



Oregon Educators Benefit Board Minutes October 25, 2007

The Oregon Educators Benefit Board held a regular meeting on October 25, 2007, at the Willamette Education Service District, 2600 Pringle Road in Salem, Oregon. Chair Steve McNannay called the meeting to order at 10:15 a.m.

Attendees

Board Members:

Brett M. Yancey, Vice Chair
Michael J. Cannarella
Richard T. Clarke
Ron A. Gallinat
Alison S. Little, MD
Victor S. Musial
Peter M. Tarzian
Thomas A. Husted

Board Members Absent:

Mylia Christensen
Steve H. McNannay

OEBB Staff:

Jean Thorne, PEBB/OEBB Administrator
Denise Hall, OEBB Deputy Administrator
Carolyn Bader, Contracts Officer
Glenn Baly, Program/Policy Analyst
Ali Hassoun, Financial Coordinator
Scott Rupp, Communications Coordinator
Heidi Williams, Director of Operations
Rose Mann, Executive Assistant

Watson Wyatt Consultants:

Geoff Brown
Steve Carlson
Anne Thompson
Carol Butterfield

Guests:

Approved November 8, 2007

Steve Schmick, Kaiser Permanente
Shelia Jameson, OEA Choice Trust
Doug Franz, Regence
Megan Myrick, Willamette Dental
Gordon Hoberg, ODS
Renee McDonald, Regence
Brian Riney, Providence
Randy Skinner, Advantage
Carolyn Van Dyke, CCIS
John Dalen, City County Insurance Services
Diana Skutack, Benefit Help Solution
Lisa Trussel, Health Net of Oregon
Mary Margaret Castaneda, Health Net



Brett Yancey welcomed Board members, OEBC staff and guests.

1. Approval of October 11, 2007, Board meeting minutes (Attachment 1)

Ron Gallinat moved to approve the Board meeting minutes of October 11, 2007. Richard Clarke seconded the motion. The motion carried 8 - 0.

2. Plan Design Workgroup Report and Preliminary Recommendations (Attachments 2 -5, A, B, and C)

Steve Carlson explained that the information from the survey has been incorporated into the handouts presented at today's meeting (Handouts A, B, and C).

Geoff Brown stated that 92 percent of districts (representing 95 percent of the population) have provided data to date. All but 20 districts have provided information. Watson Wyatt received direct input on all but 72 out of 217 districts. Three districts have declined to participate.

Steve Carlson stated that today's discussion will focus on medical, dental and vision plans.

Steve Carlson reviewed the proposed definition of comparability and explained that a definition explaining how Watson Wyatt arrived at the actuarial values has been added below the Design definition included in Attachment A. A new OEBC option will be considered "comparable" to a pre-OEBC option if the difference between their actuarial values is less than or equal to 2.5 percent. Actuarial values will be determined using an industry standard valuation model

based on a broad (national) claims dataset of allowed charges to determine the estimated claims that would be paid under the particular plan option.

Steve Carlson explained that an appropriate trend factor will be applied to a district's prior plan option based on prevailing rates in Oregon at the time the comparability test is conducted. The trend factor will be specific and appropriate to the type of coverage. Things that will affect the trend factor will be what is happening in the medical community such as new services being available and the price of those services and shifts in utilization (new services may be used more or used less). The trend adjustment will not be a one-time occurrence. The Board can approve trend factors each year or approve a methodology to measure trend factors which can be used each year. The Board will discuss the methodology further after the first of the year.

Steve Carlson explained that the Scope applies to all plans prior to coming into OEBC and there was a discussion in the workgroup that there might be exceptions if a current plan has less than 100 employees enrolled pre-OEBC.

Steve Carlson also reviewed the proposed OEBC plans (Attachment 2). He explained that there are predominantly HMO and PPO plans and the workgroup is recommending that HMO and PPO plans be offered with a choice of benefit levels and possibly networks. Steve explained that the workgroup came up with 13 plan options and determined that the employee groups can pick up to four plans from those 13 that OEBC offers. Members will then be able to pick among those four plans.

All plan options will provide the same (favorable) reimbursement for preventive services including periodic exams and screenings per attached US Preventive Services Task Force guidelines (in Attachment A). The workgroup recommends 100% coverage, with or without co-pay. Further discussions are necessary to determine if the Board supports first dollar benefits for preventive services obtained in-network.

