Chair Kimberly Hendricks will convene a public meeting of the PEBB Board on Tuesday, December 21, 2021, at 9:30 a.m. The meeting will be held via video conference using Microsoft Teams.

PEBB BOARD AGENDA
DECEMBER 21, 2021

Click here to join the meeting

I.	9:30 a.m. – 9:35 a.m. Attachment 1 **ACTION**	**Call to order and approval of November 16, 2021 Board Meeting minutes** *Kimberly Hendricks, Chair*
II.	9:35 a.m. – 9:45 a.m. Attachments 2, 2.1 and 2a **ACTION**	**OAR Division 65 (SB 551) – request to file as permanent rule** **OAR Division 15 – request to file as temporary rule and move into the permanent rulemaking process (SB 748 and housekeeping)** *April Kelly, Program Benefits and Services Coordinator* *Glenn Baly, Program Policy Liaison*
III.	9:45 a.m. – 10:00 a.m.	**Value-based Compact Committee Update** *Jeremy Vandehey, Director - Health Policy & Analytics Division*
IV.	10:00 a.m. – 11:30 a.m. Attachment 2	**Utilization Dashboard** *Emery Chen, Mercer Health & Benefits, LLC*
	11:30 a.m. – 11:40 a.m.	***BREAK***
V.	11:40 a.m. – 11:50 a.m. Information Only	**Consultant RFP Update** *Brian Olson, Contracts Manager*
VI.	11:50 a.m. – 12:05 p.m.	**Innovation Workgroup Update** *Margaret Smith-Isa, Program Development Coordinator*
VII.	12:05 a.m. – 12:10 p.m.	**Other Business/Public Comment**
		ADJOURN

Public Employees' Benefit Board
Meeting Minutes
November 16, 2021

The Public Employees' Benefit Board held a regular meeting on November 16, 2021 via Microsoft Teams video conferencing. Chair Kimberly Hendricks called the meeting to order at 9:30 a.m.

Attendees

Board Members:
Kimberly Hendricks, Chair
Shaun Parkman, Vice Chair
Kim Harman
Siobhan Martin
Kate Nass
Mark Perlman
Jeremy Vandehey

Board Members Excused/Absent:
Dana Hargunani
Senator Betsy Johnson (non-voting member)
Representative Andrea Salinas (non-voting member)

PEBB Staff:
Ali Hassoun, Director
Damian Brayko, Deputy Director
Cindy Bowman, Director of Operations
Brian Olson, Contracts Manager
Glenn Baly, Program/Policy Liaison
April Kelly, Benefits and Services Coordinator
Rose Mann, Board Policy and Planning Coordinator

Consultants and Presenters:
Steven Noeldner, Rin

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I. Roll call and approval of September 21 and October 19, 2021 Meetings Minutes (Attachment 1and 1a)

Chair Kimberly Hendricks called the meeting to order and asked for a motion to approve the minutes from both the September21 and October 19, 2021 PEBB Board meetings.

MOTION

Siobhan Martin moved to approve both the minutes from the September 21 and October 16, 2021, PEBB Board meetings. Kim Harman seconded the motion. The motion carried.

II. PEBB Member Advisory Committee (PMAC) Recommendations

Brian Olson, Contracts Manager/PMAC Staffer and Steven Noeldner, Principal, Total Health Management Mercer Health & Benefits, LLC led the Board through a discussion on HEM recommendations from the PEBB Member Advisory Committee. They discussed the process steps and reviewed PEBB- specific data.

Consultants with Mercer presented HEM evidence for best practices and along with PMAC suggested several employer incentive models and discussed a future HEM program.

PMAC asked if the Board had any other ideas or guidance for PMAC going forward.

Brian Olson stated that he and Theresa Cross would be able to come back to the Board with better information on how the committees fit together and the different roles they could play that are unique to them. Brian and Theresa will come back to the Board at a future meeting with a proposal on how the work can fit together within the health equity lens because that is a priority.

III. Innovation Workgroup Update (Attachment 3)

Shaun Parkman, IW Vice Chair, and Margaret Smith-Isa, Program Development Coordinator reported to the Board on the Innovation Workgroup and the ongoing discussion on; Centers of Excellence program; the hospital cap,specifically related to financial audit of the cap and behavioral health networks.

IV. Other Business and Public Comment

There being no public comment nor further business to come before the Board, Chair Kimberly Hendricks adjourned the meeting at 11:50 p.m.

Summary and Background

PEBB staff brought this new rule in Division 65 for your review and approval at your Board meeting in September. These were due to the SB 551 program being introduced and being effective October 1, 2021. We asked for approval to file temporary and move into the permanent rulemaking process. We filed these rules with the Secretary of State's office and opened public comment in October. We received one public comment from the Oregon Community College Association (OCCA) which represents 17 community colleges. Their comment was reviewed and incorporated into the rule language (highlighted below).

PEBB staff are requesting the approval to repeal the temporary rules and file the language below permanent.

Rule Language

Chapter 101: Public Employees' Benefit Board
New Division 65: SB 551
New Section: 0001

(1) "SB 551 eligible member" is defined as a part time faculty employee who is deemed eligible to receive coverage through PEBB by an Oregon public institution of higher education based on the requirements of SB 551 (2021). "SB 551 eligible member" does not mean or include a part time faculty member who is currently eligible for employer-paid benefits through the Public Employees Benefit Board (PEBB) or the Oregon Educators Benefit Board (OEBB).

(2) SB 551 eligible member may only enroll in employee-only, full time medical/pharmacy coverage. SB 551 members may waive medical/pharmacy coverage but may not opt out of coverage and receive a monetary incentive.

(3) SB 551 eligible members are not eligible for the Health Engagement Model (HEM) program.

(4) Persons currently eligible for PEBB or OEBB coverage as a subscriber or dependent are not SB 551 eligible. PEBB reserves the right to audit and retroactively terminate PEBB SB 551 coverage.

(5) If the SB 551 eligible member misses their enrollment period to enroll in coverage, they will have the ability to appeal to PEBB for enrollment.

(6) Coverage elected under this section is effective the entire plan year unless the SB 551 eligible member is terminated by PEBB or an Oregon institution of public education for failure to meet SB 551 eligibility or participation requirements.

(7) PEBB will not credit deductibles, out of pocket maximums for SB 551 members who transfer between a PEBB medical plan and an OEBB medical plan.

(8) It shall be the sole responsibility of the Oregon public institution of higher education to determine eligibility for coverage.

(9) It shall be the sole responsibility of the part time faculty member to submit all information necessary to the home institution to make an eligibility determination for SB 551 coverage.

(10) The SB 551 eligible member is eligible to continue coverage through COBRA should their coverage end and they meet the criteria for COBRA continuation coverage as per OAR 101-030-0005.

Oregon Community College Association

260 13th Street NE, Salem, OR 97301
Phone: (503) 399-9912
http://www.occa17.com

October 31, 2021

Ms. April Kelly
Oregon Educators Benefit Board
Administrative Rules Coordinator
500 Summer Street NE, E-88
Salem, Oregon 97301

RE: OEBB SB 551 Proposed Rules

Dear Ms. Kelly:

Thank you for the opportunity to provide public comment on the proposed rule changes necessary to implement SB 551 (2021). I am submitting these comments on behalf of the seventeen community colleges represented by the Oregon Community College Association related to proposed Oregon Administrative Rule 111-070-0075 - Administration of SB 551.

We appreciate the collaborative effort in which OEBB and PEBB have engaged to date with representatives of community colleges and universities to implement SB 551 on a quick timeline so our institutions could offer open enrollment to eligible employees by the October 2021 effective date. It was very helpful to higher education institutions as we moved administration of the previous OEBB administered self-pay program to an institution administered program.

Overall, we support the draft proposed rules with one clarification to the definition of "SB 551 eligible member". The definition "SB 551 eligible member" inadvertently excludes some community college part-time faculty who are not currently eligible for employer paid OEBB benefits but are on a list of part-time faculty who are eligible for a fully self-pay medical insurance benefit offered by at least one community college. These faculty are not currently receiving employer paid health benefits through OEBB or PEBB but could appear to be eligible for OEBB or PEBB benefits under the proposed rule definition as written. We do not believe it was the intent of the Legislature to exclude eligible part-time faculty members who are only eligible for a self-pay option offered through a college's OEBB plan. These employees are similar to those who were covered under the prior HB 2557 self-pay benefit SB 551 is replacing. We propose that you clarify this exclusion definition as follows with added language in **bold**:

> "SB 551 eligible member" does not mean or include a part-time faculty member who is **currently** eligible for **employer paid** benefits through the Public Employees Benefit Board (PEBB) or the Oregon Educators Benefit Board (OEBB).

Thank you for your consideration of this clarification. Please do not hesitate to contact me if you have any questions.

Sincerely,

Karen M. Smith
Senior Policy Advisor and General Counsel

Summary and Background

PEBB staff began reviewing rules for proposed updates in the summer of 2019 with anticipation to start rulemaking in early 2020. The identified proposed updates were "housekeeping" in nature and were meant to update our rules with our current processes and/or clarify language. In March/April 2020 Agency Rule Coordinators were given a directive that all non-COVID related rulemaking needed to be put on hold.

PEBB staff are now resuming the rulemaking process and starting with Division 15. We are starting with Division 15 because in the 2021 Legislative Session, Senate Bill (SB) 748 was passed that expanded eligibility for disabled dependents. Those proposed changes are reflected under 101-015-0011(4). We worked on this language internally and with our counsel at Department of Justice over the last several months. These proposed changes have also been reviewed by a Rules Advisory Committee.

PEBB staff are requesting the approval to file temporary because SB 748 becomes effective January 1, 2022. We want to ensure our rule language also becomes effective January 1, 2022. We are also requesting approval to move into the permanent rulemaking process and open the following rules up for public comment: 101-015-0005, -0011, -0026, & -0045.

Rule Language

Division 15
ELIGIBILITY

101-015-0005
Eligible Individuals

(1) The following individuals are eligible to participate in PEBB-sponsored benefit plans:

(a) An eligible employee as defined in OAR 101-010-0005(~~18~~**20**).

(b) A permanent position seasonal or intermittent employee who meets the following requirements:

(A) An individual hired for the first time if expected to work a 90-**calendar** day continual period and works at least half-time or in a position classified as job share. The eligible employee must enroll within 30 days of the hire or eligibility date; or

(B) An individual hired for the first time working at least half-time or in a position classified as job share who was not expected to work a 90-**calendar** day or more continual period and works longer than a 90-day continual period. The employee is eligible for enrollment retroactively effective to the first day of the month following the original hire or eligibility date; or

(C) A previously ineligible employee returning to work is eligible for benefit plans after 60 calendar days of employment within the current or immediately previous plan year. The 60 calendar days of employment need not be consecutive.

(c) An appointed temporary or impermanent employee who (i) as of the date of hire, is expected to work an average of 30 or more hours per week for a 90-day continual period, or (ii) has worked an average of 30 hours or more per week for a full initial measurement period (1,560 hours) and is in a subsequent benefit eligible stability period.

(d) A current spouse, domestic partner, or an eligible dependent child listed by the person who is eligible under subsection (1)(a), (b), (c), or (d) of this rule on the required enrollment form or the electronic equivalent.

(e) An appointed and elected official. Eligibility for benefit plans begins on the first day of the month following the date the official takes the oath of office.

(2) The eligible employee is responsible to maintain a valid PEBB enrollment for all eligible family members receiving coverage. See OAR 101-020-0025.

101-015-0011
Dependent Child

(1) A dependent child must meet the following eligibility conditions to receive PEBB health plan coverage:
(a) The child is:

(A) An eligible employee's, spouse's, or domestic partner's son, daughter, stepson, stepdaughter, adopted child; or
(B) A Child by Affidavit **which** includes but **is** not limited to a foster child, grandchild, child placed for adoption, or court ordered placement of a child who lives in the household of the eligible employee, and is the eligible employee's IRS dependent. The employee must provide court ordered documentation of guardianship and the notarized Affidavit of Child Dependency upon enrollment. The exception would be newborns or adopted children who are automatically covered as an eligible PEBB individual the first 31 days from birth or placement without documentation and Affidavit in place. The Affidavit and documentation must be on file the first of the month following the event date in order to meet eligibility and continue coverage under the PEBB plans. Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first; An eligible employee may not add a child by affidavit age 18 or older to PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18; or,
(C) The biological child of an eligible dependent child of an eligible employee, spouse, or domestic partner (a grandchild by affidavit) and meets all the following criteria:
(i) The child's parent will not be older than age 26 ~~on the last day of the plan year~~, is unmarried and without a domestic partner. Both the child's parent and the child live in the household of the eligible employee, and both the child and grandchild are the eligible employee's IRS dependent **and must claim both child and grandchild on their most recent years tax return.** The child's parent has PEBB health coverage through the eligible employee. The grandchild is automatically covered as an eligible PEBB individual the first 31 days from birth without documentation and Affidavit in place. The Affidavit and any appropriate documentation must be on file the first of the month following the event date ~~in order~~ to meet eligibility and continue coverage under the PEBB rules. An eligible employee may not add a grandchild age 18 or older to their PEBB coverage unless they can provide court ordered documentation for responsibility of the child beyond the age of 18.
(ii) ~~The child will not have attained age 27 in the plan year.~~ **Once the child no longer meets the requirements of section (5) of this rule, the child and grandchild will no longer be eligible.** ~~The exception is a child who meets all the requirements of section (4) of this rule.~~

(D) Covered if the eligible employee loses their spouse or domestic partner by death, the dependents (i.e. child of domestic partner, stepchild, grandchild) may continue PEBB health plan coverage provided they are currently enrolled, and eligibility is still being met. For biological, stepchildren or children of domestic partners, coverage ends the last day of the month in which they turn 26. For Child by Affidavit of Dependency, coverage ends the last day of the month in which the court ordered guardianship ends or age 18. For Grandchild by Affidavit, eligibility ends when the grandchild no longer meets the definition of Grandchild by Affidavit.
(2) During ~~Open~~ Enrollment, **as a new hire and during annual open enrollment,** the employee may

enroll a Child by Affidavit or Grandchild by Affidavit if the appropriate notarized affidavit and court ordered documentation is submitted within seven calendar days after ~~open~~ enrollment closes. ~~The exception is for a newly eligible employee after the closure of the open enrollment period but before the start of the new plan year. The employee must complete the paper open enrollment forms and submit the required court ordered documentation and notarized affidavit, as listed in section (3) of this rule, to the agency before the start of the new plan year.~~ If the employee does not submit the court ordered documentation as required, the child's enrollment will not activate. PEBB Coverage ends the last day of the month in which the court ordered guardianship ends or age 18, whichever comes first.
"Example: Jack's foster child Joe is receiving PEBB coverage. Jack's legal documentation used at the time of Joe's enrollment stated that Jack will no longer be responsible for Joe when Joe turns 18. Joe's birth date is November 11, if there is no change to the court ordered responsibility, Joes' PEBB coverage will terminate November 30 the year he turns 18.

(3) ~~Newly eligible employees or employees~~ **Employees** with a midyear change requesting to enroll a Child by Affidavit or Grandchild by Affidavit must submit the appropriate court ordered documentation and the notarized Child by Affidavit or Grandchild by Affidavit to the agency within the allowable enrollment time. The agency will not process the employee's enrollments until the employee submits all ~~of~~ the following:
(a) Completed and signed appropriate forms;
(b) Completed and notarized affidavit; and
(c) Court ordered documentation as required.
(4) There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability, when all the criteria in this section are met.
(a) The employee must submit to PEBB any appeal and enrollment forms to enroll a disabled child age 26 or older, or to indicate the child disabled in the PEBB benefit record when the child is already receiving coverage.
(b) The child's attending physician must submit documentation of the child's disability to the employee's health plan. The health plan provides a medical review of the physician's medical documentation and provides PEBB a disability determination based on the review.
(c) When the employee requests to enroll a disabled child over the age of 26:
(A) **(i)** The child must be the employee's qualifying IRS dependent **and must be claimed on the eligible employees' most recent years tax return, or**

(ii) The child files a tax return and demonstrates that their adjusted gross income does not exceed 150 percent of the federal poverty level (FPL), or

(iii) The employee is the legal guardian of the disabled dependent child.
(B) The physician must verify to the health plan that the disability existed before the child attained age 26.
(C) The child must be unable to engage in substantial gainful activity because of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
(D) The employee must provide evidence to PEBB that the child has had continuous health plan coverage, group or individual, prior to attaining age 26 and the coverage remains in effect. The other coverage must continue until the employee's medical plan approves the child's health status as disabled and the PEBB plan is effective. If the child has not had continuous coverage, the child is not eligible for PEBB coverage.
(d) When a disabled child is receiving coverage beyond the age of 26, the employee's health plan can review the child's health status at any time and determine if the child continues to meet the criteria for a disabled child.
(e) If a disabled dependent child's PEBB health coverage terminates for any reason after the age of 26, the child is ineligible for future enrollment as a dependent child under that PEBB coverage. The exception is termination of the child's coverage due to the employee's termination of employment when the

employee is rehired later into a PEBB benefit eligible position. In this situation, to enroll the child again as disabled all PEBB criteria for disabled child within (4) of this rule must be met.

(f) Imputed taxes may apply, per IRC provisions, when an employee enrolls and covers dependents on their PEBB coverage that are not claimed on their federal taxes, and thus are not tax dependents.

(5) Beginning January 1, 2019, PEBB will terminate all plan coverage for dependent children who reach age 26 during a calendar year at midnight on the last day of the month in which the dependent turned 26. PEBB will not terminate coverage for children age 26 or older when approved by the health plan as incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability pursuant to section (4) of this rule. The exception ~~would be~~ **is** Child and Grandchild by Affidavit, see section B~~(i).~~

101-015-0026
Domestic Partnership

(1) Certificate of Registered Domestic Partnership. When a Registered Domestic Partnership exists and the eligible employee wants to enroll the domestic partner or the domestic partner's eligible children in benefit plans, the employee may electronically enroll or submit enrollment update forms to the agency at the appropriate time as defined by PEBB enrollment rules.

(2) PEBB Affidavit of Domestic Partnership. An eligible employee and an individual of the opposite ~~sex~~, or ~~of the~~ same sex without a Certificate of Registered Domestic Partnership, who want enrollment in PEBB plans as Domestic Partners must meet all of the following criteria:

(a) Are both at least 18 years of age;

(b) Are responsible for each other's welfare and are each other's sole domestic partners;

(c) Are not married to anyone;

(d) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(e) Currently share the same regular permanent residence;

(f) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter, and any other expenses of maintaining a household. Financial information must be provided if requested, and;

(g) Eligible employees must submit enrollment forms and a notarized affidavit to enroll domestic partners and children. To enroll eligible dependent children of a domestic partnership by affidavit in benefit plans, whether or not the enrollment includes the domestic partner, the employee must submit an Affidavit of Domestic Partnership.

(A) For ~~open~~ enrollment, the agency must receive the notarized affidavit within five business days following close date of the ~~open~~ enrollment period. ~~The exception is for an employee who is a newly eligible employee after the closure of the open enrollment period but before the start of the new plan year. The employee must complete paper open enrollment forms and submit the notarized affidavit to their agency before the start of the new plan year. The agency or PEBB will not process an employee's domestic partner or partner's children until the enrollment documentation submission is complete.~~

(B) ~~Newly eligible employees or employees~~ **Employees** with qualified mid-year changes may only enroll a domestic partner or partner's children by submitting the correct enrollment forms and notarized affidavit within the allowable time for the enrollment type. Agencies will not process a domestic partner or a partner's children's enrollment until the enrollment documentation submission is complete.

