



DESCHUTES COUNTY SELF-FUNDED PLAN ANALYSIS

Presented to:
Employee Benefits Advisory Committee

Presented by
The Segal Company

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OVERVIEW

The Segal Company was requested to assist Deschutes County by analyzing the County's self-funded plans which are structured for sustainability, simplicity, and compliance with the Affordable Care Act (Health Care Reform) federal regulations. Additionally, Segal was asked to identify any additional ways to encourage participants to make cost appropriate health care decisions. The project included an analysis of plan design, cost structure, and recommendations for future modifications including estimating the possible financial impact of various future plan design changes. Segal was also asked to consider ways to encourage the use of the new Deschutes County onsite clinic. This report is intended to provide information to the County as requested.

Observations, projections and recommendations in this report were based on data and information provided to Segal by the County and its plan claims administrator, Employee Benefit Management Services, Inc (EBMS). Historical data was received for the periods Aug 2007 to Jul 2008, Aug 2008 to Jul 2009, Aug 2009 to Jul 2010 and Aug 2010 to May 2011. Note the last period is only a 10-month period, not a 12-month period.

A Word About Privacy: The data presented here does not contain individual identifiers (no names or SSNs, etc.) and specific medical conditions are not identified. While this report is intended to be void of protected health information or PHI (in accordance with HIPAA Privacy regulations), it is recommended that this report not be further released beyond the individuals to whom it was delivered.

A Word About Projections: Projections provided in this report are an estimate of future cost and is based on information available to The Segal Company at the time the projection was made. The Segal Company has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, health trend rates and claims volatility. Unless otherwise noted, these projections do not include any cost or savings impact resulting from health care reform legislation or other recently passed federal regulations.

The comments in this report are intended to provide our views as employee benefits professionals and are NOT intended to provide legal advice. As with all issues involving laws/regulations you should refer to your legal counsel for authoritative advice.

ANALYSIS OF PLAN FINANCIALS

The medical, pharmacy, dental and vision program (the Plan) has been self-funded since 2001. Table 1 (on the next page) includes a summary of financial results for the last six fiscal years. The Plan has operated with a surplus each year (see Table 1 line item L) until the most recent two fiscal years. The most recent two fiscal years show a deficit of roughly \$1.0 million per year. In analyzing this historical information, Segal added two additional line items "IBNR" (incurred but not reported) reserve and "Contingency Reserve." While these are not cash outlays on the income statement, they are recommended reserves that should be reflected on the balance sheet.

IBNR represents the anticipated outstanding obligations to the County as of the end of each plan year for unpaid claims for services that have already been received by Plan participants. This is a future liability that generally accepted accounting practices require an asset as an offset. State insurance regulators may also require self-funded plans to demonstrate adequate reserves to protect Plan participants. Segal reviewed the Plan's historical "claim lag" pattern to estimate the IBNR at 14% of paid claims.

Contingency Reserve represents a recommended amount of money that should be set aside to cover claim fluctuation. Unlike a fully insured plan, the County bears the cost of all claims up to the stop loss limits of its reinsurance policy. That is, all medical/pharmacy claims below \$225,000 per person (specific stop loss) and before the aggregating-specific deductible (\$100,000) and overall medical/pharmacy claims (aggregate stop loss) up to the attachment point (125% of expected annual claims). Most self-funded plans will set aside a contingency reserve to cover the 25% corridor or a portion thereof. Smaller plans or those that have a higher specific stop loss deductible (which can lead to greater variability in claims) generally reserve the full amount. Segal added lines "q" and "r" in Table 1 to derive "Unencumbered Funds." If the County decides on a policy to spend down some of the cash in the Trust Fund, it should establish a policy that fully funds the IBNR and Contingency reserves.

Table 1 (next page) also shows the cost of the self-funded plan on a **per employee per year (PEPY)** basis. These figures are useful as they show the cost trend from year to year as opposed to looking at changes in employee contribution rates or internal departmental charges. Both fiscal year 2010 and 2011 are within an expected trend range. Because the Plan is running in a \$1.0 million deficit in each of the most recent two fiscal years it would indicate that current contributions are insufficient by 7.0%-7.4% to cover claims and administrative expenses of the Plan and is causing the Plan to "dip into savings" to pay current year claim obligations.

TABLE 1

	----- ACTUAL -----					
	7/1/2005 to 6/30/2006	7/1/2006 to 6/30/2007	7/1/2007 to 6/30/2008	7/1/2008 to 6/30/2009	7/1/2009 to 6/30/2010	7/1/2010 to 6/30/2011
Income:						
(a) County Contributions	\$9,280,948	\$10,749,334	\$12,361,420	\$12,742,412	\$10,523,568	\$11,407,042
(b) COIC	\$654,770	\$753,151	\$925,921	\$1,197,050	\$1,135,675	\$1,434,919
(c) Employee Contributions	\$314,160	\$318,290	\$337,117	\$347,028	\$340,983	\$534,405
(d) Self-Pay/Retiree	\$428,109	\$531,126	\$547,314	\$624,646	\$614,039	\$732,526
(e) Rx Rebates/Federal Payments	\$31,814	\$168,328	\$42,898	\$35,068	\$42,066	\$188,466
(f) Investment Income	\$210,371	\$423,772	\$538,585	\$414,626	\$208,595	\$109,027
(g) Total Income (a+b+c+d+e+f)	\$10,920,172	\$12,944,001	\$14,753,255	\$15,360,830	\$12,864,926	\$14,406,385
Expenses:						
(h) Claims Paid	\$7,822,868	\$8,874,050	\$10,154,510	\$11,675,675	\$12,804,507	\$14,003,295
(i) Personal Services	\$136,668	\$88,727	\$103,326	\$108,328	\$103,742	\$127,664
(j) Materials & Services	\$383,020	\$384,202	\$393,886	\$544,448	\$863,334	\$1,340,152
(k) Total Expenses (h+i+j)	\$8,342,556	\$9,346,979	\$10,651,722	\$12,328,451	\$13,771,583	\$15,471,111
(l) Plan Year Surplus/Deficit (g-k)	\$2,577,616	\$3,597,022	\$4,101,533	\$3,032,379	(\$906,657)	(\$1,064,726)
(m) Surplus/Deficit as a % of Income	23.6%	27.8%	27.8%	19.7%	-7.0%	-7.4%
Plan Assets						
(n) Beginning Cash	\$4,586,247	\$7,163,863	\$10,760,885	\$14,862,418	\$17,894,797	\$16,988,140
(o) Change in Cash due to Plan Yr	\$2,577,616	\$3,597,022	\$4,101,533	\$3,032,379	(\$906,657)	(\$1,064,726)
(p) Ending Cash (m+n)	\$7,163,863	\$10,760,885	\$14,862,418	\$17,894,797	\$16,988,140	\$15,923,414
Liabilities & Contingency Reserve						
(q) Est. IBNR Reserve (h x 14%)	\$1,095,202	\$1,242,367	\$1,421,631	\$1,634,595	\$1,792,631	\$1,960,461
(r) Contingency Reserve (h x 20%)*	\$1,564,574	\$1,774,810	\$2,030,902	\$2,335,135	\$2,560,901	\$2,800,659
(s) Unencumbered Funds (p-q-r)	\$4,504,087	\$7,743,708	\$11,409,885	\$13,925,067	\$12,634,608	\$11,162,294
Avg Number Covered			923	973	980	1,005
Per Employee Per Year Cost			\$11,732	\$12,885	\$14,218	\$15,564
Year-over-Year Change in PEPY				9.8%	10.3%	9.5%

TABLE 2	----- PROJECTED -----			
	FY 2012	FY 2013	FY 2014	FY 2015
Income:				
(a) County Contributions	\$12,065,711	\$12,065,711	\$12,065,711	\$12,065,711
(b) COIC	\$1,260,000	\$1,260,000	\$1,260,000	\$1,260,000
(c) Employee Contributions	\$630,000	\$630,000	\$630,000	\$630,000
(d) Self-Pay/Retiree	\$500,000	\$500,000	\$500,000	\$500,000
(e) Rx Rebates/Federal Payments	\$0	\$0	\$0	\$0
(f) Investment Income	\$80,000	\$80,000	\$70,000	\$70,000
(g) Total Income (a+b+c+d+e+f)	\$14,535,711	\$14,535,711	\$14,525,711	\$14,525,711
Expenses:				
(h) Claims Paid	\$15,461,547	\$16,930,394	\$18,538,781	\$20,299,965
(i) Personal Services	\$130,062	\$139,166	\$148,908	\$159,332
(j) Materials & Services	\$2,382,077	\$2,548,822	\$2,727,240	\$2,918,147
(k) Total Expenses (h+i+j)	\$17,973,686	\$19,618,382	\$21,414,929	\$23,377,444
(l) Plan Year Surplus/Deficit (g-k)	(\$3,437,975)	(\$5,082,671)	(\$6,889,218)	(\$8,851,733)
(m) Surplus/Deficit as a % of Income	-23.7%	-35.0%	-47.4%	-60.9%
Plan Assets				
(n) Beginning Cash	\$15,923,414	\$12,485,439	\$7,402,768	\$513,550
(o) Change in Cash due to Plan Yr	(\$3,437,975)	(\$5,082,671)	(\$6,889,218)	(\$8,851,733)
(p) Ending Cash (m+n)	\$12,485,439	\$7,402,768	\$513,550	(\$8,338,183)
Liabilities & Contingency Reserve				
(q) Est. IBNR Reserve (h x 14%)	\$2,164,617	\$2,370,255	\$2,595,429	\$2,841,995
(r) Contingency Reserve (h x 20%)	\$3,092,309	\$3,386,079	\$3,707,756	\$4,059,993
(s) Unencumbered Funds (p-q-r)	\$7,228,513	\$1,646,434	(\$5,789,635)	(\$15,240,171)
Summary Metrics				
Avg Number Covered	1,018	1,018	1,018	1,018
Per Employee Per Year Cost	\$17,856	\$19,473	\$21,257	\$23,206
Year-over-Year Change in PEPY	14.7%	9.1%	9.2%	9.2%

Table 2 (above) contains **projections** for fiscal years ending 2012 through 2015. The plan year deficit for 2012 does not include the projected cost of the plan to comply with health reform, which is estimated at additional \$360,000. The following assumptions were used to develop projections:

- Income for 2012 was provided by the County.
- Contributions for fiscal years 2013-2015 are displayed with no increase over 2012 levels except for reductions in investment income for 2014 and 2015 (due to lower investible assets as cash reserves are spent down). This allows the impact of a “do nothing” strategy to be evaluated and the effects of trend on claims cost and administrative expense increases.

- > Projected claims paid for fiscal year 2012 are based on historical claims information adjusted for changes in enrollment and a weighted annual trend of 9.3% (medical: 10.2%, pharmacy: 9%, dental: 6%, vision: 3%). Claims for fiscal years 2013-2015 are trended at 9.5% from the preceding fiscal year. No claim fluctuation margin has been added to the projection although it is reasonable to include margin given the relatively small size of the Plan population (greater claim variability) and the uncertainty surrounding healthcare reform and its impact on costs.
- > Personal services and materials & services were provided for fiscal year 2012. For fiscal years 2013-2015, a trend of 7% was applied.
- > Projected number of employees is based on a May 2011 census and assumes no growth or reduction in Plan participants.
- > Per employee per year costs are computed as the total expense (line k) plus the incremental increase in IBNR (current year IBNR minus prior year IBNR) divided by the average period lives.

The Table 2 projection shows that if no change to contributions or plan design are made, deficit spending will occur and erode the Trust Fund's cash. It is estimated that by 2014, the Plan would deficit spend to the point where nearly all required IBNR reserves and all the contingency reserve would be depleted. By 2015, the Plan would be unable to fund its obligations and would become insolvent.

Table 3 below visually displays the impact of a “do-nothing” approach.

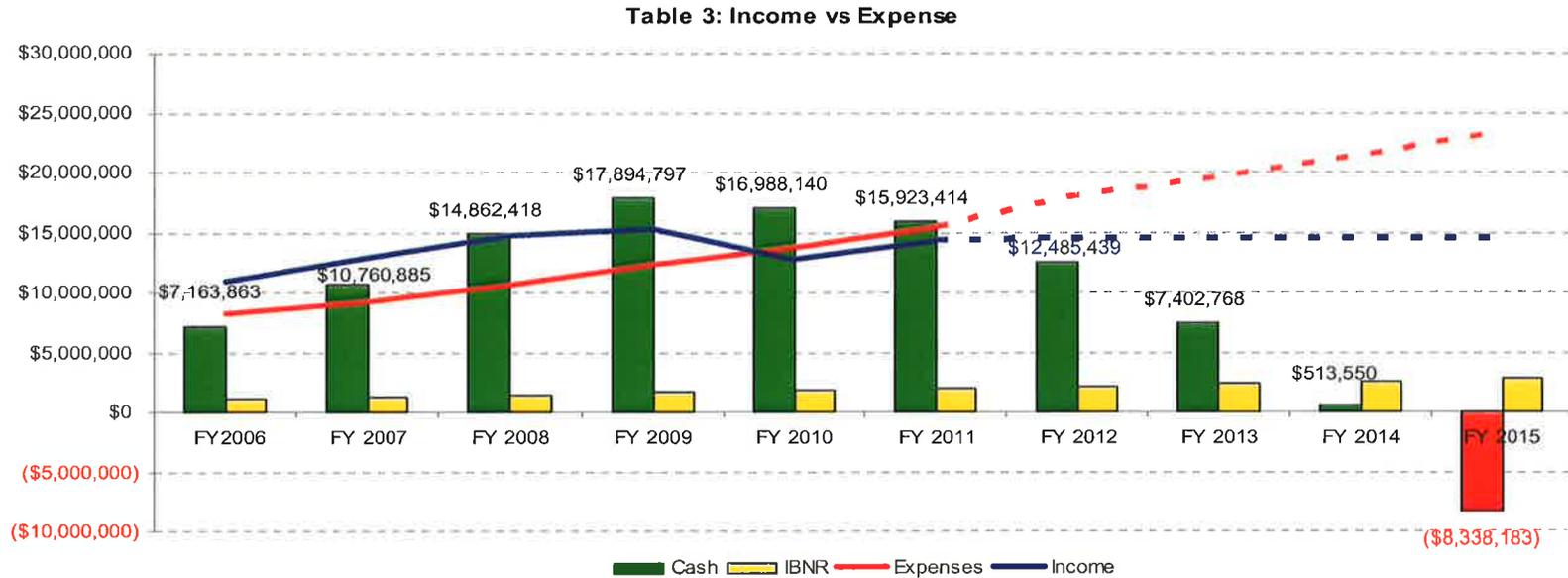


Table 3 shows how the Trust built up assets (assets being the Plan’s IBNR, contingency reserves and unencumbered funds) in the 2006 through 2009 fiscal years through excess contributions. In the 2010 and 2011 fiscal years, the Plan’s expenses exceeded contributions indicating an insufficient contribution rate. Without changes in contributions or benefit levels, the dotted lines indicate a widening of expenses over income and a further depleting of the Trust Fund’s cash. **By 2014, the Trust Fund is projected to not have enough cash to cover its liabilities and reserves.**

