among other stakeholders to help engage the joint board-appointed committee in meaningful discussions on the merging of OEBB and PEBB. The committee reached consensus in every meeting before moving forward.

3.0 Background

Oregon Educators Benefit Board (OEBB)

Enabling legislation: OEBB's authority lies in ORS 243.860 through ORS 243.886. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts.

The Oregon Educators Benefit Board was established by the 2007 Legislature. The purpose in creating OEBB was to eliminate the wide-ranging disparities between health plans offered by school districts and to respond to the rapidly rising costs of health care. A statewide pool such as OEBB creates purchasing power and avoids unstable premium swings experienced by school districts with volatile claims experience. Streamlining administration and eliminating third-party fees and duplication of work were also large cost savers upon the formation of OEBB. School districts benefit from cost predictability and controlling of expenditures year-over-year. Since its inception in 2008, OEBB's average annual premium cost to members has increased at 2.9 percent annually.

OEBB provides a comprehensive selection of benefit plan options for most of Oregon's K-12 school districts, education service districts and community colleges, as well as a number of charter schools and local governments across the state. OEBB offers a multitude of plans that resembles an "Exchange." OEBB started offering medical, dental, and vision coverage in 2008 and has since added a broad range of additional benefits including life, accidental death and dismemberment (AD&D), short-term and long-term disability and long-term care insurance, as well as an employee assistance program (EAP), a health savings account (HSA), flexible spending accounts (FSAs), and commuter savings accounts. Each of the 249 employer entities OEBB serves maintains a unique service area, eligibility requirements, cost sharing, and population. OEBB's plans are designed to be flexible and accommodate the needs of all employers participating in OEBB and the members enrolled in OEBB plans.

OEBB provides benefits for 152,585 individuals, including actively employed and retired subscribers and their dependents.

Public Employees' Benefit Board (PEBB)

Enabling legislation: PEBB's authority lies in ORS 243.061 through ORS 243.302. House Bill 2279 (2013) expanded participation eligibility to include local governments and special districts.

As directed by the 1997 Legislature, the Public Employees' Benefit Board (PEBB) was established in 1998 to merge the State Employees' Benefit Board (SEBB) and the Bargaining Unit Benefits Board (BUBB) programs into one program. PEBB's mission is to provide a high-quality plan of health and other benefits for state employees at a cost that is affordable to both the employees and the state. Its statutes create an eight-member board whose members are appointed by the Governor and confirmed by the Senate. PEBB serves broadly diverse constituencies, including the State of Oregon (as an employer), employees who live and work in every county of the state, the Legislature, taxpayers, labor unions and health policy groups.

PEBB designs, contracts for and administers health plans, group policies and flexible spending accounts for PEBB members. More than 139,473 Oregonians are enrolled as PEBB members. They include active employees, spouse and domestic partner dependents, child dependents up to age 26, and adult children with disabilities over age 26, from: state agencies, universities, Lottery and semi-independent agencies, and local governments and special districts.

As with OEBB, the PEBB Board has made significant contributions in health care delivery system reform. Several years ago the PEBB Board adopted a strategic vision to guide its work and has been able to accomplish many of its goals. The board continues to focus on:

- Creating an innovative delivery system in communities statewide that provides evidence-based medicine to maximize health care access and use dollars wisely.
- Continually improving health care quality and outcomes, rather than just providing health care.
- Promotion of consumer education, healthy behaviors and informed choices.
- Appropriate market and consumer incentives that encourage the right care at the right time.
- System-wide transparency in reporting of costs, outcomes and other useful data.

PEBB has saved over $100 million since moving to self-insurance in 2010. This is detailed in Appendix C.

4.0 OEBB and PEBB program comparison

The following matrices compare the composition and representation of the boards, stakeholder groups, cost sharing structures, demographics, administration of plans, and plan design/plan offerings. The two boards have many similarities and just as many differences. The more significant differences include the "local rule" culture of school districts versus the umbrella of state agencies under the three branches of state government (executive, legislative and judicial).

Current board seats

OEBB	PEBB
2 members district boards	2 OHA management reps
2 members district management	2 non-OHA management reps
2 members largest union (OEA)	2 members largest union (SEIU)
1 member second largest union (OSEA)	1 member second largest union (AFSCME)
1 member from another union	1 member from another union
2 members with health policy / risk mgmt experience	1 non-voting member of State Senate
1 local government management	1 non-voting member of State House of Representatives
1 local government labor	

	OEBB	PEBB
Plan Year	Oct 1 – Sept 30	Jan 1 – Dec 31

Employers	• Approx. 250 individual employers:
	  • School districts
	  • Education service districts
	  • Community colleges
	  • Counties
		• State agencies
		• Lottery
		• Universities
		• Semi-independent agencies
		• Other special districts

	OEBB	PEBB
Enrollment	**March 2017 Census:** 63,003 (41.3%) Subscribers 89,582 (58.7%) Dependents 152,585 Total lives **Subscribers by plan:** 11,679 (18.5%) Kaiser 15,195 (24.1%) Moda Synergy Summit 26,744 (42.4%) Moda PPO 3,659 (5.9%) Waive Medical 5,726 (9.1%) Medical Opt out	**March 2017 Census:** 54,544 (39.1%) Subscribers 84,929 (60.9%) Dependents 139,473 Total lives **Subscribers by plan:** 9.023 (16.5%) Kaiser 2,778 (5.1%) Moda Synergy Summit 17,948 (32.9%) Providence Choice 20,747 (38.0%) PEBB Statewide 478 (0.9%) Waive Medical 2,734 (5.0%) Medical Opt Out 836 (1.5%) AllCare (*Plan is not offered in 2018)
Enrollment System	• Employees and employers have access to update records • Invoices are sent to employers for collection of premiums	• Employees and employers have access to update records • System interfaces with 5 payroll centers for collection of premiums
Contribution	• Each employer determines contribution amount • Employer collects employee contribution and sends to OEBB with employer portion	• Agencies pay 95% or 99%, depending on plan chosen • Universities pay 95% or 97% depending on plan choice • Payroll systems collect employee and employer portion and forward to PEBB
Plan Offerings	Operates like an exchange. Employers can choose to offer all the plans listed below or a subset of plans. Plan offerings are determined by insurance committees, employer/employee committees, collective bargaining negotiations. **Medical:** • Kaiser HMO (1 plan design) • Kaiser Deductible HMO (2 plan designs, 1 requires an HSA) • Moda Synergy/Summit CCM (5 plan designs, 1 requires an HSA) • Moda PPO; (4 plan designs, including one high deductible health plan HSA compliant) • Bronze plan for employees eligible due to part-time status (1 plan design) • Part-time plans also available **Dental:** • Delta Dental Premier (3 plan design) • Delta Dental Exclusive Provider Organization (EPO) (1 plan design) • Kaiser HMO (1 plan design) • Willamette Dental Group HMO (1 plan design) **Vision:** • Kaiser HMO (1 plan design) • Moda (3 plan designs) • VSP (2 plan designs)	IRS Section 125 Cafeteria Plan All employers must offer all plans. **Medical:** • Kaiser HMO (1 plan design) • Kaiser Deductible HMO (1 plan design, no HSA) • Moda Synergy/Summit CCM (1 plan design) • Providence Choice CCM (1 plan design) • PEBB Statewide PPO (1 plan design) • Part-time plans also available **Dental:** • Delta Dental PPO (1 plan design) • Delta Dental Premier (1 plan design) • Kaiser HMO (1 plan design) • Willamette Dental Group HMO (1 plan design) **Vision:** • Kaiser HMO (1 plan design) • VSP (2 plan designs)