(3) An imputed value for the fair market value of the domestic partner and domestic partner's dependent children's insurance premium will be added to the eligible employee's taxable wages.

(4) An eligible employee ending a domestic partnership established under the PEBB Affidavit of Domestic Partnership must complete and submit a Termination of Domestic Partnership form and enrollment update forms to the agency within 30 days of the event. ~~If the domestic partnership was established under the Certificate of Registered Domestic Partnership, only enrollment update forms must be submitted to the agency within 30 days of the event.~~ Insurance coverage for the domestic partner and domestic partner's dependent children ends the last day of the month ~~that~~ **in which** eligibility is lost.

101-015-0045
Eligibility Verifications and Reviews

(1) PEBB shall plan and conduct eligibility verifications and reviews to monitor compliance with PEBB administrative rules. Reviews shall include but are not ~~be~~ limited to the following:
(a) Dependent eligibility;
(b) Employee eligibility;
(c) Election change limitations; and
(d) Plan enrollment limitations.
(2) Employee eligibility, election change and plan enrollment reviews may occur on a random basis throughout the year, or if anomalies in data warrant a formal review. The Eligible Employee is responsible to submit documentation upon request.
(3) Dependent eligibility reviews shall be completed as needed. The Eligible Employee, Retiree, Self-Pay or COBRA participant is responsible to submit documentation upon request. In the event the required documentation is not provided to sufficiently prove the dependent meets eligibility requirements, or the documentation provided is insufficient, the dependent's coverage will be terminated prospectively. Retroactive terminations may occur if the documentation provided shows the dependent was not eligible for coverage and the member misrepresented the dependent as being an eligible dependent as defined by OAR 101-010-0005.
(4) If an Eligible Employee does not complete the dependent eligibility review and moves to a different Agency under PEBB, their terminated dependent records may be locked in the PEBB benefit management system. The Eligible Employee must submit documentation to PEBB to be verified before the dependent records are unlocked.

(5) An Eligible Employee adding a new or previous dependent to enrollments after failing to verify dependent eligibility will be required to provide DEV documentation along with the enrollment form to PEBB. Enrollments will not take effect until the verification of eligibility. The effective date of coverage is the first of the month following receipt of the form and all appropriate verification documents by PEBB.

Value-based Payment Compact Workgroup Status Update

December 2021

Cost Growth Target and Value-based Payment Compact

The Cost Growth Target (CGT) is a legislatively established target rate for health care cost growth in the state, which applies to all payers and large provider organizations. Payers are required to submit data to the CGT program. There are no reporting requirements for provider organizations.

One strategy to help contain health care cost growth and meet the CGT is the VBP Compact.

The VBP Compact is a voluntary commitment by payers and providers to moving more payments to advanced value-based payment models in the next 3 years.

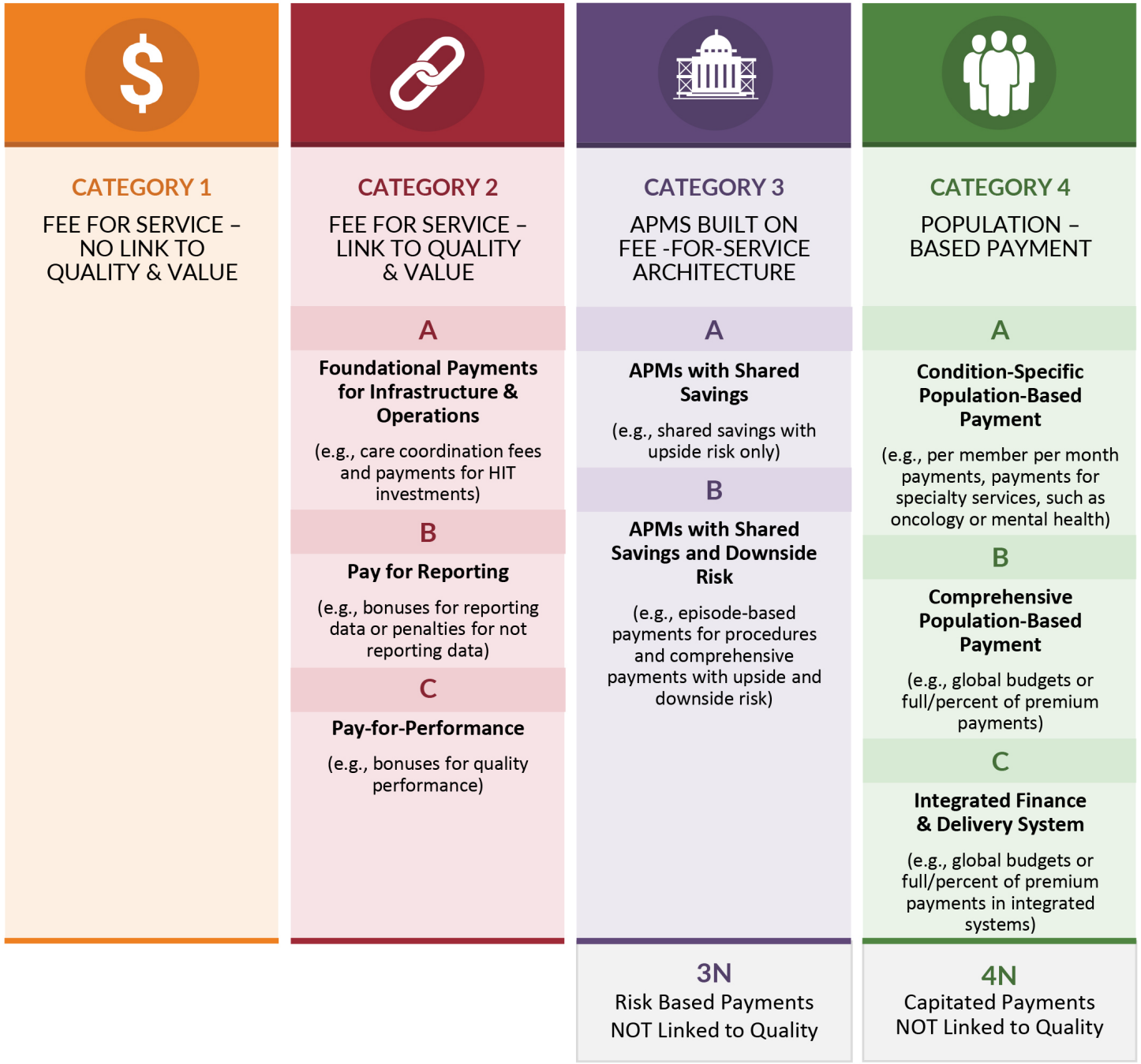
Oregon's path so far…

Cost Growth Target legislation established Implementation Committee (2019)

Committee recommended principles for accelerating adoption of advanced VBP as key strategy to meet the target (2020)

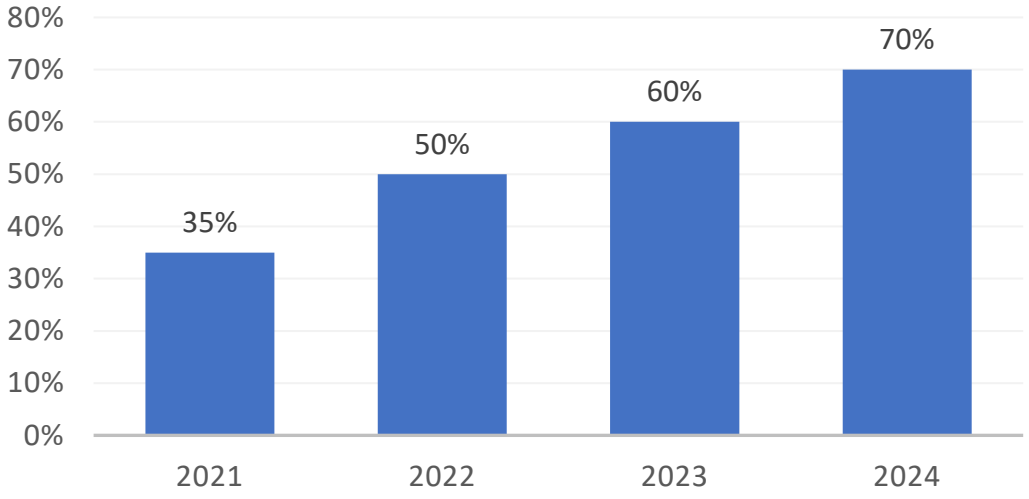
VBP Compact and Workgroup developed based on Committee's principles (2021)

The HCP-LAN created a value-based payment framework to accelerate the shift to value-based care in order to achieve better outcomes at lower cost.

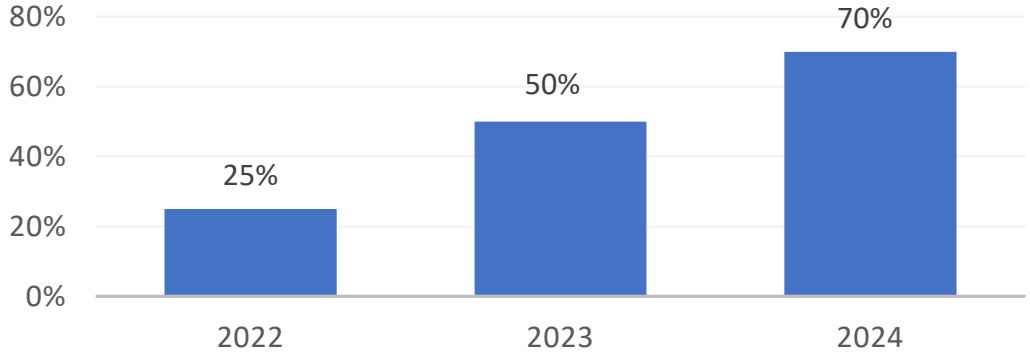


VBP Targets: From Cost Growth Target Implementation Committee

All payments under advanced VBP payment models (3A and higher)



Payments to primary care practices and general acute care hospitals under advanced VBP models (3B and higher)



Value Based Payment Compact

47

Signatories, including commercial payers, Medicaid, Medicaid Advantage, health systems & clinics

73%

Oregonians represented by Compact signatories

VBP Compact Workgroup

Charge:

The Value-Based Payment (VBP) Compact Workgroup (Workgroup) is charged with ensuring the Oregon VBP Compact is successfully implemented. The Workgroup will identify paths to accelerate the adoption of VBP across the state; highlight challenges and barriers to implementation and recommend policy change and solutions; coordinate and align with other state VBP efforts; and monitor progress on achieving the Compact principles, including the VBP targets.

Goals:

The primary goal of the Workgroup is to accelerate the adoption of VBPs statewide across clinical, insurance and geographic markets. This work will support Oregon's sustainable cost growth target. The Workgroup also will provide leadership to coordinate and align with other groups focused on statewide VBP initiatives.

Deliverables:

- A "Statewide VBP Roadmap" that outlines a plan for implementing the Compact and is focused on lowering the rate of cost growth, improving quality and outcomes, and fostering health equity.
- An evaluation framework to monitor progress toward achieving Roadmap goals (e.g., measuring VBP's impact on achieving Oregon's cost growth target and achievement of quality measures).
- Recommendations to address challenges and barriers to VBP implementation.
- An annual public report detailing Roadmap implementation progress.

The Workgroup convened in June and meets monthly

Doug Boysen, Co-Chair, *Samaritan Health Services*

Elizabeth Powers, Co-Chair, *Winding Waters Community Health Center & Wallowa Memorial Hospital*

Ken Provencher, Co-Chair, *PacificSource*

Amy Dowd, *CareOregon*

Eleanor Escafi, *Cambia Health Solutions*

Kevin Ewanchyna, *Samaritan Health Services & Oregon Medical Association*

Kirsten Isaacson, *SEIU Local 49 & Oregon Health Policy Board*

Richard Jamison, *The Oregon Clinic*

Leah Mitchell, *Salem Health*

Gil Munoz, *Virginia Garcia Memorial Health Center*

William Olson, *Providence Health & Services*

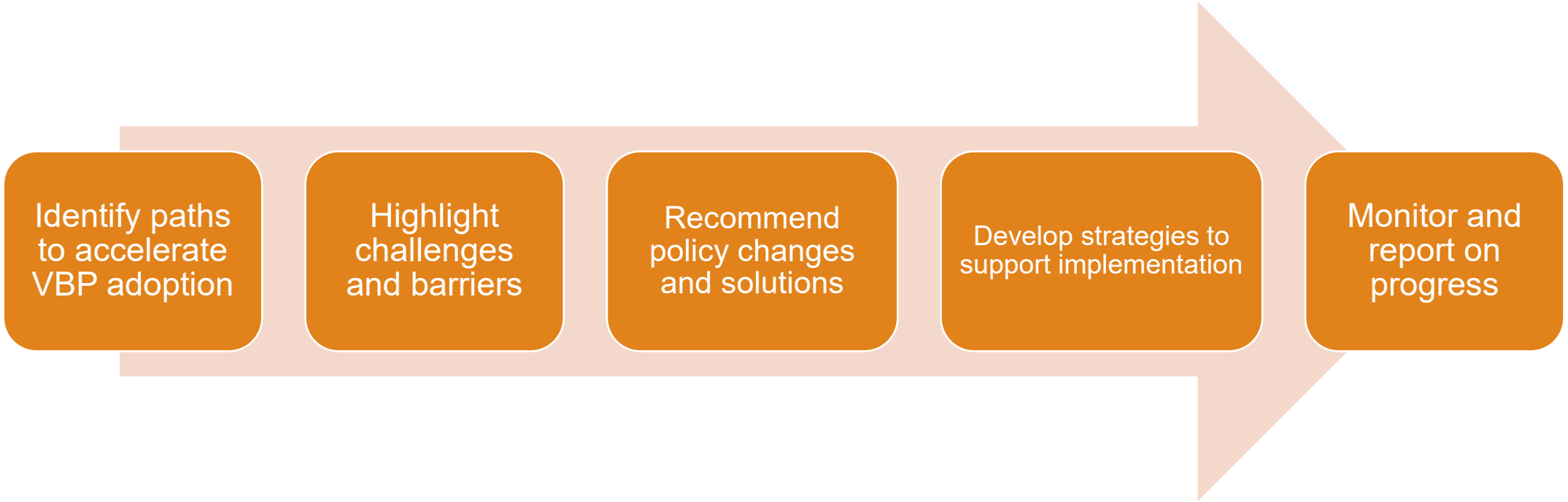
Jeff Perry, *Multnomah County Health Center*

Tom Syltebo, *Oregon Educators Benefit Board*

James Tan, *Kaiser Permanente*

Jeremy Vandehey, *Oregon Health Authority & Public Employees' Benefit Board*

The Workgroup is charged with ensuring the Compact is successfully implemented.



Challenges and strategies to VBP adoption are under discussion

- The Roadmap, which will include challenges and strategies, is in development and will be complete in February.
- The Workgroup hasn’t landed on contents of Roadmap.
- The following challenges and strategies are in DRAFT form and are being explored and discussed.
- Additional challenges and strategies will be added.

Challenge: Lack of will to change

Potential strategies

1. Assess the current environment to understand VBP implementation
2. Present the case in a compelling and understandable way, customized for different audiences
   - Develop a provider toolkit with readiness assessment, sample contracts, guidance on negotiation, etc.
3. Provide technical assistance to providers
4. Incentivize participation through grants and enhanced payments
5. Publish a public report card on payer and provider adoption

Challenge: Provider fear of financial loss

Potential strategies

1. Provide technical assistance and glidepath to VBP adoption
2. Educate providers about how VBPs help maintain financial stability
3. Explore financial vehicles to cover potential losses such as bonds and reinsurance
4. Explore risk corridors

Challenge: Small patient populations

Potential strategies

1. Explore collaborative ways for payers to combine populations
2. Explore specific risk-adjustment methodologies to support all patients, including complex patients
3. Leverage IPAs and clinically integrated networks to organize smaller groups of providers

Challenge: Multiple VBP models within one clinical setting

Potential strategies

1. Develop common menu of models across payers
2. Specify required aligned elements – such as quality metrics and risk adjustment
3. Specify elements that can vary – such as attribution and payment model design

More to come…

FOCUS ON EQUITY

FINE TUNING STRATEGIES

PRIORITIZATION

ACTORS – WHO DOES WHAT?