Specific PPO provisions will include:

- Office Visits –
 - ✓ Some options would apply deductible and coinsurance for office visits -- like other services
 - ✓ Alternative options would be available where a co pay applies instead
- Emergency Room Visits

- ✓ Most plan options apply same initial dollar co pay of \$100/visit, waived if admitted (exception for plans with \$500 deductible and up)
- ✓ Coinsurance also applies and always at the in-network level
- Out-of-Network cost-sharing
 - ✓ Will always be greater than in-network (e.g., coinsurance, out-of-pocket maximum)

The workgroup also discussed proposed covered services (Attachment C). **Steve Carlson** stated that some areas of covered services will require further discussion with the Quality Workgroup (the Plan Design and Quality workgroups will have a joint meeting on October 31).

Brett Yancey asked about members being able to opt out and stated that different districts have different understandings about opt-out and asked if this will be an issue for individual districts (part of collective bargaining agreements) or is it an OEBC issue? **Steve Carlson** stated that he does not see this as an OEBC issue unless there is a risk attached. **Brett Yancey** suggested that this issue be placed on the Issues Log and that it be discussed in more detail at a later meeting.

The Plan Design Workgroup will present proposed medical plan designs and the comparability standard for the Boards' final review and consideration at the November 8, 2007, Board meeting.

LUNCH - 12:05 to 12:40

Steve Carlson stated that the workgroup proposes offering four pharmacy plans; three with open formulary and one with a closed formulary available to HMO enrollees. The workgroup is recommending that the employee groups will match those four choices with the medical plans they choose. Each group may select a pharmacy plan option to be paired with each of their selected medical plan options. They need not select the same pharmacy option for all medical plan options, but they can have only one pharmacy option associated with each medical plan.

Ron Gallinat stated that he would prefer for the districts to have options on pharmacy plans so that they can better meet the comparability of their current plans.

All pharmacy plan options will include the following:

- Same formulary, with basis in medical evidence
- Lower cost-sharing for generics and mail order
- An annual out-of pocket maximum of \$1,000 for members

- Certain preventive medication will be provided at 100% coverage – recommendation to be determined with the Quality Workgroup

Jean Thorne asked whether it was realistic to assume that health plans would be willing to have a common formulary, given that this will be in a fully-insured environment. **Steve Carlson** indicated that it probably was not, but that OEBC could direct that the health plan formularies meet certain criteria, such as making sure that each class of drugs had at least one drug on the preferred tier.

Victor Musial expressed concern about not having any non-preferred drugs with flat co pays for classified employees or those who don't make a lot of money and have to budget for prescriptions.

Steve Carlson responded that Watson Wyatt can bring back an example as it relates to administration and selection.

Steve Carlson reviewed the proposed dental plans (Attachment 4) and explained that Watson Wyatt valued a couple of plans that have integrated medical and dental deductible plans, but the workgroup is not recommending plans that have integrated medical and dental deductibles in the future.

Steve Carlson stated that the workgroup is recommending making nine dental plans available that will include PPO and DHMO plan types. Each employee group will then be able to select up to three options to offer members. Each employee group may elect an orthodontia option to be paired with each of the dental options offered and they must include orthodontia in all options or exclude orthodontia from all options.

Steve Carlson stated that the workgroup is recommending four vision plan options (Attachment 5) and each employee group may select one option to offer to its members.

The next steps will be to look at the concerns surrounding the pharmacy issue, work with the Quality Workgroup on exclusions and covered services, determine life/disability plan designs, and look at long-term care plan designs. If any Board members have questions regarding the Plan Design Workgroup they should contact Denise Hall, deputy administrator.

3. Administration Workgroup Report and Preliminary Recommendations

Heidi Williams reported on the Administration Workgroup and preliminary recommendations.

The Administration Workgroup has reviewed and discussed several different administrative models. The workgroup considered internal centralization with full automation or partial automation, third party administrator (TPA) or decentralization as it is currently.

The workgroup ruled out decentralization as a viable option for the following reasons:

- It is the least efficient process to administer benefits;
- It does not move OEGB toward their vision;
- It is a more costly model and will not result in administrative savings over time;
- It does not allow for efficient online delivery of information and health decision support tools (which could be part of a future vision) and;
- It does not easily lend itself to allowing for online enrollment (OEGB staff talked to different stakeholders, who all desired/supported an online benefit enrollment process).

The workgroup ruled out a Third Party Administration (TPA) model for the following reasons:

- It is considered to be associated with significantly greater costs than a comparable internally centralized model (although the TPA model is a common administrative model).
- It is believed that there are processes, lessons learned, and potentially technology that can be leveraged from PEBB that would give OEGB a 'jump-start' on an internally centralized model (using the pebb.benefits system as a starting point).
- An internally centralized model with sourced externally developed technology will allow OEGB more flexibility of approach (regarding administration and participant call support).
- A TPA would likely not be quite as familiar with the workings of the school districts.