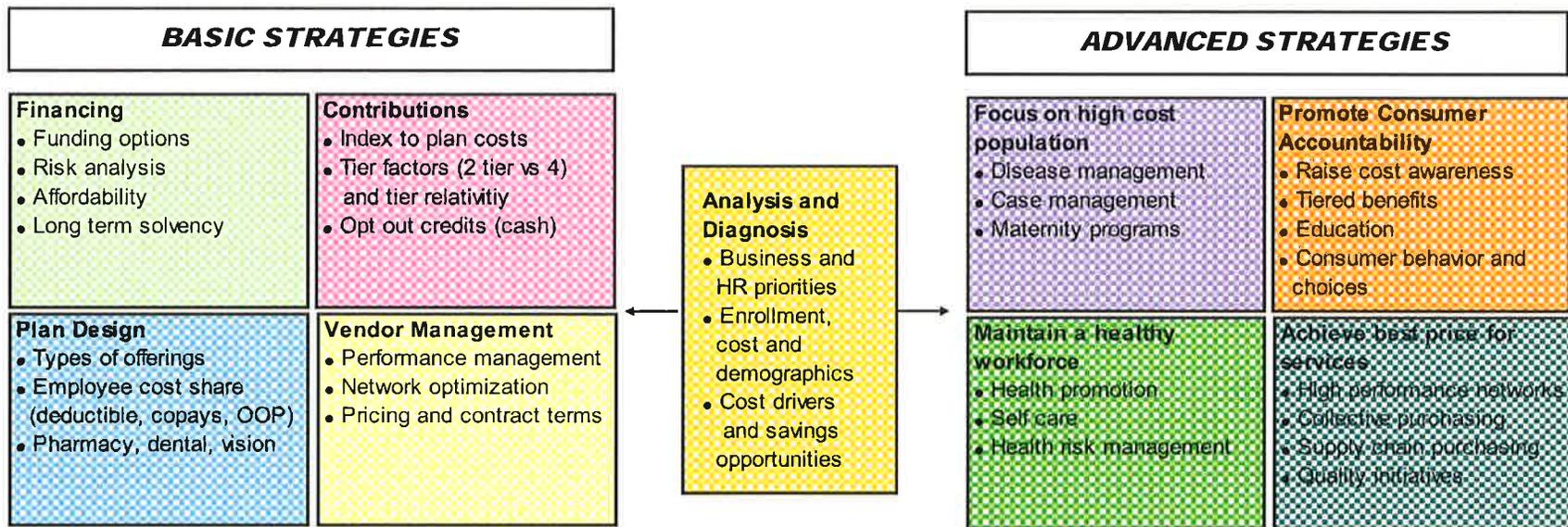
Most immediate, is the fact that the **Trust is on schedule to spend 23.7%, nearly 24% more than is collected in contributions for the 2012 fiscal year, which will further deplete the fund’s cash.**

If the “can is kicked down the road” rather than addressing solutions today with a sense of urgency, it is likely that drastic steps will need to take place in the future to keep the Plan solvent. While this forecast paints a dire long-term financial picture, the good news is that the County is in a position today, if it takes action, to slow down this progression or prevent insolvency. Ideally, the Trust Fund should be self-sustaining without the need to borrow from the County’s general assets.

As is outlined in the Strategies display below, there are **Basic budget-balancing tactics** including financial, contributions, plan design and vendor management that the County should consider to reverse the projected financial situation.

Once the Basic Strategies have been fully addressed, the County can then focus more attention on **Advanced Cost-savings Strategies** as outlined below.

Our report will present a number of observations and ideas about the Deschutes County benefits programs and offer insight into cost drivers and cost-saving strategies including vendor contract language redesign recommendations and competitive bidding opportunities.

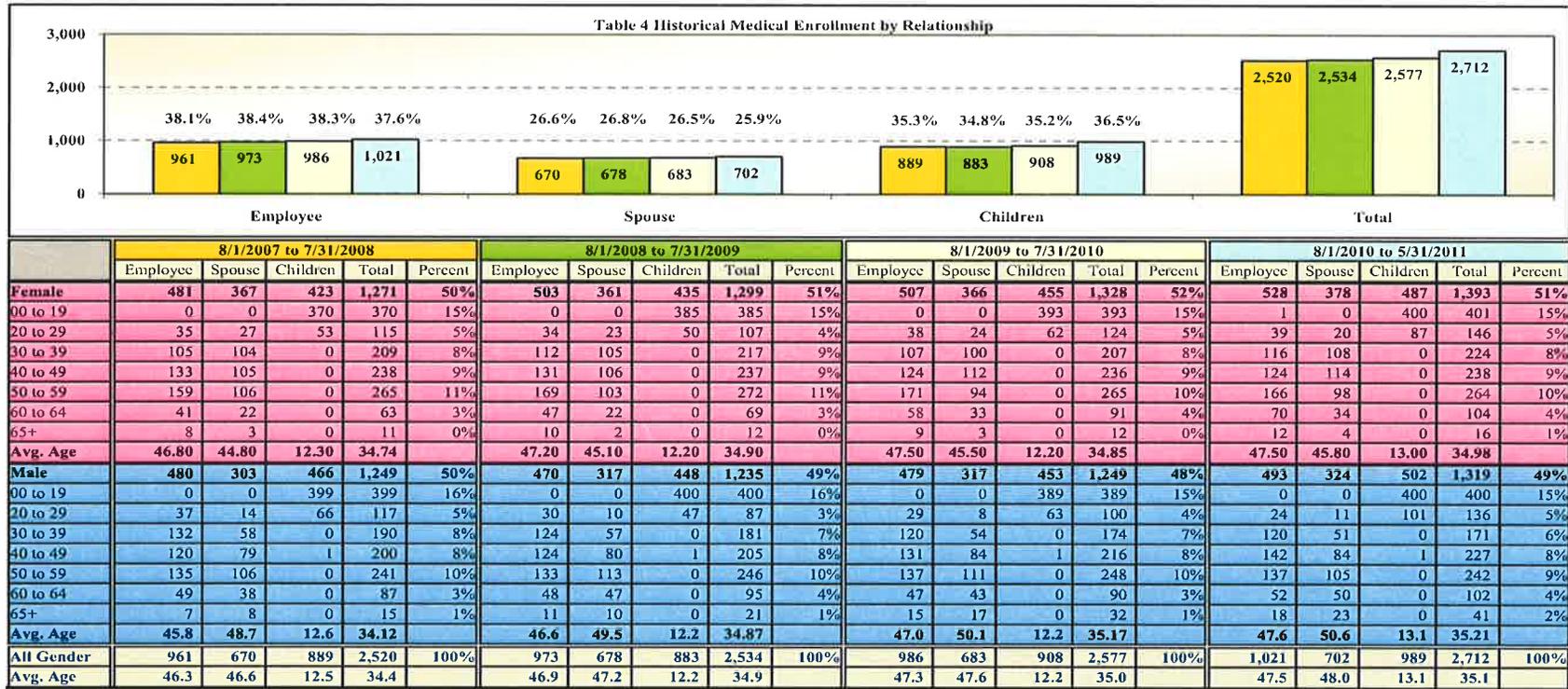


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COST DRIVERS

Segal requested a number of reports from EBMS, the Third Party Administrator (TPA), regarding how plan participants are utilizing medical, pharmacy, dental and vision benefits. Reports were received for the periods Aug 2007 to Jul 2008, Aug 2008 to Jul 2009, Aug 2009 to Jul 2010 and Aug 2010 to May 2011. After analyzing this data, Segal has the following observations:

Demographics



Note: Census reported as of the last day of each respective period.

Table 4 (above) demonstrates that the County's average employee age (47.5) is generally consistent with the average age of other employers in the U.S. while the average participant age and gender nearly mirror the demographic makeup of the general Oregon population (Data Source: [Oregon Office of Economic Analysis, Population Forecasts, Components of Change, Table C](#)). The County's employee age trend in the past few years reflects the gradual aging of the population which is a major determinant in the utilization (and cost) of health care services for which the County must plan to accommodate. There is little the County can do about people getting older. However it does mean that programs to keep healthy Plan participants from becoming sick and the sick from becoming chronic become paramount in controlling Plan cost.

The majority of the participants enrolled in the County's plan are dependents (spouse and children) (67.4%) versus employees (37.6%). This is a fact that the County should consider when creating contribution strategy design options, in particular a three or four-tier premium structure to replace the current two-tier structure. Total enrollment in the Plan has been stable if not increasing slightly which means higher overall Plan costs (more participants = more claims) and a greater economic burden to the County as the primary financier of the Plan. Slightly more females than males are covered under the Plan.

Table 5: Claims Cost By Member Type *

Member	8/1/2007 to 7/31/2008		8/1/2008 to 7/31/2009		8/1/2009 to 7/31/2010		8/1/2010 to 5/31/2011	
	Claims Paid	Paid Claim Cost per Member	Claims Paid	Paid Claim Cost per Member	Claims Paid	Paid Claim Cost per Member	Claims Paid	Paid Claim Cost per Member**
Employee	\$4,776,695	\$5,138.53	\$6,226,474	\$6,388.31	\$6,790,827	\$6,925.88	\$5,496,120	\$6,540.40
Spouse	\$3,524,237	\$5,359.38	\$3,497,981	\$5,137.79	\$3,947,678	\$5,728.88	\$3,530,673	\$5,996.90
Child	\$1,456,652	\$1,701.36	\$2,097,315	\$2,287.15	\$2,335,381	\$2,563.77	\$2,035,745	\$2,490.72
Total	\$9,757,584	\$3,993.55	\$11,821,770	\$4,595.44	\$13,073,886	\$5,066.42	\$11,062,538	\$4,924.53

* Excludes admin expense and clinic costs. ** Annualized

Table 5 shows that County employees are the most expensive Plan members followed by spouses and children. While dependents are less expensive on a per member basis, the County's generous contribution strategy (\$50 contribution single or family) and two-tier contribution structure attracts an abnormally high number of family participants. The average contract size (# of members divided by # of employees) is 2.67 whereas a normal health plan would have a contract size ranging from 1.8 to 2.2. While it might be viewed as logical then to add dependents (especially children) to the Plan because it reduces the marginal cost per member, each additional member, on the other hand, does not add additional marginal revenue under the current two-tier contribution structure. Thus, the County is absorbing the cost of each additional dependent added to the Plan.

A two-tier contribution structure is not as common a contribution strategy these days and the County should consider a three or four-tier structure where employee contributions reflect a more equitable distribution of costs. This change will have winners and losers (Employee plus Spouse for example would pay less while Employee and Family would pay more). A higher dependent contribution should also be

considered since it is likely that the generous contribution by the County is attracting participants who might otherwise be covered under a working spouse's employer plan.

Other contribution design options could include consideration for a cash out option or allowing active employees to enroll in a high deductible health plan (to replace the current High Option) where the County contributes to a health savings account (HSA) fund. We recognize that the County has concerns around anti-selection and rightfully so. However, if designed properly, both options could result in savings to the County even though an element of anti-selection would be present. Yes, choice equals anti-selection but contributions can be structured to minimize the impact.

Another contribution strategy could be the addition of a tobacco-user rate differential (surcharge) which is becoming more popular with plan sponsors who recognize the cost difference (absenteeism, productivity, and health care cost) between a non-smoker and a smoker. HIPAA (Health Insurance Portability and Accountability Act) permits employers to establish a maximum premium percentage of 20%.

Large Claims

In Table 6, below, Large Claims generally have a significant bearing on plan costs. Fortunately for the County, the reports from the TPA demonstrates that both the frequency of large claims and the magnitude of cost related to large claims is relatively low for the County as compared to other commercial employers. Large claims represent only 3.9% to 5.2% of total medical and prescription drug costs. Typical ranges are in excess of 10% of claims. If the County were to fall more in line with norms, large claim costs could materially impact future Plan cost.

Table 6: Large Claims In Excess Of \$50,000

06/01/2010 to 05/31/2011		
General Description	Billed Amt	Paid Amt
1 Cardiac	\$ 114,663.22	\$ 105,360.53
2 Cancer	\$ 76,590.22	\$ 71,228.92
3 Cancer	\$ 68,917.69	\$ 60,111.35
4 Neurosurgical	\$ 67,160.62	\$ 59,076.70
5 Gastrointestinal	\$ 75,174.22	\$ 57,132.41
6 Reconstructive	\$ 66,618.25	\$ 56,029.24
7 Cardiac	\$ 55,744.04	\$ 50,147.70
	\$ 524,868.26	\$ 459,086.85
Percent of Period Medical/Rx Claims		3.91%

Table 6: Large Claims In Excess Of \$50,000

06/01/2009 to 05/31/2010			
General Description	Billed Amt	Paid Amt	
1 Neurosurgical	\$ 126,055.17	\$ 115,970.75	
2 Cardiac	\$ 115,491.23	\$ 107,406.84	
3 Orthopedic	\$ 110,131.54	\$ 102,422.33	
4 Newborn	\$ 89,092.75	\$ 67,710.49	
5 Newborn	\$ 89,092.75	\$ 67,424.16	
6 Wound	\$ 108,045.05	\$ 64,827.03	
7 Respiratory	\$ 55,429.00	\$ 51,548.99	
	\$ 693,337.49	\$ 577,310.59	
Percent of Period Medical/Rx Claims		5.17%	

EBMS has not yet confirmed whether the two newborn claims in 2009-2010 are duplicate or two separate children.

The varying diagnoses for the large claim population suggests that no one disease or risk factor has significant prevalence in the County's population as a contributor to large claims. The types of conditions manifested by the past two years of large claim data suggests a mix of cardiac, cancer, newborn, and neurosurgical disorders and these conditions are not unexpected as reasons for large claims.

Primary Care Physicians (PCP)

Table 7: Comparison of Select Primary Care Utilization and Cost

PRACTITIONER TYPE	8/1/2007 to 7/31/2008		8/1/2008 to 7/31/2009		8/1/2009 to 7/31/2010		8/1/2010 to 5/31/2011	
	# of Claims	Cost per Claim *	# of Claims	Cost per Claim*	# of Claims	Cost per Claim*	# of Claims	Cost per Claim*
FAMILY PRACTITIONER	2,514	\$85.93	2,658	\$99.28	2,607	\$108.78	2,152	\$124.63
INTERNAL MEDICINE PHYSICIAN	993	\$95.90	919	\$129.84	993	\$130.41	1,061	\$139.48
NURSE PRACTITIONER	472	\$89.84	561	\$89.47	599	\$108.85	542	\$107.18
PHYSICIAN ASSISTANT	441	\$69.91	602	\$93.38	527	\$87.66	488	\$106.06
GENERAL PRACTITIONER	126	\$74.53	126	\$104.39	88	\$119.19	121	\$163.00

* Plan paid cost (does not include member cost sharing - copays, deductibles or coinsurance)

Table 7 (above) shows the range of primary care physicians and the average cost per claim paid by the Plan from year to year. While it is expected that the cost the Plan pays toward PCP services would increase from year to year, it appears that the County's cost increases are in excess of normal medical trend. This could be due to your medical network not being able to negotiate favorable terms from providers. To a lesser extent, it may be due to the leveraging effect of having participants pay fixed copays for office visits instead of

paying a percentage of the gradually rising claim costs from year to year. That is, as the cost of the service increases from year to year, the Plan absorbs the full amount of the cost increase since the participant cost remains flat (unless benefit changes are made to the Plan).

