Report to the Legislature

PEBB Health Benefit Plan — Cost and Utilization Trends, Demographics, and Impacts of Alternative Consumer-Directed Health Plan

Second Engrossed Senate Bill 5773, Chapter 8
Laws of 2011, RCW 41.05.065 (6)

November 30, 2015

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Executive Summary

HCA is required to submit a report to relevant legislative policy and fiscal committees by November 30, 2015, and each year thereafter, as directed by RCW41.05.065 (6)(b). The report is to evaluate the impact of the newly offered consumer-directed health plan (CDHP) and will include:

1. Public Employees Benefits Board (PEBB) health plan cost and service utilization trends for the previous three years, in total and for each health plan offered to employees.
2. For each health plan offered to employees, the number and percentage of employees and dependents enrolled in the plan, and the age and gender demographics of enrollees in each plan.
3. Any impact of enrollment in alternatives to the most comprehensive plan, including the high deductible health plan with a health savings account, on the cost of health benefits for those employees who have chosen to remain enrolled in the most comprehensive plan.

As shown in Chart 1, the average member enrollment in CDHPs is approximately 4 to 6 percent. This reflects a slightly higher trend from 2012 through 2014.
1. Health Plan Cost and Service Utilization

The attached report detailing health plan cost and service utilization is provided by the Milliman actuarial firm. On HCA's behalf, Milliman actuaries calculated cost trends based on Allowed and Paid Claims1 PMPM (Per Member Per Month) for Non-Medicare PEBB enrollees.

The report finds that for 2012 through 2014, the allowed claims PMPM for non-CDHPs ranged from $408 in CY12 to $441 in CY14; this range was 3 to 4 percent higher than the average of all plans. The allowed claims PMPM for CDHPs ranged from $172 in CY12 to $202 in CY14, which was 42 to 47 percent lower than the average of non-CDHPs.

The service utilization of non-CDHPs in the period from 2012 to 2014 was about 3 percent higher than the average of all plans, whereas CDHPs showed about 54 to 59 percent lower utilization compared to non-CDHPs.

2. Employees and Dependent Enrollment and Demographics

CDHP members comprised about 4 to 6 percent of all plan members on average during the report period. Compared to plans that were not CDHPs, CDHPs showed a lower average age distribution. About 78 percent of all CDHP members were under age 50; about 65 percent of members in non-CDHPs were under age 50.

CDHPs also show a slightly higher ratio of dependent enrollment compared to non-CDHPs. Gender distribution for all plans is approximately the same.

3. Impact of CDHPs on Other Plans

Since the CDHPs were introduced in 2012, and plan-specific risk scores and utilization data did not become available until 2014, the most comprehensive data and the most experience is shown in the impact in 2014. The CDHPs are still new offerings, and their impact is anticipated to continue to vary as the plans mature over time.

This report focuses on measuring the impact that enrollment in CDHPs has had on every plan in the PEBB portfolio rather than the impact on just the most comprehensive plan. Also, in keeping with statutory language, this report does not speculate on or address possible additional impacts, such as differences in plan richness, administrative costs, or unit costs.

According to Milliman's analysis for both Uniform Medical Plan (UMP) and Group Health (GH), the introduction of CDHPs lowered member contributions in non-CDHPs in 2012 and

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1 Allowed Claims equals the amount that was allowed by the health plan and Paid Claims equals the amount paid by the plan after adjusting co-payment, deductible and other plan payment amounts.
2013, and raised employee contributions for non-CDHP members in 2014. This impact was due to the mechanics of the bid rate and employee contribution calculation process.

Overall, the estimated impact on non-CDHPs was as follows (see Chart 12 on page 13):
- a contribution decrease of $4.66 in CY12,
- a contribution decrease of $4.24 in CY13, and
- a contribution increase of $5.63 in CY14.

**PEBB Health Benefit Plan Analysis**

**Health Plan Cost and Service Utilization**

1) Health Plan Cost Trends

Charts 2 through 5, and Tables 1 and 2, show cost trends for CDHPs and non-CDHPs, calculated as allowed and paid claims PMPM for 2011 through 2014. Allowed and paid claims PMPM are based on the entire PEBB non-Medicare risk pool enrollment.

The allowed claims are the benefit costs allowed by the health plans whereas paid claims are the amounts paid by the plans after adjusting for copayments, deductibles, and payments by other plans or responsible third parties. The benefit plan design determines the paid-to-allowed ratio for each plan; the final impact on employee contribution levels in this report is calculated from the modeled premium cost for each plan, adjusted by the paid-to-allowed ratio.

