Request for Proposal

Medical and Rx Plan Design Options

A presentation to OEBB Board

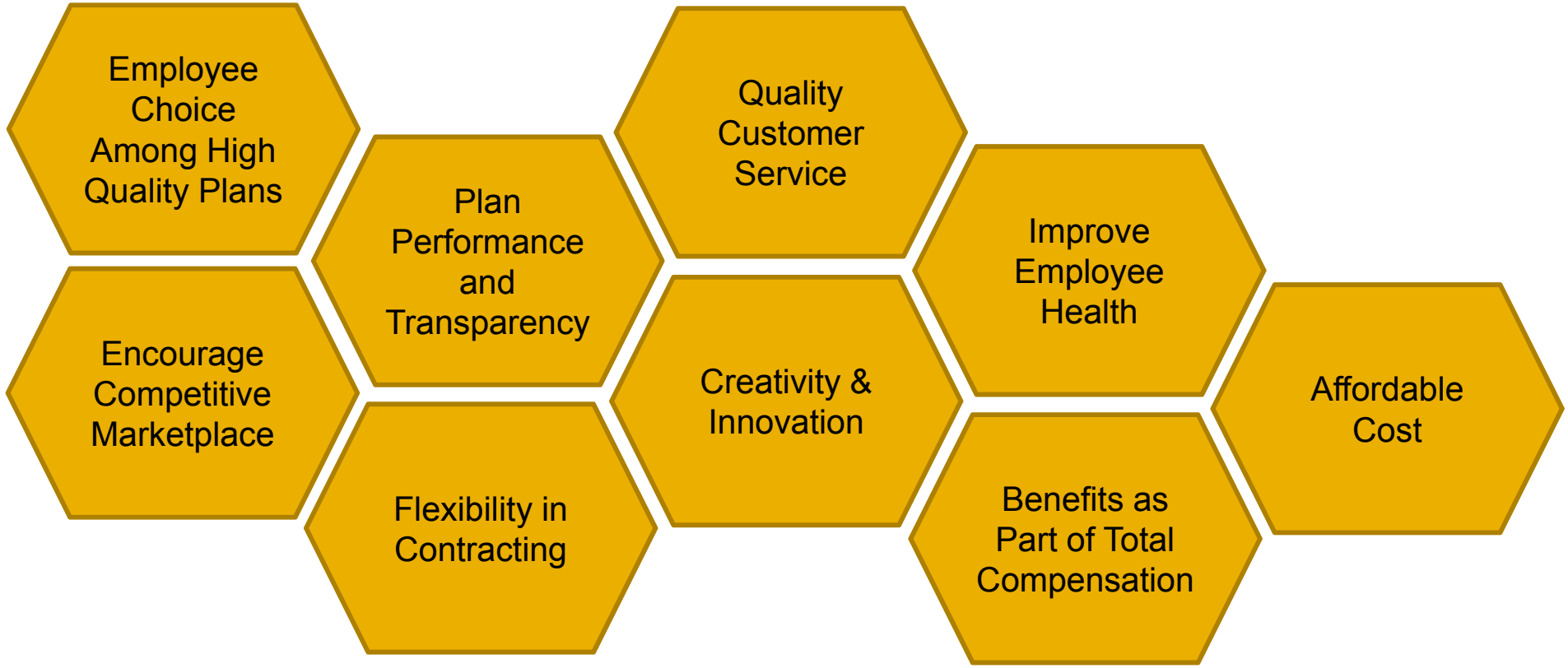
by Steve Carlson, Kim Hickman, Jenny Marks

Discussion Outline

- Things to consider in developing plan design
  - OEBB guiding principles
  - OEBB goals for the RFP
  - Balance of choice and cost
  - Impacts on plan cost
  - What does choice mean?
  - Ways of offering choice
- Plan design options for consideration
  - Review options
  - Consider pros and cons
- Summary
  - Overview of options
  - Ways to mitigate risk and cost

