Coordinated Care Model Alignment Work Group

Operationalizing the Principles of Oregon's Coordinated Care Model: A High-Level Framework for Procurement and Contracting

This framework is designed to be used by self-insured purchasers, however similar language can be used for a fully-insured product. It is by design written at a relatively high level. The framework includes the critical elements of the model. For procurement purposes, additional detail would be required in most instances. Some concepts, such as value-based benefit design, fall under a number of the elements. For the purposes of this framework they are included in one place. These Coordinated Care Model elements may be phased in over time if an employer is not able to implement all pieces at once. As evidenced throughout this document, a number of the Coordinated Care Model elements include specific measures or targets that could be adopted to encourage progress towards transformation of specific areas, included in this document. These targets should serve as a guide to measure progress and are an option for those interested in being more transformative, but each purchaser may develop targets that are appropriate given their current baseline.

Other content, such as reporting requirements and value-based purchasing language, while important, fall outside the scope of this framework and are not included.

I. Use best practices to manage and coordinate care

Application of evidence-based best practices of care delivery produces better care, improved outcomes and lower costs, and creates a positive patient experience.

1. **Primary care clinician**. Plan Participant shall be required to identify a primary care clinician. The Administrator shall make sure each Plan Participant has an identified primary care clinician and the clinician establishes a relationship with every attributed Plan Participant if one does not already exist at the time of enrollment.
2. **PCPCH**. The Administrator shall encourage its contracted primary care practices to operate as a high-functioning Patient Centered Primary Care Home (PCPCH) or similar primary care transformation, hold PCPCHs accountable for performance, and shall support PCPCHs with needed payer-supplied data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization, and quality information, utilization and cost measures for attributed Plan Participants. More information about the Patient Centered Primary Care Home Program can be found at http://www.oregon.gov/oha/pcpch/Pages/index.aspx.

- **Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline)**:**
  - The Administrator shall require that 85% of enrollees receive services from contracted primary care practices that operate as high-functioning PCPCHs (aggressive)
  - The Administrator shall require that 75% of enrollees receive services from contracted primary care practices that operate as high-functioning PCPCHs (moderate)
  - The Administrator shall require that 65% of enrollees receive services from contracted primary care practices to operate as high-functioning PCPCHs (easier)

3. **Team-based care**. The Administrator's contracted providers shall be encouraged to provide patient-centered, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange. The Administrator shall ensure providers are knowledgeable in the clinical evidence for patient-centered team-based care and are increasingly practicing in such manner over the term of the contract.
   - **Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
     - The Administrator's contracted providers shall be required to provide patient-centered, team-based care. (very aggressive)
     - The Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract. (very aggressive)
     - 75% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (aggressive)
     - 50% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (moderate)
     - 25% of the Administrator's contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (easier).
4. **Care coordination**. The Administrator shall ensure the provision of care coordination for patients at high-risk of future intensive service use. Care coordination may be provided through a combination of PCPCHs, coordinated care entities (such as CCOs or ACOs), and the Administrator. Where care coordination is

available to a consumer through more than one organization, the Administrator shall ensure these efforts are coordinated. Care coordination shall include integration of long-term services and supports (LTSS) with needed health care services, and shall leverage community-based human services to address social determinants of health, including housing and employment and coordination of population health. (LTSS: Medicaid only).

5. **Behavioral/physical health integration**. Behavioral health and primary care services shall be integrated through the application of evidence-based best practice strategies, including but not limited to co-location (including reverse co-location, which is defined as placement of primary care resources in community mental health settings), use of an integrated medical record, use of a shared treatment plan, and integrated payment.
6. **Clinical protocols**. Contracted providers shall be required to specify and implement clinical protocols reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse (waste). For example, a clinical protocol may include a treatment plan for treating an individual with COPD or stroke management.
7. **Formulary development**. The Administrator shall develop a formulary design which includes prescription drug coverage for each therapeutic class, but is flexible enough to allow for access to products outside the formulary in special circumstance. The formulary should be reviewed and amended at a minimum on an annual basis.
8. **Electronic Health Record (EHR)**. Contracted physician providers shall be required to adopt and fully utilize certified Electronic Health Records (EHR) systems across care settings. Such providers shall implement systems to ensure data completeness and accuracy.
    - **Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
        - All contracted providers, beyond the contracted physician providers noted above, shall be required to adopt and fully utilize certified, interoperable EHRs. (very aggressive)
        - Purchasers and providers shall ensure that patients have secure access to their clinical health records electronically, such as through a patient portal, as well as ensure patients have the capacity to share information electronically with their providers.