An internally supported centralized model would have the following short-term (next 12 months) goals:

- On-line entry of eligibility. School district and education service district (ESD) designated personnel will enter members' eligibility information on-line. This will include edits and changes as members' eligibility status changes.
- On-line enrollment for benefits using a centralized system that will enable the member to select and enroll for benefit plans and options

available based on eligibility data determined by the school district or ESD.

- Electronic transfer of enrollment and benefit selection data to the carriers.
- Receipt and payment of premiums. School districts and ESDs would submit their premium payments to an OEGB-designated account. OEGB staff would issue payments to the carriers on behalf of the school districts and ESDs. The intent is to set up an electronic transfer of funds whereby school districts and ESDs will transfer premium payments from their account to a designated OEGB account and OEGB will electronically transfer premium payments to carriers.

The following are long-term goals for centralized administration with full automation to be accomplished over the next three years:

- Electronic transfer of funds from school districts and ESDs to a designated OEGB account. OEGB would then electronically transfer premium payments to carriers.
- Electronic transfer of eligibility data whereby school districts and ESDs can send electronic files of all eligible members or changes that occur.
- Continued process improvements and system enhancements that would be determined on an ongoing basis.

On-line enrollment and other short-term goals will be the priority of the OEGB staff. OEGB will continue to update the Board on development related to the long-term goals.

To implement the centralized model would require the following next steps:

- Obtain funding and position authority (will require requesting authority during the 2008 Special Session);
- Determine contracting authority for systems, programming, etc; and
- Determine best contracting method to use considering time factor, resources, expertise and risk

Jean Thorne explained that in order to move an issue to the Special Session an agency has to get support from the Governor's Office and the Governor's Office is in support of this funding. Because of timing issues related to the Special Session, she indicated that general Board direction was needed at this time as to whether a centralized model was supported. The Board indicated concurrence with this direction.

Heidi Williams explained that the workgroup also discussed two possible customer service models. The decentralized model would be a three-tiered

model where the members would go to the carriers for claims questions, then to the local school district for other questions, and if a school district has a more complex question they would then call OEBC. The centralized model will have OEBC as the call center for all questions. The workgroup recommends the decentralized model where members can call their local school district first and then if the school district does not have an answer the school district would contact OEBC. The workgroup agreed that many members will prefer being able to contact someone locally with whom they are familiar and whom they trust rather than calling a stranger at OEBC.

Tom Husted explained that the decentralized customer service model may be an added cost to districts and this needs to be considered. **Heidi Williams** explained that the workgroup discussed the fact that some districts may not have dedicated staff to answer questions and considered OEBC staff answering members' questions for the smaller districts.

Peter Tarzian suggested that OEBC budget for a customer service core initially.

Brett Yancey stated that people want to contact a person with whom they have a relationship.

Heidi Williams explained that the workgroup looked at OEBC's role in customer service as being more supportive as opposed to controlling. Training will be provided to the designated people in the school districts.

Peter Tarzian suggested that if customer service is presented to the districts as more of a partnership then the reception and cooperation will be much greater.

The workgroup will come back with more information and recommendations on the customer service model.

4. Quality Workgroup Report and Preliminary Recommendations

Jean Thorne presented proposed recommendations of the Quality Workgroup.

During its plan design process, OEBC should consider the availability and member cost sharing for the following programs and services as means to improve overall health and wellness. Bidders will be asked to separately bid on the following elements so that the cost of these elements can be assessed against standard ("comparable") plan designs:

- 100% coverage of US Preventive Services Task Force recommended periodic preventive screenings (not annual physical exams across the board).

- 100% coverage of immunizations
- Prescription drug plan possibilities regarding three-tiered designs to include:
 - ✓ Lower co-pay for generic equivalents;
 - ✓ Higher co-pay or co-insurance for non-preferred brand levels;
 - ✓ Percentage co-insurance for non preferred brand levels;
 - ✓ Possible front end deductible for individual and family that exempts the generic out-of-pocket and;
 - ✓ Annual maximum out-of-pockets for individual and family

Other plan considerations:

- Coverage for preventive medications and medications used in chronic disease management;
- Possible coverage designs for specialty medications;
- Special coverage rules and designs for insulin and diabetic supplies;
- Coverage of select tobacco cessation medications along with home-delivered over-the-counter (OTC) nicotine replacement patches/gum/lozenges

The workgroup recommends the following requirements for submitting a bid:

- Plans must have participated in the eValue8 Request for Information (RFI) in 2007 or participate in 2008 to be considered as a potential vendor. Selected plans must also continue to participate in eValue8 as a contract requirement. EValue8 is a nationally-recognized tool developed by the National Business Coalition on Health that provides purchasers with the ability to evaluate the performance of health plans on a wide variety of quality indicators. Almost all of the Oregon-based health plans participated in eValue8 in 2007. Requiring participation in the eValue8 RFI will provide OEBC with a baseline measurement on participating health plans processes and systems related to a large number of quality indicators. Subsequent eValue8 assessments can then be used in bringing about quality improvements at participating health plans through the contract renewal process.