5.0 Joint board model selection process

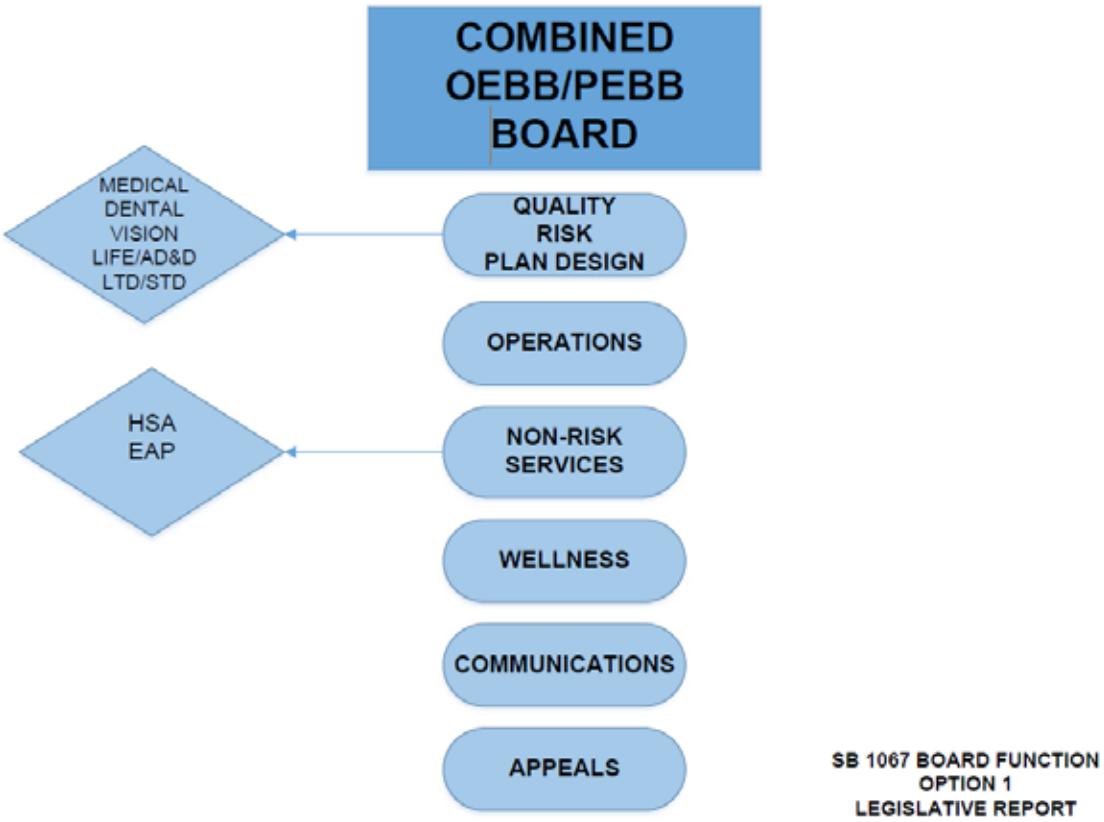
The SB 1067 Committee discussed three joint board models for merging the two boards over the course of seven committee meetings beginning in August 2017 and concluding in December 2017. The goals of the committee reflect those as directed in SB 1067: to reduce overall costs, create efficiencies and eliminate duplication in the OEBB and PEBB programs. The desired outcome of the committee was to accomplish those goals while still maintaining a "member group focus" so all OEBB and PEBB member and stakeholder needs are met. The 3.4 percent expenditure goal the boards have been working under for the past few years is now in statute and will continue to be considered a guiding principle of any current and future board discussions.

The challenges in merging two very complex, self-directed boards are immense. The SB 1067 Committee grappled with striking a balance between gaining efficiencies, limiting member disruption, ensuring financial sustainability and managing risk. From an administrative perspective, the merger of OEBB and PEBB staff members has already started so it does not result in a fundamental shift in the programs' existing values or culture.

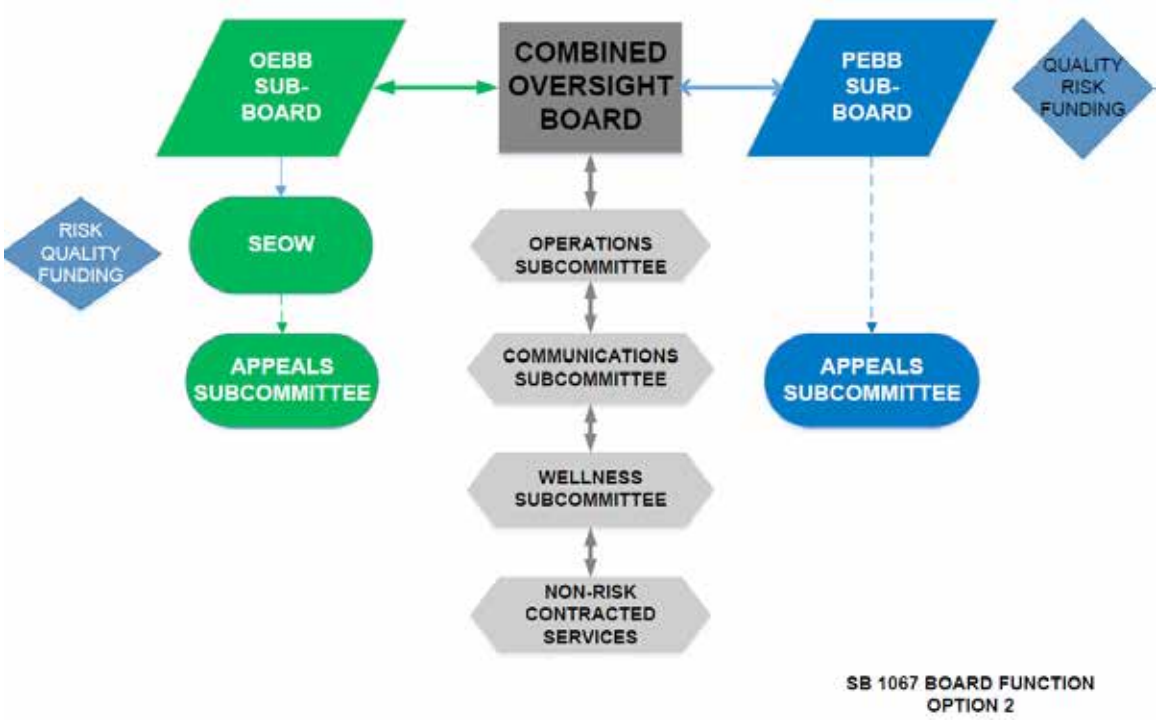
When considering how to merge two boards with so many different characteristics, the committee found challenges in nearly every aspect that it considered merging. The committee considered a number of board models and frameworks, reviewed qualitative and quantitative input and data, and considered each option carefully. Eventually, the committee chose three board structure models that would fit the criteria it was looking for while maintaining stakeholder representation with varying levels of disruption. All three board model options are similar in the amount of potential cost savings, although they differed greatly in the amount of potential member disruption. During the discussion of each board model option, the SB 1067 Committee identified important factors that would either aid or impede the achievement of the desired results.

Distinguishing characteristics of the three board model options and the feedback from the deliberations of the committee are shown below.