**Chart 2: Allowed Claims PMPM**
Chart 3: Allowed Claims PMPM by Plan

Table 1: Allowed Claims PMPM*

<table>
<thead>
<tr>
<th>Plan</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PMPM*</td>
<td>PMPM*</td>
<td>% Change</td>
<td>PMPM*</td>
</tr>
<tr>
<td>Group Health CDHP</td>
<td>N/A</td>
<td>$141</td>
<td>N/A</td>
<td>$174</td>
</tr>
<tr>
<td>Group Health Classic</td>
<td>$472</td>
<td>$479</td>
<td>1.5%</td>
<td>$478</td>
</tr>
<tr>
<td>Group Health Value</td>
<td>$295</td>
<td>$312</td>
<td>5.6%</td>
<td>$334</td>
</tr>
<tr>
<td>Uniform Medical Plan CDHP</td>
<td>N/A</td>
<td>$184</td>
<td>N/A</td>
<td>$213</td>
</tr>
<tr>
<td>Uniform Medical Plan Classic</td>
<td>$415</td>
<td>$438</td>
<td>5.5%</td>
<td>$461</td>
</tr>
<tr>
<td>CDHPs</td>
<td>N/A</td>
<td>$172</td>
<td>N/A</td>
<td>$202</td>
</tr>
<tr>
<td>Non-CDHPs</td>
<td>$392</td>
<td>$408</td>
<td>4.2%</td>
<td>$428</td>
</tr>
<tr>
<td>All Plans</td>
<td>$392</td>
<td>$408</td>
<td>1.6%</td>
<td>$416</td>
</tr>
</tbody>
</table>

*Per Member Per Month (PMPM) includes medical and prescription costs.

Chart 4: Paid Claims PMPM

Table:

<table>
<thead>
<tr>
<th>Plan</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDHPs</td>
<td>$116</td>
<td>$137</td>
<td>$137</td>
<td>$134</td>
</tr>
<tr>
<td>Non-CDHPs</td>
<td>$326</td>
<td>$342</td>
<td>$360</td>
<td>$380</td>
</tr>
<tr>
<td>All Plans</td>
<td>$326</td>
<td>$332</td>
<td>$348</td>
<td>$365</td>
</tr>
</tbody>
</table>
Non-CDHPs show moderate increases in both allowed and paid claims PMPM. CDHPs show allowed claims PMPM ($172 in CY12, $202 in CY13, and $195 in CY15) that are 42 to 47 percent lower than non-CDHPs ($408 in CY12, $428 in CY13, and $441 in CY14), and paid claims PMPM ($116 in CY12, $137 in CY13, and $134 in CY14) that are 62 to 66 percent lower than non-CDHPs ($342 in CY12, $360 in CY13, and $380 in CY14). While various factors account for the difference, the low average population age and low utilization claims costs are likely to be the main factors.

2) Service Utilization Trends
Chart 6 and Table 3 show utilization (per 1,000 members\(^2\)) for 2011 through 2014 based on the entire PEBB non-Medicare risk pool enrollment. Utilization for non-CDHPs is approximately 3% higher (80,211 in CY12, 84,396 in CY13, and 86,392 in CY14) compared to non-CDHPs (76,642 in CY12, 80,136 in CY13, and 82,176 in CY14) for total hospital days and total encounters. Utilization for CDHPs is approximately 2 to 3% lower for hospital days and encounters for each year. The utilization trend for non-CDHPs has increased in CY13 and CY14, while CDHPs have remained relatively stable. The difference in utilization between CDHPs and non-CDHPs is likely due to the low average population age and low utilization claims costs.
to the average for all plans (78,146 for CY12, 81,943 for CY13, and 83,501 for CY14). They also show a moderate increase in utilization (3.6% in CY12, 5.2% in CY13, and 2.4% in CY14), which is slightly more than the average for all plans (0.9% in CY12, 4.9% in CY13, and 1.9% in CY14).

**Table 3: PEBB Health Plan Service Utilization Trends**

<table>
<thead>
<tr>
<th>Plan</th>
<th>Utilization per 1,000 members</th>
<th>2011</th>
<th>2012</th>
<th>% Change</th>
<th>2013</th>
<th>2014</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization</td>
<td>% Change</td>
<td>Utilization</td>
<td>% Change</td>
<td>Utilization</td>
<td>% Change</td>
<td></td>
</tr>
<tr>
<td>Group Health CDHP</td>
<td>N/A</td>
<td>21,491</td>
<td>N/A</td>
<td>30,066</td>
<td>39.9%</td>
<td>25,962</td>
<td>-13.7%</td>
</tr>
<tr>
<td>Group Health Classic</td>
<td>86,729</td>
<td>84,963</td>
<td>-2.0%</td>
<td>88,031</td>
<td>3.6%</td>
<td>86,338</td>
<td>-1.9%</td>
</tr>
<tr>
<td>Group Health Value</td>
<td>53,745</td>
<td>54,164</td>
<td>0.8%</td>
<td>59,706</td>
<td>10.2%</td>
<td>59,208</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Uniform Medical Plan CDHP</td>
<td>N/A</td>
<td>36,788</td>
<td>N/A</td>
<td>41,952</td>
<td>14.0%</td>
<td>43,352</td>
<td>3.3%</td>
</tr>
<tr>
<td>Uniform Medical Plan Classic</td>
<td>85,094</td>
<td>90,575</td>
<td>6.4%</td>
<td>94,295</td>
<td>4.1%</td>
<td>97,644</td>
<td>3.6%</td>
</tr>
<tr>
<td>CDHPs</td>
<td>N/A</td>
<td>33,026</td>
<td>N/A</td>
<td>39,109</td>
<td>18.4%</td>
<td>39,076</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Non-CDHPs</td>
<td>77,436</td>
<td>80,211</td>
<td>3.6%</td>
<td>84,396</td>
<td>5.2%</td>
<td>86,392</td>
<td>2.4%</td>
</tr>
<tr>
<td>All Plans</td>
<td>77,436</td>
<td>78,146</td>
<td>0.9%</td>
<td>81,943</td>
<td>4.9%</td>
<td>83,501</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