Bidders will be asked to provide data on their ability and projected costs for providing or implementing the following quality-improvement programs and services. This information, along with provided data on past experience and effectiveness, will be used in the selection process:

- Consumer information and resources
 - ✓ On-line provider quality and cost rating tools by procedure

- Integration and Technology -
 - ✓ Active promotion of electronic medical records
 - ✓ Provision of standard Personal Health Records for beneficiaries, with feeds from member and various data sources
 - ✓ Provide incentives for interoperable Health IT
 - ✓ Behavioral health networks that include 24/7 support to members and primary care
 - ✓ Participation in community collaborative efforts to create “medical homes” that allow patients to receive personalized care and resources that are coordinated and managed by a single practitioner or team

- Measurement and Reporting
 - ✓ Actively encourage contracted hospitals participation and reporting to the Leapfrog Initiative
 - ✓ Provide support to community collaborative efforts on primary care measurement and reporting (Oregon has a broad-based effort involving most health plans that will serve as a basis for more valid physician performance reporting and improvement than if it is only done on an individual plan basis)
 - ✓ Required reporting on selected (OEBC defined) Healthcare Effectiveness Data and Information Set (HEDIS) measures
 - ✓ Study geographic variation in care and provide related beneficiary and provider education

- Programs and Services
 - ✓ Centers of Excellence for targeted procedures (e.g., major surgeries, transplants)
 - ✓ Use of value-based plan designs (e.g., Rx, pay-for-performance)

- Utilization Management
 - ✓ Mandatory “notification” of non-emergency hospital admissions (stronger alternative: mandatory “Pre-admission review”) with financial penalty
 - ✓ Length of stay management (concurrent review, including proactive discharge planning at admission)
 - ✓ Large case management
 - ✓ Coordination with short-term disability, EAPs, health care decision-support

- ✓ Targeted retrospective review of non-preauthorized admissions to improve quality in the future.
- Pharmaceutical Benefit Management
 - ✓ Programs, Services and Utilization
 - Program to increase generic drug utilization by prescribers and providers
 - Maintenance of an evidence-based formulary, including a detailed process regarding formulary creation and management
 - Management of a step therapy program
 - Quantifiable and documented prescription management prior authorization process.
 - Prescriber engagement and feedback program
 - Medication adherence program
 - ✓ Patient Safety
 - Promotion and incentives for e-prescribing use and systems
 - Review of patients' adverse events
 - Program/systems to reduce dispensing errors

The following are proposed specific actions or items that OEBC will require a health plan contract recipient to provide or undertake once a contract with OEBC has been signed:

- Reporting of selected (OEBC defined) HEDIS measures by health plans
- Participating in community collaborative efforts to create "medical homes" that allow patients to receive personalized care and resources that are coordinated and managed by a single practitioner or team.
- Continued participation in eValue8
- Requiring detailed performance guarantees in regard to the pharmacy benefit that may include: speed to answer, abandon rates, member satisfaction, OEBC satisfaction, turn-around time at home delivery, accuracy at home delivery, key indicator milestones or benchmarks
- Complete transparency in regard to all prescription pricing components

The Quality Workgroup recommends that the following disease and health management programs/services be included in the selection process. The recommendations are based on best practices among large health plans in the

United States that were derived from published medical evidence and from expert opinions and experiences. The October 1, 2008, recommendations are aligned, as best they know at the moment in time, with prevailing levels of benefits among Oregon Health plans for school district employees. Vendors will be asked to provide data on their ability and projected costs for providing or implementing the following programs and services. This information along with provided data on past experience and effectiveness will be used in the selection process. Additional elements are to be considered for potential inclusion on October 1, 2009.