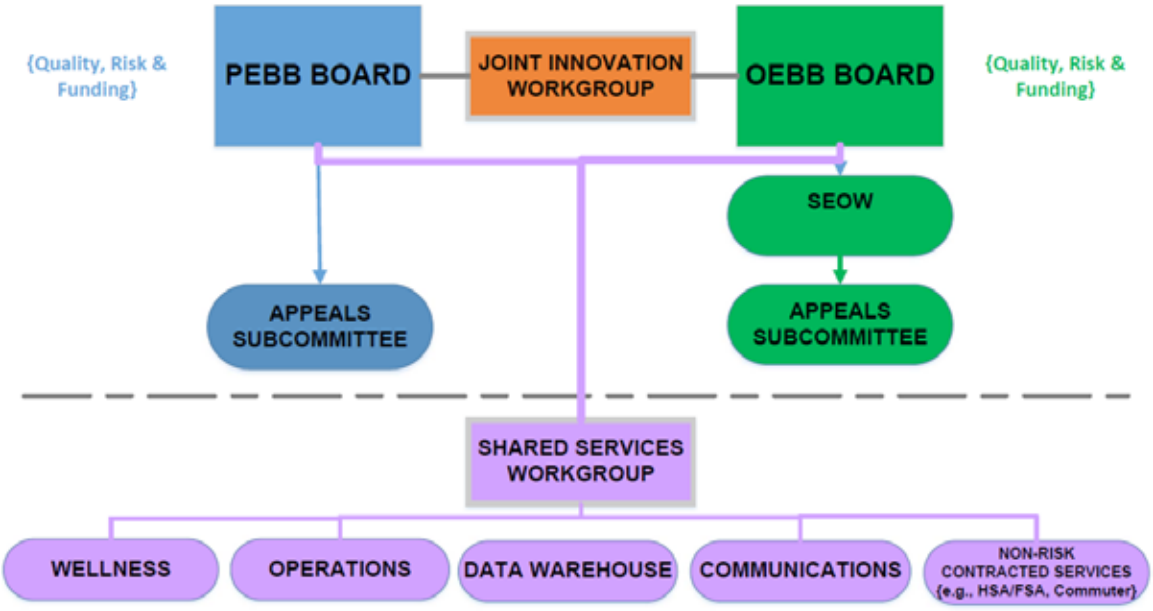
Board Model Option 1: A full merger of the OEBB and PEBB boards into one combined board. The legal and governance structures of the OEBB and PEBB boards would sunset and new statutory authority would be required to establish the new joint board legal and governance structure. All business processes would need to be amended in some form.



Board Model Option 2: Create a merged "oversight" board while maintaining OEBB and PEBB Boards as "subgroups." A merged oversight board would be the new legal and governance structure over the OEBB and PEBB Board subgroups. The OEBB and PEBB subgroups would continue meeting monthly and presiding over decisions on annual plan renewals, plan designs, funding and other program and administrative decisions. The subgroups would make recommendations to the merged oversight board, which would meet on an as needed basis to accept or reject the subgroups' recommendations.



Board Model Option 3 (see Appendix A): A hybrid merger of the OEBB and PEBB boards. The boards maintain their separate legal structure and governance, and create a combined "innovation" subgroup of the OEBB and PEBB boards and a "shared services" subgroup for administrative efficiencies.



SB 1067 BOARD FUNCTION
OPTION 3
LEGISLATIVE REPORT 2017

Evaluation of merger options - Opportunities for cost savings and efficiencies			
Area of Evaluation	Option #1	Option #2	Option #3
1) Cost savings through merging of risk pools	Minimal savings (less than 0.5%)	Minimal savings (less than 0.5%)	Minimal savings (less than 0.5%)
2) Administrative efficiencies, e.g., joint RFPs, merging of PEBB and OEBB staff	Same savings across options	Same savings across options	Same savings across options
3) Achieve savings through innovative strategies to reduce claims costs	Some savings	Some savings	Highest level of potential savings through Shared Services Model and Joint Innovation Workgroup
4) Member group focus/ responsiveness	Lowest level of member group focus/ responsiveness across options	Some loss of member responsiveness/focus	Highest level of member responsiveness/ group focus
5) Program flexibility/ efficiency	Lowest level of flexibility, due to expanded board, need for consensus-building	Some loss of flexibility/ “nimbleness”	Highest level of flexibility/ “nimbleness”
6) Program disruption	Highest level of disruption across options	Some disruption	Lowest level of disruption across options
7) Board education requirement	Highest level of board education required learning and staying abreast of other program’s ongoing issues	Some need for board education regarding other program’s ongoing issues	Lowest level required for board education

The committee’s selected board model option is included in section 7.0 SB 1067 Committee Recommendation.

6.0 Fiscal Analysis

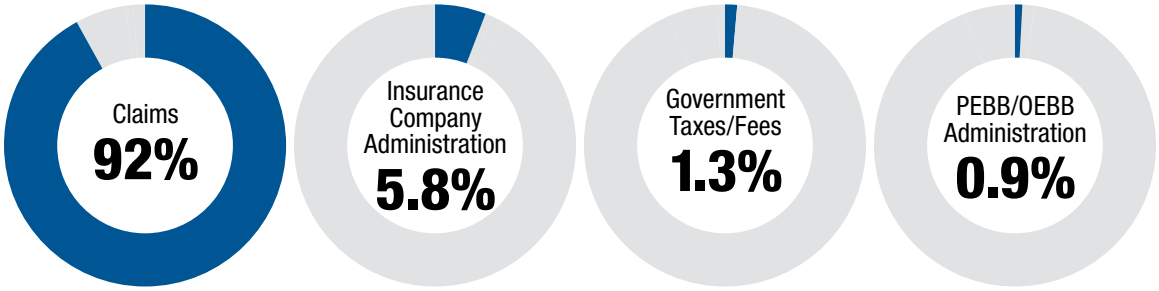
SB 1067 requires that a fiscal analysis be submitted along with the report to the Ways and Means committee. A key objective of the SB 1067 Committee and both OEBB and PEBB boards is to provide affordable, comprehensive health insurance options at a price employees and employers can afford to pay. One assumption included in SB 1067 indicates that simply combining the two unique groups of more than 140,000 members, results in significant savings for all participants. SB 1067 also assumes that quantifiable savings and efficiencies can be achieved through eliminating duplication of operational and administrative services to members of OEBB and PEBB. The SB 1067 Committee asked OEBB and PEBB staff and the OEBB and PEBB consultant and actuaries to perform an analysis of savings potential for combining purchasing power of benefit plan offerings and identify any areas where administrative savings could be realized.

Staff and consultants were able to identify several areas where efficiencies could be gained and savings could be generated. But they also noted that the anticipated savings in costs, simply due to combining two uniquely different risk pools, is low relative to the total combined benefit plan costs for OEBB and PEBB. This assumes the benefit levels, choice of plans, and all other program elements remain unchanged, or constant. The largest opportunity for savings would be generated by increased efficiencies of claims and utilization through benefit plan design, choice of plan offerings, utilization and disease management efforts, provider and pharmacy reimbursement models and advancement of organized systems of care. These combined efforts to increase efficiencies in claims and utilization would be the work of the new OEBB and PEBB Boards structures through the new Joint Innovation Subgroup, as designed in Model 3. As discussed above, the Innovation Subgroup will conduct various levels of analysis focused on exploring opportunities in the areas of provider and pharmacy contracting, innovative payment methodologies, clinical management programs, plan design and plan offerings, funding options, risk management strategies and so on.

The pie charts below visually explains where OEBB and PEBB's costs come from and where there is the most opportunity to impact premiums. Claims to health care providers make up the largest component of cost. Claims are impacted by:

- Demographics of who is covered
- Plan design: deductibles, out-of-pocket maximums, copays, coinsurance
- Utilization of services
- Prevalence of disease, claims, and utilization management programs
- Provider and pharmacy network contracting

OEBB/PEBB distribution of cost



A. Fiscal analysis of merging the OEBB and PEBB risk pools

For purposes of this report, the SB 1067 Committee assumed that "merging the functions and operations of the programs" does not include merging the risk pools, as that would be the work of a joint OEBB and PEBB board moving forward beyond February 2018, if such a direction were taken. With that said, the committee requested that the report include a fiscal analysis of merging the risk pools.