CDHPs’ utilizations are approximately 55 to 59 percent lower (33,026 in CY12, 39,109 in CY13, and 39,076 in CY14) compared to non-CDHPs (80,211 in CY12, 84,396 in CY13, and 86,392 in CY14). It is likely that the higher deductible amounts for CDHPs and low risk scores for the low age population are the major factors causing the lower utilization.
Employees and Dependents—Enrollment and Demographics

Charts 7 and 8 show enrollment by type of plan and age group for years 2011 through 2014; Table 4 provides a detailed breakdown. All counts are displayed in average members, an actuarial measure used by Milliman that averages relative costs based on the age and gender distribution of a plan’s members.

CDHPs represent 4 to 6 percent of all plan members and are generally younger than non-CDHP members. In CDHPs, 77 to 79 percent of members were under age 50 compared to 65 to 66 percent of members in non-CDHPs. See Charts 7 and 8, as well as Table 4.

**Chart 7: Member Distribution by Age Band**

**Chart 8: Member Distribution by Age Band (Under 50 and Over 50)**
Table 4: Demographics by Age Band

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>4,287</td>
<td>5,216</td>
<td>5,843</td>
<td>83,221</td>
<td>78,305</td>
<td>78,604</td>
<td>79,479</td>
<td>83,221</td>
<td>82,591</td>
<td>83,820</td>
<td>85,322</td>
</tr>
<tr>
<td>25 to 34</td>
<td>1,405</td>
<td>2,101</td>
<td>2,716</td>
<td>28,528</td>
<td>26,854</td>
<td>27,457</td>
<td>28,290</td>
<td>28,528</td>
<td>28,259</td>
<td>29,558</td>
<td>31,007</td>
</tr>
<tr>
<td>35 to 44</td>
<td>2,022</td>
<td>2,493</td>
<td>2,778</td>
<td>38,308</td>
<td>35,610</td>
<td>35,409</td>
<td>35,535</td>
<td>38,308</td>
<td>37,632</td>
<td>37,902</td>
<td>38,313</td>
</tr>
<tr>
<td>45 to 54</td>
<td>2,036</td>
<td>2,331</td>
<td>2,559</td>
<td>48,229</td>
<td>43,887</td>
<td>42,740</td>
<td>42,297</td>
<td>48,229</td>
<td>45,923</td>
<td>45,071</td>
<td>44,855</td>
</tr>
<tr>
<td>55 to 64</td>
<td>1,568</td>
<td>1,878</td>
<td>2,055</td>
<td>57,444</td>
<td>54,074</td>
<td>53,024</td>
<td>51,798</td>
<td>57,444</td>
<td>55,642</td>
<td>54,902</td>
<td>53,853</td>
</tr>
<tr>
<td>Over 65</td>
<td>74</td>
<td>94</td>
<td>112</td>
<td>8,397</td>
<td>9,192</td>
<td>9,871</td>
<td>10,422</td>
<td>8,397</td>
<td>9,266</td>
<td>9,965</td>
<td>10,533</td>
</tr>
<tr>
<td>Ratio to All Plans</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
<td>100%</td>
<td>96%</td>
<td>95%</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Chart 9 and Table 5 show the distribution of members by gender for each year from 2011 through 2014. Non-CDHPs and CDHPs show approximately the same distribution rates over the three year period.

![Chart 9: Distribution by Gender](image)

Table 5: Demographics – Average Members and Distribution by Gender

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>5,478</td>
<td>6,779</td>
<td>7,751</td>
<td>123,219</td>
<td>115,534</td>
<td>115,098</td>
<td>115,356</td>
<td>123,219</td>
<td>121,012</td>
<td>121,877</td>
<td>123,107</td>
</tr>
<tr>
<td>Female</td>
<td>5,913</td>
<td>7,333</td>
<td>8,311</td>
<td>140,908</td>
<td>132,388</td>
<td>132,008</td>
<td>132,465</td>
<td>140,908</td>
<td>138,301</td>
<td>139,341</td>
<td>140,776</td>
</tr>
<tr>
<td>Male</td>
<td>48.1%</td>
<td>48.0%</td>
<td>48.3%</td>
<td>46.7%</td>
<td>46.6%</td>
<td>46.6%</td>
<td>46.5%</td>
<td>46.7%</td>
<td>46.7%</td>
<td>46.7%</td>
<td>46.7%</td>
</tr>
<tr>
<td>Female</td>
<td>51.9%</td>
<td>52.0%</td>
<td>51.7%</td>
<td>53.3%</td>
<td>53.4%</td>
<td>53.4%</td>
<td>53.5%</td>
<td>53.3%</td>
<td>53.3%</td>
<td>53.3%</td>
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</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Chart 10 and Table 6 display member type (employees vs. dependents), enrollment, and distribution. CDHPs show a slightly higher dependent enrollment ratio compared to non-CDHPs.