Mercer

welcome to brighter

Oregon's Public Employees' Benefits Board

December Utilization Report

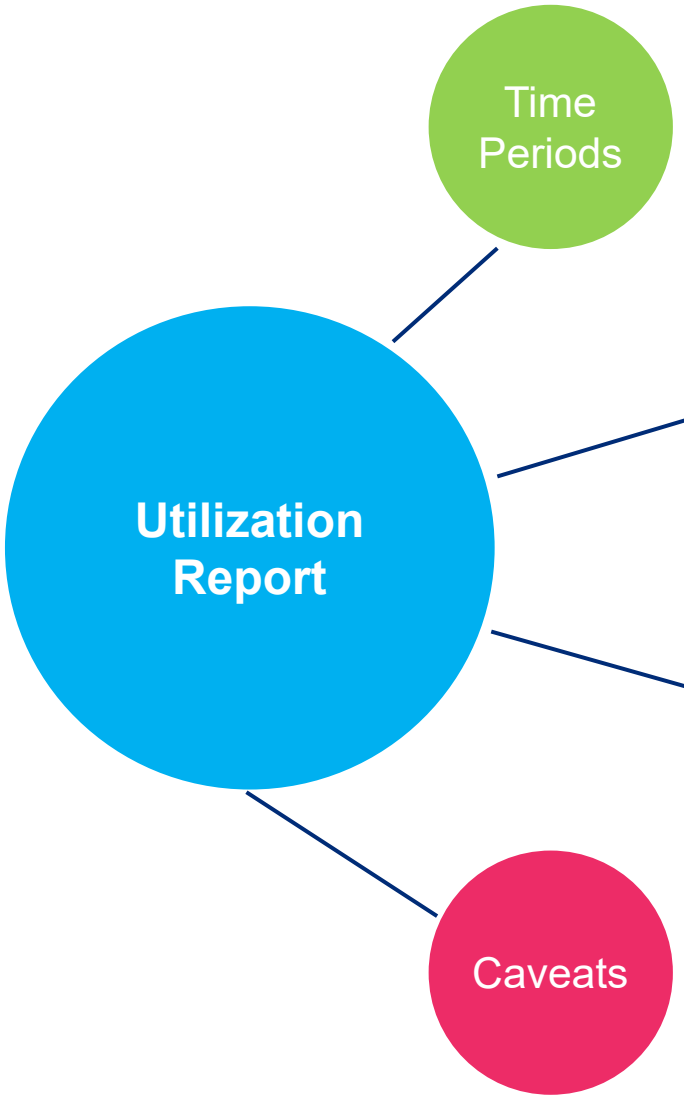
PB Attachment 4
December 21, 2021
Emery Chen, ASA, MAAA

1. Data and assumptions
2. COVID-19 updates and impact
3. Aggregate costs
4. Trend components
5. Trends by place of service
6. Top opportunities and next steps
7. Appendix
8. Low value care

Agenda

Data and assumptions

Data and assumptions



- Current Period – July 2020 to June 2021
- One Year Prior – July 2019 to June 2020
- Two Years Prior – July 2018 to June 2019

- Self-Insured:
  - Statewide
  - Providence Choice
  - Moda (effective 1/1/2019)
- Fully-Insured:
  - Kaiser HMO
  - Kaiser Deductible
  - AllCare (not shown in charts)

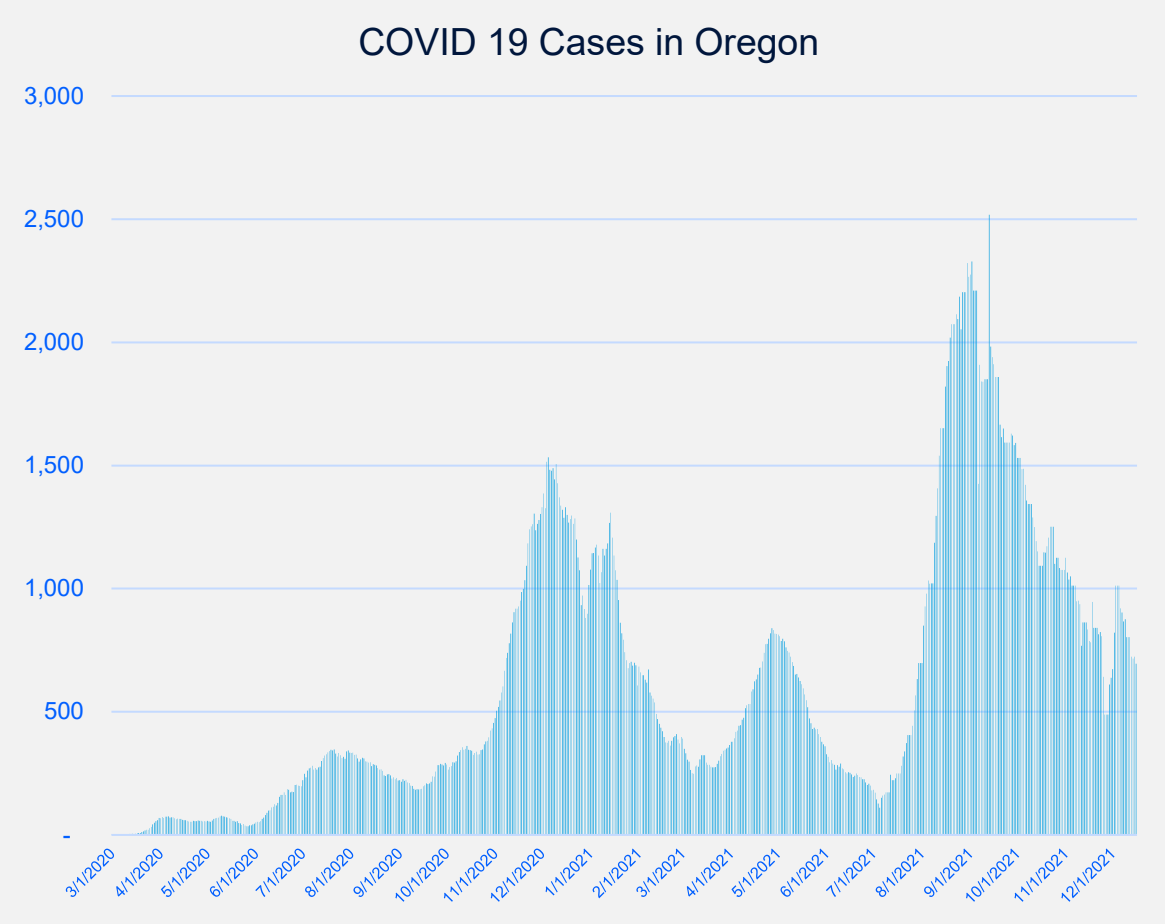
- Incurred claims

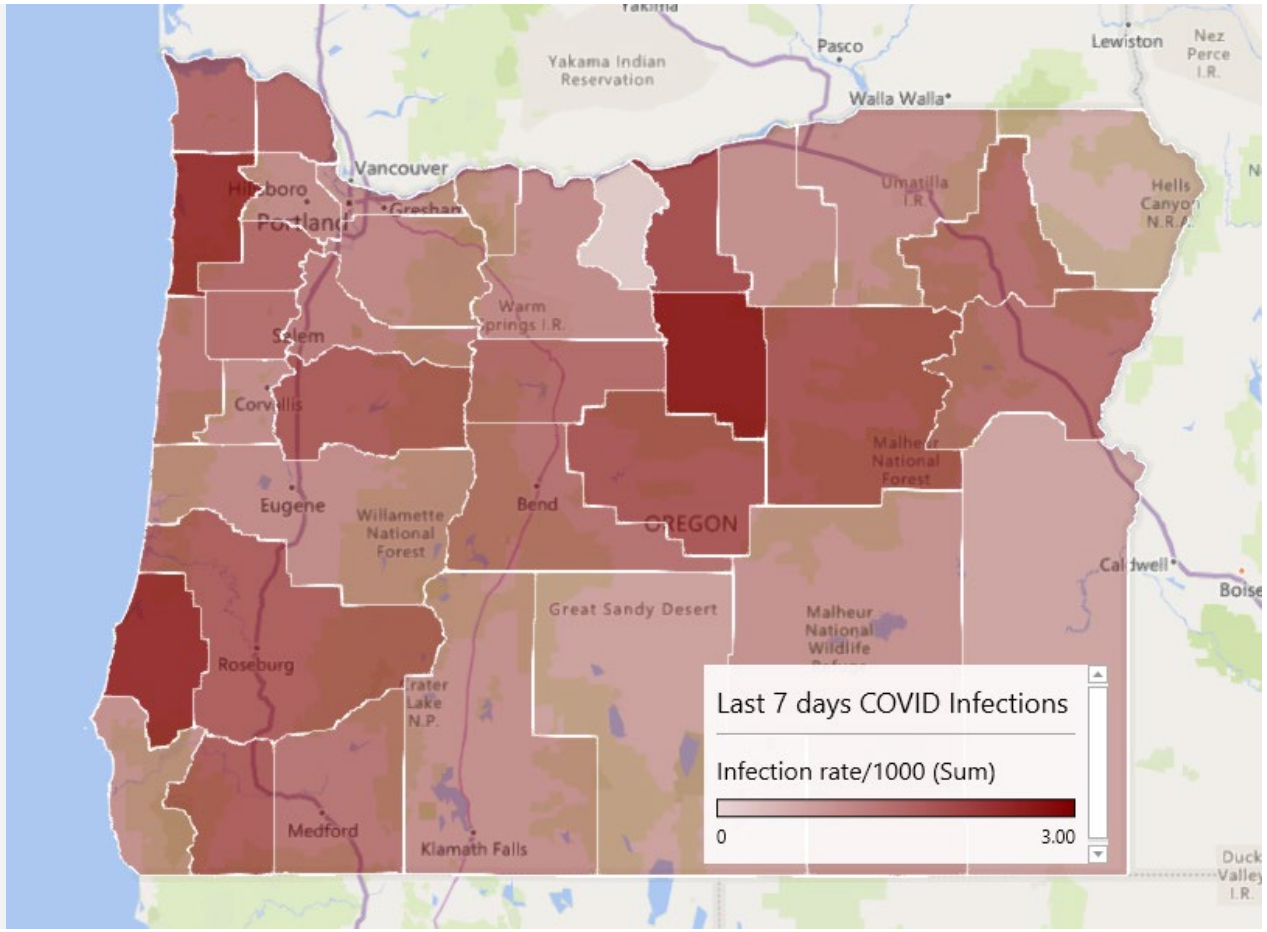
- Kaiser utilization reporting excludes approximately $22.2 million in Integrated Care fees for Current period, $19.4 million for One Year Prior, and $19.8 million for the Two Years Prior
- Integrated Care fees are per member costs for non-claim services
- In rare instances for double covered members, Kaiser's reported Charge Allowed Amount is overstated; Kaiser has corrected this issue as of July 2021, however, claims run in this report may be slightly overstated due to this issue

COVID-19 updates and impact

2

COVID-19 Latest Updates





COVID-19 Latest Updates

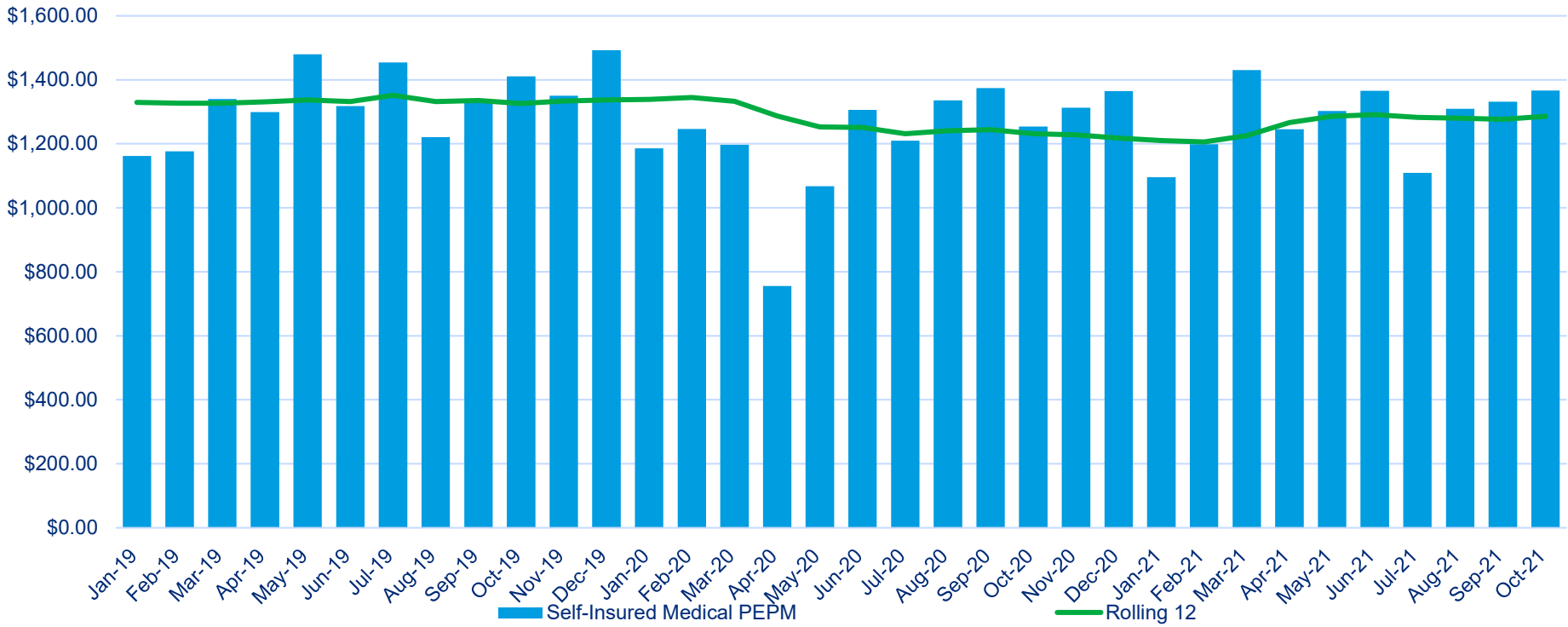
Vaccination Rates (Mid-October)

- Providence Choice
  - Fully vaccinated 82.9% of subscribers, 2.8% have been partially vaccinated
- Statewide
  - Fully vaccinated 78.9% of subscribers; 3.3% have been partially vaccinated
- Moda
  - Fully vaccinated 79.0% of subscribers, 1.8% have been partially vaccinated
- Kaiser
  - 86.2% of subscribers fully vaccinated with another 3.1% of members with a vaccine initiated
- Across Oregon, 71.3% of adults 18 to 64 were vaccinated as of December 14

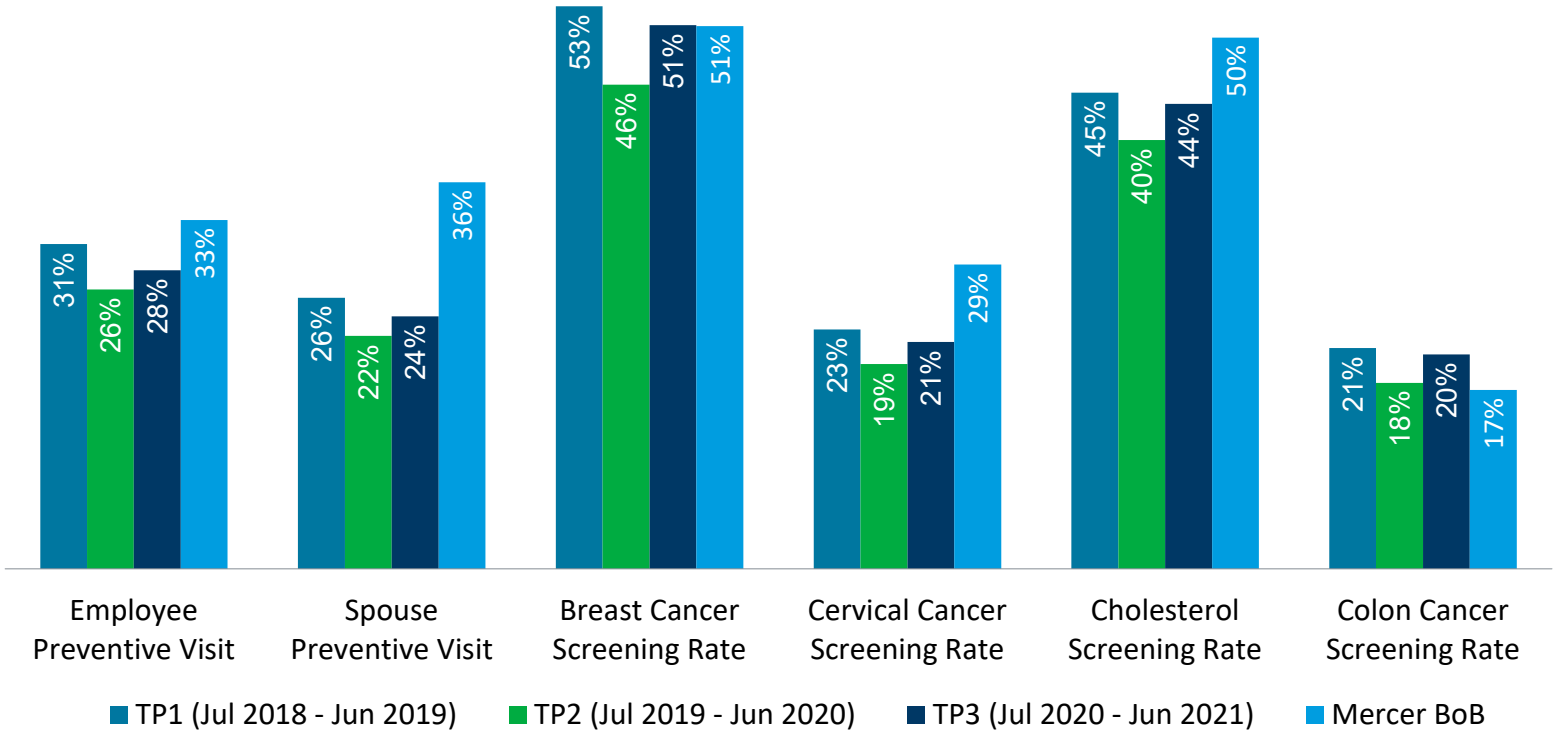
COVID-19 Latest Updates

$181m

Surplus since January 2020 as a result of delayed or deferred care; $109m in 2020 and an additional $72m through October 2021



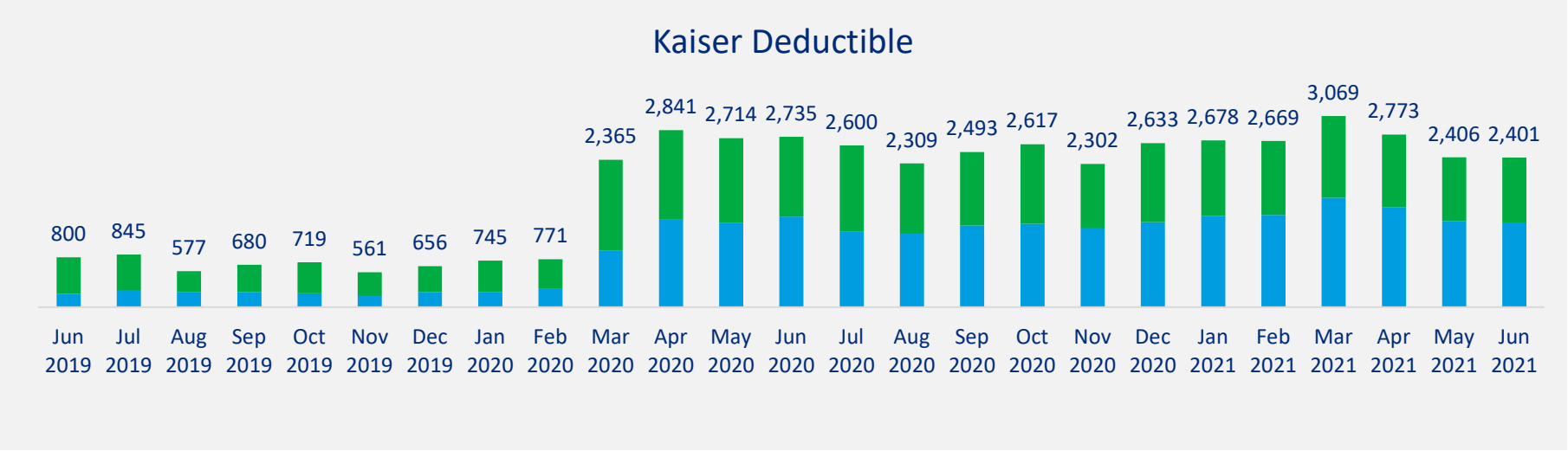
Preventive screening rates

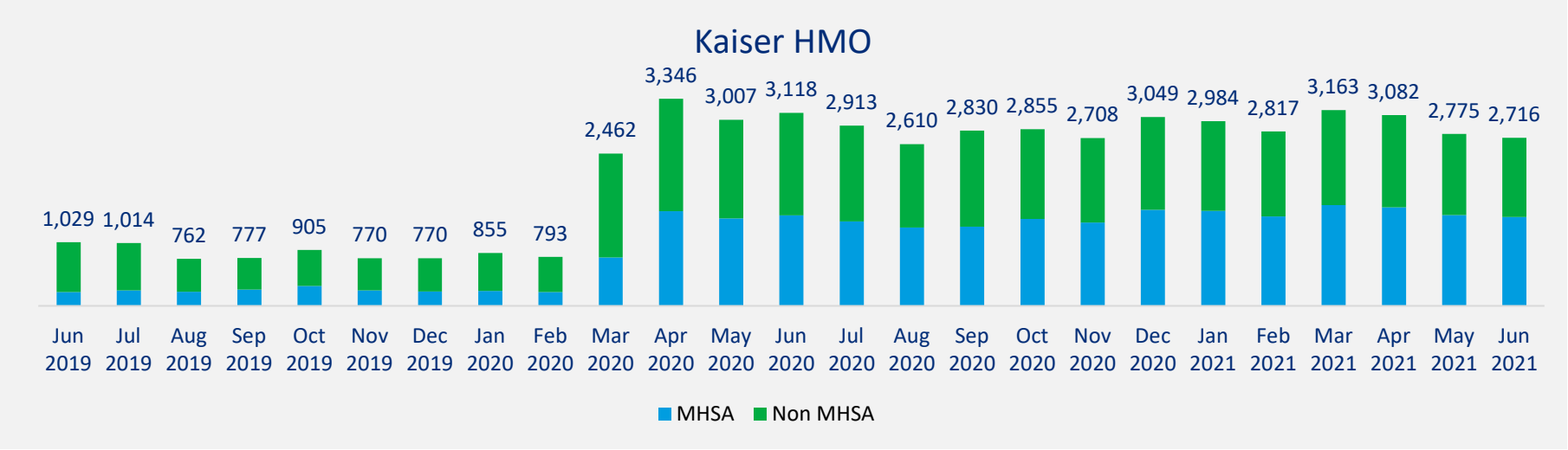


- Preventive Screening rates have increased from the prior period, but remains below Pre-COVID levels and BoB
  - Breast cancer rates jumped 5 points and is in line with BoB
- Percentage of members with preventive visits have increased but are still below pre-COVID
- Ensure carriers and PEBB continue to communicate importance of preventive visits