According to PEBB's actuarial consultant, all other things (e.g., benefits, provider networks) being equal, merging the pools may provide greater stability in the long term with regard to the fluctuation in claims costs, but any savings associated with combining them would be minimal. While increased leverage from a combined pool may yield reduced administrative fees, the impact of those savings in comparison to the total costs is relatively small. The expected claims costs of the combined risk pool—with no other changes—would not decrease from what the separate pools generate.

PEBB is a combination of self-insured and fully insured plans. OEBB plans are fully insured, primarily through a minimum premium arrangement. Reference the Appendix for a thorough look at PEBB's self-insured plan business, as well as OEBB's fully-insured plan business. A fully combined, joint board (Committee Option 1) would likely have three potential options, once merged:

- PEBB could move to all fully insured plans;
- OEBB could become self-insured; or
- The PEBB/OEBB portfolio could remain a combination of the two.

A joint board would have to grapple with decisions related to the differing benefit plan designs, funding mechanisms and level of choice between the two programs. The number and type of carriers and benefit plans offered to OEBB and PEBB members will affect the potential for savings or costs to each of the risk pools. Collective bargaining agreements would affect the plan offerings and choices available. A new joint OEBB and PEBB board would need to assess potential unintended consequences of decisions for the merged group, such as creating an oligopoly through lost "diversification" across multiple payers/insurers in the state, or promoting wellness and preventive care programs that may have higher initial claims costs with an expectation of improved claims costs in the future.

According to the OEBB and PEBB actuarial consultants, if PEBB were to change the self-funded pool to an insured arrangement similar to what OEBB currently has with Moda, PEBB's insurance carrier would be required to pay the Health Insurance Provider (HIP) fee as part of the premiums. The HIP fee, imposed as part of the Affordable Care Act, is roughly 3 percent of premium for Moda. This would be an additional cost to the PEBB pool of up to $20 million per year based on projected self-insured medical and dental costs.

In addition to the HIP fee, an additional risk margin would be built into the premium by the insurer. Assuming that represents 1 percent of the premium, the added cost to PEBB would be $7 million per year in addition to the loss of any associated savings that can be reinvested in member benefits when claims are low. While it may be beyond the purview of the SB 1067 Committee, it's notable that if OEBB were to change from the current insured/minimum premium arrangement to a self-funded model, the elimination of the HIP fee would create savings. OEBB's actuary estimates that the annual amount of the HIP fee is about $17 million (3 percent) for the medical plans and an additional $500,000 (1 percent) for the dental plans.

In order to move to a self-funded arrangement, OEBB (or the combined pool) would need to establish sufficient reserves. Two types of reserves would need to be established: IBNP (provision for incurred-but-not-paid claims) and contingency (provision for actual claims exceeding the expected in any one year). The IBNP reserve could be established through a set-aside of a portion of the self-insured

"premium" rates in the first three months or so of the first year of self-insurance. For OEBB, a rough estimate of the needed IBNP reserve would be $60-70 million, but again, this could be funded through the plan rates themselves. A prudent level of contingency reserve would be 10-15 percent of annual expected claims under the self-insured program, which OEBB's actuary estimates to be about $50-75 million currently. It is not reasonable to expect that the contingency reserve could be funded through plan rates, at least not in the near term. New legislative investment would thus be required.

The OEBB/PEBB portfolio could remain as it is now – a combination of self-insured and fully insured plans. This scenario could conceivably create challenges related to funding, reserves, plan design and enrollment for a joint board to tackle. It is generally considered that the financial impact would be minimal.

There would be some expected savings in carrier administrative costs as a result of increased purchasing power from a larger pool if the combined group were to select a common administrator/carrier. PEBB's actuary estimates the lowered administrative fees could save $2 million annually which is 0.2 percent of the Total Funds budget for a combined OEBB/PEBB contract. Using observed reductions from their administrative fee benchmarking tool, PEBB's actuary estimated $2 per employee per month (PEPM) savings resulting from doubling 40,000 employees to 80,000 employees. Additional savings from the competition inherent in an RFP would be above and beyond those due to economies of scale.

Other considerations:

> The combined OEBB/PEBB group could further leverage its purchasing power by advancing coordinated care programs, supporting new payment methodologies with providers and promoting efficient utilization of care by members. These efforts will be led by the joint OEBB-PEBB Innovation subgroup and do not require the merging of risk pools.

Additional, albeit more moderate, savings are expected to be achieved through the already-planned joint OEBB-PEBB requests for proposals for life, accident, disability, employee assistance program, flexible spending account and COBRA administration services, which are not contemplated as part of this analysis.

Targeting claims and utilization savings and efficiencies

- Provider reimbursement: Targeting network provider costs could carry a significant impact (though only where there is provider competition in Oregon today) and opportunities for alternative payment models (APMs). This is dependent on knowing details of funding arrangements, plan selections, and plan choices to OEBB and PEBB participants. This would be an area that a new Joint Innovation Subgroup would look at to assess any level of potential savings.
- Pharmacy contracting: a special case of provider reimbursement where OEBB and PEBB may be able to leverage additional savings by combining into one pool and "carving out" pharmacy to a separate pharmacy vendor, while retaining their own current carriers. Further analysis would be needed to identify the potential savings amount. The Joint Innovation Workgroup would conduct this analysis if Model 3 is selected.

Savings potential affected by stakeholder interests

- Control of plan design – at least for some members, this may be a subject of collective bargaining. Even where collective bargaining does not apply, stakeholders will be sensitive to their voices potentially being diluted under new board representation.
- Fairness issues related to one board population subsidizing the other population – members of current OEBB and PEBB will be sensitive to the possibility of paying more or benefitting less from combining with another group whose costs are higher or whose benefits are less generous.
- Ability to opt-out or be required to join pools – Some school districts are still not "in" OEBB. Will this be a one-for-all pool, to include all school districts, cities, counties, and government groups? If an opt-out is still possible, allowing for risk selection, this may compromise some of the savings potential of the merger and create instability in the pool when younger, healthier districts are allowed to stay out.
- Maintaining rate structures, composite rates and some plan designs due to specific bargaining agreements.

Obstacles to merging the pools (or areas where there will be winners and losers)

- OEBB and PEBB costs (i.e., premium rates) are not the same today. Further analysis would be needed to adjust the pools for age, sex, family status, location and plan value and determine how similar or dissimilar the costs are.

- If above is true, then combining risk pools will result in one group generally winning (average costs lower than current costs) and the other losing (average costs higher than current costs).
- Obtaining the reserves to move the OEBB pool to a self-funded arrangement: as noted under Section A above, both IBNP and contingency reserves would need to be established.
- Different plan years: OEBB and PEBB's programs renew on different anniversary dates. This has implications for premium rates and other contractual terms. It also presents administrative challenges, new inefficiencies and member disruption to migrate one population to align its plan year with the other.

B. Other savings opportunities

Joint RFP savings opportunities for service contracts

OEBB and PEBB released a joint request for proposals for EAP services in 2010 and consulting services in 2014. Vendors could respond by making a bid for the business of OEBB exclusively, PEBB exclusively, or bid for both OEBB and PEBB business combined. All respondents submitted financial offers for all three options. A discount was offered by all vendors if they were chosen for both programs over just one program. In going back and researching the level of discount offered by the vendors if they were to be selected for both OEBB and PEBB exclusively, the discount was $210,000 total funds. These are very small contract sizes in comparison to medical or dental insurance carrier contracts, but they do represent a $210,000 annual savings, which is 0.0003 percent of the Total Funds budget.

OEBB and PEBB cost containment programs

OEBB and PEBB have recognized and taken steps to provide incentives for appropriate care and management of chronic conditions through benefit plan design with the goal containing costs:

- Members have no copayment, coinsurance, or deductible for office visits associated with management of certain chronic conditions (asthma, diabetes, cardiovascular disease and congestive heart failure).
- Value pharmacy benefit provides medications used to manage common chronic conditions with no copayment.
- Condition management and prevention programs offered at no out-of-pocket cost to members under OEBB and PEBB medical plans, including evidence-based programs for members living with a chronic condition and prevention programs that specifically target members at risk for development of diabetes.