Things to Consider in Developing Plan Design

OEBB Guiding Principles



OEBB Goals for 2015 – 16 Renewals

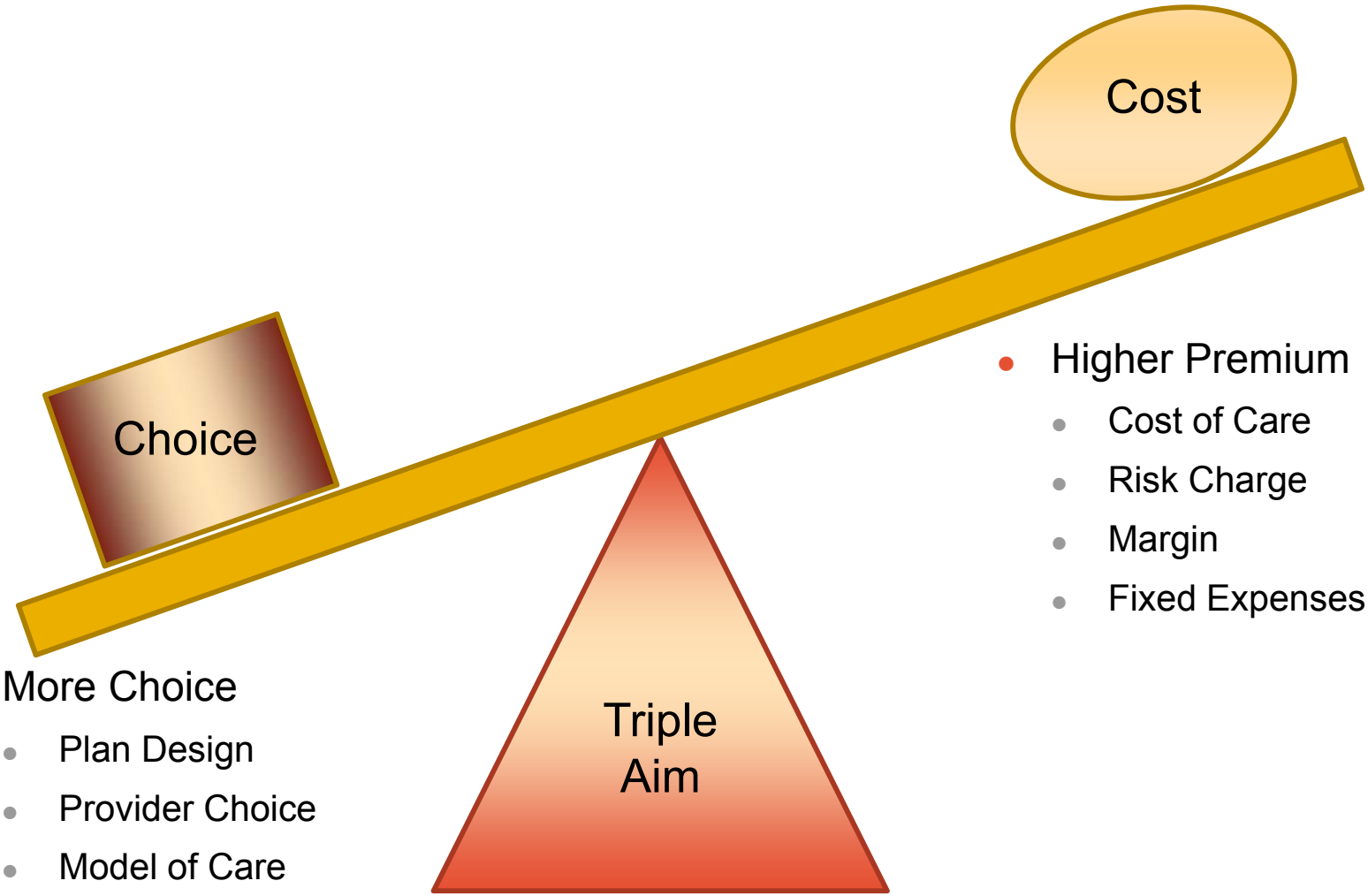
Sustainability:
- Maintain **sustainable plan options and program costs**
- Maintain compliance with state and federal laws and regulations related to health care
- **Limit spending increases to 4.4%** to align with the Governor's Budget

Choice:
- Offer a **variety of plans to meet entity and member needs**

Organized Systems of Care:
- Promote programs that deliver the **right care** at the **right time** in an **efficient manner**
- Support Oregon's health care system transformation efforts

Partnership:
- Advance OEBB program goals and **health care efficiency** in **partnership** with **vendors**, PEBB, **OHA** and participating **entities and members**

OEBB Goals — Balance Member Choice With Cost



- More Choice
  - Plan Design
  - Provider Choice
  - Model of Care
  - Vendors

- Higher Premium
  - Cost of Care
  - Risk Charge
  - Margin
  - Fixed Expenses

What Impacts Plan Cost?

Claims Utilization & Underlying Risk

- Large numbers of individuals within the same carrier leads to:
  - Stable experience and rates
  - Lower risk charges and margins
- Too many plans and/or vendors introduces anti-selection concerns and can lead to higher costs

Fixed Expenses

- Economies of scale help reduce fixed, non-health care related, expenses
- OEBB and entities' plan communication and administration expenses are impacted by the number of plan offerings

Geography & Demographics of the Population

- Health care costs vary across Oregon geographies
  - Plans offered in only low cost parts of the state may result in higher costs for plans offered statewide
  - Proposers able to "cherry-pick" will select locations where they can be successful and offer low rates
  - PPOs required to quote on a statewide basis may be concerned about competition from low cost plans resulting in increased risk charges and margins, or unwillingness to quote on a fully insured basis

What Does Choice Mean?

- For members, choice has traditionally been about physician access and plan cost — premium share or plan cost share (deductible, copayments, coinsurance)
- More broadly, member choice can mean differences in:
  - Costs at the point of care versus open enrollment
  - Differences in models of care
  - Plan design/plan cost share
  - Physician access
  - Premium
- Per the MIT/OEBB study, more plan design options do not necessarily lead to member choices that provide for the lowest total cost (premium+ out-of-pocket costs): there appears to be a point of diminishing returns

Ways to Offer Choice

- OEBB plans today to offer all members a choice in:
  - Physician access
  - Plan design/cost share
  - Premium levels
- In some areas of the state, members also have a choice between Kaiser and Moda Health
- Other kinds of choice could be offered through:
  - Introduction of additional vendors/carriers
  - Introduction of market-driven innovate plan designs
    - Bidders to propose new/creative plan designs
  - Plan designs to allow choice at point of care
- The following are brief overviews of these additional types of choice
  - Based on today's discussion, if these alternatives are of interest, Towers Watson and staff can develop actual plan designs for the Boards consideration

Ways to Offer Choice - Examples

Introduce new vendors

- Add additional carriers
  - Maintain similar plan offerings, new vendors all bid on existing plans
  - Consolidate plan offerings, new vendors bid on same plan options