Telemedicine visits per 1,000 members

Includes telehealth visits to community providers

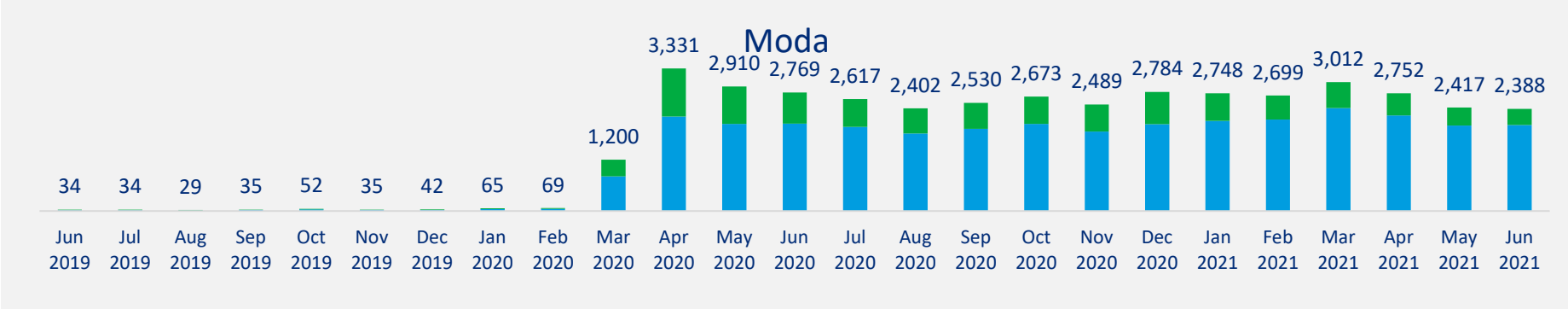


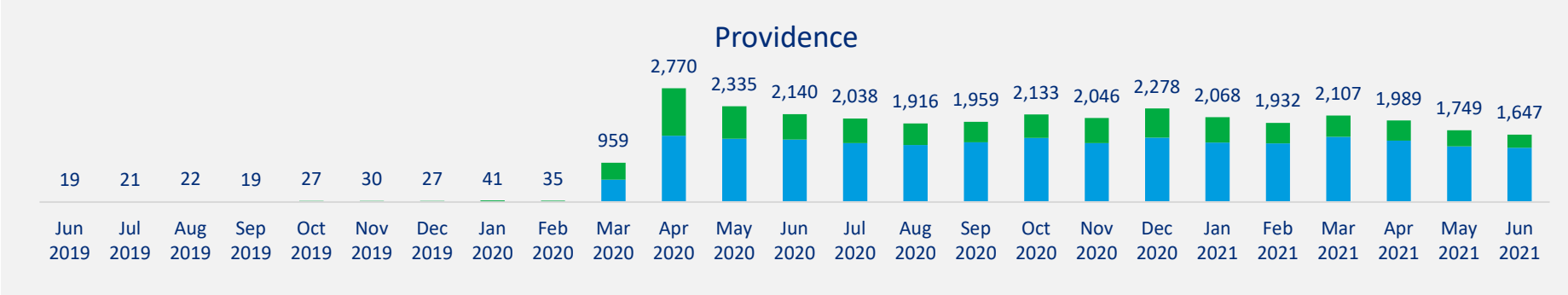


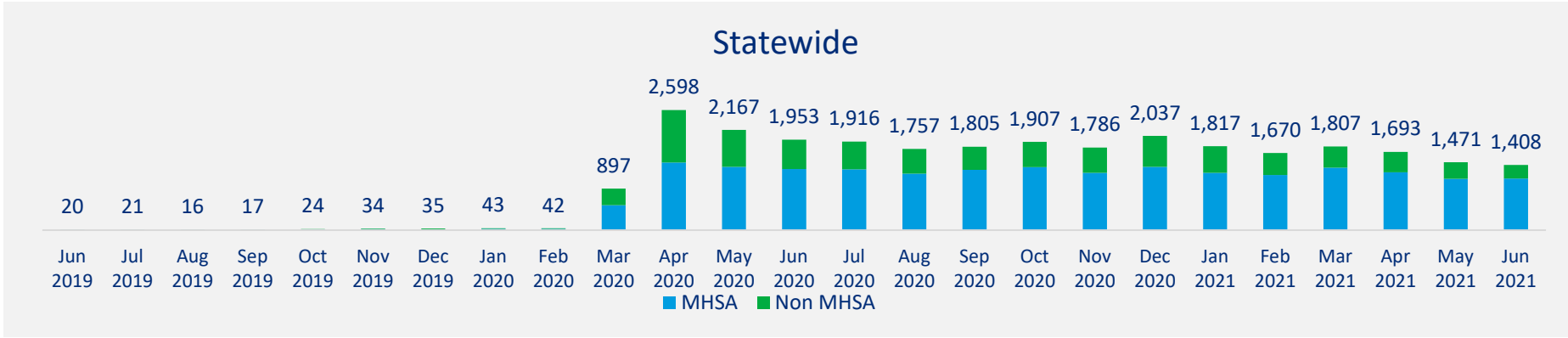
- Members continue to utilize telemedicine for mental health and substance abuse (MHSA) as at the beginning of the COVID pandemic
- Utilization of telemedicine for non-MHSA services remain high, but have decreased 5%+ since 2020
- Kaiser in-person office visits have had a commensurate decrease in claims

Telemedicine visits per 1,000 members

Includes telehealth visits to community providers

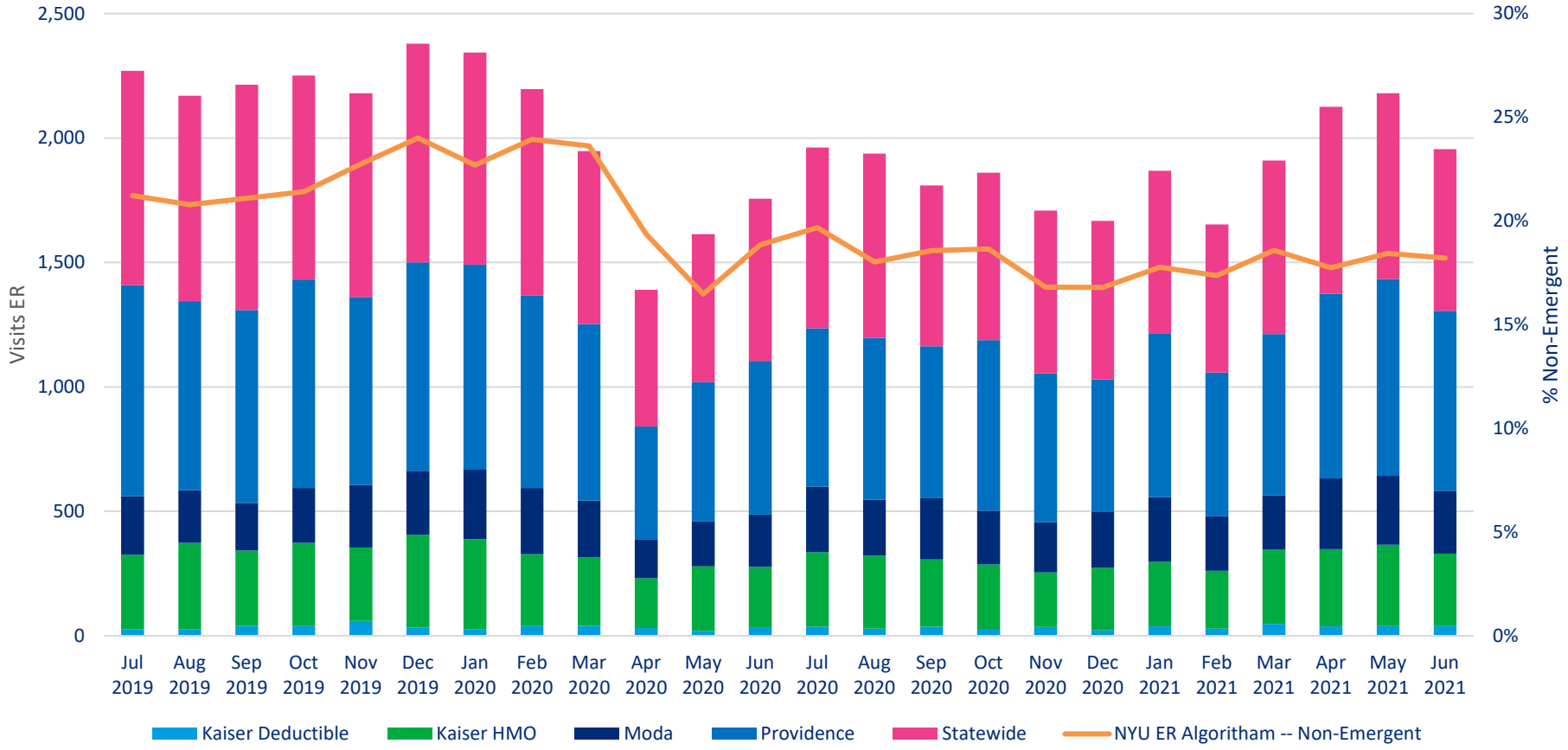






- Members continue to utilize telemedicine for mental health and substance abuse as at the beginning of the COVID pandemic
- Utilization of telemedicine for non-MHSA services remain high, but have decreased 20%+ since 2020

Emergency room visits

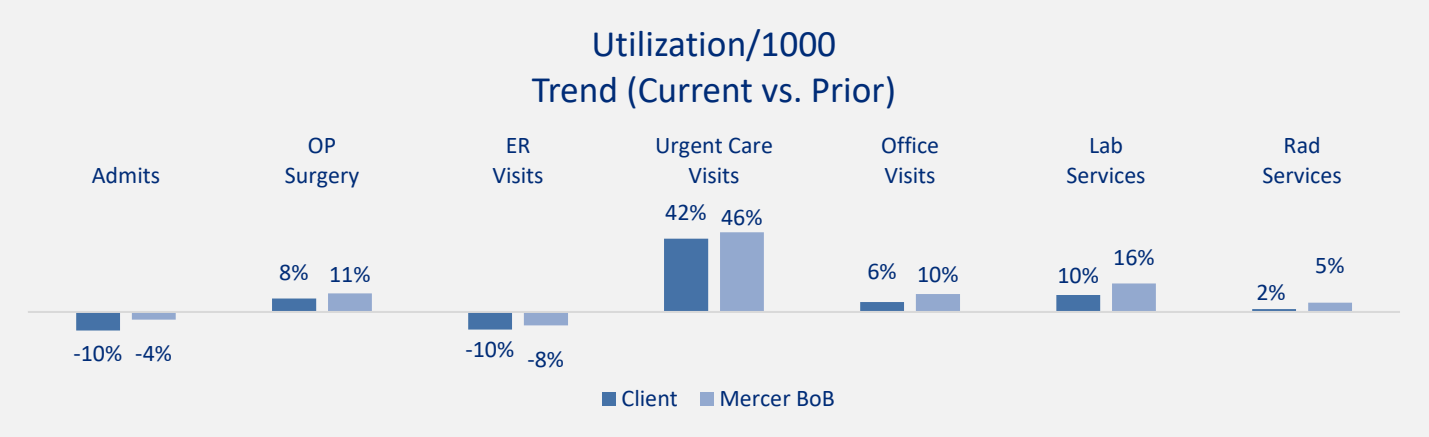


- Total emergency room visits decreased by 8% in the current period over the prior
- Percentage of ER visits defined by the NYU classification as non-emergent decreased from 22% in the prior period to 18% in the current period
  - Total non-emergent visits decreased by 23%
  - Shifting of non-emergent ER visits to telemedicine would save over $1 million per year (based on cost difference of $1,000 per diverted visit)

COVID-19 impact on healthcare utilization

Utilization for all service categories are moving towards pre-COVID levels, except Admissions and ER visits

Utilization / 1000	PEBB				Mercer BoB			
	Jul 2018 - Jun 2019	Jul 2019 - Jun 2020	Jul 2020 - Jun 2021	Trend (current/ prior)	Jul 2018 - Jun 2019	Jul 2019 - Jun 2020	Jul 2020 - Jun 2021	Trend (current/ prior)
Admissions	50.8	47.0	42.1	-10%	53.6	49.9	47.8	-4%
Outpatient Surgery	184.4	162.3	174.9	8%	190.1	170.1	188.4	11%
ER Visits	196.6	182.0	163.9	-10%	221.7	203.6	188.0	-8%
Urgent Care Visits	113.8	115.1	163.4	42%	163.1	168.0	244.4	46%
Office Visits	8,633.0	8,147.6	8,611.3	6%	6,643.9	6,252.6	6,902.1	10%
Telemedicine Visits	186.2	865.2	2,154.2	149%	53.0	447.9	1,156.2	158%
Lab Services	6,526.9	6,055.3	6,646.7	10%	7,225.2	6,652.3	7,735.9	16%
Radiology Services	1,774.4	1,613.6	1,640.8	2%	1,718.3	1,593.7	1,679.8	5%



Each time period reflects identical 3 months of runout for COVID-19 impact analysis and comparison of prior and current time periods

Observations

- Admissions and ER visits Utilization per 1,000 PEBB members continues to decrease over three years, similar to benchmark
  - 42% increase in Urgent care similar to benchmark over most recent period
- PEBB telehealth has 149% increase in line with benchmark
- Outpatient surgery has return of services
- Lab services increased due to COVID-19 services

Long term COVID-19 impacts

- According to the CDC, some members who had COVID-19 can experience new symptoms of COVID-19 a month or later from the initial infection
- Some PEBB members have new health issues and higher claims costs post infection

Potential Symptoms

- Difficulty breathing or shortness of breath
- Tiredness or fatigue
- Difficulty thinking or concentrating
- Heart palpitations
- Joint or muscle pain
- Sleep problems
- Mood changes

New Diagnoses (2 months+ after Positive COVID-19 Test)	Patients	% of COVID Positive
Fatigue	135	3%
Depression	115	3%
Hypertension	57	1%
Osteoarthritis	57	1%
Asthma	35	1%
1 or more diagnoses	**364**	**9%**

PMPM Cost	1 or More Diagnoses	No New Diagnoses
Pre-COVID	$1,148	$856
Post-COVID (beyond 2 months)	$1,401	$768
% Change	22%	-10%

- **COVID-19 positive test is based on claims data incurred through July 2021; some members may have tested positive but was not captured in the claims data**
- **Diagnoses is based on claims with the diagnosis codes from August 2018 through July 2021; some members may have had claims with the diagnoses prior to August 2018**

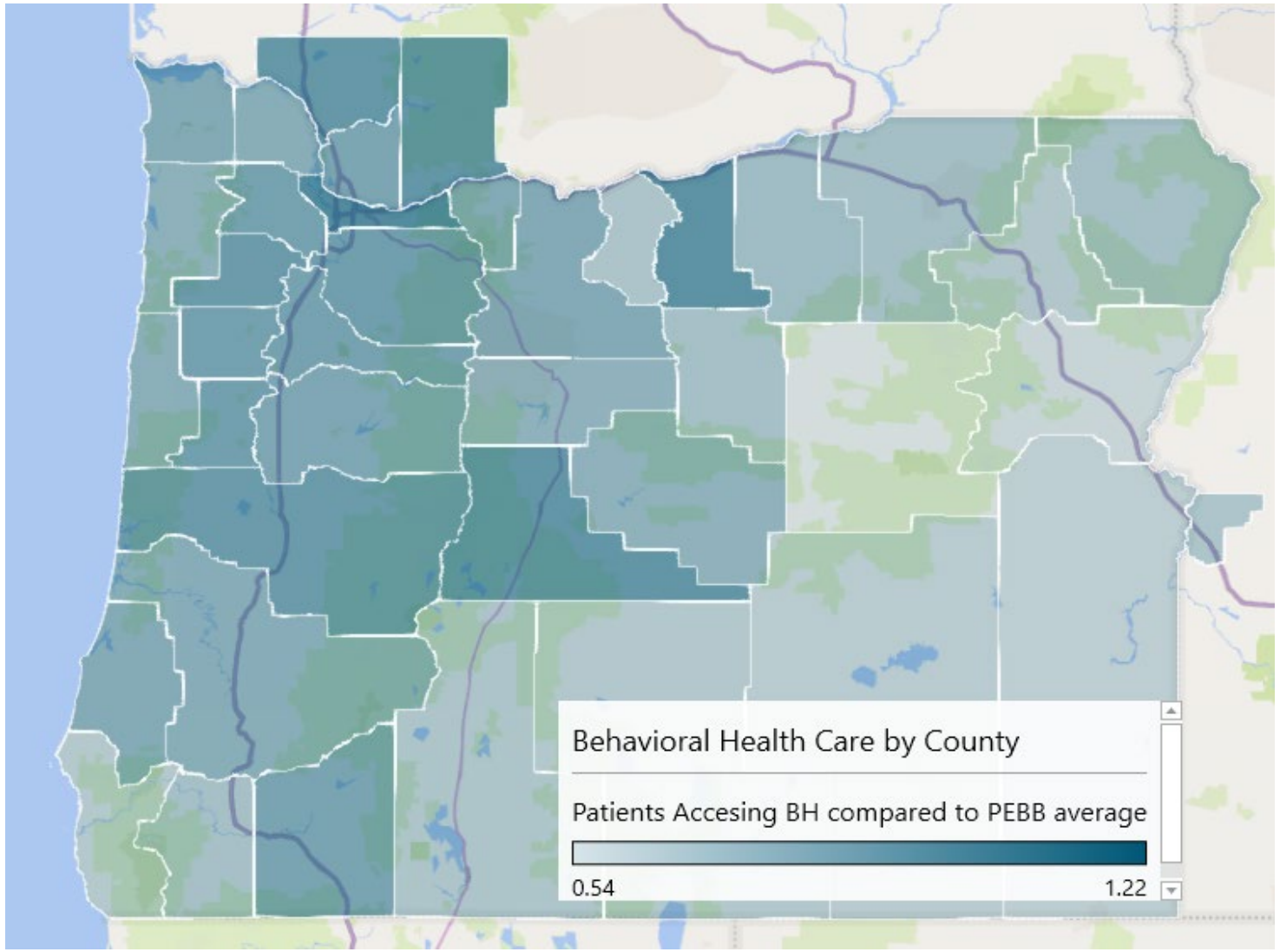
Behavioral health utilization

Increased Diagnoses of Behavioral Health Conditions

- Members with Anxiety have increased 17% over the past two years
- Depression diagnoses increased 5%
- PEBB is 60% higher for anxiety and 89% higher for depression compared to Mercer's book-of-business