- Members who complete an annual health assessment to identify personal health risks and commit to engage in health activities to reduce their risk receive an incentive in the form of a lower medical plan deductible for OEBB members, and an additional monthly incentive payment added to their paycheck for PEBB members.

Wellness programs and incentives

OEBB and PEBB support prevention and member wellness by offering members no-cost programs through carrier contracts and direct vendor contracting. Programs include:

- Better Choices Better Health: helps people living with a chronic condition to live healthier lives.
- Employee Assistance Program (EAP): provides emotional, social and financial health services.
- Healthy Team Healthy U: offers members a foundation of knowledge and skills to help members live a healthier lifestyle.
- MoodHelper online tool: helps members overcome depression.
- Quit For Life and other tobacco cessation resources: help members overcome tobacco use.
- Weight Watchers: designed to help members achieve their weight loss goals and maintain them.

Providing direct incentives to members outside of plan benefits comes with initial upfront costs to fund and administer. This appears as a direct cost to the program for any and all years the incentive is provided. Several years of claims data are needed to analyze whether or not the incentive has a measurable, sustained impact on participant health care claims costs. This type of analysis is possible and in theory could show an impact on costs. However, any potential cost savings would not be realized until future years after the upfront costs of the incentive have been incurred.

Organized systems of care

Systems of care are designed to support advanced primary care, coordinate providers across the continuum of care, and engage in risk-sharing arrangements focused on managing care appropriately. OEBB and PEBB expanded their regional systems of care throughout the state, which provide members improved, better-integrated care at an affordable cost. Regional systems of care focus on primary care and prevention and encourage members to share in the responsibility for their own health outcomes.

Coordinated care model plans

Controlling premium costs is a major challenge for both OEBB and PEBB. Premium costs are affected by external drivers, such as:

- Utilization – challenge of PPO plans
- Inflation in health care costs
- Chronic conditions
- Majority of members have sedentary occupations, increasing the long-term risks of multiple chronic conditions
- Significant percent of population are obese or overweight

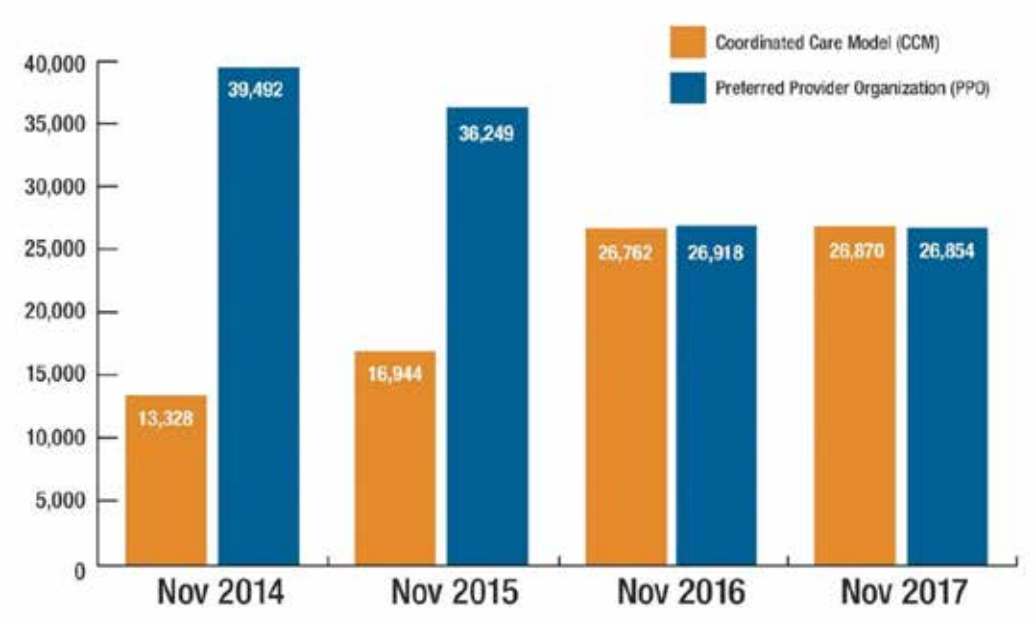
OEBB and PEBB believe the coordinated care model (CCM) is essential for achieving success in managing overall costs. They are continuing to add systems of care throughout the state with a focus on integrated care and reducing health care costs and health disparities. The boards would like to further pursue plans and providers who use creative and innovative evidence-based practices.

OEBB and PEBB conducted RFPs for comprehensive medical, pharmacy and vision services. During the 2016 medical plan renewal process, OEBB introduced new medical plans for the 2016-17 plan year. As the board evaluated plan offerings and prepared to release the Medical Request for Proposal (RFP), they created a focus group to evaluate affordability among employer entity plan offerings. This affordability focus group established criteria to ensure affordable health plan options across the state. Strategies included:

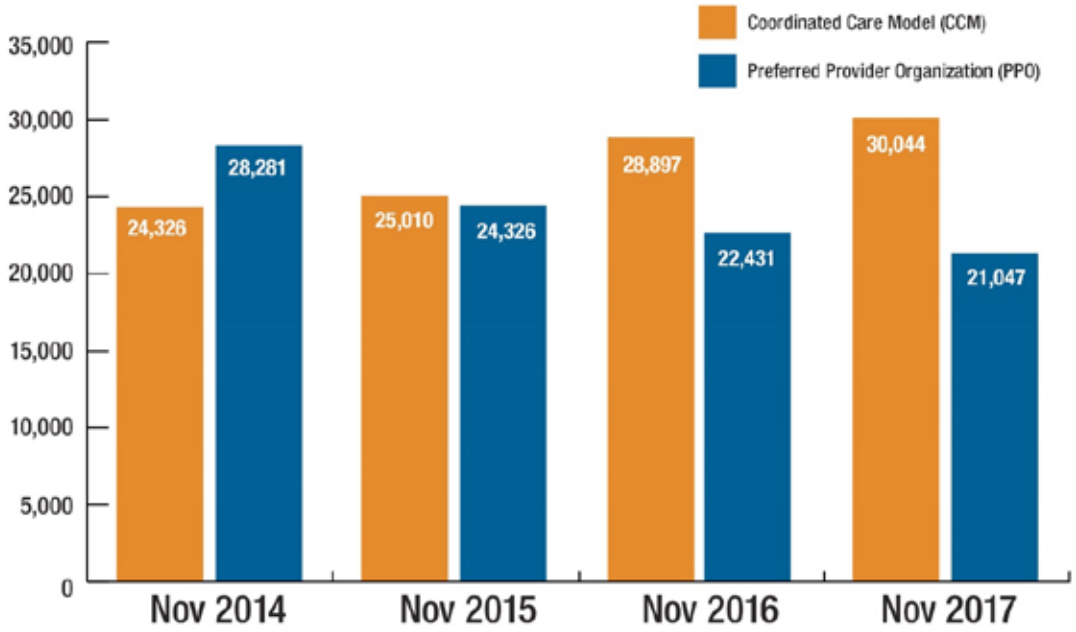
- Engaging employers at regular intervals to ensure the affordability definition remains relevant to all participating entities.
- Monitor and audit utilization and plan performance to ensure high quality benefits.
- Incorporate criteria specific to legislative cost requirements (3.4 percent renewal increase cap) into carrier contracts.
- Require proposers to outline their plans and specific steps they will take to promote these criteria in medical offices and care locations around the state.