	Positive Aspects	Negative Aspects
35 Plan Choices (Based on current OEBB plan offerings)	• Significant choice of designs, vendors and models of care for members • Carriers compete for members on plan features other than basic deductible/copay	• More plan choice between plans and between vendors will result in additional rate conservatism (margin/risk charges) • Potentially difficult for members to make good choices based on number of plans • Small CCM proposers may not be able to offer all plan designs • Entities/Insurance Committees may limit the available options due to administrative concerns

Ways to Offer Choice - Examples

Innovative plan designs

- Offer a statewide PPO plan, and
- Instead of, or in addition to, requiring CCM proposers to bid on an OEBB-directed plan design, allow CCMs proposers to offer their own plan design options to OEBB

	Positive Aspects	Negative Aspects
Expand Variety in CCM Plan Design Offerings	• Increases the variety of plans offered • Allows for differentiation between CCMs on more than just providers and models of care • Allows for experimentation in plan design and program management • Successful alternate programs or plan features could later be leveraged across OEBB	• More choice between plans and between vendors will result in additional rate conservatism (margin/risk charges) • Makes communication of plan design harder • Makes overall program analysis harder for the Board and SEOW with multiple plan designs, features and models of care • Harder to compare plan costs between plan designs with unique features • Moves away from simplification

Ways to Offer Choice - Examples

Designs with differences at the point of care

- Offer choice to the member at the point of service with a three tier PPO design incorporating CCMs as coverage tier rather than a plan option
  - Highest level benefits available if care is provided through CCM network, neutral level benefits for care provided through PPO network, lower benefits for non-network care

	Positive Aspects	Negative Aspects
Three Tier PPO Design • **90%/70%/50%** • **Copays for CCM office visits, labs**	• Provides members choice at the point of service • Allows for a more gradual transition to CCM models of care • Avoids offering multiple plans/vendors • If available statewide, could eliminate rating issues associated with regional programs	• New benefit tier structure may be confusing to members • May not be attractive to proposers based on members ability to easily seek care outside of the CCM network • Harder for proposers to deliver on population health if members can easily access opt out of the CCM-level care • CCM proposers may not be able to offer 3-tier design based on their provider contracts

Options Based on Current Plans

Specific Plan Offering Alternatives for Consideration

- Based on previous Board discussions regarding plan design, the following design alternatives are based on:
  - Continuation of substantially similar plan designs as are offered today
  - Continuation of a statewide PPO offering
- In developing plan design options for the Board's consideration, Towers Watson has assumed the following:
  - No more that three CCM organizations will be offered in any one area of the state
  - Only one administrator will be selected to offer a statewide PPO
  - No more than One administrator will be selected in any one area of the state to offer an HMO offering
- Even with these limitations, based on PEBB final RFP overall results, OEBB could have 5+ vendors offering significantly more plan offerings than today
- The following scenarios are not exhaustive and are meant to stimulate discussions to help identify the Board's preferred approach in the RFP

Option 1 — Maintain Current Offerings

8 PPOs, 8 CCMs and 3 HMOs

Medical/Pharmacy Plan

Design alternatives for consideration

Option 1: Continue current plan offerings

- Utilize the current PPO plan designs (Plan A – H) and require all proposers offer PPO plans on a statewide basis
- Utilize 8 plan designs matching Plans A – H and require CCM proposers offer those plans on a statewide basis
- Utilize the current HMO plan designs (Plan 1 – 3) and require regionally based CCM proposers offer those plans

Positive Aspects	Negative Aspects
• Maximizes the number of plan designs available statewide	• More choice between plans and between vendors will result in additional rate conservatism (margin/risk charges)
• Provides both CCM plan design and vendor choices to members served by both a statewide and regional CCM	• Could result in up to 22 plan offerings if 3 CCMs were allowed in a region (ex. 8 statewide PPO offerings, 8 statewide CCM offerings, and 2 regional CCMs with 3 offerings each)
• Reinforces OEBB's interest in statewide solutions which reduces the cost pressures of regional rating	• Potentially difficult for members to make choices based care quality (PPO vs. CCM) due to number of plan design options
	• Regional CCMs may not be able to administer a HSA-enabled plan design
	• Likely to have the highest premium cost

Option 2 — Nine Total Plan Designs

4 PPO, 4 CCM and 1 HMO

Medical/Pharmacy Plan

Design alternatives for consideration

Option 2: Consolidate plan offerings

- Develop four new PPO plan designs that straddle the current designs and require all proposers on the PPO offer those plans on a statewide basis
- Develop four new CCM plan designs and require all CCM proposers offer those plans, whether quoting a statewide or regional offering
- Offer one HMO-style plan as an option for proposers to quote
- Likely to have a lower total premium cost than Option 1

Positive Aspects	Negative Aspects
• Provides more meaningful choice among plan values (see chart next page)	• Reduces the number of plans to choose from
• Fewer plan choices will help reduce adverse selection and may improve rates through reduced margins and risk charges	• Could result in up to 17 plan offerings if 3 CCMs were allowed in a region (e.g., 4 statewide PPOs, 3 regional CCMs with 4 offerings each and 1 HMO)
• Allows for similar plan designs across vendors	• Proposed plan designs would require members enrolled in Plan G to move to a CCM plan to find a comparable plan
	• Small CCM proposers may not be able to offer all plan designs

Medical/Pharmacy Plan
Considerations for plan changes

Plan value comparison

- The tables below compare the estimated actuarial values of the current statewide plans to the proposed consolidated plan offerings