PEBB Health Benefit Plan—Trends, Demographics, and Impacts
November 30, 2015
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Table 6: Average Members and Distribution by Member Type

<table>
<thead>
<tr>
<th></th>
<th>CDHPs</th>
<th>Non-CDHPs</th>
<th>All Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>4,884</td>
<td>6,290</td>
<td>7,303</td>
</tr>
<tr>
<td>Dependent</td>
<td>6,508</td>
<td>7,822</td>
<td>8,759</td>
</tr>
<tr>
<td>Employee</td>
<td>42.9%</td>
<td>44.6%</td>
<td>45.5%</td>
</tr>
<tr>
<td>Dependent</td>
<td>57.1%</td>
<td>55.4%</td>
<td>54.5%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Impact of CDHPs on Non-CDHPs

Methodology

Milliman measured the impact of CDHP alternatives on all existing plans by creating a “modeled premium” and comparing it to the actual premiums from the procurement process. The model simulates a scenario in which members in existing plans would not be impacted by the introduction of CDHPs. The model focuses on measuring the impact that enrollment in CDHPs has had on every plan in the PEBB portfolio rather than impact on the most comprehensive plan.

Experience shows that PEBB members are much more likely to switch from one plan to another within a carrier family than they are to switch between carriers. Since there is little movement between carriers, comparing the impact of movement from one carrier to the most comprehensive plan in another carrier may be misleading and may not reflect the reality of how the new CDHPs have impacted all PEBB plans.

The difference between the actual and modeled bid rates displayed in Table 7 represents the impact that CDHP enrollment has had on those members who have elected to remain within other plan options. This impact could be from differences in plan richness, administrative costs, unit costs, differences in morbidity that are not accounted for in the procurement risk score model, or other factors such as actual to expected pricing variation. Please note that, in keeping
with statutory language, this report does not speculate on or address these possible additional impacts.

A negative impact implies that members in the plan are underpaying compared to what would be expected in the modeled scenario. A positive impact implies that members are overpaying.

**Analysis**

The modeled impact on UMP Classic, displayed in Chart 11, was negative in CY12 and CY13: UMP Classic members were paying lower contributions ($3.78 in CY12, and $4.99 in CY13). In CY14, the impact on UMP Classic was positive (higher contribution $6.74).

![Chart 11: Impact on UMP Plans](chart)

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniform Medical Plan CDHP</td>
<td>$48.79</td>
<td>$35.72</td>
<td>-$58.39</td>
</tr>
<tr>
<td>Uniform Medical Plan Classic</td>
<td>-$3.78</td>
<td>-$4.99</td>
<td>$6.74</td>
</tr>
</tbody>
</table>

The impact of the GH CDHP on GH Classic and Value plans is complicated and difficult to isolate. The GH CDHP had a positive impact in 2012 and 2013, which means GH Value and Classic plan members overall were paying lower contributions. There was a negative impact in 2014, which means plan members paid higher contributions overall for GH Value and Classic plans.

Table 7 shows the CDHP impact based on modeled bid rate for all plans.
Table 7: CDHP Impact based on Modeled Bid Rate

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Plan</th>
<th>Modeled Bid Rate With HSA**</th>
<th>Modeled Employee Contribution</th>
<th>Actual Bid Rate With HSA**</th>
<th>Actual Employee Contribution</th>
<th>Impact ($)</th>
<th>Impact % on Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UMP</td>
<td>Uniform Medical Plan CDHP</td>
<td>$425.2</td>
<td>-$18.8</td>
<td>$473.6</td>
<td>$30.0</td>
<td>$48.8</td>
<td>10.3%</td>
</tr>
<tr>
<td>UMP</td>
<td>Uniform Medical Plan Classic</td>
<td>$533.8</td>
<td>$89.8</td>
<td>$529.9</td>
<td>$66.0</td>
<td>-$3.8</td>
<td>-0.7%</td>
</tr>
<tr>
<td>GH</td>
<td>Group Health CDHP</td>
<td>$360.8</td>
<td>-$83.2</td>
<td>$472.7</td>
<td>$29.0</td>
<td>$112.2</td>
<td>23.7%</td>
</tr>
<tr>
<td>GH</td>
<td>Group Health Value</td>
<td>$510.8</td>
<td>$66.8</td>
<td>$500.4</td>
<td>$56.0</td>
<td>-$10.8</td>
<td>-2.2%</td>
</tr>
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* Per Adult Unit Per Month (PAUPM), ** Health Savings Account (HAS) Employer Contributions

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Plan</th>
<th>Modeled Bid Rate With HSA**</th>
<th>Modeled Employee Contribution</th>
<th>Actual Bid Rate With HSA**</th>
<th>Actual Employee Contribution</th>
<th>Impact ($)</th>
<th>Impact % on Actual</th>
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* Per Adult Unit Per Month (PAUPM), ** Health Savings Account (HAS) Employer Contributions