Recommendations for October 1, 2008:

- Health Management
 - ✓ Web portal
 - ✓ Online lifestyle change programs
 - ✓ Online health search engine
 - ✓ Online health information
 - ✓ Tobacco cessation program (online and telephone), including home-delivered nicotine replacement therapy medications (nicotine patch, gum, or lozenges)
- Disease Management Program focusing on cardiovascular, diabetes, lower back pain, high risk maternity
 - ✓ Predictive modeling by the carrier or vendor
 - ✓ Effective outreach and participant engagement
 - ✓ Coaching by RNs (online and telephone)
 - ✓ Other online and mailed educational programs, materials, tools and clinical monitoring
 - ✓ Coordination with short-term disability program, EAPs, utilization management, health care decision-support
- Health Care Decision-support
 - ✓ RN coaching for preference-sensitive conditions (online and telephone)
 - ✓ RN coaching for triage of minor illnesses & injuries (online and telephone)
 - ✓ Online tools
 - ✓ Home-delivered self-care book to each family

Proposed recommendation for October 1, 2009 – The programs and services listed below are recommended additions to be potentially used in the assessing and scoring for contract renewal/selection on October 1, 2009:

- Health Management
 - ✓ Online and paper Health Risk Appraisals
 - ✓ Onsite biometric screenings
 - ✓ Lifestyle behavior change coaching (e.g., exercise, weight management, stress management, nutrition)
 - ✓ Personalization of online health information/tools and telephone services

- Disease Management
 - Expanded disease management program (to be verified by Avoidable Claims Analysis) that may include depression, asthma, Chronic Obstructive Pulmonary Disease, and other conditions for improvements in quality and cost management

Recommendation for Disease/Health management Request for Proposals

The Quality Workgroup and Watson Wyatt believe that no health insurance company, nor any single carve-out vendor, has best-practice services in all areas. The Quality Workgroup recommends that the OEBC request for proposal for health and disease management services be available to both health insurance companies and specialty carve-out vendors. The proposals will be evaluated on a number of factors, including program quality, outcomes, costs and member satisfaction. OEBC can then select the vendor(s) best able to administer an optimal health and /or disease management program at the lowest cost.

Alison Little asked if it would make a difference if the providers are given a year to participate in eValue8? **Jean Thorne** explained that if they are required to participate this year then the Board will have good baseline information for comparison for renewal of contracts.

Alison Little stated that she is not prepared to say that all of these quality components are important, especially disease management since she has not yet seen evidence that disease management helps at all.

Richard Clarke stated that he believes the Board needs to be clear about the scoring criteria.

The Board expressed the following concerns around the quality component of plan designs:

- Criteria scoring
- Issues of affordability
- The possibility of the elimination of potential vendors based on them not being able to meet every one of these criteria.

The Board agreed to require participation in eValue8 as a requirement for submitting a bid.

The workgroup will continue its review and address these concerns.

5. Communications/Change Management Workgroup Report

Scott Rupp reported on the proposed recommendations of the Communication/Change Management Workgroup. The workgroup discussed the preliminary charter for the Outreach Network (Attachment 8).

The Oregon Educators Benefit Board Outreach Network would be a representative group of school district and education service district employees from districts throughout Oregon. The Outreach Network would provide the Board with qualitative information about the development of the OEBB benefit plans and programs and its communication to members.

Members of the OEBB Outreach Network would be self-nominated and selected to represent the Board without regard to an individual's race, color, religion, gender, marital status, national origin, political affiliation or age.

The Network would serve to gather data, report perceptions, report reactions on issues of their constituents in their respective geographic regions. The information gathered will help the Board and staff shape programs and messaging to achieve short-and long-term goals. The Outreach Network would have no authority to direct program development or communication, but would provide a vital link with districts and future members.

The OEBB is committed to keeping the Outreach Network informed of progress at key milestones. The Board's expectation is that the Outreach Network would provide timely and candid feedback. The OEBB staff will facilitate communication with Outreach Network members via teleconference, e-correspondence and printed materials or face-to-face.

The ideal Outreach Network member is energetic, respected by their colleagues, possesses the ability to clearly explain complicated matters to others, has a desire to make a direct impact on their peers' lives, and is connected to the community.

Scott Rupp stated that a more comprehensive plan and an application packet will be presented to the Board at the next meeting.

Concerns were expressed by Board members with the concept of the network "representing" the Board. The workgroup does not intend for the network members to formally represent the Board, so will amend that language.

Brett Yancey suggested adding a statement about being unbiased and objective.

Peter Tarzian explained that the plan would be to have Outreach Network training around the state that will include labor and management.

On other issues:

Richard Clarke asked about the time frame for plan designs to be communicated to the constituents. He believes this should be released prior to the RFPs going out.

Plan Designs will be posted on the OEBC Website once approved by the Board. Watson Wyatt will provide a cover letter about what is being looked at, how these proposed plans were arrived at and why.

There were no public comments.

Due to time constraints, the Board deferred the Work plan update and the Issues Log to a future meeting.

There being no further business to come before the Board the meeting adjourned at 3:45 p.m.