Plan	Current Enrollment	Estimated Actuarial Value
Plan A/As	1,576	86.4%
Plan B/Bs	3,149	85.0%
Plan C/Cs	10,172	83.8%
Plan D/Ds	3,379	81.8%
Plan E/Es	4,957	80.4%
Plan F/Fs	3,265	78.6%
Plan G/Gs	5,814	77.2%
Plan H/Hs	9,945	75.2%
Plan 1	9,782	92.4%

Plan	Estimated Actuarial Value
PPO 300	85.4%
PPO 600	82.7%
PPO 1000	80.8%
PPO 1500-HSA	75.2%
CCM 300	85.4%
CCM 600	82.7%
CCM 1000	80.8%
CCM 1500-HRA	77.2%
Plan 1 — HMO	92.4%

Traditional Statewide PPO Plan
Proposed plan designs

- Provides continued access to a number of statewide PPO options with a similar range of plans but with more meaningful differences in plans
- PPO proposers would be required to offer all four plan designs

PPO Plan Provisions	PPO – 300		PPO – 600		PPO – 1000		PPO – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,000/$3,000		$1,500/$3,000	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$4,250/ $12,700	$8,500/ $25,400	$5,000/$10,000	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	----------	
MMH Incentive Care	$10	50%	$15	50%	$15	50%	20%	50%
MMH Primary Care	$20	50%	$30	50%	$30	50%	20%	50%
Non-MMH Incentive	20% (ded waived)	50%	20% (ded waived)	50%	20% (ded waived)	50%	20%	50%
Non-MMH Primary Care	20%	50%	20%	50%	20%	50%	20%	50%
Specialist	20%	50%	20%	50%	20%	50%	20%	50%
Lab	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50		$50		$50		20%	
Emergency	$100 + 20%		$100 + 20%		$100 + 20%		20%	
Other Services	20%	50%	20%	50%	20%	50%	20%	50%
Pharmacy	Same as current		Same as current		Same as current		Same as current	

*HSA-compliant plan, but could be used with or without funding to HSA
**Maximum Cost Share includes Pharmacy and ACT

Regional CCM Plans
Proposed plan designs

- Offers similar plan values as proposed PPO offering
- Introduces managed care attributes of low, fixed copayments for primary care and specialist office visits and labs
- Creates alignment with the OHA's coordinated care model initiatives
- Provides meaningful differences in plan designs and will allow OEBB to offer plans through multiple health systems in response to the RFP
- CCM proposers would be required to offer all four plan designs

CCM Plan Provisions	CCM – 300		CCM – 600		CCM – 1000		CCM – $1500*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,000/$3,000		$1,500/$4,500	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$4,250/ $12,700	$8,500/ $25,400	$6,350/ $12,700	$12,700/ $25,400
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400
MMH Incentive/Primary Care	$10	50%	$10	50%	$10	50%	$10	50%
Specialist	$20	50%	$20	50%	$20	50%	$20	50%
Lab	$10	50%	$10	50%	$10	50%	$10	50%
Urgent Care	$50		$50		$50		$50	
Emergency	$100 + 20%		$100 + 20%		$100 + 20%		$100 + 20%	
Other Services	20%	50%	20%	50%	20%	50%	20%	50%
Pharmacy	Same as current		Same as current		Same as current		Same as current	

*Not HSA-compliant

**Maximum Cost Share includes Pharmacy and ACT

Optional HMO Offering
Proposed plan design

- Allow PPO and CCM proposers to offer a copayment based HMO-style offering similar to the current Plan 1

HMO Plan Provisions	HMO In-Net Only
Deductible (single/family)	$0
OOP Max (single/family)	$1,500/ $4,500
Max Cost Share** (single/family)	N/A
PCP Office Visit	$20
Specialist Office Visit	$30
Lab	$20
Urgent Care	$35
Emergency	$100
Pharmacy	4-Tier Design

Option 3 — Eleven Total Plan Designs

5 PPO, 5 CCM and 1 HMO

Medical/Pharmacy Plan

Design alternatives for consideration

Option 3: Consolidate plan offerings

- Develop five new PPO plan designs that straddle the current designs and require all proposers on the PPO offer those plans on a statewide basis;
- Develop five new CCM plan designs and require all CCMs proposers offer those plans, whether quoting a statewide or regional offering
- Offer one HMO-style plan as an option for proposers to quote
- Likely to have premium costs higher than Option 2 but lower than Option 1

Positive Aspects	Negative Aspects
• Provides more meaningful choice among plan values (see chart next page)	• Reduces the number of plans to choose from
• Fewer plan choices may help reduce adverse selection and may improve rates through reduced margins and risk charges	• Could result in up to 21 plan offerings if 3 CCMs were allowed in a region (ex. 5 statewide PPOs, 5 statewide/regional CCMs with 3 offerings each)
• Maintains Plan G equivalent plan PPO option and Plan H equivalent plan CCM option; issues of concern to some entities	• Small CCM proposers may not be able to offer all plan designs

Medical/Pharmacy Plan
Considerations for plan changes

Plan value comparison

- The tables below compare the estimated actuarial values of the current statewide plans to the proposed consolidated plan offerings

Plan	Current Enrollment	Estimated Actuarial Value
Plan A/As	1,576	86.4%
Plan B/Bs	3,149	85.0%
Plan C/Cs	10,172	83.8%
Plan D/Ds	3,379	81.8%
Plan E/Es	4,957	80.4%
Plan F/Fs	3,265	78.6%
Plan G/Gs	5,814	77.2%
Plan H/Hs	9,945	75.2%
Kaiser Plan 1	9,782	92.4%