This suggests that PPO network discounts have not kept pace with billed charges and are therefore not adequate to keep the County's costs at or below expected trend (9%-10%). It could also suggest that provider upcoding might be occurring, meaning that in the range of CPT codes a PCP could bill for an office visit, they are selecting the higher paying CPT codes instead of lower paying CPT codes. It could also be that the cost of a visit is increasing because the PCP performs more billable services during an office visit such as adding an EKG, urinalysis, or spirometry study causing the cost of the visit to be more than the norm.

It is unusual that the County's average cost of a visit to a General Practitioner would exceed the average cost of a visit to an Internal Medicine Physician (Internist). Sometimes plans have to remove certain providers from their in-network list in order to save plan costs. The costs noted in Table 7 indicate that an onsite Clinic approach to managing simple health care issues may be more cost effective than obtaining discounts fees from a network as long as the average cost per service in the Clinic is less than those shown in the table (plus member copay).

Emergency Room (ER) versus Urgent Care

Table 8: Comparison of Emergency Room and Urgent Care Utilization and Cost

Service Location	8/1/2007 to 7/31/2008		8/1/2008 to 7/31/2009		8/1/2009 to 7/31/2010		8/1/2010 to 5/31/2011	
	# of Claims	Cost per Claim						
Emergency Room	684	\$406.13	993	\$361.45	922	\$422.44	665	\$399.09
Urgent Care	1,093	\$107.32	1,024	\$122.45	924	\$147.04	783	\$163.93

There are generally two components to the cost of an Emergency Room (ER) visit: the facility fee and a separate physician visit fee. EBMS, your TPA, reports that the data in the above table reflects a combination of both facility fees and professional fees. The data in this Table 8 above suggests that:

- a. The severity and complexity of the County's ER visits appear to be low (relative to the cost of ER visits in other commercial populations) resulting in a relatively inexpensive average cost for an ER visit. This suggests that the types of conditions being treated in the ER may not truly be of an "emergency" nature; or
- b. That the County is receiving significant discounts on ER visits, however Table 9 demonstrates that the discount the County is receiving for ER claims is only 8.5%; or
- c. The cost displayed in the table is not reflective of both ER facility and professional fees; or
- d. Some combination of a through c above.

As you can see in Table 8, the cost of a visit to an urgent care center is substantially less than the cost of a visit to an emergency room. Fortunately, County plan participants are using Urgent care facilities a little more frequently than the ER but it appears that the County could provide more communication on the capabilities of urgent care facilities and continually educate participants about the value and cost-effectiveness of urgent care over ER for non-emergency situations.

Top 5 Paid Service Categories

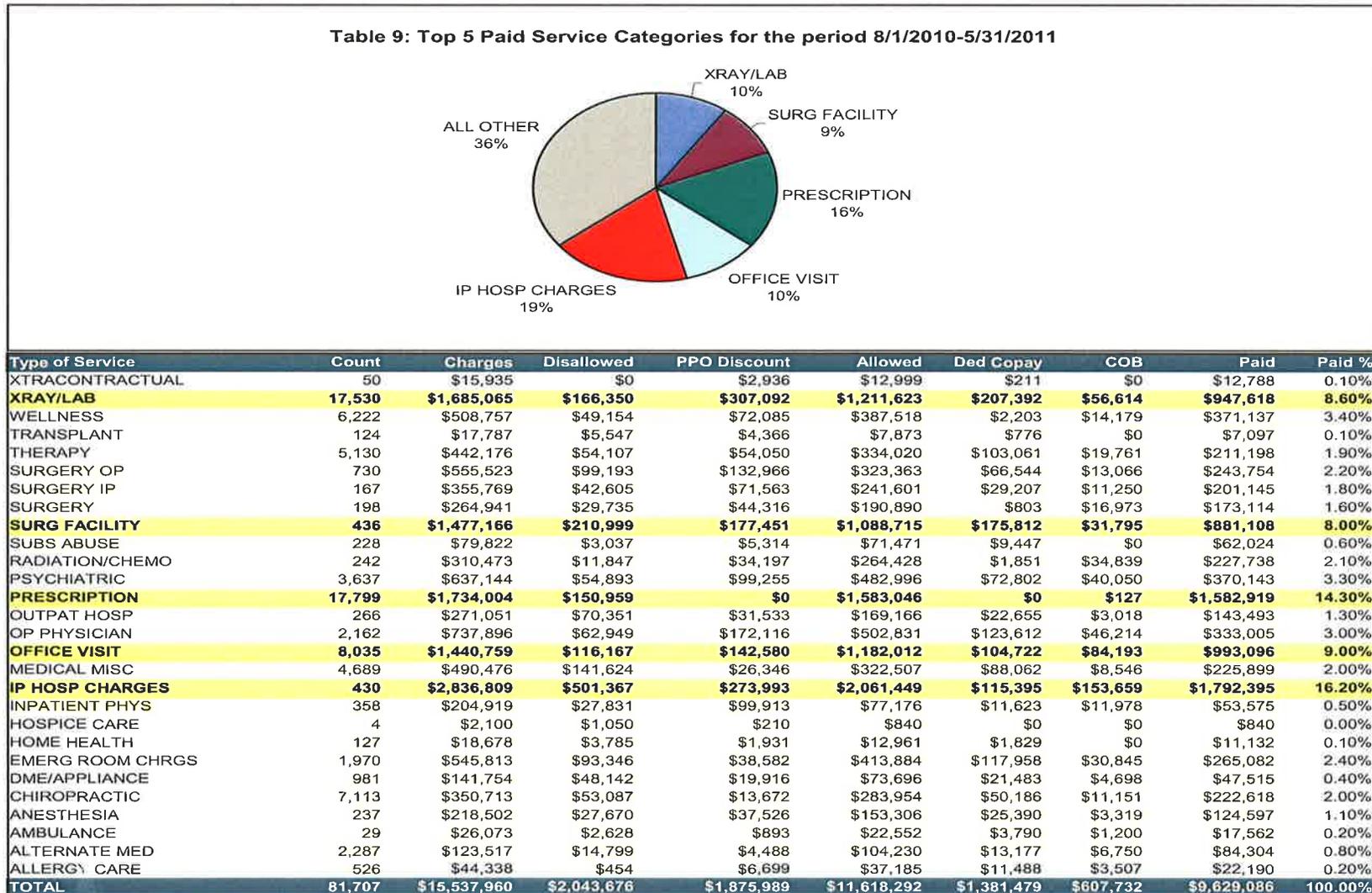


Table 9 (above) demonstrates the types of services (array of claim categories) submitted to the plan for payment. You can see both the frequency of claims (the Count column) submitted by type of service as well as the amount of money the Plan paid toward those services (the Paid column).

By referencing the last column (paid %), you can see that **Inpatient Hospital Charges** represent the greatest percentage of paid claims. This is typical of a commercial employer plan.

This is followed by the greatest percent of paid costs for these four service categories:

- > **Office Visits**
- > **Outpatient Prescription Drugs**
- > **X-ray/Lab Services**
- > **Outpatient Surgical Facilities**

In fact, Segal's review of the past four years of County data on paid service categories demonstrates that these five types of service categories, noted in **bold** above, are consistently the greatest percentage of County paid claims year after year.

This data suggests that the County should focus primarily on these five service categories (in bold above) in terms of obtaining the deepest network discounts, optimal Pharmacy Benefit Manager (PBM) discounts for outpatient drugs and the most creative plan designs for these service categories in order to positively impact paid claims in future years.

Discounts by Service Category

Table 10: Discounts By Service Categories

Paid Dates 8/1/2010 to 5/31/2011

Type of Service	Count	Charges	Disallowed	PPO Discount	Discount %	Allowed	Ded Copay	COB	Paid	Paid %
XTRACONTRACTUAL	50	\$15,935	\$0	\$2,936	18.4%	\$12,999	\$211	\$0	\$12,788	0.1%
XRAY/LAB	17,530	\$1,685,065	\$166,350	\$307,092	20.2%	\$1,211,623	\$207,392	\$56,614	\$947,618	8.6%
WELLNESS	6,222	\$508,757	\$49,154	\$72,085	15.7%	\$387,518	\$2,203	\$14,179	\$371,137	3.4%
TRANSPLANT	124	\$17,787	\$5,547	\$4,366	35.7%	\$7,873	\$776	\$0	\$7,097	0.1%
THERAPY	5,130	\$442,176	\$54,107	\$54,050	13.9%	\$334,020	\$103,061	\$19,761	\$211,198	1.9%
SURGERY OP	730	\$555,523	\$99,193	\$132,966	29.1%	\$323,363	\$66,544	\$13,066	\$243,754	2.2%
SURGERY IP	167	\$355,769	\$42,605	\$71,563	22.9%	\$241,601	\$29,207	\$11,250	\$201,145	1.8%
SURGERY	198	\$264,941	\$29,735	\$44,316	18.8%	\$190,890	\$803	\$16,973	\$173,114	1.6%
SURG FACILITY	436	\$1,477,166	\$210,999	\$177,451	14.0%	\$1,088,715	\$175,812	\$31,795	\$881,108	8.0%
SUBS ABUSE	228	\$79,822	\$3,037	\$5,314	6.9%	\$71,471	\$9,447	\$0	\$62,024	0.6%
RADIATION/CHEMO	242	\$310,473	\$11,847	\$34,197	11.5%	\$264,428	\$1,851	\$34,839	\$227,738	2.1%
PSYCHIATRIC	3,637	\$637,144	\$54,893	\$99,255	17.0%	\$482,996	\$72,802	\$40,050	\$370,143	3.3%
OUTPUT HOSP	266	\$271,051	\$70,351	\$31,533	15.7%	\$169,166	\$22,655	\$3,018	\$143,493	1.3%
OP PHYSICIAN	2,162	\$737,896	\$62,949	\$172,116	25.5%	\$502,831	\$123,612	\$46,214	\$333,005	3.0%
OFFICE VISIT	8,035	\$1,440,759	\$116,167	\$142,580	10.8%	\$1,182,012	\$104,722	\$84,193	\$993,096	9.0%
MEDICAL MISC	4,689	\$490,476	\$141,624	\$26,346	7.6%	\$322,507	\$88,062	\$8,546	\$225,899	2.0%
IP HOSP CHARGES	430	\$2,836,809	\$501,367	\$273,993	11.7%	\$2,061,449	\$115,395	\$153,659	\$1,792,395	16.2%
INPATIENT PHYS	358	\$204,919	\$27,831	\$99,913	56.4%	\$77,176	\$11,623	\$11,978	\$53,575	0.5%
HOSPICE CARE	4	\$2,100	\$1,050	\$210	20.0%	\$840	\$0	\$0	\$840	0.0%
HOME HEALTH	127	\$18,678	\$3,785	\$1,931	13.0%	\$12,961	\$1,829	\$0	\$11,132	0.1%
EMERG ROOM CHRGS	1,970	\$545,813	\$93,346	\$38,582	8.5%	\$413,884	\$117,958	\$30,845	\$265,082	2.4%
DME/APPLIANCE	981	\$141,754	\$48,142	\$19,916	21.3%	\$73,696	\$21,483	\$4,698	\$47,515	0.4%
CHIROPRACTIC	7,113	\$350,713	\$53,087	\$13,672	4.6%	\$283,954	\$50,186	\$11,151	\$222,618	2.0%
ANESTHESIA	237	\$218,502	\$27,670	\$37,526	19.7%	\$153,306	\$25,390	\$3,319	\$124,597	1.1%
AMBULANCE	29	\$26,073	\$2,628	\$893	3.8%	\$22,552	\$3,790	\$1,200	\$17,562	0.2%
ALTERNATE MED	2,287	\$123,517	\$14,799	\$4,488	4.1%	\$104,230	\$13,177	\$6,750	\$84,304	0.8%
ALLERGY CARE	526	\$44,338	\$454	\$6,699	15.3%	\$37,185	\$11,488	\$3,507	\$22,190	0.2%
TOTAL	63,908	\$13,803,956	\$1,892,717	\$1,875,989	15.7%	\$10,035,246	\$1,381,479	\$607,605	\$8,046,167	100.0%

The above Table 10 displays a report from EBMS showing the frequency and costs associated with the service categories of recently paid claims. Segal has added a **discount percent column** to help visualize the average discount off billed charges that the County is receiving for each service category. This report demonstrates that the total discount is 15.7% excluding outpatient prescription drug, dental and vision claims; however, EBMS has another report broken out by network by month that shows a total of all network discounts of 19% (Segal notes that the paid claim volume of both reports is different by about a million dollars). Segal is not able to validate the true discount based on these two differing reports. We would hope the County could consistently obtain at least 20%+ on average discounts from primarily central Oregon providers. The County may want to consider a substantiated discount analysis study at another time.

The gray shaded rows in Table 10 bring to your attention certain service categories where the County and your plan participants do not appear to be receiving the best possible discount (less than 15%) or no discounts off billed charges and which Segal believes could be improved. There are certain rows not highlighted, where the discount is less than 15% but Segal acknowledges that it may be difficult for the County to obtain a substantial discount due to the nature of the services (such as ambulance or ER).

Discounts from preferred provider networks are one of the primary ways that plans control costs. Directing plan participants to use network providers saves both the plan and the participant significant costs. One of the key advantages for using network providers is that they are required by their network contract arrangement to accept the pre-negotiated discount off billed charges and to not balance bill the participant or the Plan for the difference between billed charges and the amount the network determined was allowed under the contract.