Utilization Patterns

- Members accessing behavioral health services is higher along the I-5 corridor and in Deschutes County
- Utilization in Eastern and Southwest Oregon is lower



Aggregate costs

Annual costs
Self-insured

	Two Years Prior	One Year Prior	% Change	Current	% Change
Aggregate					
Medical	$605,417,778	$565,645,198	-6.6%	$568,730,584	0.5%
Prescription Drug	$94,052,861	$100,882,042	7.3%	$112,544,665	11.6%
Total	**$699,470,639**	**$666,527,240**	**-4.7%**	**$681,275,249**	**2.2%**
Per Employee Per Year					
Medical	$14,155	$13,106	-7.4%	$13,068	-0.3%
Prescription Drug	$2,199	$2,337	6.3%	$2,586	10.6%
Total	**$16,353**	**$15,444**	**-5.6%**	**$15,654**	**1.4%**
Average Annual Membership					
Employees	42,772	43,158	0.9%	43,520	0.8%
Members	112,163	111,929	-0.2%	112,484	0.5%

- **Medical costs per employee slightly decreased in the current period as return of services were offset by lower reimbursement levels from SB1067**
- **Rx costs have increased with specialty drugs the largest driver of the increase; additional source of cost increase is COVID-19 vaccinations**
- **Both medical and prescription drug costs include impact of rebates**
- **Moda is included as a self-insured plan in all time periods**

Annual costs
Fully-insured

	Two Years Prior	One Year Prior	% Change	Current	% Change
Aggregate					
Medical	$125,618,921	$115,692,723	-7.9%	$125,137,886	8.2%
Prescription Drug	$19,255,334	$20,732,343	7.7%	$22,115,984	6.7%
Total	**$144,874,255**	**$136,425,066**	**-5.8%**	**$147,253,870**	**7.9%**
Per Employee Per Year					
Medical	$13,521	$12,130	-10.3%	$11,953	-1.5%
Prescription Drug	$2,073	$2,174	4.9%	$2,112	-2.8%
Total	**$15,593**	**$14,304**	**-8.3%**	**$14,065**	**-1.7%**
Average Annual Membership					
Employees	9,291	9,537	2.7%	10,469	9.8%
Members	23,825	24,048	0.9%	25,757	7.1%

- **Moda became self-funded effective 1/1/19 and is in the prior slide**
- **Medical claims are lower due to the impacts of changes in utilization from COVID -19 and SB1067; prescription drug claims decreased as prescriptions shift from retail to mail order**
- **Kaiser integrated care fees are included**

Annual costs
Total PEBB

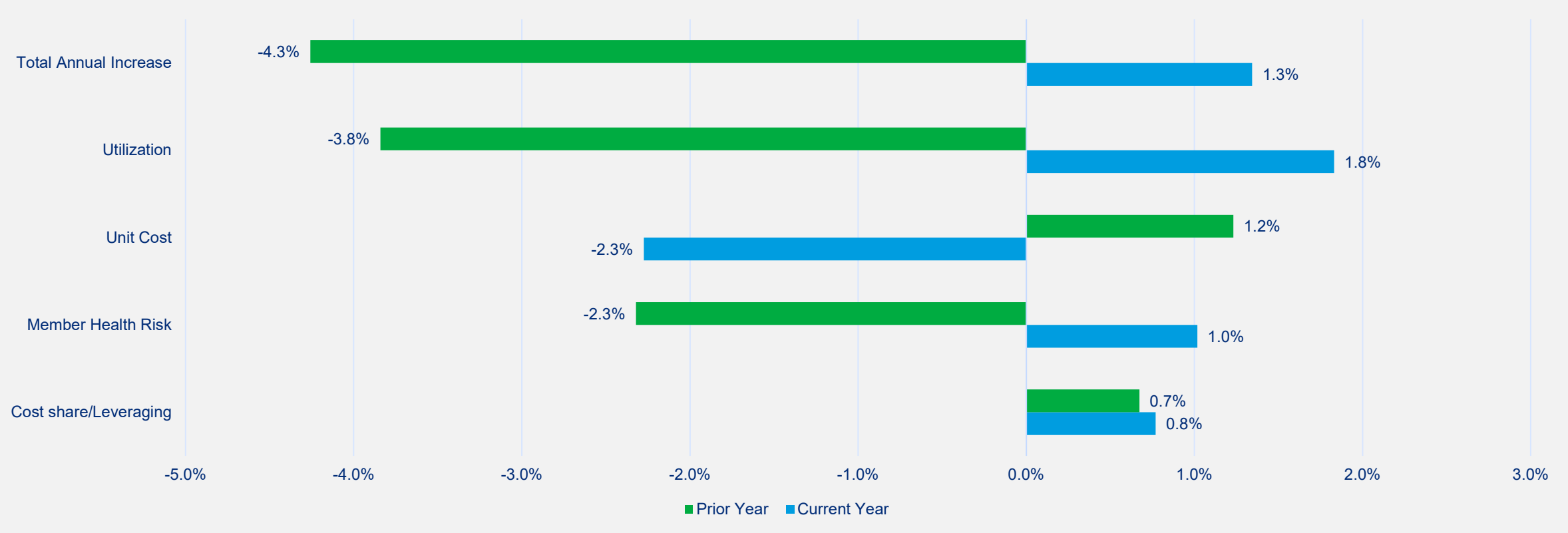
	Two Years Prior	One Year Prior	% Change	Current	% Change
Aggregate					
Medical	$731,036,699	$681,337,921	-6.8%	$693,868,469	1.8%
Prescription Drug	$113,308,195	$121,614,385	7.3%	$134,660,649	10.7%
Total	**$844,344,894**	**$802,952,306**	**-4.9%**	**$828,529,119**	**3.2%**
Per Employee Per Year					
Medical	$14,041	$12,930	-7.9%	$12,852	-0.6%
Prescription Drug	$2,176	$2,308	6.0%	$2,494	8.1%
Total	**$16,218**	**$15,237**	**-6.0%**	**$15,346**	**0.7%**
Average Annual Membership					
Employees	52,063	52,696	1.2%	53,989	2.5%
Members	135,988	135,976	0.0%	138,241	1.7%

- **Per employee costs per year increased less than the 3.4% limitation for both 2021 and 2020**

Trend Components

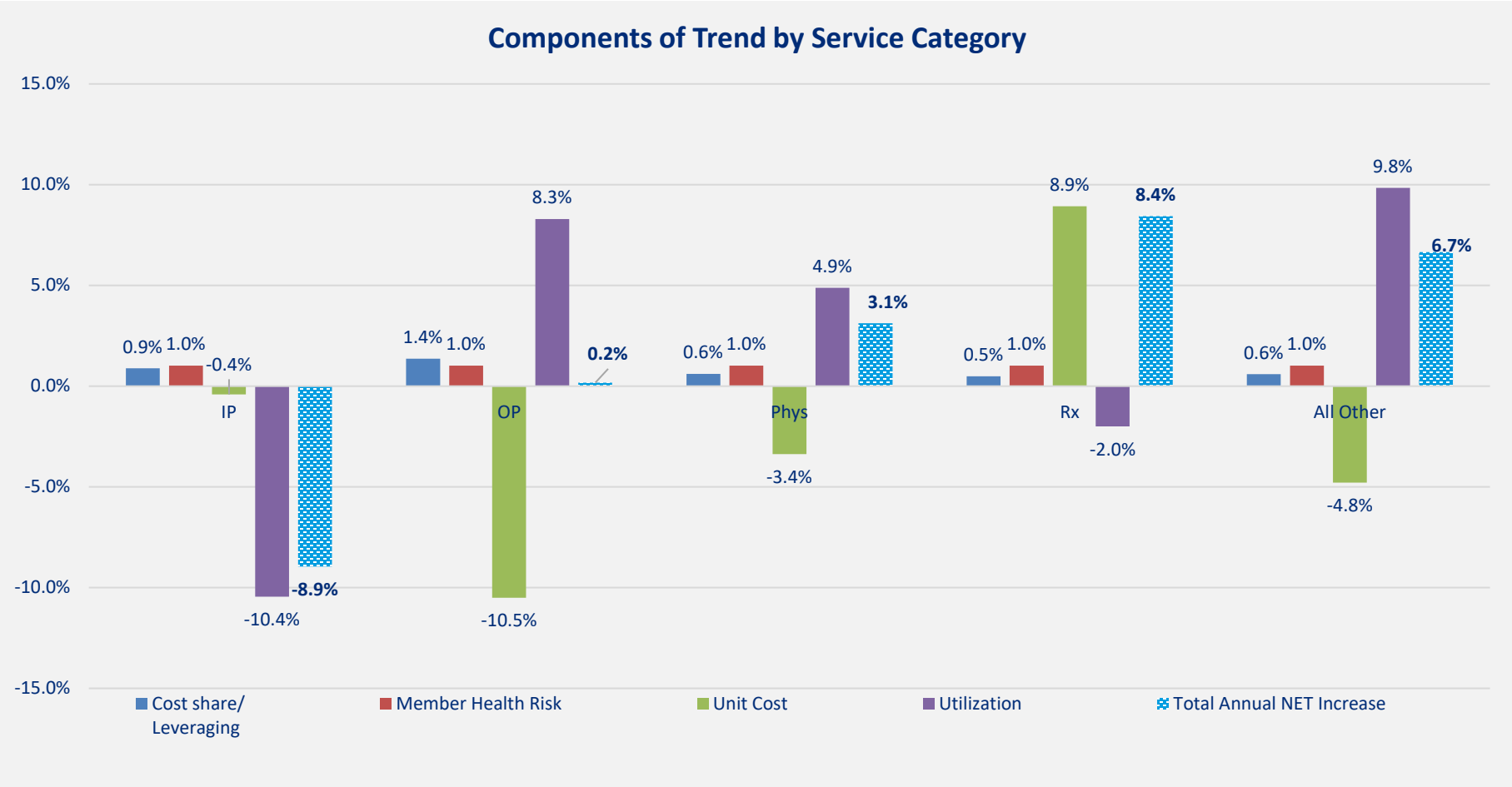
4

Trend components



- **Largest contributors to unit cost increases for current period are specialty drugs in a professional and PBM setting; specialty drugs in a facility setting have decreased**
- **Behavioral health costs have increased in utilization and unit cost**
- **Unit cost includes reimbursement rates, mix of services, and intensity**
- **This slide reflects *paid* claims**

Trend components by service category



Service Category	Overall PMPM Trend
IP (Inpatient)	-8.9%
OP (Outpatient)	0.2%
Phys (Physician)	3.1%
Rx (Pharmacy)	8.4%
All Other	6.7%

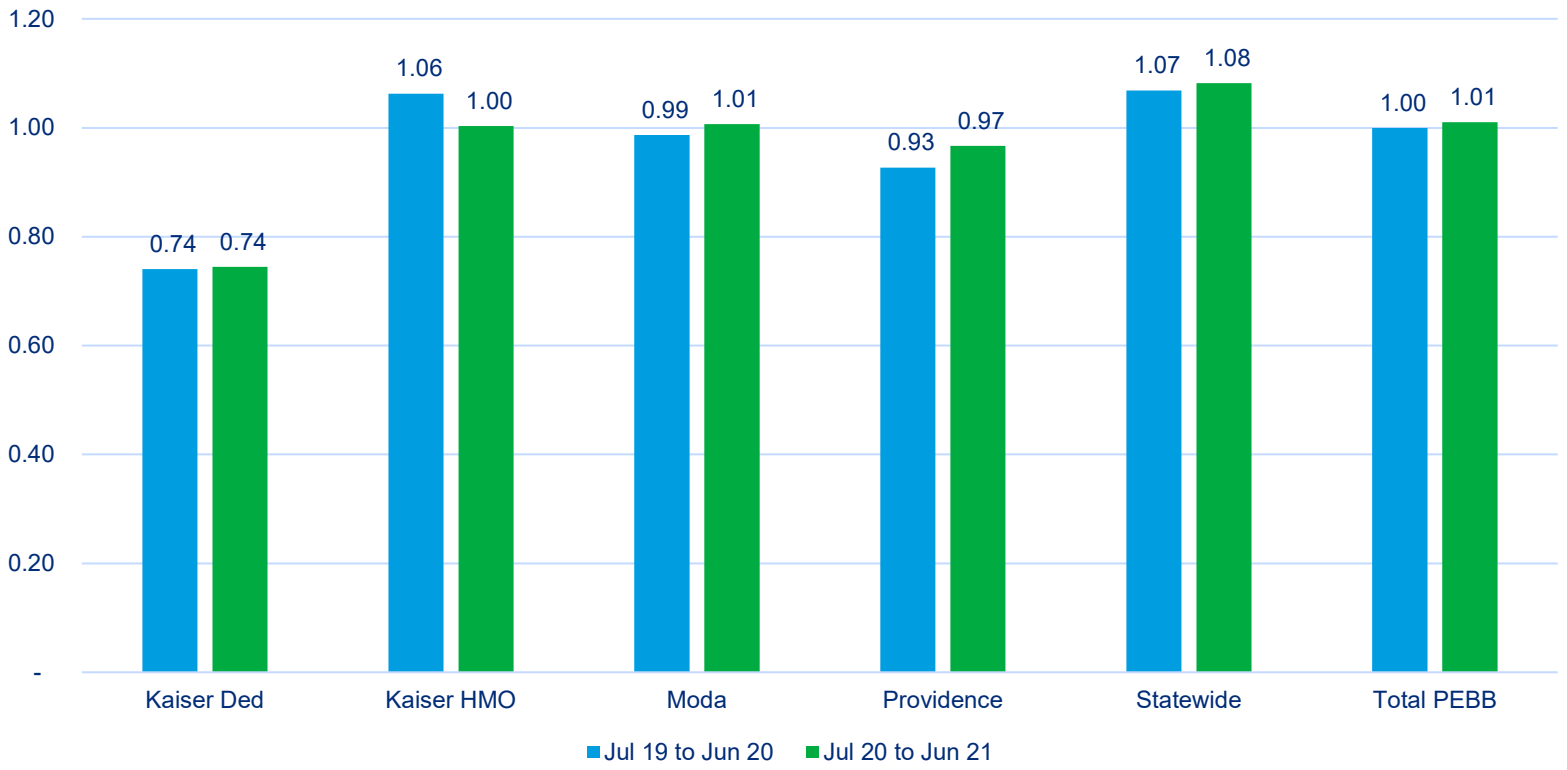
Trend components by service category

BY PLAN	Largest Component of Change	PMPM $ and % change	Other cost drivers (PMPM change)
Choice	Prescription specialty drugs	• $9.78 PMPM • 21.5%	• Facility outpatient surgery (+$7.14) • Mental Health other outpatient (+$5.71)
Statewide	Facility inpatient surgical	• ($10.61) PMPM • (16.5%)	• Prescription specialty drugs (+$7.95) • Facility outpatient specialty Rx (-$6.89)
Moda	Mental Health other outpatient	• $8.10 PMPM • 36.7%	• Prescription specialty drugs (+$7.39) • Professional services other (+$3.32)
Kaiser Deductible	Physician non-specialty office visit	• ($7.85) PMPM • (26.8%)	• Facility inpatient surgical (+$7.47) • Facility inpatient maternity (+$6.85)
Kaiser HMO	Physician non-specialty office visit	• ($8.19) PMPM • (24.8%)	• Physician non-specialty outpatient other (+$5.34) • Professional services other (+$4.80)

- Unit cost includes reimbursement increases, mix of services change, and technology
- This slide reflects *paid* claims
- Moda inpatient maternity costs have moderated due to changes in SB1067 rules starting December 2020

Risk scores
By plan

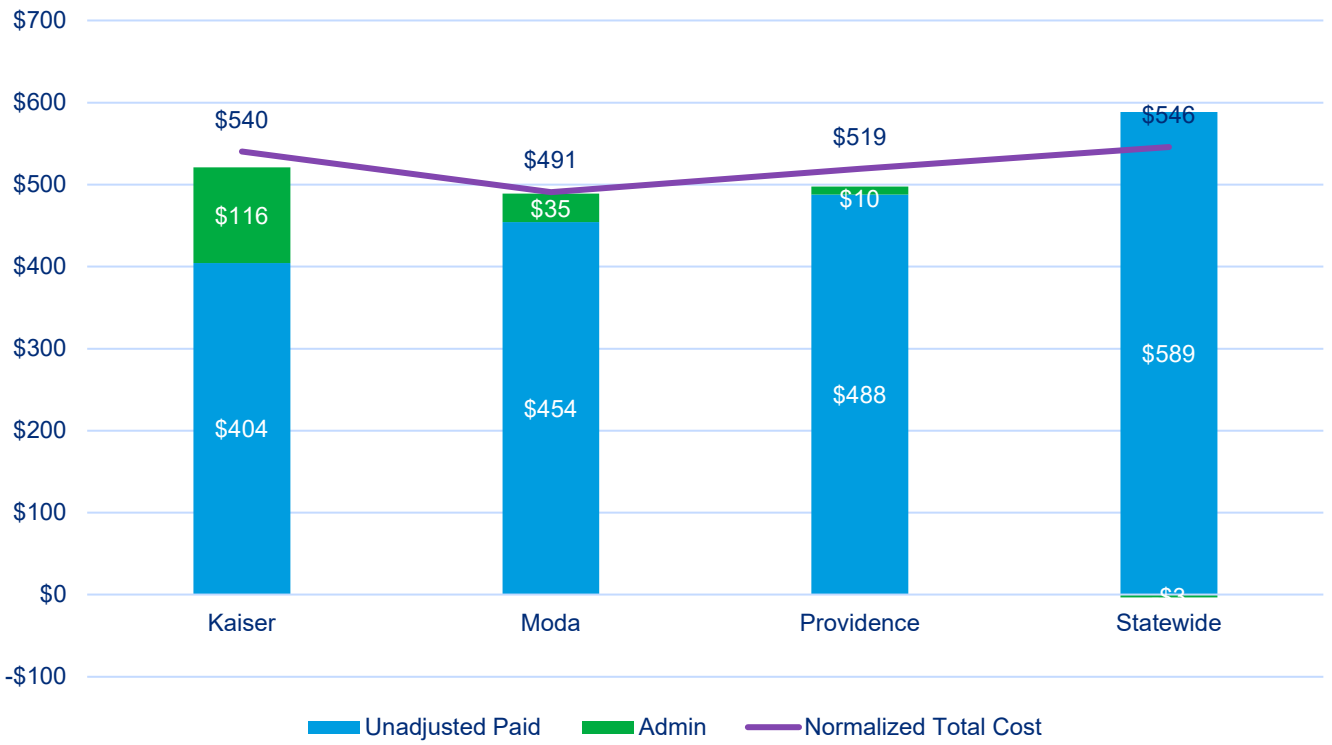
Risk increased 1% across all of PEBB, with the largest increase coming on the Providence plan