Plan	Estimated Actuarial Value
PPO 300	85.4%
PPO 600	82.7%
PPO 1000	80.8%
PPO 1500 - HRA	77.2%
PPO 1500-HSA	75.2%
CCM 300	85.4%
CCM 600	82.7%
CCM 1000	80.8%
CCM 1500-HRA	77.2%
CCM 1500 - HSA	75.2%
HMO Plan	92.4%

Traditional Statewide PPO Plan

Proposed plan designs

- Provides continued access to a number of statewide PPO options with a similar range of plans but with more meaningful differences in plans
- PPO proposers would be required to offer all five plan designs

PPO Plan Provisions	PPO – 300		PPO – 600		PPO – 1000		PPO – 1500		PPO – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,000/$3,000		**$1,500/$4,500**		$1,500/$3,000	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$4,250/ $12,700	$8,500/ $25,400	**$6,350/ $12,700**	**$12,700/ $25,400**	$5,000/$10,000	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	**$6,600/ $13,200**	**$12,700/ $25,400**	----------	
MMH Incentive Care	$10	50%	$15	50%	$15	50%	**$15**	**50%**	20%	50%
MMH Primary Care	$20	50%	$30	50%	$30	50%	**$30**	**50%**	20%	50%
Non-MMH Incentive	20% (ded waived)	50%	20% (ded waived)	50%	20% (ded waived)	50%	**20% (ded waived)**	**50%**	20%	50%
Non-MMH Primary Care	20%	50%	20%	50%	20%	50%	**20%**	**50%**	20%	50%
Specialist	20%	50%	20%	50%	20%	50%	**20%**	**50%**	20%	50%
Lab	20%	50%	20%	50%	20%	50%	**20%**	**50%**	20%	50%
Urgent Care	$50		$50		$50		**$50**		20%	
Emergency	$100 + 20%		$100 + 20%		$100 + 20%		**$100 + 20%**		20%	
Other Services	20%	50%	20%	50%	20%	50%	**20%**	**50%**	20%	50%
Pharmacy	Same as current		Same as current		Same as current		**Same as current**		Same as current	

*HSA-compliant plan, but could be used with or without funding to HSA

**Maximum Cost Share includes Pharmacy and ACT

Regional CCM Plans
Proposed plan designs

- Introduces managed care attributes of low, fixed copayments for primary care and specialist office visits and labs
- Creates alignment with the OHA's coordinated care model initiatives
- Provides meaningful differences in plan designs and will allow OEBB to offer plans through multiple health systems in response to the RFP
- CCM proposers would be required to offer all five plan designs

CCM Plan Provisions	CCM – 300		CCM – 600		CCM – 1000		CCM – 1500		CCM – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,000/$3,000		$1,500/$4,500		**$1,500/$3,000**	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$4,250/ $12,700	$8,500/ $25,400	$6,350/ $12,700	$12,700/ $25,400	**$5,000/$10,000**	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$12,700/ $25,400	----------	
MMH Incentive/PCP	$10	50%	$15	50%	$15	50%	$15	50%	**20%**	**50%**
Specialist	$20	50%	$30	50%	$30	50%	$30	50%	**20%**	**50%**
Lab	$10	50%	$15	50%	$15	50%	$15	50%	**20%**	**50%**
Urgent Care	$50		$50		$50		$50		**20%**	
Emergency	$100 + 20%		$100 + 20%		$100 + 20%		$100 + 20%		**20%**	
Other Services	20%	50%	20%	50%	20%	50%	20%	50%	**20%**	**50%**
Pharmacy	Same as current		Same as current		Same as current		Same as current		**Same as current**	

*HSA-compliant plan, but could be used with or without funding to HSA
**Maximum Cost Share includes Pharmacy and ACT

Optional HMO Offering
Proposed plan design

- Allow PPO and CCM proposers to offer a copayment based HMO-style offering similar to current Plan 1

HMO Plan Provisions	HMO In-Net
Deductible (single/family)	$0
OOP Max (single/family)	$1,500/$4,500
Max Cost Share** (single/family)	N/A
PCP Office Visit	$20
Specialist Office Visit	$30
Lab	$20
Urgent Care	$35
Emergency	$100
Pharmacy	4-Tier Design

Option 4 — Ten Total Plan Designs

5 PPO, 3 CCM & 2 HMO

Medical/Pharmacy Plan

Design alternatives for consideration

Option 4: Consolidate plan offerings

- Develop five new PPO plan designs that straddle the current designs and require all proposers on the PPO offer those plans on a statewide basis;
- Develop three new CCM plan designs and require all CCMs proposers offer those plans, whether quoting a statewide or regional offering
- Offer two HMO-style plans as an option for proposers to quote

Positive Aspects	Negative Aspects
• Provides more meaningful choice among plan values (see chart next page)	• Reduces the number of plans to choose from
• Fewer plan choices may help reduce adverse selection and may improve rates through reduced margins and risk charges	• Small CCM proposers may not be able to offer all plan designs
• Maintains Plan G equivalent PPO plan, issue of concern to some entities	• Could result in up to 16 plan offerings if 3 CCMs were allowed in a region (ex. 5 statewide PPO offerings, 3 statewide/regional CCMs with 3 offerings each and 1 HMO with 2 offerings)
	• Likely to have premium costs similar to Option 3

Medical/Pharmacy Plan
Considerations for plan changes

Plan value comparison

- The tables below compare the estimated actuarial values of the current statewide plans to the proposed consolidated plan offerings