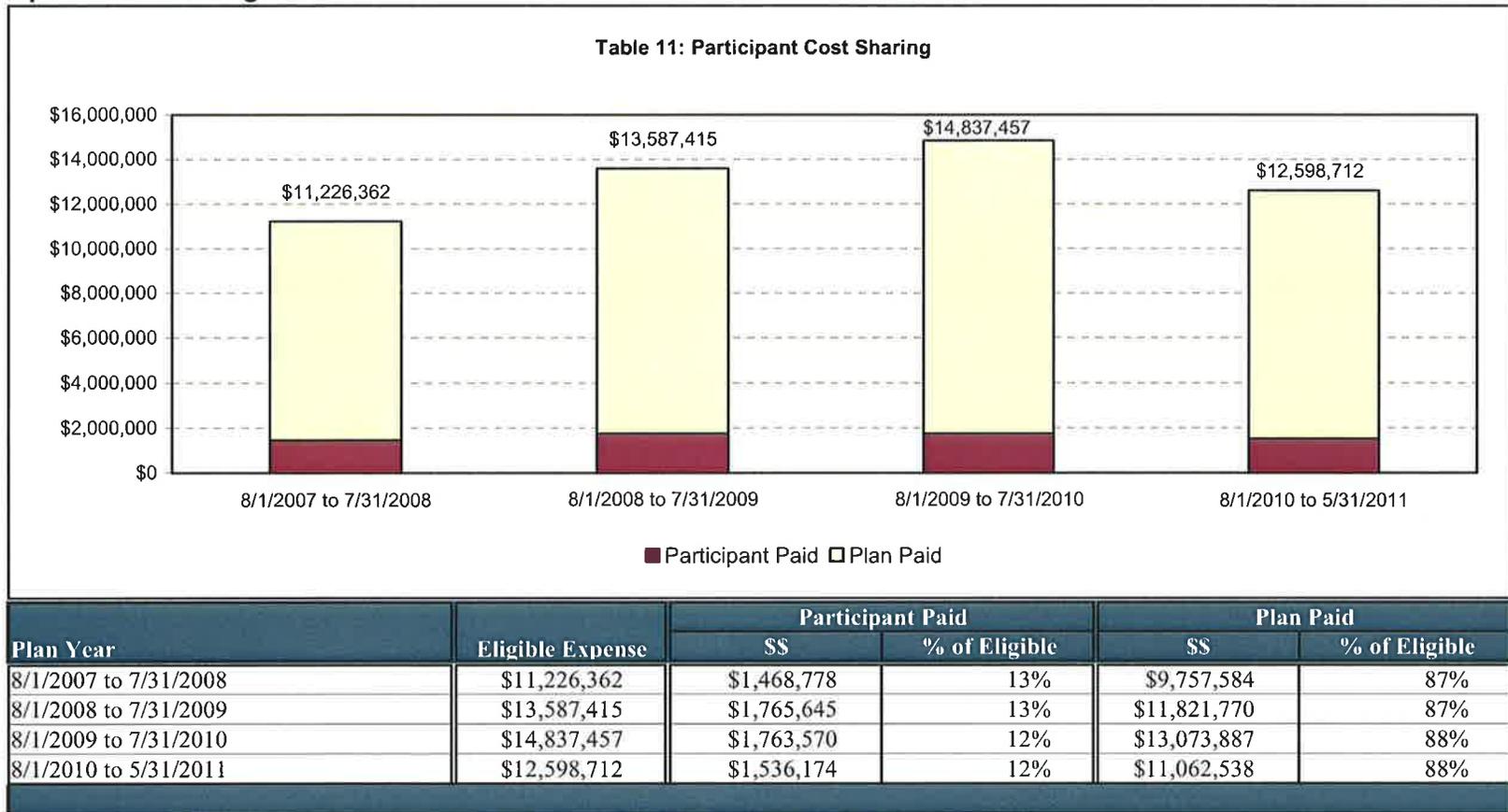
Major metropolitan areas commonly have network contracts that result in discounts of 60%+ for inpatient admissions and 45%-50% off billed charges for outpatient professional fees. Non-metropolitan areas (rural areas with sole community provider hospitals and minimal numbers of physicians) are often only able to obtain discounts that are half what is possible in a major metropolitan location. For this reason, some rural plans create plan design steerage to direct elective services toward major metropolitan areas to take advantage of significant discounts. Additionally, some plan sponsors regularly take steps to investigate the depth of discount possibilities with various regional networks to assure that they are getting the deepest discounts possible.

Additionally, some rural plan sponsors can negotiate directly with key community providers sometimes more effectively than a national or regional PPO network.

With respect to dental, the Plan appears to be an indemnity program where providers are paid at retail pricing. The Plan is paying in excess of \$1 million in dental claims. Segal recommends consideration for a **dental PPO network**. There are a number of dental networks available (Oregon Dental Service – “ODS”, Guardian, PPO USA) that can obtain discounts ranging at least 6-12% and perhaps more if the County were to choose a smaller dental network. (for example, ODS has a Premier network which they say has upwards of 93% of Oregon dentists under contract and a PPO network with around 47% of Oregon dentists...the PPO network is able to obtain higher discounts than the Premier network).

- ODS would likely require that they become the dental claims payor and their fee would likely be higher than the fee currently charged by EBMS. However, the savings from discounts on dental services should more than offset the increased claim processing administrative fee.
- PPO USA and Guardian rent their networks (\$.80-\$.90 PEPM) and this would allow the County to continue to use EBMS as the claims payor (assuming they are an approved TPA). The County could also consider a disincentive type plan (like the medical PPO) to encourage the use of in-network providers.

Participant Cost Sharing



Excludes clinic costs, administrative expense, reserves for IBNR and any other ancillary costs necessary to maintaining the program.

This Table 11 (above) depicts the participant versus County cost sharing (defined as participant deductible, copay and out-of-pocket divided by the total cost of the claim) on paid medical and dental claims over the past four years. As you can see, the County is picking up the majority of claim costs each year. You will also note that the participant's percent of payment toward claim costs has been relatively constant from year to year causing the County to absorb all the annual cost increases. Most plan sponsors seek to develop a participant/employer cost sharing percentage design that aligns with their unique philosophy of benefits delivery and overall total compensation strategy. While an 80/20 cost-sharing logic is a very reasonable goal (similar to Medicare's traditional health plan cost-sharing logic), some plan sponsors have had to be more generous (e.g. 81%-84%) in the amount the plan pays in order to achieve recruitment and retention goals. The County, however, is even more generous, paying 87%-88%.

4

COST REDUCTION AND OTHER IDEAS

Vendor Management

The County subcontracts for a variety of services to administer the plan. Obtaining maximum services for minimal administrative fees is likely your primary goal. The complexity of health care administration often results in contracts for services that are not always clearly drafted and lack details that explain "how" the service will be administered or exactly which services and reports will be provided during the contract period.

Segal reviewed the contracts and data provided on these following key vendors: Pharmacy Benefit Manager (PBM) for outpatient prescription drug services, Stop loss, Third Party Administration (TPA) for claims administration, CareLink medical management services and Medical Plan PPO Network.

Prescription Drug Program

PBM services are obtained through a direct contract with Northwest Pharmacy Services (NWPS). The arrangement does not appear to be a traditional PBM contract. Segal's national pharmacy practice reviewed the contract and PBM reports and offer the following observations:

- The administration fee of \$1.40 per script is high and it is not clear what actual level of service is being delivered by NWPS for the admin fee.)
- No indication of the structure or breadth of the retail pharmacy network
- Assuming pricing is pre-rollback, discounts are not aggressive (note contract is dated 2006)
- Retail brand discounts are at 14% (benchmark = AWP -16%-17% pre rollback)
- Retail generic--no aggregate guarantees
- The County indicates the retail dispensing fee is at \$2.50 per script (Segal notes benchmark = \$1.25 to \$1.75 per Rx)
- Mail Brand discount is at AWP -19% (Benchmark = AWP-24%-28% pre rollback)
- Rebates at 100% of collected--At market, but would also suggest a corresponding guarantee per prescription
- None of the price points include any type of guarantee subject to independent audit

- > No audit rights are noted in the contract document
- > No performance guarantees of any type are included in the document
- > 60 day termination without cause after first year of contract is included

The most concerning issues appear to be uncompetitive discounts from AWP and the lack of pricing guarantees and audit rights. Segal suggests the County may want to consider the value of

- a. examining some pharmacy data to determine what level of discounts, dispensing fees, and rebates are actually being delivered;
- b. negotiating with the PBM for enhanced contract terms; and/or
- c. investigate the value of bidding for retail, mail order and specialty outpatient prescription drug services.

In terms of the County's outpatient prescription drug utilization, Segal has the following observations:

- > Extremely low utilization of the pharmacy plan. This could suggest that members are not filling needed prescriptions but further study is needed to verify drug compliance. Compliance studies can be done by most PBMs.
- > Normalizing for the increase in membership, the County is seeing their participants take more drugs and higher cost drugs.
- > The generic dispensing rate at 67.5% in 2010 is low compared to benchmarks. Most of Segal's public sector and multiemployer clients have generic fill rates in the low 70s. With the number of drugs moving to generic from brand status, the County should consider plan designs to take advantage of this financial savings. Despite the increase to 70.5% generic fill in early 2011, the County could mitigate trend by encouraging the use of more generics in their plan.
- > Very low utilization of the mail order benefit. This is usually a function of plan design and given the deeper discounts offered under mail order prescriptions, the County may want to review the plan design alignment of the retail versus mail copays.
- > The County's #2 utilized drug, Nexium, is chronically overutilized and there are many generic alternatives that have similar clinical results. There are many clinical edits and programs that the County could implement in order to control the utilization of Nexium to less costly alternatives.
- > The County has an unusually high utilization of specialty drugs, which are the most expensive types of drugs. Three of the top five drugs filled are specialty and rarely is a plan's top utilized drug classified as a specialty drug.
- > As for the potential for fraud and/or abuse in this plan, Segal does not see any major red flags in the Top Drug by Cost reports so far. Segal does not see Oxycontin on the Top 25 Drugs by Cost, however, there are other potential fraud and/or abuse drugs in the Top 50 by both Cost and Utilization, which are likely being over utilized by some participants. The County may want to consider further drug analysis to help identify specific participants who have unusual utilization patterns and the results of the analysis would help in the design of clinical edits to limit overutilization of dangerous drugs.

Stop Loss

The renewal rates proposed by OptumHealth are higher than seen from the national stop loss database maintained by Segal. However, this could be heavily influenced by the medical network utilized by the County as well as the rural landscape for central Oregon. EBMS also indicates that they market the stop loss every year.

EBMS indicates that only Medicare-eligible retirees are excluded from the stop loss contract.

Special attention should be given to ensure that the stop loss contract does not have any exclusions, limitations and plan definitions that are more restrictive than the underlying County plan so as not to exclude services that would otherwise be payable by the Plan. EBMS indicates that only Medicare-eligible retirees are excluded from the stop loss contract. Segal can assist the County with this process.

Third Party Administration

EBMS is the claim payor for medical, dental and vision coverages. EBMS also provides HIPAA and COBRA administration services as well as utilization management, large case management, and chronic disease management. The current fee charged by EBMS is \$29.00 per employee per month (PEPM) and the 2011-2012 renewal fee is \$30.35 PEPM (4.7% increase). The proposed fee is "middle of the pack" in terms of pricing for TPAs and a further evaluation of their services, claim paying accuracy, comprehensiveness and customer service are beyond the scope of this project. EBMS appears to provide responsive customer service (at least to Segal's request for data for this project). Some potential considerations:

- Segal has been informed that the County's CPA performed a claims audit in 2007-2008; however, the results of that audit are unknown to Segal. At a minimum, a formal claims audit should be performed at least every 5 years to evaluate claim paying accuracy, evaluation of claim system capabilities to detect up coding, proper application of network discounts and identification of other potential fraudulent claim activities. Some self-funded plan sponsors do this auditing every year or every 2-3 years.
- Consider an evaluation of non-claim paying services (medical management, disease management) to determine the prevalence with the County's population and effectiveness of the program. Performance guarantees should be a consideration for many of these programs.
- EBMS is paid a 3% fee on provider savings when the Multi-Plan secondary network is accessed. EBMS indicates this fee is for repricing claims.
- The County may want to investigate if it could save money by obtaining secondary or wrap network discounts through a direct network vendor contract rather than accessing the networks under contract to EBMS.

Segal can provide claim audit services if the County has an interest in examining its TPA operations.

Efficacy of the CareLink Utilization Management (UM) Program

Segal was provided with CareLink Utilization Management reports for the period 2007 through April 2011. CareLink is a UM program (based in Montana) obtained through a subcontracting relationship with EBMS. The reports provide a listing of the number of cases contacting CareLink under the precertification requirement of the program and the maternity management program. The reports do not demonstrate that CareLink denied or modified any precertification requests or shortened the length of stay during an inpatient admission during concurrent review, thus it appears that all requests for precertification were approved. This could mean either excellent physician management of patients or generous decision-making under the CareLink program.

UM savings is calculated by CareLink by subtracting the number of days requested during precertification from the number of days the patient actually stayed as an inpatient. This number is then multiplied by an average charge per day. The report does not indicate the number of days that the CareLink program authorized during precertification or concurrent review. There is no objective evidence that the CareLink program produced the financial savings that the reports display. Segal would have hoped to see a precertification report detail the # of days requested, the # of days authorized and the # of days actually used, along with cases not approved.

- The average charge per day, ranging from \$4,256 to \$6,792 is substantially more than the value of the typical final days of a typical hospital stay, which of course are the only days that a UM firm could reasonably be expected to reduce through creative discharge planning. For instance, for a patient with heart surgery who develops a wound infection, it is unreasonable to think that this person could have been discharged in the first few days when the daily charge was significant (due to surgery, heart monitoring, ICU, IV medications, IV antibiotics, pain medications, etc). Instead it might be possible through effective UM, to have the last day or two of the hospital stay cut short and to transition the patient home with periodic home care for IV antibiotics, wound care, etc. Thus the average daily charges associated with the final inpatient days should be substantially less expensive than the average of the entire hospital stay. Segal is concerned that CareLink's dollar multiplier used in the calculation of savings is significantly high. Further, CareLink does not appear to offset their estimated savings with the fees the County is paying for their UM services to show a true net savings on their reports.
- Segal was provided with a CareLink brochure describing the "**Priority Maternity Care**" program. It is described on the brochure as a "first trimester screening for high-risk patients" that offers "an educational and empowerment program for eligible female employees or dependent spouse" as a "means to positively affect a pregnancy and the health of the baby." The brochure describes that savings are realized "by averting potential pre-term births," "reduce physician/urgent care visits," and to "enhance awareness of and satisfaction and perception of employers' benefit program." The CareLink maternity reports provided to Segal track a variety of stats, such as the number of cases participating in the program, whether the case is high risk or low risk (the definition of risk is not explained), whether the delivery was a c-section or vaginal birth, the birth weight as normal or large, number of infants delivered, the number of calls placed to the mother, and demonstrates a variety of mailings of letters. Segal was not provided with any reports to demonstrate that the Priority Maternity Care program accomplished what the brochure indicates will happen: no evidence that pregnancy women were contacted in their first trimester, or that the program averted a potential pre-term birth, resulted in reduction of physician/urgent care visits or produced satisfaction with the County's benefit program.
- According to the EBMS contract, the County is paying approximately \$3.60 PEPM for UM and case management, plus an additional \$340 per case for screening of maternity cases.