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Plan</th>
<th>Modeled Bid Rate With HSA**</th>
<th>Modeled Employee Contribution</th>
<th>Actual Bid Rate With HSA**</th>
<th>Actual Employee Contribution</th>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td>$543.3</td>
<td>$77.0</td>
<td>$1.0</td>
<td>0.2%</td>
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</table>

* Per Adult Unit Per Month (PAUPM), ** Health Savings Account (HAS) Employer Contributions

There was an overall $3.27 negative impact of CDHPs on non-CDHPs from 2011 to 2014 (-$4.66 in CY12, -$4.24 in CY13, and +$5.63 in CY14). This impact is displayed graphically in Chart 12. We expect the impact will continue to vary as the plans mature.
Chart 12: Impact on Non-CDHPs and CDHPs

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<th>2012</th>
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<td>CDHPs</td>
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<td>Non-CDHPs</td>
<td>-$4.66</td>
<td>-$4.24</td>
<td>$5.63</td>
</tr>
</tbody>
</table>
November 13, 2015

Thuy Hua-Ly
Chief Financial Officer
Washington State Health Care Authority
626 8th Ave. SE, M/S 45500
Olympia, WA 98504-5500

Stephen Lee
Fiscal Information & Data Analyst
Washington State Health Care Authority
626 8th Ave. SE, M/S 45500
Olympia, WA 98504-5500

Re: Legislative Report Regarding Implementation of CDHPs

Thuy and Stephen,

As requested in work order #PEBB-0316, we have prepared this report to comply with the legislative requirements set forth in RCW 41.05.065(6) relating to the establishment of the consumer driven health plan (CDHP) option for employees covered by the Public Employee Benefits Board (PEBB) program. We understand that you may use this information as a supplemental appendix to a formal report submitted by the Washington State Health Care Authority (HCA) to the Washington State Legislature. It is not appropriate for any other purpose and should be referenced in its entirety as supplementary material.

Scope of Analysis

This analysis aims to address the data summaries and analysis specifically requested by the relevant RCW, and to analyze the impact of introducing CDHP benefit plans into the PEBB portfolio starting in 2012. In areas where the RCW was not sufficiently clear to prescribe a certain approach or data summary, care has been taken to develop a methodology and provide results that are actuarially sound and consistent with our understanding of the RCW. Although there are other policy implications associated with these summaries, discussion of these implications is outside of the scope of this report.

Summary of Requirements

Three specific summaries were required by RCW 41.05.065(6). These summaries are:

(i) Public employee’s benefits board health plan cost and service utilization trends for the previous three years, in total and for each health plan offered to employees;
Exhibit 1 shows the unit cost and utilization trends for 2011 through 2014. The trend information is displayed separately for each plan, as well as subtotals by CDHP and Non-CDHP options, and in total for all plans.

(ii) For each health plan offered to employees, the number and percentage of employees and dependents enrolled in the plan, and the age and gender demographics of enrollees in each plan;

Exhibit 2 shows the detailed breakout of enrollment by plan for each year from 2011 through 2014 by key demographic groups. Enrollment is also shown for the CDHP and non-CDHP subtotals, and for all plans.

(iii) Any impact of enrollment in alternatives to the most comprehensive plan, including the high deductible health plan with a health savings account, upon the cost of health benefits for those employees who have chosen to remain enrolled in the most comprehensive plan.

Based on discussion with HCA, our modeling is focused on measuring the impact that enrollment in CDHPs has had on every plan in the PEBB portfolio. This is a wider scope than what is explicitly stated in the RCW, which only requests the measurement of the impact on the most comprehensive plan. We chose to widen the scope of this impact measurement because it is our experience that PEBB members are much more likely to switch from one plan to another within a carrier (i.e. UMP Classic to UMP CDHP, or Group Health Classic to Group Health CDHP) than they are to switch between carriers (Group Health Classic to UMP CDHP, for example). Since there is little movement between carriers, comparing the impact of a CDHP from one carrier to the most comprehensive plan in another carrier could be misleading and does not reflect the reality of how the new CDHPs have impacted all PEBB plans.

Exhibits 3a and 3b show the development of the impact that enrollment in the CDHPs has had on every plan.

Overall our analysis shows that for both UMP and Group Health the introduction of the CDHPs has lowered the employee contribution for members in the non-CDHPs in 2012 and 2013, and raised the employee contribution for members in the non-CDHPs in 2014. This impact is due to the specific mechanics of the complex bid rate and employee contribution calculation process. The CDHPs are still a relatively new plan offering, and we expect that the impact that offering CDHPs will have on members in the non-CDHPs will continue to vary as the plans mature over the coming years.