Plan	Current Enrollment	Estimated Actuarial Value
Plan A/As	1,576	86.4%
Plan B/Bs	3,149	85.0%
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Plan D/Ds	3,379	81.8%
Plan E/Es	4,957	80.4%
Plan F/Fs	3,265	78.6%
Plan G/Gs	5,814	77.2%
Plan H/Hs	9,945	75.2%
Kaiser Plan 1	9,782	92.4%
Kaiser Plan 2	177	88.0%

Plan	Estimated Actuarial Value
PPO 300	85.4%
PPO 600	82.7%
PPO 1000	80.8%
PPO 1500 - HRA	77.2%
PPO 1500-HSA	75.2%
CCM 300	85.4%
CCM 600	82.7%
CCM 1500-HRA	77.2%
HMO Plan 1	92.4%
HMO Plan 2	88.0%

Traditional Statewide PPO Plan
Proposed plan designs

- Provides continued access to a number of statewide PPO options with a similar range of plans but with more meaningful differences in plans
- PPO proposers would be required to offer all five plan designs

PPO Plan Provisions	PPO – 300		PPO – 600		PPO – 1000		PPO – 1500		PPO – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,000/$3,000		$1,500/$4,500		$1,500/$3,000	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$4,250/ $12,700	$8,500/ $25,400	$6,350/ $12,700	$12,700/ $25,400	$5,000/$10,000	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$12,700/ $25,400	----------	
MMH Incentive Care	$10	50%	$15	50%	$15	50%	$15	50%	20%	50%
MMH Primary Care	$20	50%	$30	50%	$30	50%	$30	50%	20%	50%
Non-MMH Incentive	20% (ded waived)	50%	20% (ded waived)	50%	20% (ded waived)	50%	20% (ded waived)	50%	20%	50%
Non-MMH Primary Care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Specialist	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Lab	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50		$50		$50		$50		20%	
Emergency	$100 + 20%		$100 + 20%		$100 + 20%		$100 + 20%		20%	
Other Services	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Pharmacy	Same as current		Same as current		Same as current		Same as current		Same as current	

*HSA-compliant plan, but could be used with or without funding to HSA

**Maximum Cost Share includes Pharmacy and ACT

Regional CCM Plans
Proposed plan designs

- Introduces managed care attributes of low, fixed copayments for primary care and specialist office visits and labs
- Creates alignment with the OHA's coordinated care model initiatives
- Provides meaningful differences in plan designs and will allow OEBB to offer plans through multiple health systems in response to the RFP
- CCM proposers would be required to offer all three plan designs

CCM Plan Provisions	CCM – 300		CCM – 600		CCM – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$600/$1,800		$1,500/$3,000	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$3,800/ $11,400	$7,600/ $22,800	$5,000/$10,000	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400	----------	
MMH Incentive/Primary Care	$10	50%	$15	50%	20%	50%
Specialist	$20	50%	$30	50%	20%	50%
Lab	$10	50%	$15	50%	20%	50%
Urgent Care	$50		$50		20%	
Emergency	$100 + 20%		$100 + 20%		20%	
Other Services	20%	50%	20%	50%	20%	50%
Pharmacy	Same as current		Same as current		Same as current	

*HSA-compliant plan, but could be used with or without funding to HSA
**Maximum Cost Share includes Pharmacy and ACT

Optional HMO Offering
Proposed plan design

- Allow PPO and CCM proposers to offer two copayment based HMO-style offerings similar to current Plans 1 and 2

HMO Plan Provisions	HMO Plan 1	HMO Plan 2 In-Net
Deductible (single/family)	$0	$300
OOP Max (single/family)	$1,500/$4,500	$3,500/$7,000
Max Cost Share** (single/family)	N/A	N/A
PCP Office Visit	$20	$25
Specialist Office Visit	$20	$35
Lab	$30	$25
Urgent Care	$35	$40
Emergency	$100	20%
Pharmacy	4-Tier Design	4-Tier Design

Option 5 — Five Total Plan Designs

2 PPO, 2 CCM & 1 HMO

Medical/Pharmacy Plan

Design alternatives for consideration

Option 5: Significantly consolidate plan offerings

- Develop two new PPO plan designs — a high and low plan offering — and require all proposers on the PPO offer those plans on a statewide basis;
- Develop two new CCM plan designs — a high and low plan offering — and require all CCMs proposers offer those plans, whether quoting a statewide or regional offering
- Offer one HMO plan design
- Likely to have the lowest overall premium cost

Positive Aspects	Negative Aspects
• Fewer plan choices will help reduce adverse selection and may improve rates through reduced margins and risk charges	• Limits the number of plans to choose from and is significantly different than the marketplace OEBB offers today
• Easier for members to understand benefit choices	• Proposed plan designs would result in a significant number of members having changes in their benefits
• Lower administrative expenses for OEBB and entities	• Could result in up to 9 plan offerings if 3 CCMs were allowed in a region (ex. 2 statewide PPO offerings, 2 statewide/regional CCMs with 3 offerings each and 1 HMO offering)
	• Plan members choice would be limited if no CCM or HMO was offered in their geography

Medical/Pharmacy Plan
Considerations for plan changes

Plan value comparison

- The tables below compare the actuarial values of the current statewide plans to the proposed consolidated plan offerings

Plan	Current Enrollment	Actuarial Value
Plan A	1,576	86.4%
Plan B	3,149	85.0%
Plan C	10,172	83.8%
Plan D	3,379	81.8%
Plan E	4,957	80.4%
Plan F	3,265	78.6%
Plan G	5,814	77.2%
Plan H	9,945	75.2%
Plan 1	9,782	92.4%