The following graphic illustrate OEBB and PEBB members moving from a preferred provider organization (PPO) plan to a coordinated care model (CCM) plan with lower premium share:

OEBB: Member migration from a PPO plan to a CCM plan



PEBB: Member migration from a PPO plan to a CCM plan



C. Administrative savings and efficiencies

As two well-established "sister" benefits programs, OEBB and PEBB frequently engage in joint ventures and share best practices. Staff have already merged in areas such as Financial Services, Contracts Administration and Program Administration. This has allowed OEBB and PEBB each to reduce the number of FTE administering the programs by 14 percent from the 2015-17 biennium (as shown in the table below). The state of Washington's "PEB" program staff maintains a 40 percent higher FTE count for the administration of their program than does OEBB and PEBB, to cover virtually the same number of lives (public employees and school district employees). From an administrative savings perspective, the value in formally merging the entire operations and administration areas of OEBB and PEBB is that it would leverage already established "proven" systems and procedures across both programs. Attempting to customize within an existing infrastructure, on the other hand, invites risk as well as cost and process inefficiencies. OEBB and PEBB have designed and implemented a cross-training strategy so staff can be trained and shared across both programs. This creates flexibility and cost efficiency by eliminating the need for temporary staff during open enrollment.

Position resource cost efficiencies

	2015–17 Leg. Approved Budget	2017–19 Leg. Approved Budget	Staffing Decrease
PEBB			
Positions	22	19	(-14%)
FTE	21.50	18.50	(-14%)

OEBB			
Positions	22	19	(-14%)
FTE	22.00	19.00	(-14%)

OEBB and PEBB benefit management systems status (IT)

OEBB and PEBB both provide custom-built benefit management systems. OEBB serves primarily Oregon school district employees, community college employees, some other governmental entity employees, and early retirees of those entities. PEBB serves state employees, university employees, semi-independent state agency employees, and early retirees of those entities. PEBB's system was built around 2006. OEBB's system was copied from PEBB's in 2009 and then customized from there. Both systems are very similar in functionality and architecture. These systems are for benefit management only and do not include payroll, human resources, or financial systems. Necessary communication with these systems is through file interfaces. Both programs use the same maintenance and operations contractor, but

each has a separate contract. Combined, OEBB and PEBB serve nearly 400 separate school districts, colleges and universities, state agencies, and other governmental entities that represent approximately 115,000 employees and 285,000 total lives.

OEBB and PEBB systems have been in service over 10 years and are highly customized with nearly all code customized for each program's needs. The systems have become more and more complex, resulting in a higher likelihood of security vulnerabilities, a reliance on contracted developers who are familiar with these specific systems, and a higher cost for ongoing operations and maintenance.

IT system goals

Although OEBB and PEBB have many differences in business rules, two systems' overall functions are the same – to provide a benefit management system for public employees.

Contracting, maintenance, enhancements and issue resolution would be made more efficient in a combined system. It would reduce duplication of work and would increase the depth of the system technical knowledge to have the same maintenance and enhancement team working for both OEBB and PEBB. OEBB and PEBB systems would not rely on and ultimately pay for the technical and historical system knowledge of an individual contractor who has been around long enough to understand the details of an aging system. A new system with updated and more mainstream and modern technology and code would translate into a wider pool of potential vendors to build and maintain it. At the same time, such a system would leave leaving it to the business experts to understand the two programs' different business rules. There would be competing priorities between the programs that don't currently exist because of the split, but those are manageable.

IT system integration

Because of the number of entities involved, full integration with human resources and payroll is not realistic, but a more modern system could improve the integration among the various systems and would improve data integrity.

Full integration with finance and budgeting, COBRA, wellness programs, and the appeals processes, could be realized with a new system. Each feature would need to be weighed against cost but the potential for integration would exist. It is not now an option because of the age of the current system. Any additional seamless integration increases our data integrity and accuracy and reduces the chance for data duplication, enrollment errors, payroll deduction errors, and other errors avoidable through more integrated systems.

IT System Modernization

A new combined system would allow OEBB and PEBB to modernize all its members' and administrators' user experience. Among the top modernization goals:

- Ability to implement and maintain latest security best practices
- Mobile app compatibility
- Compatibility with commonly used browsers, operating systems and devices
- Flexibility to make changes to accommodate business partners and customers
- Expanded automated error checking and data validation
- Availability of on-demand enrollment, and training tools for members and administrators
- Self-service tools and features for members and administrators

IT system costs

Costs for a new combined system are dependent on the features considered to be mandatory versus optional. Costs are also dependent on whether the OEBB and PEBB boards decide to go with an off-the-shelf system with little customization. Such a system would not give them as much flexibility with program-related changes that impact the system, but would reduce the costs of a new system versus a highly customized system built to OEBB/PEBB requirements which would come with a higher price tag, both initially and with ongoing maintenance. There is a trade-off between costs and flexibility in the ultimate decision on which path is best for OEBB and PEBB.

As a result of the system's age, highly customized nature, and reliance on retaining developers familiar with the system, maintenance and operation costs for both systems combined are estimated at approximately $7 million to $8 million over the next three years. That amount does not include upcoming costs for security assessments and the resulting work to install security patches and remove security vulnerabilities. As the systems continue to age and become more complex, expenses for system modifications will increase; alternatively, system modifications that could improve data integrity among partners and could improve user experience could be delayed or never materialize. In addition, as the systems age, the chance of exposing sensitive member information is more likely due to the system's increasing security vulnerabilities – primarily in the web application.

7.0 SB 1067 Committee recommendation – adoption of Joint Board Model No.3

The SB 1067 Committee brought in a professional facilitator to lead a committee assessment of options for meeting the requirements of SB 1067. The facilitator structured the discussions around the three board model options and prompted a self-evaluation discussion of the current boards focused on examining what is working and what is not working, what is efficient and what is not efficient, and where and how to find cost efficiencies. The conclusion was that model No. 3 was the best model to realize savings and efficiencies while preserving stakeholder representation.

When serving a single insurance pool that is growing from 150,000 lives to 300,000 lives, conventional wisdom suggests significant cost efficiencies can be gained. However, as addressed in the fiscal analysis section, when the risk burden of the covered population does not change, the savings on volume are limited to administrative efficiencies, estimated at less than 0.5 percent. Addressing the risk profile of the larger pool, which can be done with the Joint Innovation Workgroup in model No. 3, including health promotion, care coordination, and provider payment, is where large-scale savings can be realized as explored in some detail in the fiscal analysis section.

There is an inherent value in partnering with and having access to the best programs and practices of several of the most innovative health care companies in the country, rather than being limited to just one or two companies under a full merger. The amount of savings that can be realized is not tied to which board structure is ultimately adopted, it is the value proposition each of the models brings in way of opportunities that are available to OEBB and PEBB. OEBB and PEBB staff are well-practiced in managing multiple carriers with multiple plans that may all perform certain functions differently and play a complementary role to one another.

After several committee meetings, **the SB 1067 Committee by consensus elected to move forward with Option 3,** the hybrid model (part merged, part not). It was selected by the SB 1067 Committee as the model that will bring the most opportunities in the quest to improve health care quality, reduce overall costs, and increase member satisfaction with their benefits. It allows for and encourages the boards to work collaboratively for joint opportunities in innovation that benefits both programs, creates potential savings, while still allowing for the representation of unique stakeholder needs, and ultimately member satisfaction.

- OEBB and PEBB have figured out how to best balance the needs of multiple stakeholders that may have unique service needs. The hybrid model will allow for immediate short-term savings where stakeholder interests are aligned, while still preserving stakeholder autonomy where interests are unique.
- The hybrid model does not preclude further merging of the programs in the future, should interests align further.