- EBMS provided a powerpoint presentation that was provided to the County dated March 2011 that:
 - Outlines the general type and number of inpatient admissions along with average length of stay.
 - Indicates the number of cases under case management during the period 2009-2011. There is no **case management** report to indicate the types of cases managed or the effectiveness of case management services.
 - Provides an overview of the voluntary **Health Impact program** where members with one of 9 chronic conditions are identified through claims data and are sent information about the Health Impact program. Eligible persons can then contact the CareLink nurses. The presentation indicates that through the Health Impact program members will be empowered to understand how to prevent progression of their condition, given support, coaching, and education and have access to health website and nurse triage line. The powerpoint provides a list of annual health care services the program recommends, such as office visit, lab work, eye exam, etc. and shows the number of individuals (325) with telephonic contact during the 2 year period 1/2009 thru 12/2010. The presentation also shows an average risk score of 1.39 for all members, which exceeds EBMS's block of business, which is shown as 1.05. The report indicates that there were 490 members with multiple chronic conditions in 2009 rising to 617 members in 2010. The report indicates an increasing gap in care from 2009 (31.02% gap) to 32.25% gap in care for 2010. In both 2009 and 2010, the majority of members had hyperlipidemia and/or hypertension as their chronic conditions, followed next in frequency of condition by asthma, diabetes, and coronary artery disease. Segal notes that the primary underlying health risk factor for these chronic conditions is often obesity. The County may want to focus your medical plan design support and wellness programs on ways to help plan participants reduce their weight and maintain a healthy weight over time.
 - There are no slides in the powerpoint presentation to demonstrate the effectiveness of the Healthy Impact program (are people with chronic conditions changing their behavior to take better care of themselves, closing their gaps in care and costing less money to the Plan as a result of the work of the Health Impact nurses?) No evidence of a satisfaction survey result demonstrating whether members enjoyed the Health Impact program.
 - According to the EBMS contract, the County is paying approximately \$4.25 PEPM for the Health Impact program.
- EBMS indicates to Segal that they can provide additional information to demonstrate the effectiveness of the CareLink program. In Segal's opinion, while the County is paying a substantial amount of money for the above noted UM programs (and to date, reports to demonstrate a positive financial impact have not been provided to Segal for this project), the County may want to assess the value of the CareLink services at a later date, as this type of analysis was not requested under the scope of work for this project.

Medical Network (PPO)

The County changed to First Choice Health as its primary medical plan PPO network effective 1/1/2011. What little claims data exists for the purpose of this report suggests this network is receiving similar hospital facility discounts as the prior network (Providence Preferred). However, the true discount is not able to be determined from the EBMS reports provided to Segal. A detailed analysis of the effectiveness of network discounts is beyond the scope of this project.

The County notes that First Choice Health is proposing an increase in the network access fee for 2011-2012. According to EBMS, this access fee will rise from the current fee of \$3.90 PEPM to \$4.05 PEPM and EBMS indicates this fee includes both access and repricing fee components.

While First Choice Health may have a broader network than Providence Preferred, it is unclear if this is achieved by offering providers less aggressive fee schedules which ultimately translates into lower discounts and higher claim cost for the Plan (assuming the plan is designed appropriately to discourage non-network usage). Of course, the degree to which the County wants to make accessible care available is always a consideration but greater provider access often comes at a greater cost (e.g. lesser discounts). Segal can assist the County with a discount analysis and development of scorecard criteria to make your network more accountable.

Other Ancillary Coverages (Life and Disability)

While the scope of this report focused on the self-funded program, Segal did note that life and disability programs have not been bid since 2001. The life and disability markets are highly competitive and life insurance carriers have reduced their tabular life rates in recognition of improvements in mortality. It would not be unreasonable for the County to expect a 25% to 30% reduction in life insurance premiums and a 10% to 20% reduction in disability premium rates if these programs were taken out to competitive bid.

Plan Design Ideas: Both Cost-Containment and Regulatory

The following observations include comments to help the plan comply with federal regulations or add clarity to the reader of your plan document along with a variety of plan design ideas that could result in cost-savings.

It is Segal's understanding that both of the medical PPO plans are currently "grandfathered plans" as relates to Health Reform. While we defer to your legal counsel for final determination, it appears that for active employees the County's self-funded dental and vision benefits are not currently separately elected nor have a separate premium, thus the dental and vision plans are not limited scope plan (meaning that they too must comply with Health Reform). Also, while the plan does cover actives and early retirees (not Medicare eligible retirees), the medical plans do not appear to be considered a "retiree only" plan (retiree only plans are not subject to Health Reform). So overall, it appears that the medical, prescription drug, dental and vision benefits must all comply with Health Reform requirements.

The two plan amendments (#9 and #10) that have been adopted since the 2009 restatement of the County's plan document have not remedied certain health reform wording issues as noted below. The following outlines observations from Segal's health compliance practice after review of your 2009 plan document (plan document page numbers are referenced for ease in locating the issue):

- Page 1 – There is a paragraph addressing **rescission of coverage**, which needs to be updated to comply with health reform.
- Page 3 – The plan appears to cover **domestic partners and children of the domestic partner** but we find no reminder about imputing income to the employee/retiree for these types of dependents (who are generally not tax-qualified dependents).
 - a. Page 3 – The **definition of dependent was updated in Amendment 9 to address health reform**. A few points the County might want to consider in terms of plan wording for the creation of a subsequent amendment or plan rewrite:

- b. There is no mention that the child can be **unmarried or married**. Clarifying wording to address this point is recommended.
 - c. With respect to stepchildren, the amendment continues to require that the stepchild **reside in the employee's household**. Suggest your legal counsel determine if you can continue to impose this residency requirement and still comply with Health Reform regulations.
 - d. Since Health Reform regulations indicate that children will now be able to be eligible if they are married, consider adding wording to clarify that the **spouse of dependent child (e.g. employee/retiree's son-in-law or daughter-in-law) is not eligible as a dependent**. Some employee benefit departments have already been approached by employees demanding that their child has a HIPAA Special Enrollment opportunity to enroll the child's new spouse. Having plan wording to point to can help remedy these situations.
 - e. As long as the Plans are still grandfathered, consider the value of adding wording to clarify that an adult dependent child who is eligible for (has access to) other group medical coverage is not eligible to enroll in the County's medical plan, including eligibility for the child's own employer's coverage **and the child's spouse's employer sponsored coverage** (since married children can be dependents under your plan). As is currently worded in Amendment 9, the plan only excludes a dependent child who is eligible for their own employer coverage.
 - f. Does the County want to continue health coverage for an **adult disabled child age 26 and older**, such as a child age 27 who has been disabled for several years? If so, the definition of dependent should be expanded to address this category of adult dependent child.
- > Page 3 and 4 – Regarding the definition of a dependent, the plan document and subsequent amendment #9 do not mention that a **foster child** is eligible to be covered or is excluded from coverage. There is, however, mention on page 5, that a retiree who has a foster child can have coverage for that foster child. Suggest the plan document be clear as to whether or not a foster child of an active employee and a retiree is also eligible and amend the definition of dependent child accordingly.
 - > Page 5 – There are three unique **dual coverage provisions** in the plan. Consider the value of continuing these provisions:
 - a. "in cases where an employee and his or her spouse or domestic partner each work for Deschutes County and COIC respectively, each is eligible to be covered as a dependent of the other." This kind of double coverage (generous coordination of benefits opportunity) is not commonly found in self-funded or insured plans.
 - b. "if both the mother and father are employees of COIC, their children will be covered as dependent of the mother AND father." This kind of double coverage (generous coordination of benefits opportunity) is not commonly found in self-funded or insured plans.
 - c. "in cases where the mother OR father is an employee of the County and the mother OR father is an employee of COIC, their children will be covered as dependents of the mother AND father." This kind of double coverage (generous coordination of benefits opportunity) is not commonly found in self-funded or insured plans.

Sometimes relatively minor edits to eligibility rules can positively impact claim costs.

- Page 6 – The section on **Preexisting Condition Limitations needs to be updated for health reform** to indicate that individuals under the age of 19 years are no longer subject to a pre-existing condition limitation. This means that the pre-existing condition limitation will apply only to individuals age 19 years and older until the year 2014. In 2014, the pre-existing condition limitation will need to be removed entirely in compliance with health reform provisions. Page 6 and 47 (definition of pre-existing condition) do not indicate the duration of time a person would have claims excluded from coverage if they did have a pre-existing condition (meaning does the plan have a 12 month pre-ex period or shorter timeframe?). Also on page 6 there is no indication as to when pre-existing conditions apply under this plan: does pre-ex apply to individuals enrolled during initial enrollment, special enrollment, open enrollment, and late enrollment or are some of these enrollment opportunities exempt from applying pre-existing condition limitations to enrollees?
- Page 7 – Requires that for newborns of a male dependent child the employee must provide **proof of paternity** at the plans expense. Is this a provision that is strictly enforced or only periodically enforced? Is this issue of covering children who are not the biological child of the male employee a significant expense to the plan?
- Page 14 – Has a unique **surviving spouse/children provision** that allows coverage for a surviving, divorced or legally separated spouse and children if the spouse is at least 55 years old at the time of the employee's death or at the time of the dissolution of marriage or legal separation. It is unclear if the surviving dependents are offered a choice between COBRA and surviving dependent coverage or if COBRA benefits would apply after this surviving dependents extension of benefits provision terminates. Additional wording could be added to the plan to make the intention of the benefit clearer.
- Page 17 – Offers a generous **deductible carryover provision**, which is not generally seen much anymore in plan designs.
- Page 18 and 21– Shows a **\$2,000,000 lifetime maximum on each plan option which will need to be either converted into an "overall annual maximum for the medical plan of \$2 million" or deleted entirely** in order to comply with health reform. Note that any overall annual medical plan maximum cannot exist after July 31, 2014 in compliance with health reform.
- Page 18 – For both the Standard and HDHP, there is **only one deductible that is combined for in and out-of-network**. Many plan designs have a deductible for in-network and a separate deductible for out-of-network and the two are not comingled, meaning a person cannot apply out-of-network expenses to meet the in-network deductible and vice versa.
- Page 18 – For both the Standard and HDHP, there are two separate **out-of-pocket maximums for in-network and out-of-network; however, the benefits appear to be commingled**. Many plan designs have an out-of-pocket maximum for in-network and a separate out-of-pocket maximum for out-of-network and the two are not commingled, meaning a person cannot apply out-of-network expenses to meet the in-network out-of-pocket maximum and vice versa. Further, some plans are beginning to remove a variety of non-network expenses from accumulating to the out-of-pocket maximum at all.
- Page 18 – Has a generous provision for a **supplemental accident benefit that pays the first \$500** of any accident at 100% no deductible... a provision that is generally not seen much anymore in plan designs.

- > Page 18 – **Emergency Room services are paid with a coinsurance with no copay.** This means that once someone meets their annual out-of-pocket maximum, continual trips to an emergency room will be free for the rest of that year. Many plans add a copay in addition to coinsurance and deductible for ER use so that there remains some cost-sharing for every ER visit.
- > There does not appear to be a plan design benefit listed for use of an **Urgent Care Clinic or Retail Medical Clinic.** As noted earlier in this report, urgent care is a less expensive option than ER visits and the plan design can be created in a way to help direct participants to these less costly settings for non-emergency care.
- > There does **not appear to be a copay or separate deductible for hospital admissions.** Some plans have added a copay in addition to coinsurance so that there will continue to be cost-sharing even after a person reaches their annual out-of-pocket maximum by virtue of the coinsurance they have accumulated.
- > **All office visits are paid at 100% with a \$15 copay, no deductible.** While this design would encourage participants to see any physician, copay designs tend to encourage overutilization and can be financially painful for the plan. Many plans who want to keep a copay design have at least created a split copay logic, with a lower copay, say \$20-25 to see a primary care physician (PCP) and a higher copay to see a specialist physician, say \$40-50 copay?
- > The benefit for **outpatient laboratory is generous in that it is paid at a coinsurance with no deductible.**
- > Page 19 – **Diabetes education is payable up to 3 hours per calendar year at 100%, no deductible** in-network. The County may need to evaluate whether 3 hours of training is adequate for a newly diagnosed diabetic who must learn medications, diet modifications, glucose testing, management of diabetes complications, etc. The benefit may need to be expanded to allow coverage for more hours of education and also consider the value of adding up to 8-10 visits per year with a registered dietitian to learn how to read food labels, make wise food choices, etc.
- > Page 19 – **Hospice care** is payable to a maximum of \$15,000 per lifetime. Is this a benefit that the plan considers to be an essential benefit and will **want to remove the dollar maximum** in order to comply with Health Reform?
- > Page 19 – **Inpatient rehabilitation** is payable to a maximum to 30 days per calendar year. This is about half as generous as most plans pay for inpatient rehabilitation. **Outpatient rehabilitation** is payable to a maximum of 30 visits per calendar year with a special provision allowing an additional 30 outpatient visits for certain head, spinal cord and stroke situations. Thirty (30) outpatient visits is roughly half of what is considered a normal plan design but the ability to expand the outpatient visits will help only certain diagnoses.
- > Page 19 – Mental health and substance abuse treatment appears to be complying with Mental Health Parity regulations. It is interesting that the **plan pays for residential treatment.** Most plans do not generally cover residential behavioral health care.
- > Page 19 – There is a benefit for **pervasive developmental disorder treatment** for birth to age 18 payable as any other illness. It is **unclear what kinds of services would be payable** under this particular benefit. For example, is this applied behavioral therapy classes for children diagnosed with autism or pervasive developmental disorders?

- Page 20 – **Wellness has both visit maximums and dollar maximums.** If the plan considers wellness to be an essential benefit the dollar maximums need to be removed. When the plan becomes non-grandfathered the visit maximums will likely need to be removed. On the wellness benefits, it is unclear **why the plan allows an out-of-network benefit** for this elective pre-planned service. Are there insufficient PCPs in the geographic areas where plan participants reside?
- Page 20 – Has a **generous alternative care benefit of \$1,500 per calendar year** that pays for chiropractic care, massage therapy, naturopathic treatment and acupuncture. Most plans do not cover massage therapy. Segal assumes the County has determined that alternative care is to be considered “non-essential” (in light of health reform regulations) as to why you are continuing to have a dollar maximum for this benefit.
- Page 20 – There is a **\$4,000 lifetime maximum on sleep studies.** Has the Plan had abuses in people wanting multiple sleep studies and CPAP machine ordering causing a need to place a maximum at \$4,000. Obstructive sleep apnea is a disorder commonly with rooted in obesity. Segal assumes the County has determined that sleep studies are to be considered “non-essential” (in light of health reform regulations) as to why you are continuing to have a dollar maximum for this benefit.
- Page 20 – **Organ and tissue transplants have a maximum of \$500,000 per lifetime and \$30,000 for donor maximums.** Segal assumes the County has determined that organ and tissue transplants and donor services are to be considered “non-essential” (in light of health reform regulations) as to why you are continuing to have a dollar maximum for this benefit. Most plans are removing such maximums.
- Page 20 – There is a **24-month waiting period for organ and tissue transplants**, which would appear to be impermissible under the HIPAA non-discrimination regulations that would not permit applying a waiting period in excess of 18-months for late enrollment or a 12-month waiting period for NON-late enrollees.
- Page 21 – **Describes the high deductible plan that is not HSA compatible.** Has the County given consideration to converting this to a high deductible health plan (HDHP) to be compatible with a Health Savings Account (HSA) or to adding a HSA compatible HDHP?
- Page 24 – Demonstrates the prescription drug benefits with a typical \$10 copay for generic drugs and a very **generous \$20 copay for formulary and even more generous \$35 copay for non-formulary drugs.** Most copay drug plans have significantly higher copays for non-formulary drugs and sometimes a mandatory generic provision.
- Page 25 – Lists the vision care benefits with a **\$25 copay for an eye exam** which is more expensive than most typical vision plans; however, there **does not appear to be any copay or cost-sharing for frames or contact lenses.**
- Page 25 – Has a unique **benefit for radial keratotomy** paying up to \$250 per eye to a maximum of \$500 per lifetime. Segal assumes the County has determined that radial keratotomy be considered “non-essential” as to why you are continuing (in light of health reform regulations) to have a dollar maximum for this benefit. Determine the frequency of the utilization of this benefit.
- Page 26 – Has a dental plan with a \$2,000 annual maximum. In light of health reform regulations and if your legal counsel concurs that your dental plan is not a limited scope plan, the \$2,000 annual maximum may not be able to be applied to pediatric dental services.