- **Risk scores are the relative cost of a member determined by the underlying illness burden based on age, sex, and diagnosis data. Scores are normalized to an average PEBB member from July 2019 to June 2020.**
- **Shifting of services to non-claims based interactions may be lowering risk scores which are based on claims**

Normalized costs by plan (PMPM)

Risk-adjusted costs (purple line) are lowest for Moda



- **Normalized costs refers to risk-adjusted PMPM claims, adjusted to reflect the "average" PEBB member**
- **Kaiser and Providence membership has lower risk scores than PEBB as a whole**
- **Kaiser admin includes integrated care fees; admin fees for Moda, Providence, and Statewide are offset by pharmacy rebates**

Trends by place of service

5

Trends by place of service

All Other **up 9% (+$16.0M)**

Physician Office Visits **down 8% (-$4.3M)**

Outpatient Surgery **up 8% (+$10.6M)**

Mental Health/ Substance Abuse **up 10% (+$6.1M)**

Emergency Room **down 15% (-$8.3M)**

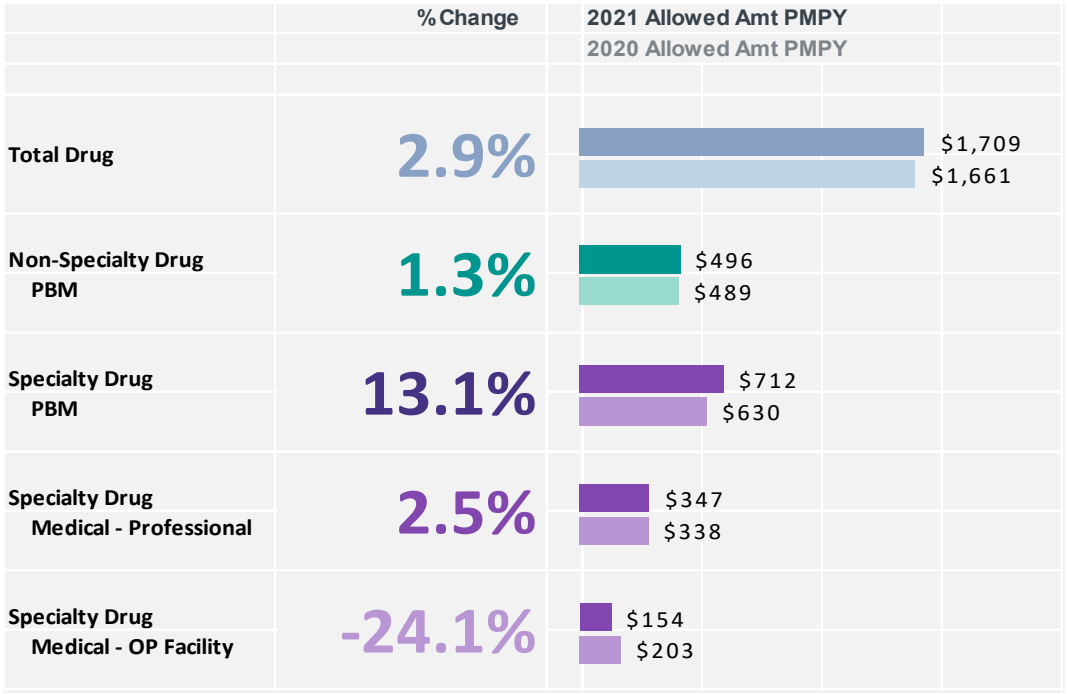
Lab **up 18% (+$6.1M)**

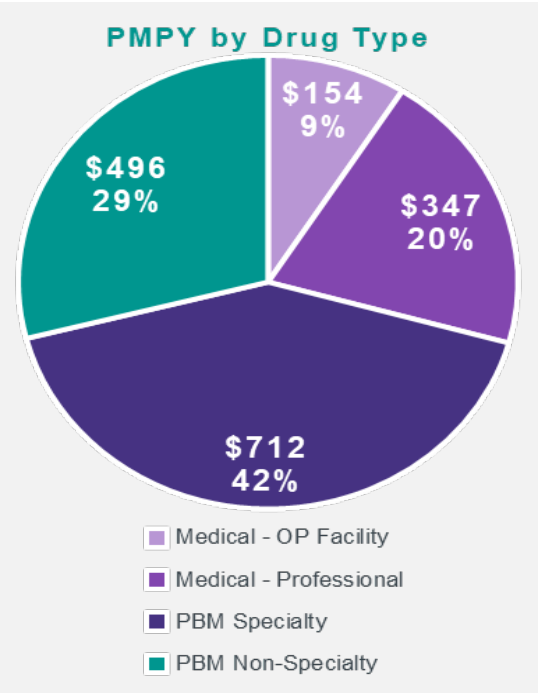
Why?

- **All Other** buckets experienced a significant increase in PMPY cost due to COVIDs impact on telemedicine utilization and cost. Total All Other accounted for 17% of total spend, which is above Mercer FOCUS BoB of 12%.
  - Services shifted from **Physician Office Visits,** resulting in a 8% decrease
- Increase in **Outpatient Surgery** was driven by return of services for Osteoarthritis, Fractures and Joint Disorders
- **Mental Health/Substance** abuse cost were primarily driven by Mental Health outpatient utilization in addition to unit cost increases. Total **Substance Abuse** decreased across all places of services (admission, outpatient and professional).
- The rise in lab services were driven by COVID testing which was 3% of lab spend in prior period and now 23%. Total spend for COVID testing was $8.2M up from $909K in the prior period.

Cost driver: pharmacy trends

Specialty PBM trend was driven by an increase in utilization (scripts per member) and total spend





Top Drug Allowed Trend Drivers:

Non-Specialty PBM

- Jardiance
  Treats type 2 diabetes
  $3.0M (+$705K over prior year)
  761 patients (617 in prior)
- Pfizer COVID-19 Vaccine
  Vaccine for COVID
  $608K ($608K over prior year)
  8,794 patients (0 in prior)

Specialty PBM

- Stelara
  Treats plaque psoriasis/psoriatic arthritis
  $9.0M (+$2.2M over prior year)
  124 patients (107 in prior)
- Trikafta
  Treats cystic fibrosis
  $2.9M (+$1.6M over prior year)
  10 patients (8 in prior)

Specialty Med Prof

- Ocrevus (J2350)
  Treats multiple sclerosis
  $1.6M (+$786K over prior year)
  30 patients (14 in prior)
- Hemlibra (J7170)
  Treats Hemophilia
  $751K (+$751K over prior year)
  2 patients (0 in prior)

Specialty Med OP Fac

- Remicade (J1745)
  Treats rheumatoid arthritis / crohn's disease
  $951K (-$2.3M over prior year)
  37 **patients** (60 in prior)
- Entyvio (J3380)
  Treats ulcerative colitis / crohn's disease
  $1.7M (-$961K over prior year)
  26 patients (28 in prior)

Top opportunities and next steps

6

Strategic recommendations

Top opportunities for improvement

1) **Mental Health**

Challenge: High prevalence of depression and anxiety

Recommendations:

- Encourage use of screenings and referrals for mental health (e.g., depression and anxiety) and substance use disorders (e.g., alcohol, tobacco, and other substances)
- Assess if carriers and EAP are evaluating and referring for burnout with members
- Evaluate adequacy of access to mental health providers and whether members can obtain timely services
- Investigate whether online behavioral health services can supplement current networks

2) **Metabolic and Cardiovascular**

Challenge: Metabolic and cardiovascular conditions amount to over $56m in allowed spend, diabetes is top spend category overall

Recommendations:

- Review clinical programs for each medical carrier to ensure optimal enrollment effectiveness
- Promotion of existing carrier programs or RFP for condition-specific point solutions if carrier programs are shown to be ineffective

3) **Musculoskeletal / Low Back Disorders**

Challenge: Disorders related to the back and joints are totaling over $49m and are two of the top six highest spend categories

Recommendations:

- Promote screening and usage of lower impact services such as carrier weight loss, back care programs, and massage & physical therapy benefits for members
- Develop plan design to incent usage of centers of excellence (with bundled payments) for musculoskeletal procedures
- Evaluate carriers' prevention strategies and integration of digital MSK solutions

4) **Specialty drugs (PBM and Medical)**

Challenge: Continued increase in unit costs for specialty drugs administered in the PBM and medical setting

Recommendations:

- For medically administered specialty drugs, carriers will continue to advance their site of care steerage programs which help move care into lower cost settings
- Promote use of specialty pharmacies which are able to drive lower costs for specialty drugs in comparison to retail settings

5) **Quality of Care for Members**

Challenge: Improvement of care for members and steerage to high quality providers

Recommendations:

- Increase performance guarantees for plans tied to quality metrics
- Consider vendors who can identify and stratify providers by quality and efficiency
- Integrate findings from the vendors with an advocacy program to steer members to high quality providers

Appendix

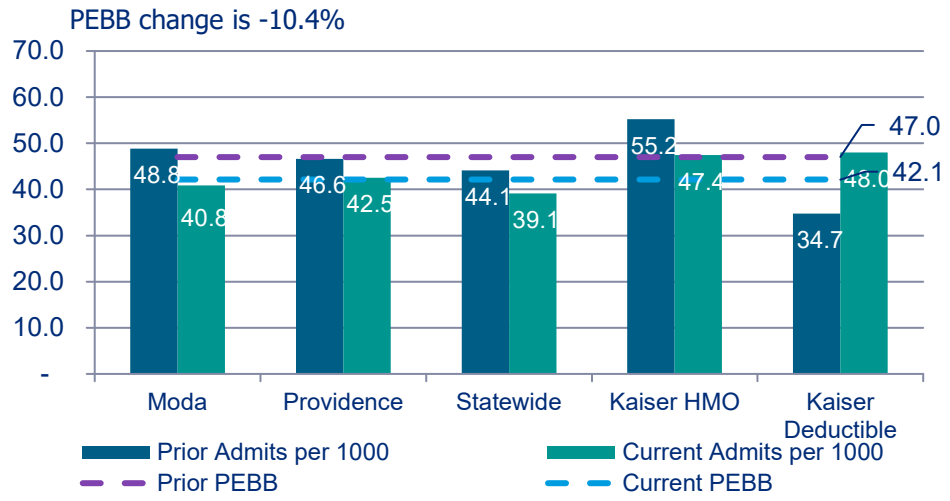
7

Utilization executive summary

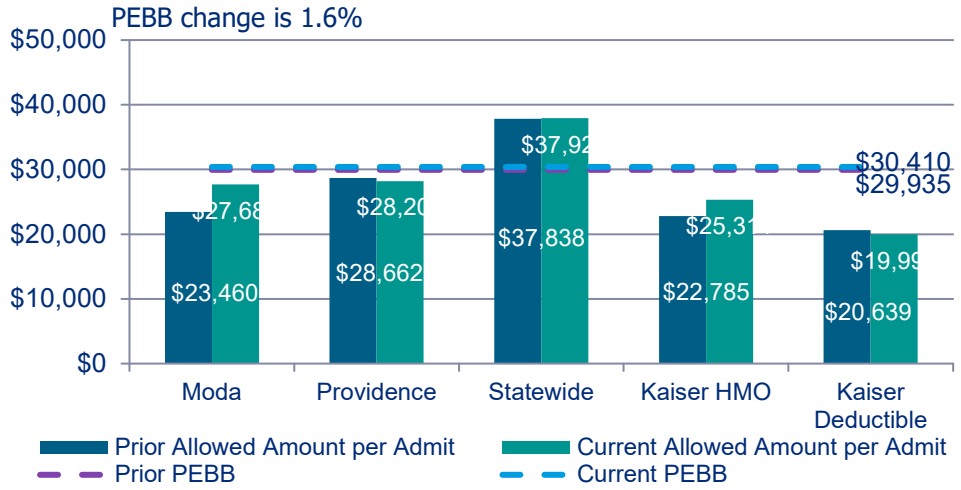
INPATIENT FACILITY	• Utilization was lower with the exception of Kaiser Deductible, which had more maternity admits
OUTPATIENT OFFICE VISITS	• Utilization of office visits increased as usage of telemedicine offset decrease in in-person visits
EMERGENCY ROOM	• Both utilization and cost per visit decreased in the current period; non-emergent emergency room visits are also lower indicating members were more selective about using the emergency room
LAB / RADIOLOGY	• Lab and radiology utilization increased 9.8% and 1.7%, respectively. Lab services impacted by COVID-19 services. Radiology cost per service decreased 5.2%.
PRESCRIPTION	• Total Specialty drug (Medical and PBM) account for 71% of total pharmacy spend, driven primarily by prescription specialty Rx

Inpatient facility

Admits per 1000



Allowed Amount per Admit



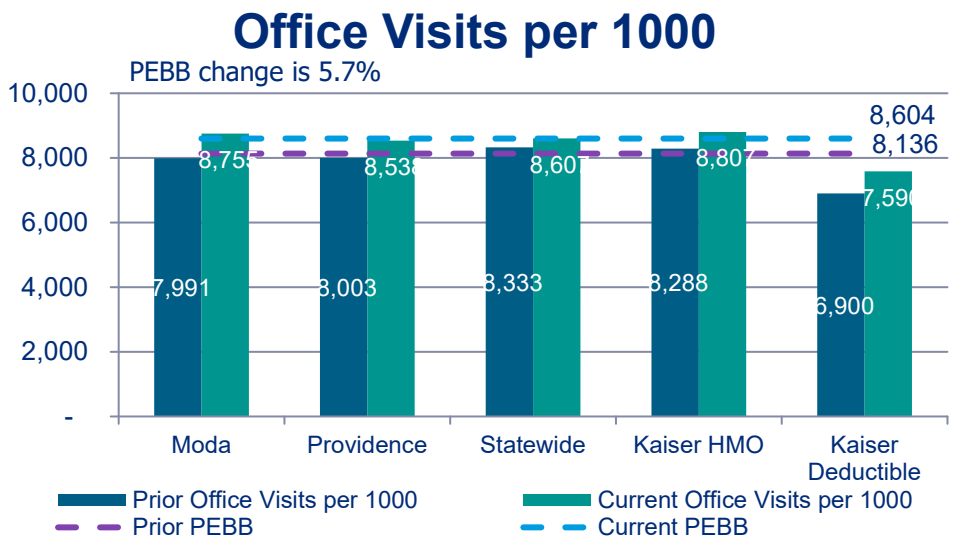
Key Insights

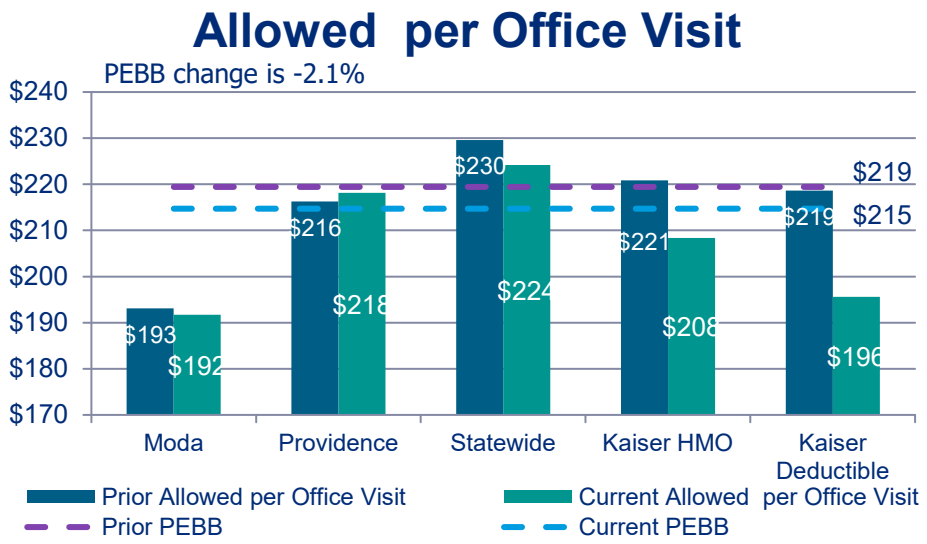
1
- All plans except for Kaiser Deductible saw a decrease in admits per 1,000 with Kaiser HMO having the largest decrease at -14.1%

2
- Allowed per admit for Moda increased 18%, Providence decreased 2% and Statewide increased slightly at 0.2%
  - Moda inpatient costs are driven by an increase in costs for newborns and intensity of surgical procedures
- Kaiser deductible admits increased by 38%, due to increased maternity deliveries

3
- Overall PEBB saw a -10% decrease in admits per 1,000
- Allowed amount per admit for PEBB overall increased by 2%

Outpatient office visits





Key Insights

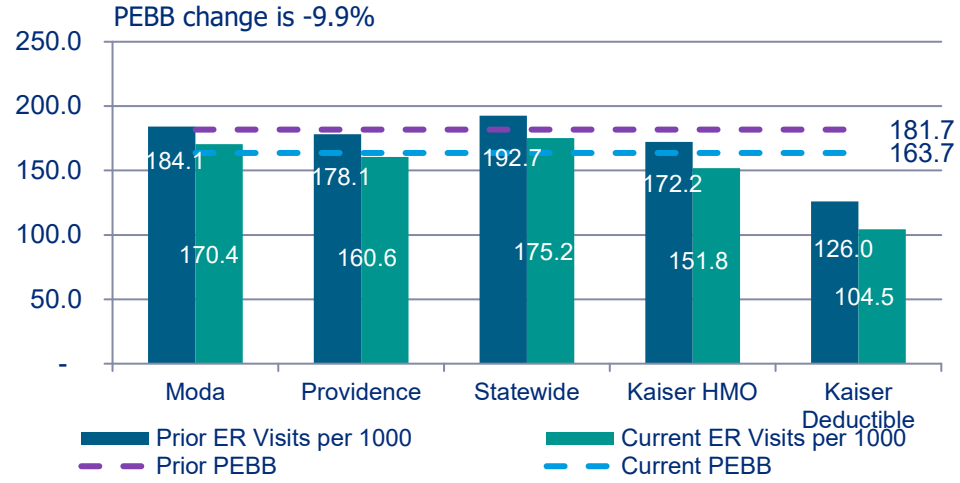
1
- Utilization per 1,000 increased due to return of care
- Office visits on this slide include MHSA and include in-person, telehealth, and walk-in retail health clinics

2
- Visits per 1,000 increased by 6% for Kaiser HMO and 10% for Kaiser Deductible
- Statewide increased 3%, Choice increased 7% and Moda decreased 10%
- In-person visits were offset by an increase in telemedicine visits