Analysis

We have organized our analysis to correspond with the three RCW requirements.
Utilization and Cost Trends:

The analysis of utilization and cost trends is found in Exhibit 1. Allowed and paid claims per member per month (PMPM), member months, and utilization per 1,000 are displayed for each year, and are based on the entirety of the PEBB, non-Medicare risk pool enrollment. The utilization trends are calculated directly from the utilization data and unadjusted for any changes in the population from year to year. From this data, allowed PMPM trends are calculated. The portion of the overall PMPM trend not explained by the utilization trend is presented in the unit cost and mix trend. This includes the impact of changes in unit cost due to contract negotiation with providers as well as trend due to changes in the underlying mix of high and low cost services provided from year to year across the various categories of service in the analysis.

Demographics:

Exhibit 2 includes the demographic summaries in total and by demographic groups. These groups include gender, age band, and member type (employee vs dependent). All counts are displayed as average members, which is total member months divided by 12.

Additionally, we have included an aggregate demographic rating factor for each plan and year based on the Milliman Health Cost Guidelines. This factor represents the relative claims cost expected from a large employer group based on their age and gender distribution, all other factors being equal. We provided this factor to allow for a quick comparison between plans and years of the age and gender demographics. This factor has not been normalized to a 1.0 for the PEBB population, so factors should not be compared to a 1.0 demographic factor, but rather to the factor of other plans or subtotals.

Impact of CDHP on Other Plans:

Background on Bid Rate and Employee Contribution Development Process

The impact that employees or members in one plan have on the claims cost, risk scores, bid rates and employee contributions of members in another plan is based on a set of very complex interactions within the PEBB program. Payment rates for the non-Medicare risk pool are based on the projected costs of each benefit plan. Bid rates are the payment rates standardized for the risk score in each plan; these bid rates are used to establish the monthly employee premium contribution for State Active employees.

The interaction between the employee contribution rates of different plans is driven by the collective bargaining agreement and the “index rate” methodology. The current collective bargaining agreement for State Active employees dictates that employees will contribute no more than 15% of the aggregate bid rate volume across all plans. The current methodology for employee premium contributions establishes the state index rate as the fixed contribution per adult unit per month that the state provides across all plans; employees pay the difference
between the index rate and the bid rate. This methodology causes some plans to have an effective contribution rate above 15% of the bid rate and other plans to have a contribution rate below 15% of the bid rate.

**Sources of Bid Rate Variation**

When the CDHPs were introduced to the PEBB program, the HCA adopted greater flexibility within the procurement process in terms of allowing the employee contribution rates to vary across plans. Prior to the introduction of CDHPs, the bid rates between the plan options were within a narrow range of values. The CDHPs have been offered with rates that are significantly lower than the non-CDHPs, which has caused aggregate bid rates to decrease. A lower bid rate volume lowers the index rate and raises the employee contribution on the existing plan. Although a bid rate represents a standardized population, there are many reasons why a lower bid rate is appropriate. The most common reasons are:

- Leaner plan design,
- Lower unit cost due to different networks,
- Lower administrative costs,
- Deviation of actual claims costs from expected results in pricing, and
- Imperfections of the risk model for a lower morbidity population.

These factors, among others, were considered as part of the process of establishing the CDHPs in 2012.

Plan design, unit cost, and administrative costs could reasonably be expected to be similar between plans in this analysis. Plan design relativity calculations indicate that the benefit relativities for the CDHPs are very close to the existing plans. Our understanding of the carriers’ network and cost structure is that they are similar for plans within a carrier. Any differences between plans would be reflected in the bid rates and impact the contribution rates for the existing plan.

Because the CDHPs were new in 2012, there was an element of pricing uncertainty between the claims costs that were assumed in development of premiums and the costs that actually occurred. Each year, new information was introduced to the pricing process that allowed pricing to be more accurate. In 2012, plan-specific information was not available for claims costs or risk scores. In 2013, plan specific risk scores became available. In 2014, the CDHPs were able to be priced using plan specific risk scores and experience, however, that experience reflected an immature plan population and we would expect claims costs to change as the plan matures. Of the three years, 2014 should give the best picture of what the impact on the existing plans will look like in later years; however, the magnitude or direction of the impact may change as the plan matures.

The procurement process has long used prospective risk scores to standardize the morbidity differences between plans in the calculation of employee contributions. Any morbidity based
variation that is not captured in the risk scores would impact the bid rate pricing for each of the plans.

**Methodology for Determining Impact of CDHPs on Members in Non-CDHPs**

We have measured the impact of the CDHP alternatives on all existing plans by creating a “modeled premium” and comparing it to the actual premiums from the procurement process. The modeled premium concept simulates a scenario in which members in existing plans would not be impacted by the introduction of CDHPs.

Exhibit 3a shows the development of the modeled premium rate. A composite carrier-wide allowed cost amount in column (A) is developed from all members covered by the carrier, regardless of their plan selection. This allowed amount represents a baseline amount of claims cost for the carrier’s population. Modeled allowed amounts for each plan are calculated by adjusting the carrier-wide allowed amounts in (A) by the plan specific concurrent risk score in (B). A modeled paid amount is then calculated in (D) by applying the historical paid to allowed factor in (C) to the modeled allowed amount. The concurrent risk score is independent of the process used in the development of the bid rates and represents our current expectation of claims distribution between the plans. In this instance the risk score is used to apportion the relative morbidity of the carrier wide experience to each plan.