There does not appear to be a dental network or plan design steerage to a network dental provider. In the first year, the plan pays 80% after a \$15 copay for Class A, B and C services and 50% for orthodontia. There does not appear to be a typical 100%, no deductible benefit for preventive and 80%/50% for other dental class tiers. **In the second year of coverage and subsequent years, the plan pays 100% after a \$15 copay for Class A, B and C services** and again 50% for orthodontia.

- > Page 57 – In the Dental Services section, **does not indicate any frequency limitations** on dental cleanings, diagnostic x-rays like bitewing and full mouth x-rays.
- > Page 30 – Regarding the Skilled Nursing Facility (SNF) benefit, the plan is worded with a Medicare-type benefit design that indicates that **SNF cannot be payable unless there has been a hospital confinement of at least 3 days**. Most plans have eliminated the requirement for hospitalization to precede a SNF admission to reduce claim costs. There does not appear to be a **SNF maximum benefit** thus no limit to the number of days someone can reside in a Skilled Nursing Facility each year. Most commercial plans have a limit of 90-120 days per year.
- > Page 33 – There does not appear to be any limit on the number of **cardiac rehabilitation visits**. Many plans have a 12-week limit.
- > Page 51 – Indicates **no coverage for self help devices such as blood pressure devices or scales**. Is this a position the plan wants to continue to take if there is an interest in having participants perform self-care to control their blood pressure, weight, and other health risk factors?
- > Page 55 – In the Prescription Drug Section, it indicates that **growth hormone is a covered benefit along with anabolic steroids**. Growth hormone is an often excluded drug except in wasting syndrome cases and many plan subject growth hormone to a precertification process to verify the medical necessity of this expensive drug therapy. Anabolic steroids generally require precertification to assure they are not being prescribed for body building purposes.

See also the Health Reform comments in Chapter 5 that should be added to the plan document.

5

IMPLICATIONS OF HEALTH REFORM

The health care reform law (the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA)), contains extensive new benefit plan mandates for both insured and self-insured plans. The law is referred to as the “Affordable Care Act” or “Act” or simply Health Reform. Plan sponsors should rely on legal counsel for authoritative advice on the interpretation and application of federal laws and regulations.

Segal has been notified that the two medical plans (the Standard Plan and the HDHP) are currently “grandfathered” for purposes of the Affordable Care Act (ACA) also called Health Care Reform. The County has an August plan year.

It appears that the County has made some amendments to the Plan to comply with Health Care Reform, including:

- Amendment #9 is an amendment to **edit the definition of Dependent Children** to include coverage to age 26.
- For plan years beginning prior to January 1, 2014, a Dependent Child who is age 19 or older is not eligible for coverage under the Plan if such adult child is eligible for coverage under another employer-sponsored health plan (other than a group health plan of a parent).

Segal suggests adding another amendment to add wording to address these other Health Reform provisions.

- **Pre-existing Conditions Cannot Apply to Individuals Under Age 19.** No pre-existing condition limitations can be applied starting in 2014.
- **Lifetime and Annual Maximums on the dollar value of “Essential Benefits” need to be removed.** Essential benefits are listed in the regulations as follows:

Essential Benefits				
ambulatory patient services	emergency services	hospitalization	maternity and newborn care	mental health and substance use disorder services including behavioral health treatment
prescription drugs	rehabilitative and habilitative services and devices	laboratory services	preventive and wellness services and chronic disease management	pediatric services, including oral and vision care

Currently there is no further description of these terms. The County should (on advice of your legal counsel) review all medical, dental and vision plan benefits where there is a dollar maximum and determine if you find the benefit to be an essential benefit. If so, the

dollar maximum needs to be removed or perhaps where possible, converted to an equivalent visit maximum. We understand that the County plans to use “up to age 19” as the age limit for “pediatric” care. Consider memorializing your decisions on what is and is not an essential benefit in meeting minutes, in case your are ever questioned by a federal agency.

- > **Rescission of Coverage:** There is wording in Article X, Section 12 (page 102), addressing eligibility in cases of fraudulent acts, that legal counsel may want to edit this further for health reform.
- > **Grandfathered plans must include a Model Notice in plan materials stating that the plan is grandfathered.** Grandfathered plans must also maintain records (available for examination) documenting their status as grandfathered.

Certain “**limited-scope**” dental and vision plans are not subject to the Act’s requirements. **Limited-scope dental or vision benefits** are those provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan. Benefits are not an integral part of a group health plan (whether provided through the same plan or a separate plan) only if:

- > (1) participants have the right to elect not to receive the coverage, and
- > (2) a participant who elects the coverage pays an additional premium or contribution for that coverage.

Self-insured dental or vision benefits are “excepted benefits” only if they are not an integral part of the group health plan.

Whether certain benefits constitute limited-scope dental or vision benefits is a matter that legal counsel will need to address definitively; however as Segal understands, the County’s self-insured dental and vision plans appear to be combined with the medical plan and therefore do not appear to be “limited scope” plans (which means that these dental and vision plans must also comply with Health Reform). Additionally, **Retiree-only plans** do not have to comply with the Act’s requirements and Segal notes that the County does not currently appear to sponsor a retiree-only plan.

Current Status *(pending confirmation by the County’s legal counsel)*

Benefit Type	Funding Arrangement	Network	Administrator	Excepted Benefit ¹
Standard Plan – Medical PPO Plan	Self-funded	First Choice Health PPO Network	EBMS	No
High Deductible Plan – Medical PPO Plan	Self-funded	First Choice Health PPO Network	EBMS	No
Dental Benefits	Self-funded (part of the medical plan benefit)	None ²	EBMS	No
Vision Care Benefits	Self-funded (part of the medical plan benefit)	None ²	EBMS	No

¹ Defer to the County’s legal counsel for definition determination.

² There is no formal network or plan design steerage toward a dental or vision provider network.

¹ The conclusions in this column should be reviewed by legal counsel

Pros Vs Cons Of Staying Grandfathered

The following table shows the changes that will and will not result in loss of grandfather status under the Affordable Care Act. A loss of grandfather status occurs on the date any of these changes becomes effective. It is **important to note** that throughout this report many suggested next steps are likely to cause the County's medical plans to lose grandfather status. This would be expected in light of the significant plan design changes the County may need to undertake to balance their budget. The cost of moving to non-grandfather status (along with the savings from plan design changes) must be factored into the County's future cost projections.

Changes That WILL Result in the Loss of Grandfathered Status
> Elimination of a benefit for a condition, including elimination of necessary element to treat a condition.
> Increasing coinsurance percentage in any amount.
> Increasing copayments by more than the greater of: \$5 adjusted for medical inflation or 15% plus medical inflation.
> Increasing deductibles or out-of-pocket maximums (or other fixed amount cost-sharing requirement) by more than 15% plus medical inflation.
> Entering into a new policy, certificate or contract of insurance with an effective date prior to November 15, 2010. Please note that the grandfathering regulations clarified that a group health plan may switch insurance companies so long as the coverage remains unchanged between the policies/plans.
> Certain changes to annual/lifetime overall dollar limits.
> Increasing the percent of premiums an employee pays by more than 5% -- need to evaluate increase in share of premium for each coverage tier.
Changes That WILL NOT Result in the Loss of Grandfathered Status:
> Addition of family members of an individual who is enrolled in a grandfathered plan or an addition of a new employee.
> Disenrollment of an individual enrolled on March 23, 2010.
> Change in total amount of premiums (provided employee share within each coverage tier does not increase more than 5%).
> Changes required to conform to state or federal law (e.g., Mental Health Parity and Addiction Equity Act)*.
> Changing a TPA or PBM*.
> Voluntarily complying with provisions of the Affordable Health Care Act*.
*These changes will not result in loss of grandfathered status if they are made without exceeding the limits set out above in this table above.
> <i>NOTE: To maintain status as a grandfathered plan, a plan must include certain statements about its grandfathered status in plan materials provided to participants and beneficiaries describing the benefits under the plan.</i>

Should the County become a **non-grandfather health plan**, the following are the tasks that would need to be accomplished as of the date the plan loses grandfather status:

Affordable Care Act Requirements For Non-Grandfathered Plan	Action Items
<p>Plan cannot exclude adult children up to age 26 who are eligible for other group coverage</p>	<ul style="list-style-type: none"> ➤ Since the Plan did adopt this exclusion when the Plan was grandfathered, now need to stop excluding adult children up to age 26 who are eligible to enroll in an another employer-sponsored group health plan. ➤ Revise plan documents, enrollment materials/forms and websites as needed.
<p>Certain preventive services without cost sharing</p> <ul style="list-style-type: none"> ➤ Plan must provide in-network coverage for specific preventive services, without imposing any cost sharing. ➤ Cover the required preventive services including standard CDC-approved immunizations and the list of preventive services recommended by the U.S. Preventive Services Task Force (USPSTF) such as mammograms and colonoscopies. Main Government Website listing Preventive Services: http://www.healthcare.gov/law/about/provisions/services/lists.html Website with more detail located at: http://www.healthcare.gov/center/regulations/prevention/taskforce.html <p><i>Regulations published July 19, 2010</i></p>	<ul style="list-style-type: none"> ➤ For the required preventive services, remove all cost-sharing from in-network providers ➤ Assure that plan document is amended to cover the required preventive services and immunizations in compliance with health reform regulations. ➤ Assure that medical plan claims payer is prepared to cover the required preventive services and immunizations in compliance with health reform regulations. ➤ Consider the need to continue to cover preventive services out-of-network. Or want to reduce the coinsurance support for out-of-network preventive services coverage?
<p>Designation of PCP, pediatrician and direct access to ob-gyn services</p> <ul style="list-style-type: none"> ➤ Plan that requires designation of a primary care provider (PCP) must permit individuals to designate any participating PCP available to accept patients, allow children to designate pediatricians as their PCP, and allow women to have direct access to ob-gyn services. These requirements apply to in-network services. ➤ Plan must provide a notice of these rights in the summary plan description and in other similar descriptions of benefits under the plan. <p><i>Regulations published June 28, 2010</i></p>	<ul style="list-style-type: none"> ➤ If Plan requires designation of a PCP, permit children to designate pediatrician as their PCP. ➤ If plan requires a referral or preauth to see an ob-gyn specialist, revise rules to allow women to have direct access to ob-gyn services without referral or preauth. ➤ Amend plan and other benefits documents to include required disclosure statements that this Plan complies with the PCP and ob-gyn access requirements.

Affordable Care Act Requirements For Non-Grandfathered Plan	Action Items
<p>Internal and external appeals</p> <ul style="list-style-type: none"> ➤ Plan must provide for internal and external review of coverage determinations and provide notice to enrollees of the available processes <p><i>Regulations published July 23, 2010</i> <i>DOL Technical Release 2010-01 and 2010-02 (released August 23 and September 20, 2010)</i> <i>Technical Release 2011-02 released June 2011.</i></p>	<ul style="list-style-type: none"> ➤ Amend internal claims and appeals rules in plan documents. ➤ Add external review process that complies with Technical Release 2010-01 and subsequent amendments to the regulations, and directly contract with at least 2 independent review organizations (IRO) by 1-1-12 or assure that all vendors who deny claims subcontract with at least 2 IROs and are prepared to administer appeals in compliance with health reform regulations. ➤ Assure that all vendors who process claim appeals (e.g. medical plan claims payer, UM firm, PBM, etc) amend their processes for claim appeals and all documents to comply with ACA regulations. ➤ Assure that claims payers revise Explanation of Benefits (EOB) forms and other appeal description documents.
<p>Hospital based Emergency Room services</p> <ul style="list-style-type: none"> ➤ Plans that cover hospital emergency services must cover these services in and out-of-network, without preauthorization ➤ Out-of-network coinsurance and copayments for ER services cannot exceed in-network coinsurance/copayments ➤ Other cost sharing (deductible, out-of-pocket max) on in-network ER services must apply generally to out-of-network ER services ➤ Comply with new definition of emergency medical services in an ER. ➤ Plan must pay a reasonable amount for ER out-of-network services (as determined under formula set out in regulations) <p><i>Regulations published June 28, 2010</i></p>	<ul style="list-style-type: none"> ➤ Assure no preauth requirement on ER services. ➤ Change cost sharing of in-network and out-of-network benefit design for ER services as needed to comply with regulations ➤ Revise/add definition of emergency medical services in an emergency room in plan documents ➤ Assure that the medical plan claims administrator is prepared to adjudicate out-of-network ER claims under the new required allowance where <u>plan must pay the “greater” of</u> <ul style="list-style-type: none"> • the negotiated amount for in-network providers (the median amount if more than 1 amount to in-network providers), or • 100% of the plan’s usual payment (Allowed Charge) formula (reduced for cost-sharing) or • the amount that Medicare Parts A or B would pay (reduced for cost-sharing).
<p>Quality reporting in 2012</p> <ul style="list-style-type: none"> ➤ The government must set quality reporting standards within two (2) years from the date the law was enacted (<i>i.e.</i>, March 23, 2012). Plans and issuers would be required to report annually to the government and to enrollees on whether the plan or coverage satisfies these standards. <p><i>Awaiting regulations</i></p>	<ul style="list-style-type: none"> ➤ No action required until regulations are issued.