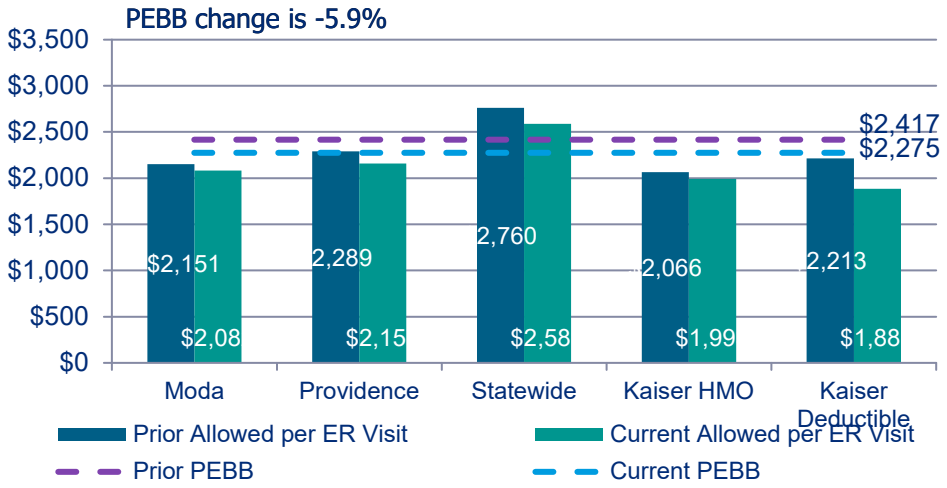
3
- Cost per visit decreased during the current period with Kaiser Deductible decreasing the most at 10.5%
- Impact of telemedicine visits and shifting of services reduced average allowed cost

Emergency room

ER Visits per 1000



Allowed Amount per ER Visit



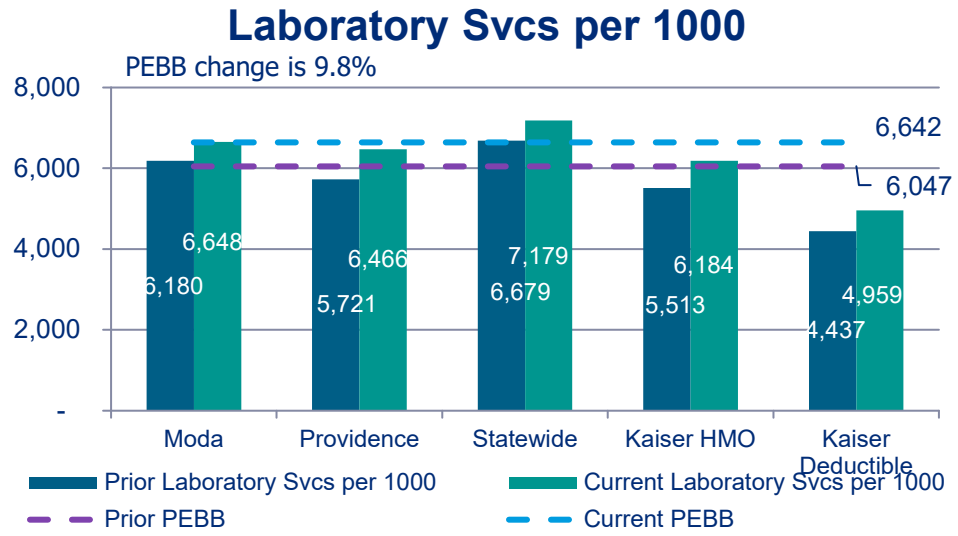
Key Insights

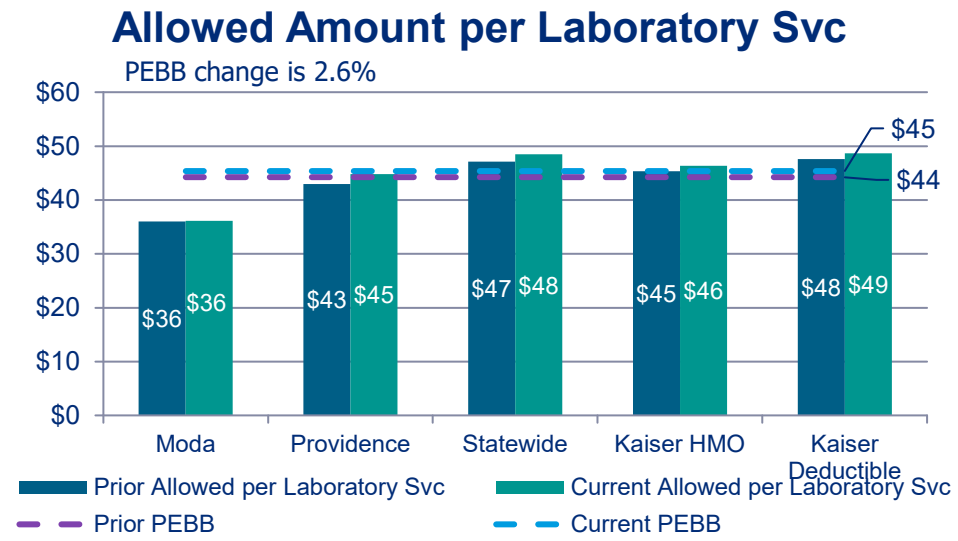
1
- ER visits per 1,000 decreased for all plans with Kaiser Deductible decreasing the most
- Some services may have been diverted to urgent care

2
- Level 5 visits increased to 29.0% of total ER visits in current time period from 26.7% in prior
  - Increase primarily observed in Choice and Statewide plans

3
- Allowed per ER visit decreased 6%, with a decrease in both intermediate and non-emergent ER costs
- ER costs are subject to 200% of Medicare at hospitals subject to the cap
- Costs shown in ER only include the emergency department costs; if a member is admitted, those costs are accounted for as inpatient

Laboratory services

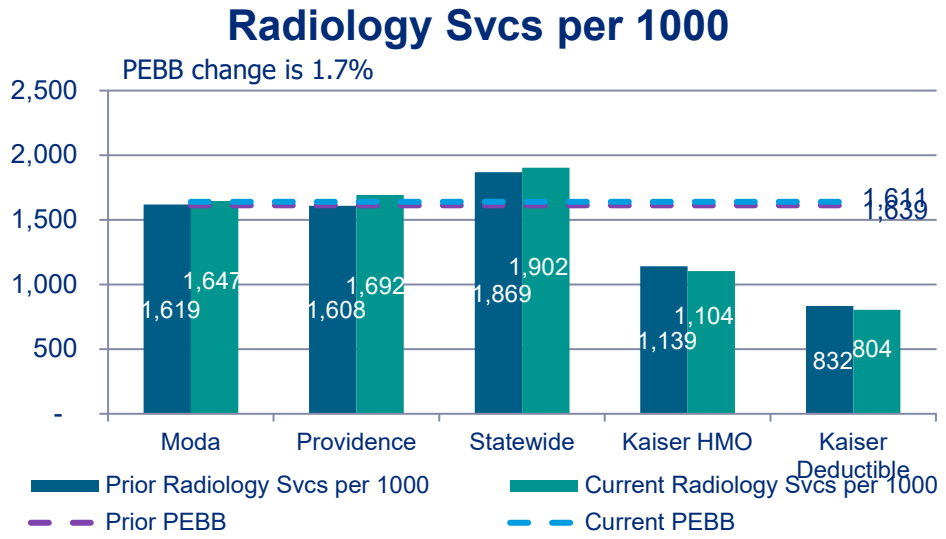


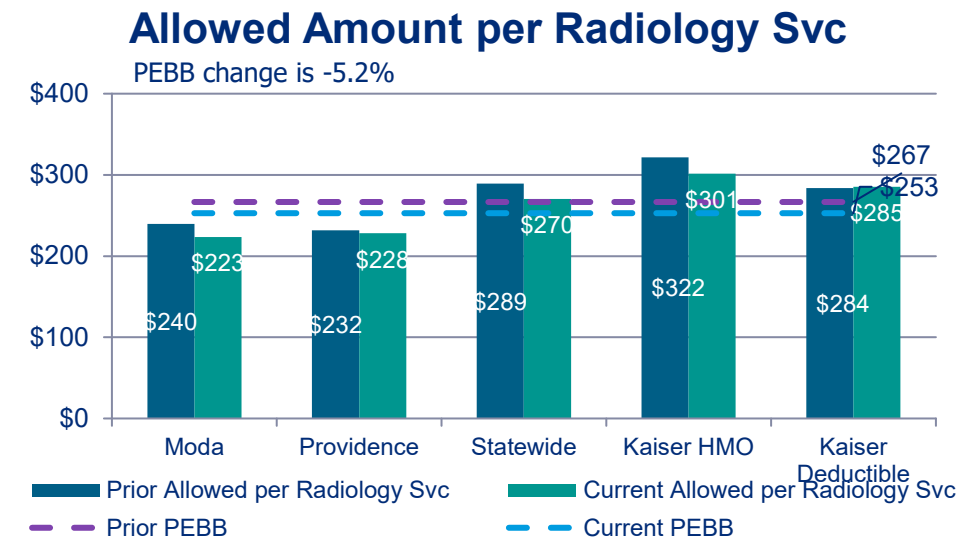


Key Insights

1. Providence and Kaiser HMO had the largest increases in lab services at 13% and 12% respectively
   - Much of increase is due to COVID-19 lab services
2. Overall, PEBB lab services increased 10% on a per 1,000 member basis in 2021 compared to 2020
3. Allowed per lab service increased slightly across all plans

Radiology services





Key Insights

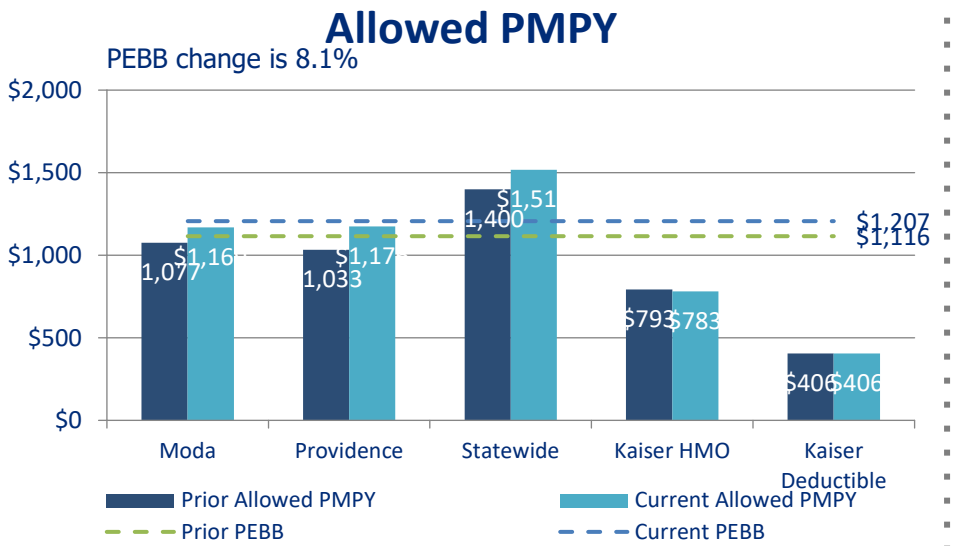
1
- Overall radiology services increased 2% in the current time period
- Providence increased the most at almost 5%

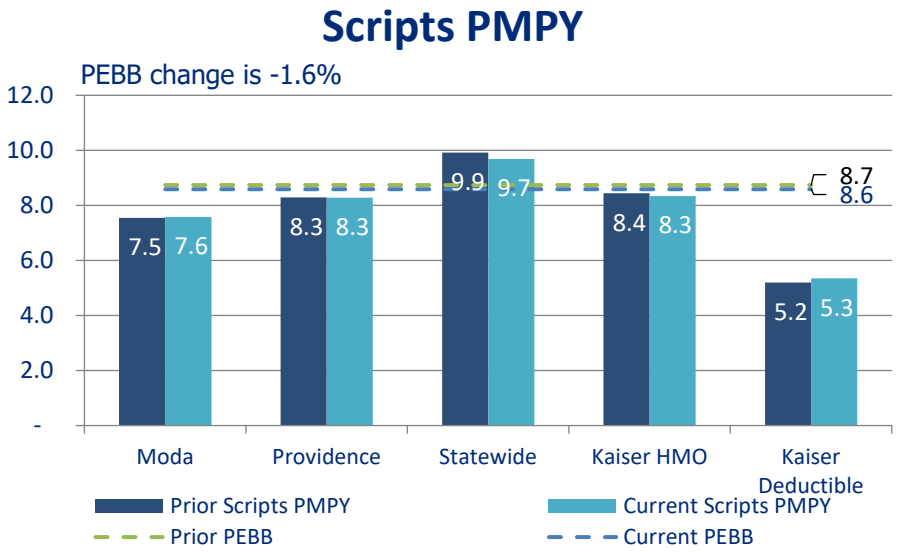
2
- Costs per service decreased 5.2% with Moda decreased 6.7% and Statewide decreased 6.6%
- Kaiser Deductible saw a slight increase at 0.6%

3
- The impact of the 200% of Medicare cap was partially mitigated by a change in mix in service

Prescription drugs — PBM

Excluding specialty



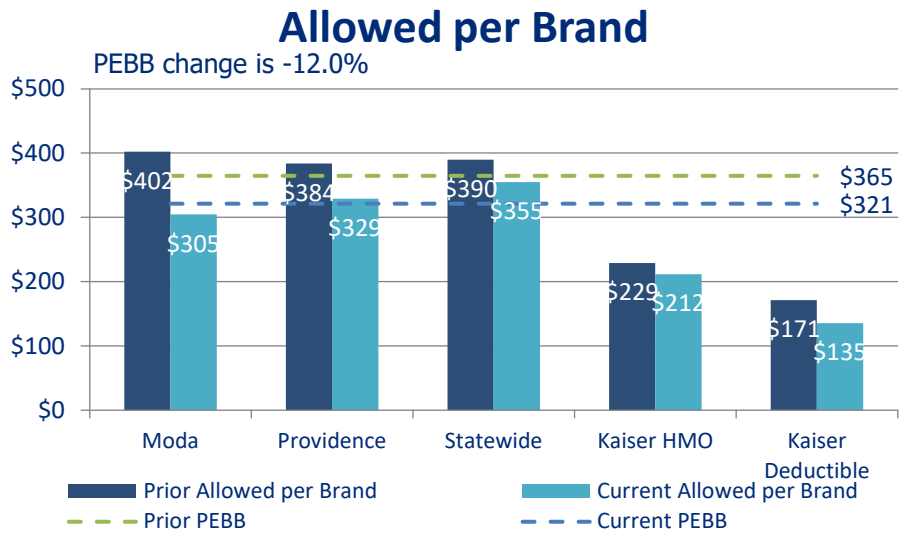


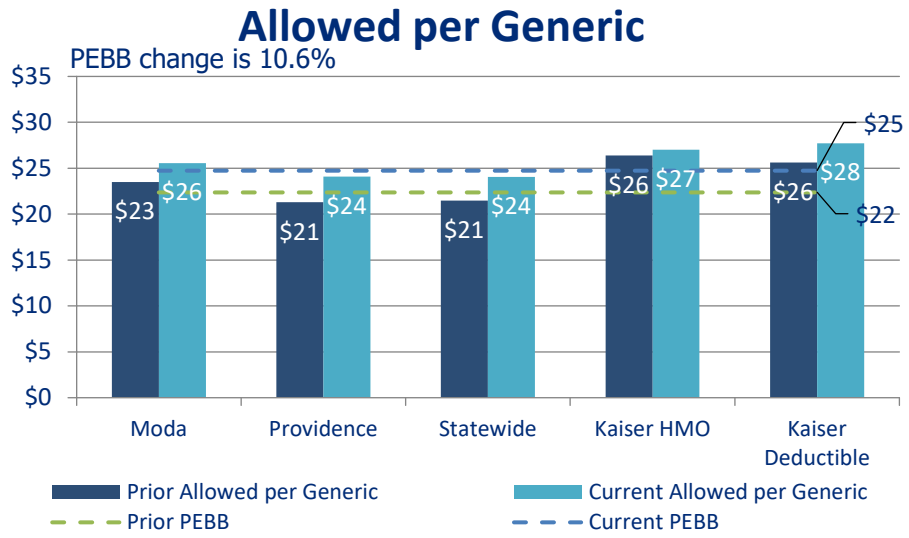
Key Insights

1. Allowed per member increased 8.4% for Statewide, 8.6% for Moda, and 13.8% for Providence
   - Allowed Specialty drugs in the PBMs increased 16.4% PMPY
2. PEBB's paid amount per member increased 8.6%, as allowed cost per script increased more than the member's portion of the cost
3. Kaiser HMO scripts per member decreased 1.2% as utilization shifted from retail to mail order

Prescription drugs — PBM

Excluding specialty





Key Insights

1

- Allowed per brand script decreased for all plans
- COVID-19 vaccines have impacted costs

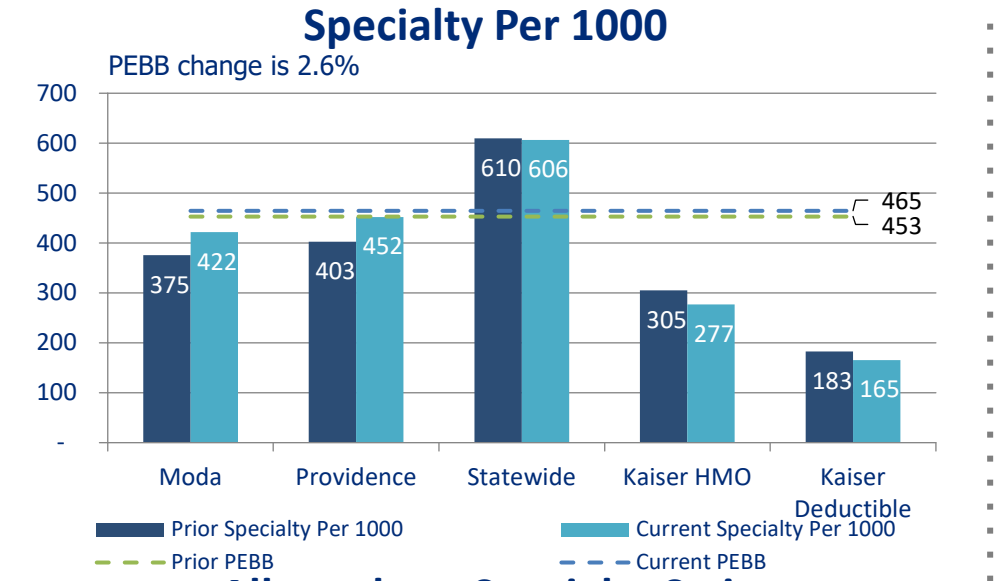
2

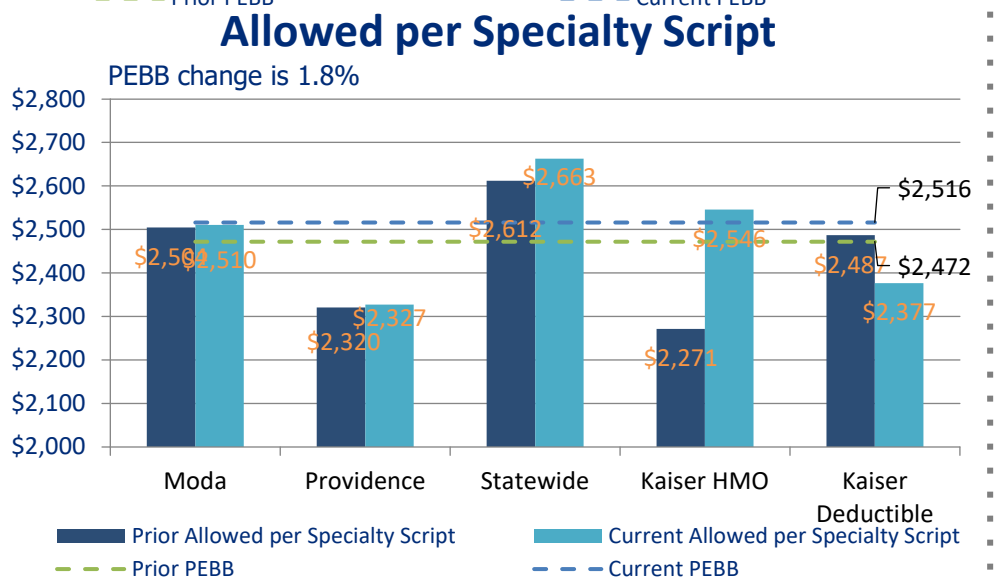
- Allowed per generic increased for all plans
- Costs exclude specialty drugs and Rx rebates