In Option 3, the Joint Innovation Subgroup provides an opportunity for OEBB and PEBB to collaborate on care coordination, strategies in primary care payment reform, and innovations in care delivery. This will be the first step toward major joint strategic initiatives. The amount of cost savings the boards can generate will be measured annually and reported to both boards as well as presented to the Legislature per SB 1067 directive. Option 3 allows for greater transparency, accountability, and competition, and provides ample opportunities for stakeholder input. Information for all subgroups will be publicly accessible. Adoption of Option 3 also presents opportunities for administrative simplification and elimination of duplication 3.

Joint Innovation Subgroup

The Innovation Subgroup would be created as a joint OEBB and PEBB subcommittee that will exist as a platform of exploration for the OEBB and PEBB boards, their carrier partners and other stakeholders. The platform would explore initiatives for measuring and improving quality of care, encouraging the development of efficient models of care, and driving efforts to ensure cost-effective care treatment protocols are followed. The Innovation subgroup will foster creativity and innovation in solving many health care-related challenges, including the triple aim goals of improving population health, improving the patient experience of care and reducing the cost of health care. The Innovation subgroup would seek to engage in strategic planning sessions on a periodic basis. It would be a place where the members of the subgroup could:

- Explore program design and plan design
- Share best practices and experience
- Enhance data aggregation, reporting capabilities and analytical integration

The work of the Innovation subgroup will include activities in the areas of quality measure alignment, value-based benefit design, health information technology opportunities, payment reform, and population health initiatives. To make this ambitious joint health care initiative meaningful and sustainable, the engagement of OEBB and PEBB stakeholders must be consistent and continuous.

Shared Services subgroups

Potentially, a great deal of the work of the OEBB and PEBB boards could be done in the Shared Services subgroups, specifically to avoid duplication. The subgroups will participate in detailed planning and provide oversight across areas including Communications, Operations, Wellness, and Non-Risk Contracted Services such as Employee Assistance Programs and Flexible Spending Account administration. The boards will set clear expectations and ensure guidelines are established for the work conducted by the subgroups and evaluate whether they are keeping the boards informed about issues facing the boards. Each subgroup charter will require a plan for stakeholder engagement to ensure that stakeholders are consulted on the development of specific work.

8.0 Stakeholder input

Stakeholders include OEBB and PEBB members, public employers, labor unions, insurance carriers, health care providers, the business community and other local and state officials. The engagement of stakeholders will be a focus in the design and planning phases. The SB 1067 Committee discussed how the joint board will need to be responsive to stakeholder needs and be inclusive in the decision-making process. This would be accomplished by providing access to information so all stakeholders can participate in a meaningful way to an outcome-driven process. Planning and thinking around stakeholder engagement will benefit from input and advice from the newly convened Joint Innovation Subgroup.

9.0 Timeline

The timeline will depend in large part on the OEBB and PEBB boards working together to coordinate a work plan. This work has already started. The first order is the OEBB and PEBB boards establishing the charters, purpose, guiding principles, and electing membership in the subgroups as put forth by the SB 1067 Committee. The timeline for this should be summer of 2018, which is after the February 2018 legislative session and the 2019 plan renewal process. The second order will be starting the strategic planning for the subgroups, which will likely require considerable research, preparation, and retreats for the boards and subgroups–The timeframe for this is early 2019. The third order is executing the implementation of the strategic plan, which would take place in Plan Year 2019.

10.0 Appendices

Appendix A. Joint Innovation Workgroup Outline

The Innovation subgroup would be created as a joint OEBB and PEBB subcommittee that will exist as a platform of exploration for the OEBB and PEBB boards, their carrier partners and other stakeholders. The platform would explore initiatives for measuring and improving quality of care, encouraging the development of efficient models of care and driving efforts to ensure cost-effective care treatment protocols are followed. The Innovation subgroup will foster creativity and innovation in solving many health care-related challenges, including the triple aim goals of improving population health, improving the patient experience of care and reducing the cost of health care.

To make this ambitious joint health care initiative be meaningful and sustainable, the engagement of OEBB and PEBB stakeholders must be consistent and continuous.

Workgroup composition

- Two voting members per board selected and voted on by the PEBB and OEBB boards
- Non-voting members
  - One member of the House Health Care Committee
  - One member of the Senate Health Care Committee
  - Two members of the Joint Ways and Means Committee
  - The PEBB/OEBB administrator

Staffing

- Non-PEBB/OEBB OHA staff
- Assigned by the Director of the Oregon Health Authority

Subject matter experts

- Invited for consultation as needed depending on topics
- Jointly determined between workgroup members and OHA staff
- Coordinated by staff support

Term limits

- Two-year terms
- No reappointment term limits because there are already term limits for being a member of the OEBB and PEBB boards
- OEBB and PEBB boards can rescind and reappoint members of corresponding OEBB and PEBB members of the workgroup as needed.

Workgroup leadership

- The voting members of the workgroup will select a chair annually
- Chair will coordinate with OHA staff to develop agendas and direction

Goals

- Sustained benefits
- Quality care
- Affordability for the state budget and members
- Influence on healthcare delivery system in Oregon
- Access

Functions

- Prioritize focus areas that have the greatest potential to achieve goals
- Direct research and consult with experts on a limited number of prioritized topics
- Develop three-year strategic focus with annual work plans
- Use joint OEBB and PEBB data to develop a set of recommendations
- Develop specific recommendations for the OEBB and PEBB boards at least annually
- Report regularly to OEBB and PEBB boards
- In the situation of an impasse related to a recommendation, report to the OEBB and PEBB boards for further direction
- Request action from the OEBB and PEBB boards based on the annual report

Focus areas (areas identified for potential change)

- Clinician services
  - » Primary care
  - » Specialist care
  - » Behavioral health
  - » Alternative care
- Pharmacy
- Facility care
  - » Inpatient
  - » Outpatient
  - » Behavioral Health
  - » Other

Appendix B: OEBB fiscal information

OEBB fully insured plans

The following slides were prepared for the OEBB Board to help it approach the RFP evaluation process.

Components of OEBB insurance premium

Claims administration	Insurance carrier's cost of processing claim payments, providing billing and customer service resources, network management and other programs such as disease management
OEBB administration	OEBB operating costs include billing entities, open enrollment administration, customer service, consulting resources, communications to OEBB members, wellness programs
Taxes and fees	State premium taxes, federal premium taxes, Affordable Care Act assessments
Risk charge/margin	Risk charge may be included in premium if there are factors that create uncertainty about future cost or which promote adverse selection and/or otherwise may cause the plan to be underfunded
Claims/utilization	Payments to providers and hospitals for healthcare services used by OEBB members. Utilization costs reflect the number of people using services and the cost and type of services used.

Source: Willis, Towers, Watson

What factors affect use of health care (claims/utilization)?

Employee and dependent participation
- Age, gender, location of covered employees
- Number of covered dependents
- Actives/retirees

Member utilization of health care services
- Types of health care services and frequency of use
- Site of service (hospital vs. outpatient setting)
- Illness burden of population

Provider reimbursement arrangements
- Competitiveness of the carrier's discounts with the physicians and hospitals
- Fee for service vs. pay for performance

Pharmacy and Technology
- New technologies and treatments
- Example: Specialty pharmacy represents fastest growing component of health care costs

Effectiveness of vendor partnerships
- Medical management programs
- Communication with members
- Coordinated care models that promote efficient health care use

Program design value and subsidy level
- Deductibles, copays, cost-sharing elements
- Employer/employee premium sharing
- HSA, HRA, opt-outs

Source: Willis, Towers, Watson

Appendix C: PEBB fiscal information

PEBB self-insured plan business

PEBB's move to self-insurance has alleviated the impact of the rapid rise of market trend and resulted in containing costs with:

- Increased PEBB membership in a patient-centered primary care home
- Implemented additional cost tiers to promote value based benefits
- Implemented benefit design changes aimed at reducing barriers to care for members with chronic diseases
- Employed cost-effective, sustainable technologies
- Achieved better cost and quality controls through direct contracting
- Maintained a leadership role in value-based health care as a purchaser of commercial medical plans

What is self-insurance?