The next step is to convert the modeled paid amounts in (D) to the required revenue for comparison to the payment rates developed during procurement. To accomplish this, modeled paid claim amounts are loaded with non-benefit expenses using the target medical loss ratio (MLR) per plan in (E) from the 2016 procurement to produce our modeled payment rate in column (F). In order for our modeled payment rate to be comparable with the original index rate the modeled payment rates are converted to an adult unit basis from a member basis, and balanced to the original payment rate at the carrier level. The resulting modeled payment rate per adult unit per month (PAUPM) is shown in (G), and comparable to the actual payment rate in (H). Payment rates shown in Exhibit 3a do not include payments for HSA contributions. As the HSA contribution is not risk adjusted, it is only included in the bid rate development within Exhibit 3b for the final impact on employee contributions.

Exhibit 3b builds on the Exhibit 3a payment rate by standardizing the required revenue into a bid rate and computing the modeled employee contributions for each plan. The modeled bid rate in (C) is developed by standardizing the modeled payment rate from Exhibit 3a, displayed again in column (A) of Exhibit 3b, using the prospective risk score in (B) from the procurement process. Employer HSA contributions in (D) are added for the CDHPs to develop the modeled bid rate for all plans in (E). This modeled bid rate is comparable to the actual bid rate from procurement displayed in (F). Modeled and actual employee contributions in (H) and (I) are then calculated from the modeled and actual bid rate using the actual index rate in (G) from each procurement cycle.
This methodology does not replicate every detail of the procurement process. Instead it represents an approximation of the procurement process.

Results

The difference between the actual and modeled bid rate is displayed in column (J), and represents the impact that enrollment on the CDHPs has had for those members that have elected to remain enrolled within the other plan options. This impact could be based on non-trivial differences in plan richness, administrative costs, unit costs, differences in morbidity that are not accounted for in the procurement risk score model, or other factors (such as actual to expected pricing variation). A negative impact implies that members in the plan are underpaying compared to what we would expect in our modeled scenario. A positive impact implies that members are overpaying.

In 2012 and 2013, the impact on UMP Classic is negative (members are paying a lower contribution). In 2014, the first year that plan specific experience is used to inform the actual bid rates, the impact on UMP Classic was positive (higher contribution). The difference between the modeled and actual premium for UMP Classic can most likely be attributed to morbidity factors that are not captured by the risk score model and differences between actual and projected experience.

The impact of the Group Health CDHP plan on the Group Health Classic and Value plans is complicated by the fact that there is significant selection between the Classic and Value plans. It is difficult to isolate the impact that any one plan has on either of the other two plans. We would recommend focusing on the UMP results, which give a clearer picture of the program impacts. The easiest way to look at the Group Health impact is to focus only on the CDHP impact. A positive CDHP impact (higher contribution) likely means that the CDHPs caused a lower contribution for the other plans, in aggregate. The Group Health CDHP had a positive impact in 2012 and 2013 and a negative impact in 2014, which means that the Value and Classic plan members were paying lower contributions in 2012 and 2013 due to the CDHP, and higher contributions in 2014.

Data and Assumptions

In the course of this analysis, we relied upon data from several sources. We reviewed this data for reasonableness, but did not conduct a full audit of this data. We found no significant issues in the data. A full description of the data sources is provided below.

Enrollment and Demographic Information:
Monthly enrollment and demographic information was obtained from the PEBB Master Enrollment Database (PMED). This data is provided by HCA to Milliman through monthly enrollment snapshots. Milliman compiles this information into a single database.
Due to the low enrollment in the Kaiser CDHP, the results for this plan were not deemed credible and are not displayed in this report.

**Claims Information:**
Quarterly medical claim information is provided to Milliman by each of the major carriers (Group Health, Kaiser, and Regence for UMP). MODA provides monthly pharmacy files. This data is compiled, grouped, and summarized by Milliman. The claims data used for this analysis include claims paid through June 2015. Since we are using claims incurred through December 2014 in this analysis we have 6 months of run-out, and no adjustments for completion were made.

Due to the low enrollment in the Kaiser CDHP, the results for this plan were not deemed credible and are not displayed in this report.

**Concurrent Risk Scores:**
The risk relativities are based on the enrollment provided by HCA and diagnoses from paid claim data for each calendar year. This data is processed through the Affordable Care Act (ACA) risk adjustment model for an Individual Platinum plan to produce the concurrent age/gender and diagnosis based risk scores. The raw risk scores are scaled such that the aggregate modeled payment rate dollars by carrier are equal to the original aggregate payment rate dollars.

**Bid Rates and Prospective Risk Scores:**
The risk relativities are based on the enrollment provided by HCA and diagnoses from paid claim data. This data is processed through the Verisk DxCG Risk Adjustment Model to produce prospective age/gender and diagnosis-based risk scores. Members with eligibility in the diagnosis period were assigned diagnosis-based risk scores while members without eligibility in the diagnosis period received an age/gender score. The health-status based risk relativities are weighted by member months with the age/gender risk relativities to complete the DxCG model output and capture the total risk by plan or carrier for the calculation of risk adjustment relativity factors. The bid rates are used for the expense index in order to ensure that the factors are revenue neutral across all of the plans in the portfolio.