3

- Generic utilization for PEBB decreased by 1.6% to 84.9%
- Utilization impacted by COVID-19 vaccines
- Some brand drugs may be covered as generic under the plans but are classified as brand in the database

Specialty drugs — (Medical + PBM)





Key Insights

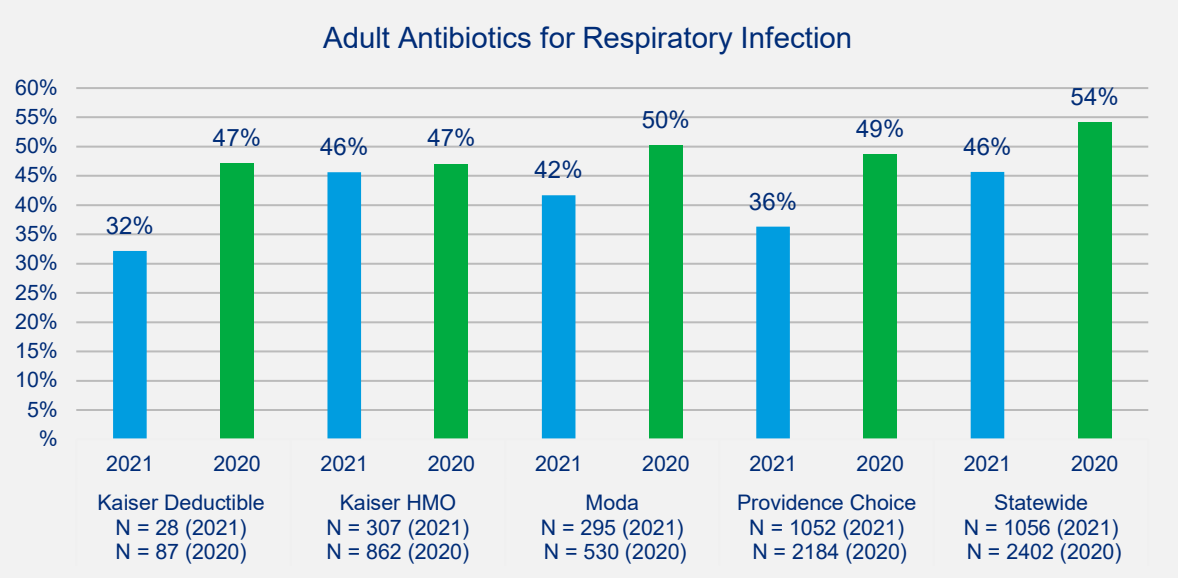
1
- Utilization of specialty drugs increased for Moda and Providence
- Moda increased 12.3% while Choice increased 12.2%

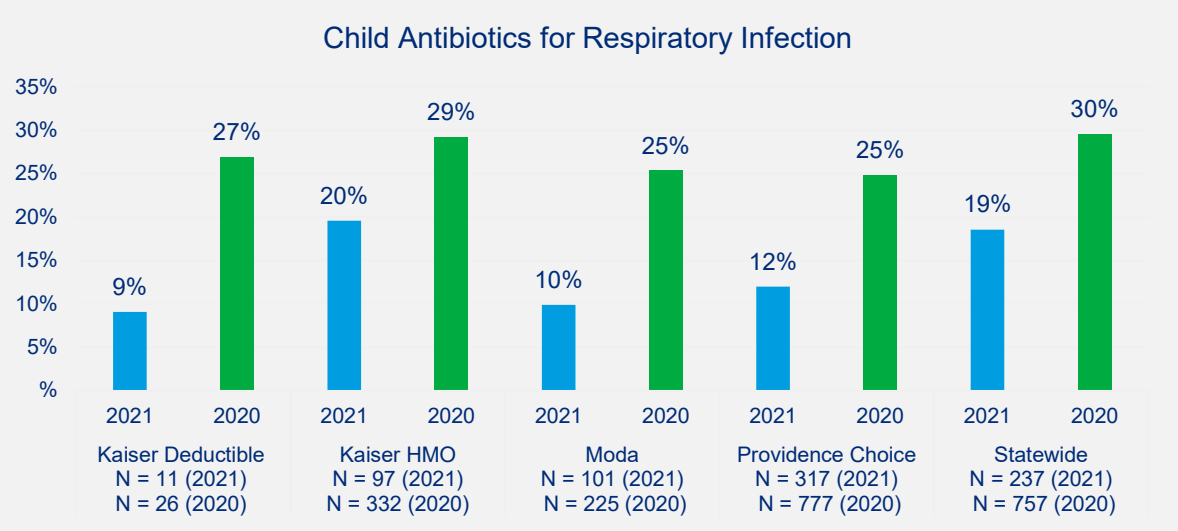
2
- Specialty drug costs now represent 18.8% of total PEBB claims
- This is an increase from 18.3% during the prior period
- Impact of SB1067 on specialty in facilities has moderated cost increase

3
- Excluding specialty drugs, the PEBB allowed cost increase of 1.5% would have decreased 0.7%, to 0.8%

Low value care

Antibiotics for respiratory infection





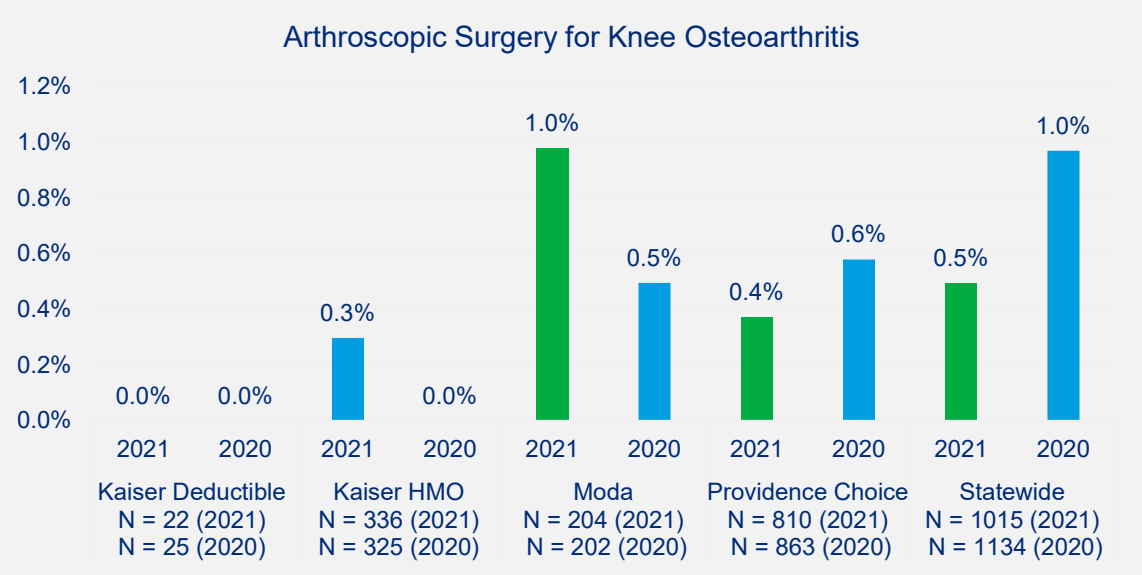
Antibiotics for Respiratory Infection

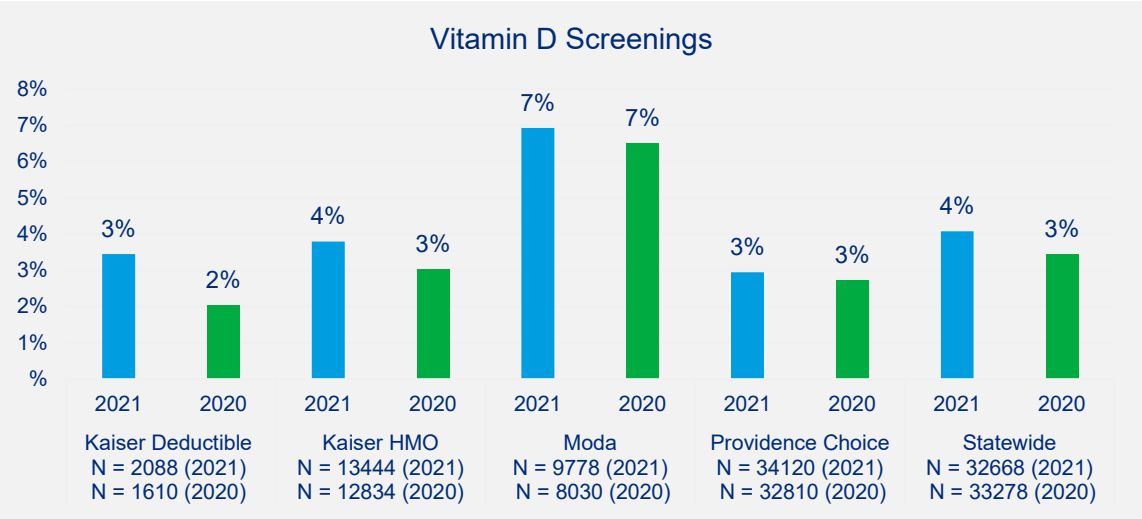
- Percentage of adults or children up to age 18 with sinusitis, common cold, or non-specific upper respiratory infection who received an oral antibiotic on the day of diagnosis or within nine days following diagnosis
- Most upper respiratory infections in the ambulatory setting are viral and do not respond to antibiotics
- Antibiotics may cause side effects and contribute to the development of antibiotic-resistant infections in the community

Key Point(s):

- All plans showed improvement in lowering the rate of antibiotics prescribed for respiratory infections, however, some drops may be a result of COVID-19

Arthroscopic knee surgery and vitamin D screening





Arthroscopic Surgery

- Percentage of patients with a diagnosis of generalized or localized osteoarthritis, or chondromalacia who have knee arthroscopy within 365 days after the last diagnosis
  - Arthroscopic surgery of the knee is not effective as primary management of knee osteoarthritis

Vitamin D

- Percentage of patients except those with a medical condition that supports a Vitamin D screening who have had a screening in the current year
  - Most individuals with suspected Vitamin D deficiencies who do not have high risk conditions that might change treatment can be advised to increase sun exposure, improve their diet, or take supplements without lab testing

Key Point(s):

- All plans showed improvement in both arthroscopic knee surgery rates (except Kaiser HMO). Vitamin D screening rates increased potentially due to return of care.

Mercer

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My name is Ryan Perkins. I work for the state of Oregon, and I'm a PEBB member on Providence Statewide. I'm writing to you about how Providence specifically, but also PEBB plans generally, are treating health-care claims related to a preventive therapeutic medication regime called PrEP, and specifically some concerns I have in regards to equitable treatment of these claims.

First, what is PrEP? PrEP is short for pre-exposure prophylaxis. It's a preventive treatment that allows people who would otherwise be at high risk of acquiring HIV (including gay and bisexual men and their sexual partners, as well as recreational injectable drug users) to have a nearly zero chance of establishing an HIV infection. PrEP is currently authorized for the name-brand drugs Truvada and Descovy, and for the generic form of Truvada as well. It's an extremely effective treatment, and extremely expensive in the US. The list price on my pharmacy receipt is about 2000 dollars for a month's supply. The expense is well worth it, in social and economic terms. People living with HIV may take Truvada or Descovy as part of their larger HIV treatment strategy, but they take at least one other HIV antiretroviral drug in order to keep the virus suppressed to undetectable and untransmittable levels. These additional drugs *each* have list prices that are comparable to or exceed those of Truvada and Descovy. Thus, besides the obvious epidemiological imperative to stop HIV spread with the use of PrEP or similar therapies, it is simply cheaper to prevent people from getting HIV than to treat people who are living with it.

Because of the high levels of cost associated with HIV care, people living with HIV have faced obstacles to receiving treatment whether or not they are insured. Insurers, until quite recently, were able to impose high levels of cost sharing on these treatments. People who take PrEP must also have quarterly blood and urine labs to test for HIV, other STIs and metabolic function, and quarterly follow-ups with a physician. Because of stigmas around HIV, not every primary care physician is comfortable prescribing PrEP themselves (although they can), and it's not uncommon for gay and bisexual men to have difficulty finding a primary care physician willing to prescribe them PrEP. Commonly, we are referred to specialist clinics. This is especially true in areas with smaller populations that are unable to support LGBT primary health clinics. This practice of referring patients out of a primary care setting into a specialist setting, before 2021, could present an obstacle to PrEP access, as specialist care has a higher level of cost sharing imposed on it by insurance providers, as much as 50% for PEBB plans.

In July 2021, the Centers for Medicare and Medicaid Services announced guidance clarifying that PrEP treatment, including the prescription *and* the lab and clinic visits associated with maintaining the prescription, must be covered by insurers without any cost-sharing whatsoever. I remember seeing a news story about this guidance, and after looking at it I called Providence, and attempted to dispute the charges with their customer service representatives, after explaining this change in federal guidance. Providence told me that the claims had been billed "incorrectly", and that I should contact my doctor's office about the billing code and ask them to resubmit the claim under a preventive code, and that the coding of the claim was an insuperable obstacle otherwise. I attempted to do this and my doctor's office was unable to find a code that would bypass copays for me. After some research, I don't believe this practice is necessarily legal.

After about 3 months of these calls, I got in touch with the Division of Insurance Regulation at the Oregon Department of Consumer and Business Services, and the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services, and submitted complaints to both of them in September.

As a result of those complaints, Providence has agreed to cover costs of my PrEP-related claims back to June 2020, a total refund of about 850 dollars, and I am very glad that they will be covering these costs. They also informed me that they are reviewing some 10000 lines of claims to reflect this change in practice. I am still concerned, though, that there remains inequitable treatment of public-sector workers covered under PEBB: specifically, in the treatment of claims before June 2020, and whether they came from a specialist or primary care office. PrEP has *always* been a preventive care service, and so should always have been covered without cost sharing. Providence should not have needed to rely on federal guidance to identify it as such, and I believe that when these claims came from a primary care office, they covered them in full, at least for some people.

I expect that Providence will say to the PEBB Board that the people they insure have a choice to seek out care from a specialist or primary care provider, but I want to remind you that our choices are in fact constrained by the doctors who practice at the clinics we can reasonably attend, based on our income, geographic location, access to cars and transit, and so on. My primary care physician basically refused to prescribe it to me himself, and was very adamant on referring me to a specialist.

I ask the PEBB board to investigate (1) Providence's practices around PrEP-related claims before June 2020; (2) how Providence is identifying PrEP-related claims that are now subject to reviews for refunds and how Providence reviews these claims once it has identified them; and (3) the past and current practices of other PEBB insurers around PrEP-related claims.

I also ask the PEBB board to investigate whether the insurers it contracts with have a robust and speedy process to conform with guidance from the Centers for Medicare and Medicaid Services about what care insurers must cover without cost sharing–based on my experience with Providence over the last 6 months, I do not believe such a process exists.

Finally, I ask the PEBB board to investigate billing practices regarding preventive care services provided at specialist clinics, and to ensure that these are being provided equitably compared to preventive care services in primary care settings. I believe Providence has a practice of denying preventive care insurance claims from specialist offices if those offices do not take a great deal of care to bill these claims exclusively with billing codes for preventive services. I was told as much by a customer service representative in March 2020, when I first tried to dispute the copays for my specialist visits and labs. I was also told this on Tuesday Dec 7, in regards to a recent claim for a Hep B vaccine administered at my specialist's office. According to CMMS, this procedure should be provided without cost sharing. When I called to ask about why I had been assessed a copay, I was told the claim code for the act of injecting a

vaccine was not tagged as preventive, and so Providence was forced to assess a copay to me, even though the claim code for the vaccine dose associated with the injection *was* tagged as preventive. I was told that in order to correct this my doctor's office would have to resubmit the claim.

I haven't been insured by Kaiser or Moda, but based on conversations with gay and bisexual friends who are, and on research I've done in the last 6 months trying to resolve this, I believe that Kaiser and Moda also put up barriers to PrEP for the people they insure, and I again urge PEBB to audit their policies for HIV medications as well. I know, in the case of Kaiser, that they have a policy of restricting patients to the generic form of Truvada as a general rule, even though there are some indications that Descovy is less likely to cause problems with bone density and kidney function than Truvada and its generic.

I would also suggest that PEBB look at the work HIV/AIDS activists and researchers have done to document currently-existing barriers to anti-HIV medication and audit the insurers it oversees to ensure that these documented barriers do not exist for public-sector workers in Oregon. Among these barriers is the use of prior authorizations as a way to discourage people from obtaining their prescriptions on the margins. A Providence customer services rep informed me on 12/13/21 that, for the 2021 and 2022 year plans, Providence charges a 10 dollar copay for a 30 dollar supply of Truvada's generic equivalent. They also informed me that they require a prior authorization for Descovy with a cost of 100 dollars for a 30 day supply. I don't believe I have been assessed co-pays for Descovy since the beginning of 2021 (although it has required a prior authorization since 2021), but it's troubling that Providence's customer service representatives told me I would be.

To conclude this written testimony, I want to note that we have, right now, the pharmaceutical tools to end the transmission of HIV, and deaths from AIDS. People continue to die of AIDS every year because of social and economic structures and practices that conspire to place the drugs out of the reach of working class people. Our existing insurance regime puts up barriers to HIV treatment for some 7.1 million men who have sex with men and 1.2 million people living with HIV. These barriers caused some 35000 people in the US to become infected with HIV in 2019. 66% of these were men who have sex with men, and while these figures have declined in recent years for Americans overall, they remain high among Black and Latino gay and bisexual men. While people are not dying of HIV now at the rates they were dying when I was a child in the 90s, in 2019 HIV was the 9th leading cause of death for Americans aged 25-34, and 10th for those aged 35-44.

When a person causes a fatal injury to someone else, knowing that their action will result in the other person's death, that constitutes murder. As I have shown above, Providence and other insurers have policies in place to discourage the use of HIV medications by people who need them, and they put these policies in place in order to save their bottom line, knowing that this will contribute to the transmission of HIV and the subsequent death of people from AIDS. This "is murder just as surely as the deed of the single individual; disguised, malicious murder, murder against which none can defend himself, which does not seem what it is, because no

man sees the murdere, because the death of the victim seems a natural one, since the offence is more one of omission than commission. But murder it remains.”