Plan	Actuarial Value
PPO High Value (Plan C equivalent)	83.8%
PPO 1500 – HSA (Plan H equivalent)	75.2%
CCM High Value (Plan B equivalent)	85.0%
CCM 1500-HRA (Plan G equivalent)	77.2%
Plan 1 — HMO	92.4%

Traditional Statewide PPO Plan
Proposed plan designs

- Provides continued access to statewide PPO options with a meaningful difference in plan values

- PPO proposers would be required to offer both plan designs

PPO Plan Provisions	PPO – 500		PPO – 1500 HSA Qualified*	
	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$500/$1,500		$1,500/$3,000	
OOP Max (single/family)	$3,300/ $9,900	$5,900/ $17,700	$5,000/$10,000	
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	----------	
MMH Incentive Care	$10	50%	20%	50%
MMH Primary Care	$20	50%	20%	50%
Non-MMH Incentive	20% (ded waived)	50%	20%	50%
Non-MMH Primary Care	20%	50%	20%	50%
Specialist	20%	50%	20%	50%
Lab	20%	50%	20%	50%
Urgent Care	$50		20%	
Emergency	$100 + 20%		20%	
Other Services	20%	50%	20%	50%
Pharmacy	Same as current		Same as current	

*HSA-compliant plan, but could be used with or without funding to HSA
**Maximum Cost Share includes Pharmacy

Regional CCM Plans
Proposed plan designs

- Introduces managed care attributes of low, fixed copayments for primary care and specialist office visits and labs
- Creates alignment with the OHA's coordinated care model initiatives
- Provides some choice in plan designs and will allow OEBB to offer plans with unique health care deliver model options
- CCM proposers would be required to offer both plan designs

CCM Plan Provisions	CCM – 300		CCM – $1500*	
	In-Net	Out-Net	In-Net	Out-Net
Deductible (single/family)	$300/$900		$1,500/$4,500	
OOP Max (single/family)	$2,950/ $8,850	$5,900/ $17,700	$6,350/ $12,700	$12,700/ $25,400
Max Cost Share** (single/family)	$6,600/ $13,200	$13,200/ $26,400	$6,600/ $13,200	$13,200/ $26,400
MMH Incentive/Primary Care	$10	50%	$10	50%
Specialist	$20	50%	$20	50%
Lab	$10	50%	$10	50%
Urgent Care	$50		$50	
Emergency	$100 + 20%		$100 + 20%	
Other Services	20%	50%	20%	50%
Pharmacy	Same as current		Same as current	

*Not HSA-compliant
**Maximum Cost Share includes Pharmacy

Optional HMO Offering
Proposed plan design

- Allow PPO and CCM proposers to offer a copayment based HMO-style offering similar to the current Plan 1

HMO Plan Provisions	HMO In-Net
Deductible (single/family)	$0
OOP Max (single/family)	$1,500/$4,500
Max Cost Share** (single/family)	N/A
PCP Office Visit	$20
Specialist Office Visit	$20
Lab	$20
Urgent Care	$35
Emergency	$50
Pharmacy	4-Tier Design

Summary

Summary of Options

	Option 1 (8 PPOs/ 8 CCMs/ 3 HMOS)	Option 2 (4 PPOs/ 4 CCMs/ 1 HMO)	Option 3 (5 PPOs/ 5 CCMs/ 1 HMO)	Option 4 (5 PPOs/ 3 CCMs/ 2 HMOs)	Option 5 (2 PPOs/ 2 CCMs/ 1 HMO)
Member Choice					
Overall Premium Cost	$$$$	$$$	$$$	$$$	$
Competition Among Vendors					
Likelihood of Increased Risk Charges					

Ways to Mitigate Risk and Cost

- Minimize the number of vendors
  - Underwriting risk is better shared over large numbers of individuals within the same carrier
  - Choice between vendors introduces anti-selection concerns and can lead to higher costs
  - Fixed costs are lower for the vendors and for OEBB and entities
- Reduce number of plans offered on a regional basis by looking for statewide vendors and use regional vendors to “fill in the gaps”
  - Statewide proposers will be more comfortable with risk and therefore add less risk and margin to rates
  - Minimizes the number of vendors
- Risk adjust premiums by requiring vendors to agree to adjust premiums based on the risk of the population that enrolls in their plan
  - Reduces risk of anti-selection so proposers would add less risk and margin to rates
  - Creates a more level playing field and more stable rates overtime
  - Difficult to get vendors to agree and requires additional actuarial support

Summary

- The RFP allows the Board an opportunity to explore new plan options and assess the cost of choice through the bid process
- Regardless of plan designs requested in the bid process or the number of vendors selected, members will be impacted by the introduction of new designs, new vendors and new models of care
- The key to the future success of OEBB plan offerings requires the Board to balance choice and cost in the effort to provide the right care and insurance protection to members