Additionally, plan sponsors have other health reform regulations to comply with however further guidance is expected on these issues:

- Starting in 2012 employers must track the cost of each employee's health coverage and **report on Form W-2**,
- Starting in 2012 group health plans must produce and distribute **uniform summaries of benefits** documents,
- A new **comparative effectiveness research fee** becomes payable for plan years beginning on or after 11-1-11. The fee is to be \$1.00 per covered life per year for the first plan year and \$2.00 per covered life per year for all subsequent years.
- There is a proposed reduction in the **Health Flexible Spending Account contributions** which will be capped at \$2,500/person per year.
- **Health care exchanges** are to open to individuals and small employers in 2014.
- This 2014 year also marks the **end of pre-existing condition limitations** on anyone, the **end of the overall annual medical plan dollar maximums**, the requirement that there be **no waiting period for benefits longer than 90 days**, certain **employer reporting to the IRS**, etc.

These additional future Health Reform obligations will need to be factored into the County's future financial planning.

6

DESCHUTES COUNTY ONSITE CLINIC (DOC)

Overview:

The Deschutes County onsite clinic opened in February 2011. The County indicates that the onsite clinic is designed to reduce dollars spent on employee health care by providing workers with easy and convenient medical resources. Specifically the clinic is designed to reach three objectives (the Triple Aim):

- Improve overall health of the County plan participant
- Reduce the cost per capita of health care to the County
- Improve the patient's health care experience at the clinic

The clinic is housed in a building owned by the County. The clinic is located at 1340 NW Wall Street, Suite 150, Bend Oregon. Staffing and delivery of clinical health care is administered through a contractual relationship with Healthstat. Clinic supplies are paid by the County. It is currently open six days a week with varying hours ranging from early am start of 7:00am to evening hours to 7:00pm and Saturday hours from (9a-1p). It is unclear whether any appointments can be made during the lunch hour or if appointment scheduling blocks out the ability to schedule appointments at certain lunch time hours.

The clinic advertises that its services are at "no cost to you." The clinic indicates that it can manage "primary care, urgent care and disease management needs." There does not appear to be a minimum age for a patient for a clinic appointment. Only the following types of individuals are eligible to seek care from the onsite clinic:

- County employees and their dependents
- County retirees and their dependents
- COIO employees, retirees and their dependents
- COBRA beneficiaries

The Healthstat contract indicates that employees are not required to "clock-out" while using the clinic services.

Individuals who are not enrolled in one of the Deschutes County medical plans are not eligible to be cared for at this onsite clinic even if they are willing to pay for the service. This includes the fact that the general public is also not allowed to be seen/treated at the onsite clinic.

The clinic offers the option to call for an appointment, walk-in or go online to make your own appointment. Online appointment-making requires a user name and password. After hours there is a recording announcing hours and days the clinic is open for service, a reminder to call 911 in an emergency and the option to leave a message and clinic staff will return the message (however it is unclear when that message would be returned). The Clinic has electronic medical records.

The clinic is adding the ability to dispense certain **pre-packaged prescription drugs** in mid-2011. According to the Healthstat contract amendment, the drugs to be added will include medication to treat common conditions including asthma, elevated cholesterol, thyroid conditions, elevated blood pressure, depression, antibiotics, birth control, shingles/herpes, allergies, sinus conditions, metabolic syndrome, and musculoskeletal issues.

There is a physician on call during operation hours so non-physician staff can confer with the physician.

Professional staff at the clinic are able to diagnose, treat and write prescriptions for common illnesses like strep throat, ear, eye, sinus, bladder and bronchial infections. Staff are able to treat minor wounds, abrasions and joint strain/sprains and provide CDC recommended vaccinations such as influenza, tetanus, Pneumovax, and Hepatitis A & B. Soon the clinic will open a full service retail pharmacy.

Regulatory Issues: Many onsite clinics go beyond dispensing over the counter pills for headaches and applying a bandaid. But when onsite clinics become more involved in the delivery of health care they can run into compliance issues with ERISA, COBRA and HIPAA as well as becoming an issue for eligibility if the user of the clinic wants to be able to contribute to a health savings account (HSA) and is receiving care before their high deductible is met. Additionally, there is some concern that a portion of the federal health reform regulation scheduled for 2018 could eventually create a tax penalty for the County because of the types/array of services able to be provided at the onsite clinic that might be perceived as an expensive "Cadillac" plan worthy of an added tax. So as the clinic considers way to expand capabilities, the County will want to involve your legal counsel to outline the pros and cons of such expansion decisions.

The Clinic may be able to evolve to become a significant partner in the County's wellness program by offering additional screening tests, educational classes on how to lower health risk factors like weight reduction, cholesterol reduction, stop smoking, stress reduction, etc.

When the County plan to lose grandfather status and will be required to add more expansive preventive services in accordance with federal regulations (see this website for the list of preventive services: <http://www.healthcare.gov/law/about/provisions/services/lists.html>), the County and clinic might be able to address which of the federally mandated preventive services can and cannot be performed at the clinic and assuring that the cost is less expensive than obtaining similar services in the community, then advertise the clinic's capabilities.

This partnership between the County and the clinic could extend to disease management efforts for individuals with chronic diseases like diabetes, heart failure, pulmonary diseases, arthritis, chronic back pain, etc. Clinic staff could also schedule one on one counseling sessions to help participants discuss health risk factors or current chronic diseases, help set health goals and monitor compliance of the goals, perhaps toward recommendation of a financial incentive for achievement of behavior change. Clinic staff could also develop to send secure email and/or text message reminders on appointments, classes, annual screening tests, etc.

There are a variety of additional questions that Segal identified but were not resolved with the data we were provided and are beyond the scope of this project. The additional questions include:

- The Healthstat contract indicates a variety of services they can offer at an onsite clinic. It is not clear how many of these services are already being performed or are desired by the County. It is unclear who at the County has ongoing responsibility to assure that Healthstat delivers on their contract requirements and other promises.
- Does the clinic give each person a satisfaction survey postcard right after the appt? Does the survey seek to determine what works well about the clinic and what needs improvement? Are clinic patients pleased with the licensed health clinicians who staff the clinic?
- Should performance guarantees be built into future Healthstat contracts?
- What can clinic staff do to facilitate return to work efforts for County employees under STD, LTD and work comp programs?
- Want to expand the capabilities of the clinic services? Add travel immunizations? Mobile mammogram truck? Add radiology, lab, chiro, acupuncture, behavioral health counselors, massage therapist, physical therapy? Sell OTC products? Provide back to school and sports physicals? Offer prenatal education, Lamaze classes, CPR classes? Treat on the job injuries?
- Is the clinic sending reports to the County on utilization and costs? Is the County tracking reduction in absenteeism, improved morale or enhanced employee productivity as a result of the clinic?
- What is the cost of a visit without any added services/supplies? Is this cost the same or less than the same service from an in-network primary care provider?
- Is the clinic preparing for HIPAA 5010 and ICD-10 compliance?
- Does the clinic have a scale that can weigh over 500 pounds which could be helpful in future wellness efforts?
- Any thought to making it NO appt needed....just walk in for care at certain hours of the day? Giving preference to those who do make an appt. Or add capability to call/page employee when appt almost ready?
- Any surveys of the County population yet on their familiarity with clinic, clinic hours, clinic capabilities, how well clinic meets consumer demand? Right hours, right days, correct kind of provider that sees patients?
- Are the services able to be performed at the clinic too limited to make people change from their family physician?
- Ever consider holding some summer activity to allow employees and their families to tour the clinic, chat with staff? Bring managers/supervisors to clinic for VIP tour? Purchase clever stress balls with clinic name/phone number for employee's desk?
- Does clinic automatically send (within 24 hrs of the visit) all visit information to the patient's family Doctor and/or specialist if they want. Want to use behavioral economics logic and make this the default event and patient can opt out of this if they want. If patient has no family Doctor, can clinic staff help them select one from the network?
- Do clinic staff obtain Health Risk Appraisal data in order to reach out to individuals with significant risk factors?

7

OTHER CONSIDERATIONS

The following are other issues the County may want to consider.

Enhancement of the County's Wellness Program

Wellness, also called health promotion or disease prevention, was originally undertaken by employers in an effort to reduce sick time and workers' compensation costs, and promote productivity.

Today it is known that over 50% of deaths in the U.S. are attributed to lifestyle and such lifestyle issues are controllable, so it is no wonder that wise employers emphasize wellness to their employee population. Worksite wellness programs provide benefits for both the employer and the employee, and the employee's newfound education and motivation often trickles down to the dependents of that employee positively impacting the whole family.

Studies show that for every 100 adults in America, 23% – 30% smoke, 55% or more are overweight or obese, 80% do not exercise regularly, 30% are prone to low back pain, and 35% are under significant stress. While an individual has no control of certain risk factors such as their age, gender, or family history, certain personal lifestyle behaviors ARE controllable such as smoking, nutritional intake affecting obesity and cholesterol levels, physical activity/exercise, etc. Surveys suggest that only 23% of us are aware of the wellness programs offered by our employer-sponsored health plans.

The County discussed having a low employee turnover rate which makes it an ideal employer to enhance existing wellness efforts and embrace a culture of wellness because successful health risk reduction will result in healthier plan participants who, because of the low turnover, will still be employed at the County with their new lower risks and healthier behaviors. It's a win-win for the participant who becomes healthier and reduces or eliminate their risk factors that lead to chronic disease and a win for the County who enjoys a lower cost health plan and more productive employees. Naturally the County, as happens with all employers, must be mindful of the need for confidentiality and employee trust in the efforts taken to refresh the County's wellness program.

The primary objective of a wellness program is to change the behavior of individuals toward a healthier lifestyle. This objective acknowledges that such positive behavioral changes will positively impact the your costs (e.g., cost of the health plan, productivity, absenteeism, disability, workers' compensation injury/recovery).

Although the objective of a wellness program is the promotion of a healthy lifestyle and the reduction or elimination of **health risk factors such as smoking, obesity, stress/depression, elevated cholesterol, elevated blood pressure, lack of exercise**, the outcomes of such programs have traditionally not been carefully measured. For example, if the program offers weight loss or smoking cessation

benefits, then the outcome would be to determine the percentage of participants who actually stopped smoking or who lost weight. However, such outcome reports are not often captured.

Further, many plan sponsors do not have an organized and meaningful plan of action for their wellness program and instead simply add an array of wellness services without a firm roadmap. There might be a health risk appraisal (HRA) questionnaire that only asks about a patient's known medical history or smoking habits but no questions to assess symptoms that could foreshadow an undiagnosed health problem. Some employers run an annual health fair inviting all sorts of vendors to display a booth without any direction as to what the employer is trying to accomplish at the health fair. Some employers have walking clubs and onsite weight reduction classes but all are poorly attended. When you stand back and look at this wellness program you may wonder what the employer is trying to accomplish.

Ideally, if the County would like to refresh your existing Wellness program, you may want to consider performing an Inventory of the wellness services you already offer so you have a clear understanding of the array of wellness services already made available to employees and dependents and a list of wellness services not yet offered. Then organize the current wellness program according to their impact on the six main health risk factors. This then gives you the roadmap on what and how to enhance your current wellness program to have an even greater effective on risk reduction. This process could be followed by the drafting of a formal written Wellness Business plan to outline a strategy for health promotion and a calendar of events that might include the addition of wellness vendors, discussion of incentive strategies to enhance participation and/or behavior change, a strategic communications plan and formal reporting and ROI. If interested, Segal can assist the County to refresh your wellness program.

Dependent Eligibility Audit

In an effort to assure that the Plan is paying only for those individuals who are eligible for coverage, many plan sponsors have performed or are planning an eligibility audit, in short, an evaluation of the people covered by the plan to see if these individuals meet the plan's definition of dependent.

From a plan sponsor's perspective, eligibility audits mean good business sense as health care costs have been rising by 7-10% a year for over a decade, and clever ways to contain costs are valued.

Many employers have "the honor system" in terms of verifying that an employee is adding a dependent who meets the plan's eligibility definition.

Recent dependent verifications have been finding 12%-20% of spouses ineligible - either voluntarily removed or canceled for failure to respond to a request for proof of eligibility. The higher percent includes plans with Domestic Partners; that category can average a 20% drop on its own.

Studies have shown an 8-12% reduction in eligible dependent children once documents are required for verification. While the percent may decrease with the removal of full-time student status, the addition of dependents to age 26 requires a watchful eye to avoid fraud and abuse.

The County may want to consider the value of implementing an eligibility audit to assure that Plan funds are being expended only for eligible individuals.

Cost-Sharing Methods

There are two primary methods to cost-sharing:

- Application of the **cost-sharing to everyone** (typically in the form of premium costs that impact users of health care and non-users)
- Application of the **cost-sharing to “users” of health services** (typically in the form of deductible, coinsurance, copay and out-of-pocket maximums when care is sought/used)

Additionally, many plan sponsors are working to find ways to have participants become wiser users of health services such that there is a significant reduction in plan cost through lower utilization and through the most cost efficient delivery of care. High deductible health plans coupled with a health reimbursement arrangement or health savings account are options to encourage wise use of health care.

Recommendations

While the numbers show that today the Trust has adequate money to meet current obligations, the financial section of this report (Table 2 and 3) illustrates that **with no substantial change in contributions and plan design, the Trust is on target to becoming insolvent.**

As noted earlier in this report, the **Trust is on schedule to spend 23.7% (\$3,440,000) more than is collected in contributions for the 2012 fiscal year further depleting the Trust fund's cash.**

If the County would like to reach the level where the Plan is not deficit spending in fiscal year 2012, **the Plan needs to reduce costs by an estimated \$3,800,000**, which includes the \$3,440,000 in contribution shortfall plus an estimated \$360,000 to account for the cost of the Plan complying with Health Reform in August 2011.

This recommendations section does not repeat all suggestions outlined on the prior pages of this report but rather highlights certain key recommendations for the County. Given the projected financial picture of the County, multiple changes will need to be made to narrow or eliminate the budget gap.