9. **Health information exchange**. Contracted physician and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.
    - **Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
        - Contracted physician and hospital providers shall be required to use real-time electronic clinical information exchange across care settings. (aggressive)
        - All contracted providers, beyond the contracted physician and hospital providers, shall be required to use real-time electronic clinical information exchange across all care settings (very aggressive)
10. **Value-Based Network Design.** Value-Based Network Design is the explicit use of employee plan benefits to create consumer incentives for use of high performance providers who adhere to evidence-based treatment guidelines.
    a. **Tiered network.** The Administrator shall make available to the Purchaser a benefit design that varies cost-sharing by provider performance. For example, the highest performing providers and/or centers of excellence are placed in Tier 1 with the lowest cost-sharing, while the lowest performing providers on a set of quality metrics are placed in Tier 3 with the highest cost sharing.
    b. **High-performing network.** The Administrator shall make available to the Purchaser a high-performing network limited to providers who have distinguished themselves based on evidence-based, statistically meaningful and risk-adjusted measures of quality as well as risk-adjusted measurement of cost and efficiency.
11. **Use of telemedicine**. The Administrator shall support provision of covered telemedicine services.

II. Share responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement on accountability for individual health behaviors.

1. **Shared decision-making.** Contracted providers shall be expected to make shared decision-making a standard of care with patients and their family members (as

appropriate), utilizing tools such as personal health self-assessments and technologies such as video and web-based decision aids to support the process.

2. **Benefit design incentives for preventive care.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for evidence-based screenings, well-child visits and other preventive care services. For example, incentives could include enriched benefit coverage, reduced cost-sharing and "extras" such as car seats and gym memberships
3. **Benefit design incentives for health behaviors.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, tobacco use and medication adherence. For example, incentives could include enriched benefit coverage, reduced cost sharing and "extras" such as gym memberships.
4. **Benefit design for evidence-based services**. The Administrator shall propose for Purchaser consideration a benefit design that varies cost-sharing for services which are nationally recognized as over-used or being driven by supply and/or physician preference rather than evidence-based practice. For example, this may include incentivizing the use of physical therapy without cost-sharing for back pain prior to receiving an MRI or reducing cost-sharing for prescription drugs related to chronic conditions such as diabetes.
5. **Patient activation.** Contracted providers shall be expected to utilize strategies that activate patients to take charge of their health and any chronic condition needing management. Such strategies shall include provider training, use of standardized assessment instruments and differentiated patient activation strategies based on assessment results.
6. **Health Risk Assessment**. The Administrators shall provide for a Health Risk Assessment and request its completion by each adult Plan Participant.

III. Measure performance

Comprehensive performance measurement, aligned across payers, supports identification of performance improvement opportunities and provider performance accountability purchasers while easing the burden of reporting for providers.

1. **Aligned measure set.** The Administrator shall adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup (https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf) or future consensus document, which aligns measures across major public and private payers, including commonly defined measures in each of the following domains and stratified by major subpopulations: a) access, b) quality, c) patient experience, d)

patient activation, e) service utilization, and f) cost. These performance measures shall be reported to the appropriate state agency or entity, including where applicable to the All Payer All Claims (APAC) Reporting Program.

2. **Administrator health informatics.** The Administrator shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients at risk for future high-intensity service use.
    - **Specific Measure That Could Be Adopted to Meet The Above Requirements:**
        - **Provider health informatics**. The Administrator shall require contracted providers operating under population-based contracts to perform analysis of integrated claim and clinical data to identify a) population characteristics, b) variation in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients in need of evidence-based services, e) patients at high risk of future high-intensity service use
3. **Administrator-level measurement**. The Administrator shall measure performance across all provider types and providers with meaningful volume for the Administrator's book of business.
4. **Provider-level measurement.** The Administrator shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.
5. **Population measurement adjustment.** The Administrator shall apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.