The plan sponsor bears most or all of the financial risk of the plan and is responsible for the actual costs of services provided under the plan.

- All major aspects of the relationship are unbundled and include a third-party administrator (TPA) or an insurance company on an administrative services only (ASO) basis to process claims.
- Important considerations
  - » All claims must be paid in full.
  - » The ultimate cost of the plan will be the claims incurred, plus cost of administration, less any investment return on plan assets.
  - » Majority of plan cost goes to pay claims and is not significantly affected by the method of financing.
  - » Stop-loss insurance is often used to provide employer protection against catastrophic individual claims and excess aggregate claims when the impact of large claims may prove detrimental to the finances of that employer.
    - » PEBB currently does not have stop-loss insurance due to the size and stability of the plan and the fact that it has a stabilization fund to provide protection against claims fluctuation.

PEBB funding history

Prior to 2010, the PEBB Statewide plan was fully-insured by Regence

- For the 2010 renewal, Regence requested a 16.8 percent increase
- Based on 11.6 percent medical and 10.1 percent prescription drug trend with 5 percent margin
- PEBB opted to go self-insured with Providence
- Renewal increase was 6 percent
- Based on 10 percent medical and 8 percent prescription drug trend with no margin
- 2010 plan year ended with a $6.9 million surplus
- PEBB saved approximately $59 million in 2010 by self-insuring

Pros and Cons of Self-Funding

Pros:

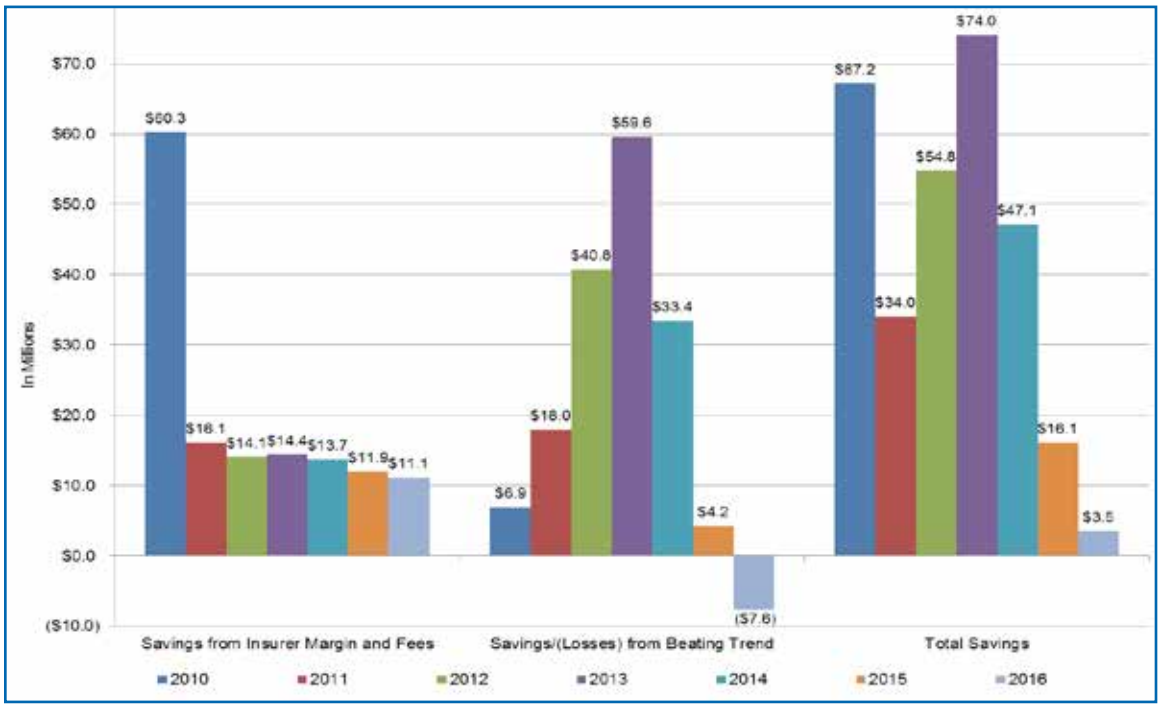
- Cash flow
- Plan design flexibility
- Ability to make claim exceptions
- Not subject to many state-mandated benefits
- Employer holds reserves
- Expanded availability of reports
- Eliminate state premium taxes and assessments

Cons:

- Increased financial risk
- Costs are not as predictable on a monthly basis
- More involvement required by employer's human resource and finance staff
- HIPAA compliance responsibility
- Legal and fiduciary responsibility

PEBB savings from self-insured plans 2010–2016

Total savings = $296.7 million



Source: Mercer

Appendix D: Payment innovations

Controlling premium costs is a major challenge for both PEBB and OEBB. Premium costs are affected by external drivers such as member utilization, lack of coordination of care, inflation in health care costs such as high cost for prescriptions and sedentary occupations that lead to long-term risks and chronic conditions.

The traditional method of controlling the cost of health care is to increase cost to members through higher deductibles, higher copayment or coinsurance, or increased premium share. OEBB and PEBB have always looked for ways to reduce costs through innovative plan designs.

Value-based benefits

Both OEBB and PEBB have implemented value-based benefit plans. Services that have shown to reduce health care costs have a lower copayment or coinsurance. Services that have other less expensive alternatives have a higher member cost share. Members are encouraged to talk to their medical providers about alternatives to these higher-cost options. Examples of these benefits include:

- No or lowered costs for visits for diabetes, coronary artery disease, asthma and chronic obstructive pulmonary disease. Regular office visits keep people with these diagnoses out of the emergency room and hospital.
- No or lowered costs for medications that help prevent or manage chronic diseases such as statins for cholesterol, asthma inhalers and depression medications.
- Additional copayment for endoscopies, sleep studies and advanced imaging technologies (CT, MRI, PET scans).
- Additional copayment for shoulder and knee arthroscopic surgery, total knee and total hip joint replacement surgery.

These benefits were highlighted in the November 2010 issue of *Health Affairs*.

Reference-based pricing

To ensure members receive high-quality, affordable care, OEBB implemented a reference price program. This program currently includes bariatric surgery (effective 10/1/13), and major joint replacement surgery and oral appliances (effective 10/1/14).

In a reference-based pricing program, Moda will pay a set amount for the services. Any costs above the set amount are the member's responsibility. Moda has contracted with specific facilities that have agreed to accept the set amount.

Travel benefits are available to OEBB members who use a participating reference price facility. This allows family or friends to accompany the patient if the services are provided out of town.

Coordinated care model plans

In PEBB's request for proposals (RFP) for the 2015 medical plans and OEBB's RFP for the 2017-18 plan year, respondents were asked to include their vision of and ability to implement a coordinated care model. Selected plans are currently:

- Promoting alternative payment methodologies such as risk sharing and global payments for obstetrics and joint replacements
- Integrating behavioral and physical health
- Supporting the use of medical homes
- Improving payments for primary care
- Putting fees at risk for meeting agreed-upon outcome metrics
- Managing costs to a 3.4 percent increase

Wellness initiatives

OEBB and PEBB have implemented wellness programs to encourage members to learn about their risks and to make changes in their lifestyles to reduce the chances of acquiring a disease.

OEBB's Healthy Futures program rewards employees for taking a risk assessment and completing two health-related activities with a $100 reduction off their annual deductible. PEBB's Health Engagement Model (HEM) pays employees $17.50 a month for completing an online risk assessment and completing two health activities. PEBB employees who do not participate in the HEM have a $100 higher annual deductible.

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