Action Items to Help Reach the \$3,800,000 Cost Reduction	Potential Savings Range
> Increase the medical plan common deductible to \$750 (3 times for family). Apply the deductible to as many medical plan benefits as possible.	\$374,000 - \$459,000
> Add deductible to outpatient lab and subject to normal plan coinsurance in and out of network.	Unknown Savings
> Increase the medical plan out-of-pocket maximum to (in-network) \$3,000 individual/\$9,000 family and (non-network) to \$6,000 individual and \$18,000/family. Apply the out-of-pocket maximum separately to the in-network and out-of-network expenses.	\$488,000 - \$600,000
> Retail: leave Generic at \$10.00 copay, change Preferred brand to 20% with minimum \$35 copay and a max of \$70 copay. Change Non-preferred brand to 20% with a minimum \$50 copay and a max of \$100 copay. Specialty drugs at 20% with a maximum \$100 copay.	\$245,000 - \$300,000
> Add generic drug utilization incentive: If generic is available and member buys a brand drug the member pays the brand copay plus the difference in cost between the brand and generic copay.	\$55,000- \$144,000

Action Items to Help Reach the \$3,800,000 Cost Reduction	Potential Savings Range
<ul style="list-style-type: none"> > <i>Option a:</i> In the medical plan, remove the copay from all office visits and switch to coinsurance after deductible met. > <i>Option b:</i> In the medical plan, create PCP copay of \$25/visit and specialist of \$50 copay/visit. Choose Option a or b but not both.	<i>Option a:</i> \$80,000 - \$98,000 or <i>Option b:</i> \$275,000 - \$337,000
<ul style="list-style-type: none"> > Add a formal dental PPO network with plan design steerage toward network providers for maximum savings. 	Discount savings ranges: \$102,000 - \$204,000
<ul style="list-style-type: none"> > Change dental plan to add a \$50 deductible. Then pay <ul style="list-style-type: none"> o 100% no deductible for preventive care, o 80% after deductible for basic, o 50% after the deductible for major services, regardless of how long a person has been covered by the dental plan. 	\$194,000 - \$237,000
<ul style="list-style-type: none"> > Competitive bidding for PBM benefits. 	\$180,000 - \$360,000
<ul style="list-style-type: none"> > Competitive bidding for life insurance, disability benefits, and stop loss. 	\$85,000 in combined savings
<ul style="list-style-type: none"> > Add a cash out option paying \$156 - \$600 per employee per year only permitted for employees who show proof of other group coverage. 	Net Potential Savings \$76,500 - \$182,000
<ul style="list-style-type: none"> > If clinic is getting generic drugs at a cost that is less than would cost the Plan if that same drug was purchased via retail or mail order, then steer utilization to the clinic. Clinic should charge ½ the retail cost (\$5.00 generics, 10% coinsurance \$17 Minimum / \$35 Maximum for Preferred Brand name drugs). 	Unknown Savings
<ul style="list-style-type: none"> > Add copay for clinic services at \$5.00 copay per visit. 	Unknown Savings
Total Potential Savings	Using Option a: \$1,880,000 - \$2,669,000 Using Option b: \$2,075,000 - \$2,908,000

Other Considerations

- Implement a dependent eligibility audit, giving the usual amnesty period before proof of dependent status is required in order to maintain coverage.
- Add premium differential for tobacco users.
- Amend plan for remaining health reform issues as noted in chapter 5 of this report and review the plan design ideas in chapter 4 for possible plan changes.
- Add a vision plan network and plan design steerage toward network providers.
- Change the High option plan to a qualified High Deductible Health Plan and allow Active participants a choice of plans. Either a buy-down strategy (where the County makes the High option a free plan or contributes to a fund) or a buy-up strategy where the Standard plan becomes a buy-up option can be considered.
- Unbundling dental and vision from medical services. To minimize anti-selection given the elective nature of dental and vision services, a two-year waiting period could be added if an employee waives coverage and then decides to re-enroll at the next open enrollment. Alternatively for dental, a waiting period could be added for more expensive major procedures (crowns, ortho, etc) to limit selection issues.
- Consider restructure of the contribution tiers from 2-level to 3 or 4 level contributions where employee contributions reflect a more equitable distribution of costs.
- Determine the desired participant vs. County cost-sharing strategy for the future, as current is 87-88% County paid.
- Perform an annual data analysis assessment of the plan and benefits utilization.
- Add medical management programs to the outpatient prescription drug benefit such as precertification, mandatory generics, step therapy, quantity limits, specialty drug management.
- Add copay to ER so that there is always cost-sharing even after the out-of-pocket maximum is met. Investigate the validity of ER use and structure plan design to assure that participants only using this expensive setting for true emergencies.
- Design steerage in the cost-sharing relationship between clinic, office visits, urgent care, and emergency rooms.

Other Considerations

- Change coordination of benefits to a carve out.
 - Add a longer benefits waiting period for new hires.
- Related to the Onsite Clinic:
- Determine which of the Health Reform preventive services can be performed cost-effectively at the onsite clinic and then advertise the availability of such services.
 - Market the clinic.
 - Enhance the onsite clinic website as an attractive vibrant source of health information so County plan participants visit the website for more than just making an appointment.
- Add copays to a variety of services so that cost-sharing continues even if the out-of-pocket maximum is reached.
 - Remove the deductible carryover provision, supplemental accident benefit, and unique dual coverage provisions.
 - Implement a more restrictive medical network with deeper network discounts (>15%) that would be better suited for Plan participants considering the projected long-term solvency of the Trust Fund. If the current network provider must be retained, negotiate to get better deals and seek to negotiate performance guarantees on less than trend unit cost increases. The County should develop a direct contract with a select number of providers and redesigning the Plan to encourage use of these providers.
 - Undertake an assessment of the effectiveness/value of the Utilization Management services paid for under the CareLink program including the Health Impact chronic disease program. Determine if the County wants to continue paying for these services and if not, what benefit design edits could help prevent overutilization of services. If so, determine if the County will remain with the CareLink program who might be persuaded to provide different types of reports on effectiveness of their services, or if the County wants to competitively bid in order to directly contract with a UM or chronic condition management program.
 - Evaluate the effectiveness of the current medical plan network discounts overall and in each service category.
 - Focus plan design controls on the five most expensive providers being used: Inpatient Hospital Charges, Office Visits, Outpatient Prescription Drugs, X-ray/Lab Services, and Outpatient Surgical Facilities.
 - Implement a regularity to auditing your vendors to assure they are administering your plan in accordance with your documents and their contract provisions.

Other Considerations

- Review the Onsite Clinic questions/suggestions from chapter 6.
- Perform a wellness inventory to assess the comprehensiveness of the County's wellness program and implement a strategic plan for wellness program improvements including ways to get employees to change behavior toward a healthier lifestyle so as to reduce claim costs and increase attendance/productivity.
- Create a "retiree-only" medical plan to avoid having to comply with health reform for retirees.

9

OVERVIEW OREGON HEALTH EXCHANGE AND COMPETITIVE BENCHMARKS

OREGON HEALTH INSURANCE EXCHANGE

- JUNE 7, 2011. Oregon passes legislation to create the Oregon Health Insurance Exchange (OHIE).
- October 2013, people will be able to sign-up for coverage effective in 2014.
- The exchange must work for people and business in order to obtain coverage.
- OHIE will be a central marketplace for carriers to compete on quality and value.
- Consumers will have apples-to-apples comparisons and know exactly what they are buying.
- Small business will be able to give employees a fixed amount of money to buy coverage from the exchange.
- People who leave their jobs can keep coverage from the exchange.
- The exchange will administer a new federal health insurance credit to help make coverage more affordable

BEYOND FEDERAL LEGISLATION

- OHIE will be run by a public board, will have at least two consumer and no more than two representatives from the health care sector.
- Carriers that do not meet minimum standards will not be allowed to market through the exchange.
- OHIE is designed to offer choice, competition, value, and transparency.
- The Oregon Exchange goes further in protecting consumers, helping small business and holding carriers accountable:
 - The exchange is accountable to a governing board and the public for service, quality, and value.
 - Ensures the OHIE is for the benefit of people and business to obtain coverage for employees and their families.

CONSUMER BENEFITS

- > Access to tax credits and subsidies
 - o Those who earn 400% of poverty (\$43,560/individual or \$89,4000/family of four)
 - o Insurance cost is 9.5%+ of income (i.e. more than \$3610 /yr or \$300 / mo if earning \$38,000)
 - o Employer provided coverage is actuarially less than 60%.
- > Ability to compare insurance products quickly and easily
- > Minimum benefit standards and cost-sharing limits including essential benefits, quality and cost standards
- > Exchange information can be accessed through phone website, or agents.
- > Small business can provide a fixed dollar amount to assist employees.
- > Employees in many cases will have more options to align coverage specific to their needs.

CENTRAL MARKETPLACE

- > Individuals and small business can start signing up for coverage effective in 2014.
- > Purchasing from the exchange is a choice. Individuals and small groups (under 100) can continue to buy privately.
- > When purchasing through the exchange, individuals and small business will have access to tax credits with cost-sharing expenses (deductibles and co-payments).
- > Starting in 2014, federal premium tax credits, and subsidies will be available. This is for people with family income up to 400% of poverty. More than ½ of US Workers may qualify.
- > Federal assistance beginning in 2014 will reduce out-of-pocket expenses for many people.

BUYING FROM THE EXCHANGE

- > Based on the actuarial value of cost of coverage when combined with costs at the point of service: Platinum 90%, Gold 80%, Silver 70%, bronze 60%, Catastrophic 30%.
- > The State of Oregon and ten largest counties, including Deschutes currently provide programs between 80% and 90% of actuarial value.
- > Employers with more than 100 employees can join the exchange in 2017.
- > Employers may choose platinum, gold, silver, etc... or may provide a defined contribution toward the cost of coverage with employees paying the difference.

EMPLOYERS TAX AND FREE-RIDER PENALTY

- Small employers may qualify for a tax incentive to help with the cost of benefits, up to 35% of premiums in 2010, up to 50% in 2014. Employers with 10 or fewer employees will receive the most.
- The vouchers that Federal Health Care Reform proposed would allow an employee to use employer funds to buy coverage from the exchange is repealed. Instead, employees who receive a subsidy they are not entitled to will pay a tax penalty.
- Employers who do not offer coverage to fulltime employees (30 hrs per wk); if they have more than 50 will pay a penalty of \$2,000 for each employee.
- Employers who do offer coverage, but have employee who buy coverage from the exchange are exempt from penalty for the first 30, then pay \$3,000/employee that qualifies for the subsidy and buys from the exchange.
- Employers subject to federal tax will be incented to offer benefits through continues pre-tax offering.

MORE TO COME

- 2014, employers with more than 200 must automatically enroll / default newly eligible employees for coverage. Employees may then opt-out.
- 2014, no more limits allowed on essential benefits.
- 2018, excise tax imposed on employer-plans with costs that exceed \$10,200 / employee or \$27,500 / family.

COMPETITIVE BENCHMARKS

State of Oregon, including the Oregon University System
Bend-La Pine Schools
City of Bend

Oregon Counties Ranked by *Population

Multnomah County, 735,334
Washington County, 529,710
Clackamas County, 375,992
Marion County, 351,715
Lane County, 351,109
Jackson County, 201,286
**Deschutes County, 157,773
Linn County, 115,584
Douglas County, 103,205

** Population is based on 2010 US census*

*** Deschutes County benefits are not illustrated*

Plan comparisons are based on the plans for fulltime employees. Information is based on the most current as posted on the website or otherwise provide through a direct request. If more than one plan is offered and only one is illustrated the plan with the highest enrollment is compared. Employee cost sharing and in some instances plan designs vary from one bargained to the next.

Employee Cost Sharing

Employer	Employee	Spouse or Child	Family	\$ Opt-Out
State of Oregon	0	0	0	Yes
Bend-La Pine Schools				
Providence	\$ 53	\$ 53	\$53	
ODS / HSA HP Plan				
<i>Contribution to HSA \$3089 annually</i>				
City of Bend	10%	10%	10%	
Multnomah County	10%	10%	10%	Yes
Washington County	\$0	\$0	\$0	
Clackamas County	\$55	\$55	\$55	Yes
Marion County	\$4	\$4	\$4	Yes
Lane County	\$0	\$0	\$0	
Jackson County	\$0	\$0 -	\$0-	
Deschutes County	\$50	\$50	\$50	
Linn County	\$10	\$80	\$80	
Douglas County				
Pacific Source PPO	\$283.92	\$283.92	\$283.92	
Pacific Source HRA	\$0	\$43.69	\$43.69	
<i>Contribution to HRA \$900 / \$1800 annually</i>				

Deductibles (does not reflect additional co-pays)

Employer	In-Network	Out-of- Network
State of Oregon	Co-Pay	No Coverage
Bend-La Pine Schools		
Providence	\$200 \$600	\$200/ \$600
ODS / HSA HP Plan	\$1500 / \$3000	\$1500 / \$3000
<i>Contribution to HSA \$3089 annually</i>		
City of Bend	?	?
Multnomah County	\$300/ \$900	\$900/\$2700
Washington County	\$250/\$750	\$250/\$750
Clackamas County	\$250/\$750	\$250/\$750
Marion County	\$1200/\$2400 \$500 / \$1500	\$1200/\$2400 \$500 / \$1500
Lane County	\$100 / \$300	?
Jackson County	\$ -	\$ -
Deschutes County	\$500/ \$1500	\$500/\$1500
Linn County	\$250/\$500	\$250/\$500
Douglas County		
Pacific Source PPO	\$250 / \$750	\$250 / \$750
Pacific Source HRA	\$2000/ \$4000	\$3000 / \$6000
<i>Contribution to HRA \$900 / \$1800 annually</i>		

Co-Insurance and Out-of-Pocket Maximums

Employer	Co-Insurance In-Network	Co-Insurance Out-of- Network	Out-of-Pocket In-Network	Out-of-Pocket Out-of-Network
State of Oregon	15%	30%	\$1000 / \$3000	\$2000 / \$6000
Bend-La Pine Schools				
Providence	20% + Co-pay	40%	\$2000 / person	\$4000 / person
ODS / HSA HP Plan	20%	40%	\$ 5000 / \$10,00	\$5,000 / \$10,000
<i>Contribution to HSA \$256.60 per month</i>				
City of Bend	?	?		
Multnomah County	15%	35%	\$1500 / \$4500	\$1500/\$4500
Washington County	20%	40%	\$1700/\$5100	\$1700/\$5100
Clackamas County	20%	20%	\$1200 / \$3600	\$1200 / \$3600
Marion County	20%	40%	\$3,800/\$7,600	\$7,600/\$15,200
	25%	50%	\$5,000/\$1,500	\$10,000/\$30,000
Lane County	\$100 / \$300	20% or Co-Pay	\$1500 / \$4500	unknown
Jackson County	\$ -	\$ -	unknown	unknown
Deschutes County	20%	40%	\$2,000 / \$6,000	\$4000 / \$12,000
Linn County	10%	20%	\$950 / \$1900	unknown
Douglas County				
Pacific Source PPO	Co- Pay	20%	\$2,000/\$4,000	\$5,000
Pacific Source HRA	20%	20%	\$3,000/\$6,000	\$6,000/\$12,000
<i>Contribution to HRA \$900 / \$1800 annually</i>				

Pharmacy

	Co-insurance	Co -Pay	Supply Days
Generic	(4) 20% (1) \$50 max	\$ 0 - \$5 (2) \$10 (1) \$15 (1)	(10) 30
Formulary Brand	(4) 20%, (5) Kaiser = Generic, \$25 + <> generic (1)	(1) \$25 (1) \$30	(10) 30
Non-Formulary Brand	(4) 20%, (4) Greater \$50 or 50% (1) 50% to \$50 max, (1) 50% up to OOP Max.	(1) \$30, (1) \$45	(10) 30
Mail Order Specialty	(1) 2.5 x's retail, (3) 20%, (1) 50% to \$125 max brand (1) greater 50% or \$150, (2) 20%	(1) \$30 gen, \$20 Brand, \$40 non(1) \$50 brand, (1) \$90 non	(1) 45 (10) 90 (10) 30
** HSA and HRA Plans are subject to the plan deductible and OOP Max.			
* Kaiser dispenses 100% generic when available, 100% brand formulary			

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