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AGENDA ITEM

[X] Action Item
[ ] Information Only

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Item Number: X

Title: Recommended Policy Changes

REPORT

In addition to new plan design strategies, PEBP's May strategic planning also centered around possible policy changes. Historically, PEBP has employed numerous calculations and processes that are outside of the norm or that do not follow more standard actuarial practices. As the program has evolved, the need to reconsider these has grown in order to provide greater stability, transparency and a more streamlined path forward.

BOARD POLICIES

Underwriting Self-Funded Plans as One Risk Pool

In a self-funded plan, a claim is PEBP's responsibility regardless of which plan the member has selected. Pricing plans based on their actuarial values (the overall average percentage of healthcare costs paid by the plan) eliminates plan "death spirals" – a situation that occurs when a less healthy population, or overly large risk pools, move to or away from a specific plan. Currently, PEBP underwrites plans separately which impacts overall experience as high cost members move from one plan to another. Underwriting plans as one single risk pool eliminates this potential issue. For example, if an EPO member who is a on $3M/year specialty medication moves to the CDHP and then back again, the member takes the experience with them from year to year, but ultimately it remains PEBP's responsibility to pay those claims regardless. By underwriting all self-funded claims experience together, that one member's claims will not adversely impact one plan's renewal over the others. Instead, the high cost claims are lumped in with a broader risk pool and neutralized. As PEBP considers moving to three plan designs, pricing each plan according the Actuarial Values becomes even more important. Under this scenario, PEBP would continue to maintain the required State and Non-State risk pools.

Contribution Strategy

When the CDHP was originally introduced, the intent was to price the HMO and CDHP plans so that the total out of pocket expenses (premiums and copays) were equivalent. Over the past decade, this pricing differential was not maintained as the HMO rates have been set based on claims experience by fully insured carriers. This has ultimately resulted in significantly higher HMO/EPO single coverage costs when compared to the CDHP. Part of this disparity could be solved by the recommendation to underwrite plans made above, however contributions strategies play a significant role as well.

PEBP recommends applying a single contribution strategy (flat dollar amount) that is consistent across all the plans. Under this new strategy, PEBP's budget projections become more stable as projections are no longer dependent on participant plan selections. It eliminates this variable and focuses solely on the tier level selections.

HSA/HRA Funding by Dependent Count

Although PEBP may not be in fortunate enough position to provide HSA/HRA contributions in PY22, the program may want to reconsider a more streamlined approach to its funding strategies regarding dependents. The current process of funding based on the number of dependents (up to 3) creates unknown variables that ultimately have an affect on budget projections. The recommendation going forward is to establish dependent funding based on one of the following:

1. Tier (Employee only, E+Spouse, E+Children, E+Family)
2. Single amount for employee only coverage and another for any dependent coverage tier
3. Single amount per employee regardless of tier

Streamlining Tier Factors

Today, PEBP receives claims estimates from Aon that are tiered based on medical and pharmacy experience for state participants, non-state participants and a separate claims experience for dental. Aon provides rates based on the experience and tier per plan, and PEBP then adds on what is referred to as the "administrative load". Some of these administrative costs are flat amounts by tier and others, such as HSA/HRA funding, vary by tier. This results in final total rates that differ from the initial actuarial rates developed by Aon. PEBP recommends the program follow a more traditional actuarial underwriting process by:

- Using a per participant per month factor for claims
- Adding on administrative fees on a per participant per month basis
- Use one tier for all plans, products, state and non-state
- Keeping this factor static for the two-year budget cycle (at a minimum)

Definition and Use of Excess Reserves

The intent of the above recommendations is to reduce the probability of the program generating excess reserves the program has experienced in the past. Providing a more actuarially sound

program will reduce some of the volatility in PEBP's budget projections, however significant changes in the program (such as the addition/elimination of a plan) may introduce unknown variables that will ultimately affect projections and possibly never fully eliminate the existence of excess reserves. It is PEBP's recommendation that excess reserves be:

1. Defined:
   Excess reserves have historically varied dramatically throughout the plan year and are heavily affected by claims experience, lag and projections.
   a. PEBP recommends excess reserves be referred to as "excess cash".
   b. PEBP recommends identifying a point in time where excess cash is reported. Reporting excess cash in September after the end of the fiscal year provides the most sound and consistent figures and allows PEBP to report on actuals versus projections.
2. Use:
   PEBP recommends the board adopt a policy regarding how the program uses excess cash. Since excess cash is not a constant, PEBP does not believe excess cash is suitable to use for any on-going costs of the program.

OPERATIONAL CHANGES

Although the below change does not require Board approval, it is important to highlight as it will be reflected in budget reports made available to the PEBP Board and public.

Rx Rebates

PEBP receives a substantial amount of pharmacy rebates every year. In FY 20, PEBP is projected to receive approximately $13M in Rx rebates. It is typical to see rebates directly offset the cost of pharmacy claims (since that is how they are generated), however currently PEBP uses it to offset administrative costs. Moving forward, beginning in FY22, PEBP will be working with the Governor's Finance Office to ensure these rebates are moved into the claims category to more provide a more accurate reflection of the underwriting of claims calculations.

PEBP Recommendations:

1. ***Underwrite all self-funded plans into one risk pool while continuing to maintain the required state and non-state risk pools***
2. ***Apply a single contribution strategy consistent across all plans***
3. ***Establish HSA/HRA funding strategy***
4. ***Streamlining tiers by following a more traditional actuarial underwriting process by:***
   a. ***Using a per participant per month factor for claims***
   b. ***Adding on administrative fees on a per participant per month basis***
   c. ***Use one tier for all plans, products, state and non-state***
   d. ***Keeping this factor static for the two-year budget cycle (at a minimum)***
5. ***Definition and use of excess reserves***