Appendix

Summary of Options	Positive Aspects	Negative Aspects
Current Plans — Offer a statewide PPO with 8 plan offerings, up to 3 regional CCMs with 8 plan offerings and 1 HMO with 3 plan offerings (up to 35 plan offerings for members)	• Significant choice of designs and vendors for members	• Potentially difficult for members to make good choices based on number of plans • Small CCM proposers may not be able to offer all plan designs • More plan choice between plans and between vendors will result in additional rate conservative-ism (margin/risk charges)
Option 1 — Continue current plan design offerings (up to 22 plan offerings for members)	• Lots of member choice on plan design and provider networks	• Likely to produce highest cost premiums due to higher risk charges and margin • Regional CCMs may not be able or willing to offer all plan designs
Option 2 — Consolidate to 4 PPOs/4 CCMs/1 HMO design (up to 17 plan offerings for members)	• Member choice is still high • Premiums will likely be lower with reduced risk charge and margin	• No Plan G option available in statewide PPO offering • Regional CCMs may not be able to or willing to offer all plan designs
Option 3 — Consolidate to 5 PPOs/5 CCMs/1 HMO designs (up to 21 plan offerings for members)	• Member choice is still high • Incorporates a Plan G option to statewide PPO offering • Incorporates an HSA-enabled CCM plan offering • Premiums will likely be slightly lower with reduced risk charge and margin	• Regional CCMs may not be able or willing to offer all plan designs
Option 4 — Consolidate to 5 PPOs/3 CCMs/1 HMOs designs (up to 15 plan offerings for members)	• Member choice is still high • Premiums will likely be slightly lower with reduced risk charge and margin	• Regional CCMs may not be able or willing to offer all plan designs
Option 5 — Consolidate to 2 PPOs/2 CCMs/1 HMO designs (up to 9 plan offerings for members)	• Meaningful choice between options • Premiums will likely be lower with reduced risk charge and margin • Likely delays excise tax on PPOs and CCMs	• Forces members to buy down or move to a high deductible health plan • Reduces members choice in plan options

OEBB Medical/Pharmacy Plans
History of plan offerings

- Three vendors were reduced to two in 2011-2012 as a result of significant rating issues
- The number of plan offerings grew with the addition of Summit/Synergy and Kaiser Plan 3 options for the 2014-15 plan year
- Several plans have similar benefit values (actuarial plan values)
- Currently significantly more members enrolled in PPO options than CCM options
- CCMs not available statewide to OEBB members
- RFP likely to result in more vendors

	Prior to 2012 – 13	2012 – 13	2013 – 14	2014 – 15	2015 – 16
Providence Options	2	N/A	N/A	N/A	N/A
Moda Options	7	7	8	8 Statewide 8 Summit/Synergy (available in select regions)	8 Statewide 8 Summit/Synergy (available in select regions)
Kaiser Options (available in select regions)	2	2	2	3	3
Total	11	9	10	19	19

History of Plan Changes for Medical/Pharmacy

Plan Years	OEBB Action
2009 – 10	• Tobacco cessation program introduced • Addition of Kaiser Plan 1A • Change pharmacy copayments (Providence)
2010 – 11	• Weight Watchers for subscribers (all plans) • Coverage for hearing aids added (all plans) • Increased specialist office visit (Kaiser 1) • Introduced $4 Rx Value Tier for: asthma, heart conditions, cholesterol, high blood pressure and diabetes (ODS and Providence) • Incentive office visits for chronic conditions (ODS) • Additional Cost Tier (ACT) added for Advanced Imaging, Sleep studies, Spine Surgery, Joint replacements, Arthroscopies (ODS)
2011 – 12	• Weight Watchers for dependents added (all plans) • Increased Rx Out of Pocket Limit (all plans) • Added copays for lab and x-ray (Kaiser 1 and 1A) • New $100 deductible and 20% coinsurance (Kaiser 1A) • Changed to Medical Home based plan design (Providence) • New deductibles, changed copay/coinsurance designs (Providence) • Changed Plan 4 to a Limited Network plan (ODS) • Increased Specialist and Urgent Care Copays (ODS) • Increased Max Out Of Pocket Limits (ODS) • Reduced Out of Network benefit (ODS)

History of Plan Changes for Medical/Pharmacy

Plan Years	OEBB Action
2012 – 13	• Providence medical plans discontinued • Coverage for bariatric surgery subject to ACT under Moda (subscribers only) (all plans) • Increased deductible (Kaiser 1A) • Added Value Tier Rx for Plan 9 • Consolidated Rx plan designs and bundled with medical (ODS) • Informed Enrollment pilot program for better consumer decision-making
2013 – 14	• Realigned deductibles and annual out of pocket maximum (OOPM) (all plans) • Enhanced substance abuse benefits (all plans) • Healthy Futures plan design incentive with lower deductible in future plan years for participants (all plans) • Wellness visits (all plans) • Reduced copay for medical homes (Moda) • Changed Rx plan designs from $4/$8/$25/50% with $1,100 annual Rx OOPM to $0/$16/25% up to $100/50% up to $300 per Rx (Moda) • Comprehensive Care Coordination program introduced (Moda) • Added lumbar discography to ACT (Moda) • Reference pricing for oral appliances for sleep apnea (Moda • Expanded Informed Enrollment tool to all OEBB members • Increased copays by $5 (Kaiser) • Dependent eligibility reviews begun • Added 90-day supply at retail for generic and value prescriptions (Moda)

History of Plan Changes for Medical/Pharmacy

Plan Years	OEBB Action
2014 – 15	• Introduced new Synergy/Summit plan options (16 new Moda plan options) • Reference based pricing for oral appliances and hip/knee replacements (Moda) • ACT added for tonsillectomies and herniorraphies (Moda) • Added End Stage Renal Disease management program (Moda) • Added coverage for Applied Behavioral Health Analysis effective 1/1/2015 (Moda) • Deductibles and copayments apply to the plan Out of Pocket Maximum limit (Moda) • Introduced new HSA compatible option (Kaiser Plan 3) • Added Home Health Palliative care and increased deductible (Kaiser Plan 2) • Added reimbursement of materials associated with group prenatal visits • Added 100% coverage for diabetic medications and supplies for women during pregnancy • Coverage for ABA therapy on all OEBB plans retroactive to October 1, 2014 • Coverage for Gender Dysphoria effective January 1, 2015