**Caveats and Limitations**

The information contained in this letter has been prepared for the Washington State Health Care Authority and its consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document and may be provided to legislative policy and fiscal committees. To the extent that the information contained in this report is provided to third parties, it should be distributed in its entirety. Any user of this information should possess a certain level of expertise in health care modeling and projections so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report...
prepared for the Washington State Health Care Authority by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the Washington State Health Care Authority’s management of the PEBB program.

In performing this analysis, Milliman has relied upon data ultimately provided by the Health Care Authority, as well as HCA’s third party administrators. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment. To the extent that there are errors contained within this data, the results of our analysis could produce erroneous results.

The analysis provided with this report represents the most current information available, and is based on the specific methodology we describe herein. Future analyses may vary from these results for many reasons, including but not limited to enrollment shifts, random claims fluctuations, and alternate methodologies. It is important to monitor enrollment and claims and make revisions to the assumptions as needed.

This analysis is subject to the terms and conditions of the Contract between Milliman and Washington State Health Care Authority.

I am a member of the American Academy of Actuaries and meet the qualification standards to perform financial projections of this type.

Closing

We recognize that this report deals with highly technical material. Please feel free to give me a call if you have any questions regarding the material presented in this report.

Sincerely,

Ben Diederich, FSA, MAAA
Consulting Actuary

Attachments

cc: David Koenig (Milliman)
### Allowed Claims PMPM

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### Paid Claims PMPM

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### Member Months

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### Utilization Per 1,000

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### PEBB - Exhibit 1

**CDHP LEG Report**

**PEBB Health Plan Cost and Service Utilization Trends for 2011 Through 2014**

**Non-Medicare Risk Pool**

#### Allowed Claims PMPM

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#### Paid Claims PMPM

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### Unit Cost and Mix Trend

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### Total Allowed PMPM Trend

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## Utilization Trend

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## Unit Cost and Mix Trend

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## Total Allowed PMPM Trend

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### Demographic Summary

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#### Age Band

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#### Avg Demographic Factor**

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#### Distribution Within Each Plan

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#### Milliman Health Cost Guidelines

The average demographic factor is based on the Milliman Health Cost Guidelines age/sex factors assigned by age band and gender to the plan's population. It is a measure of relative cost based on the age and gender distribution of members, all else being equal.

---

*Calculated as member months divided by 12

**The average demographics factor is based on the Milliman Health Cost Guidelines age/sex factors assigned by age band and gender to the plan's population. It is a measure of relative cost based on the age and gender distribution of members, all else being equal.
### Demographic Summary

<table>
<thead>
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<th>Gender</th>
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<tr>
<td>Male</td>
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<td>6,779</td>
<td>12,257</td>
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<tr>
<td>Female</td>
<td>5,913</td>
<td>7,333</td>
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<tr>
<td>Total</td>
<td>11,391</td>
<td>14,113</td>
<td>25,504</td>
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<table>
<thead>
<tr>
<th>Age Band</th>
<th>Under 25</th>
<th>25 to 29</th>
<th>30 to 34</th>
<th>35 to 39</th>
<th>40 to 44</th>
<th>45 to 49</th>
<th>50 to 54</th>
<th>55 to 59</th>
<th>60 to 64</th>
<th>Over 65</th>
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<td>5,872</td>
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### Average Members

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*Calculated as member months divided by 12

**The average demographic factor is based on the Milliman Health Cost Guidelines age/sex factors assigned by age band and gender to the plan's population. It is a measure of relative cost based on the age and gender distribution of members, all else being equal.
## CDHP Impact Summary - Payment Rate

### Year 2012

<table>
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<th>Carrier Plan</th>
<th>Allowed PMPM</th>
<th>Concurrent Risk Score</th>
<th>Paid / Allowed PMPM</th>
<th>Modeled Target Medical Loss Ratio</th>
<th>Modeled Payment PMPM</th>
<th>Scaled Modeled Payment PAUPM</th>
<th>Original Payment PAUPM</th>
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<tbody>
<tr>
<td>UMP Uniform Medical Plan CDHP</td>
<td>$424.69</td>
<td>0.54</td>
<td>0.68</td>
<td>$157.13</td>
<td>88.4%</td>
<td>$177.66</td>
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<td>$389.43</td>
<td>$576.36</td>
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<tr>
<td>GH Group Health CDHP</td>
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<td>0.61</td>
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### Year 2013

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<th>Scaled Modeled Payment PAUPM</th>
<th>Original Payment PAUPM</th>
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<tbody>
<tr>
<td>UMP Uniform Medical Plan CDHP</td>
<td>$444.06</td>
<td>0.57</td>
<td>0.69</td>
<td>$175.78</td>
<td>88.4%</td>
<td>$198.76</td>
<td>$294.07</td>
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<tr>
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### Year 2014

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<th>Original Payment PAUPM</th>
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<tbody>
<tr>
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