IV. Pay for outcomes and health

Payment for care should be based on quality and health outcomes rather than on volume of services provided. Alternative payment methodologies (APMs) such as population-based payment, episode-based payment, and offering incentives for performance and quality outcomes all support better care and decreased cost growth. The intent, over time, is to increase the use of systems of payment that improve health outcomes.

1. **Population-based contracting (global payment)**. The Administrator shall take such actions as are necessary to annually increase the proportion of providers agreeing to meet the following population-based contracting requirements:

- **Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline)**:**
  - By the end of Contract Year 3, claims for at least 60 percent of insured lives shall be covered under a population-based contract with shared savings, and claims for at least 20 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (aggressive)
  - By the end of Contract Year 3, claims for at least 45 percent of insured lives shall be covered under a population-based contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (moderate)
  - By the end of Contract Year 3, claims for at least 30 percent of insured lives shall be covered under a population-based contract with shared savings or with risk sharing. (easier)

2. **Pay providers, including both those operating under population-based contracts and those not, differentially according to performance.** The Administrator shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Compensation paid to effective and efficient providers should reflect their performance and result in market efficiencies and savings to purchasers and payers. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.
3. **Develop episode-based payment strategies.** The Administrator shall work with its provider network shall evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined treatment (e.g., knee replacement surgery).
4. **Design payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation.** The Administrator shall evaluate and implement successful approaches to payment designed to cut waste while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.
5. **Support primary care.** The Administrator shall support Patient Centered Primary Care Home (PCPCHs) or similar primary care transformation, ensuring that the level and method of compensation support an effective primary care infrastructure,

through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

V. Provide information so patients and providers know price and quality

Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

1. **Fully disclose quality performance to facilitate comparisons of providers**. The Administrator shall develop and implement a strategy to report the comparative performance of Providers, using the most current nationally-recognized or endorsed measures of hospital and physician performance. Information delivered through the Administrator's provider ranking programs should be meaningful to Plan Participants and reflect a diverse array of provider clinical attributes and activities. Information available to Plan Participants should include, but not be limited to, provider background, quality performance including specific to high-volume interventional services, patient experience, volume, and should be integrated into and accessible through one forum providing Plan Participants with a comprehensive view.
2. **Fully disclose prices to facilitate price comparisons of providers**. The Administrator shall, where permitted, make specific price information (including the price being paid to specific providers) transparent and available for use by Company and its Plan Participants, including those in consumer-directed plans. This price transparency shall cover services representing at least 80% of the Administrator's medical spend in all markets, The disclosed information shall be based on the contracted price of specific procedures and services including, without limitation, reasonable and customary estimates, to facilitate Plan Participants' informed choice of treatment and care decisions.
3. **Combine projected price information with Plan Participants' benefit design.** The Administrator shall identify and engage third-party vendors, if any are necessary, to enable the Administrator to integrate tools providing information about the price of specific services with information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans. The Administrator shall align with future transparency efforts led by the Oregon Insurance Division or other state entities.

VI. Establish a sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

1. **Population cost growth**. Population-based contracts shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the contract shall be informed by the efforts of the Sustainable Health Expenditure Work Group.
2. **Provider price growth**. Provider contracts, including but not limited to hospital and physician contracts, shall include a provision that agrees on rates, and quality incentive payments for each contract year, informed by the work of the Sustainable Health Expenditure Work Group.

Defined Terms

Administrator – the entity responsible for providing third party Plan administration services on behalf of an employer purchaser and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants.

Behavioral Health – services related to both mental health and addiction

Clinical Protocols – standardized tools designed for a particular chronic condition or procedure provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

Employer – sponsor of a group health plan with specified benefit coverage through the Administrator.

Patient Centered Primary Care Home (PCPCH) – a primary care practice which meets the State criteria for a PCPCH as defined at http://www.oregon.gov/oha/pcpch/Pages/standards.aspx.

Plan – the set of benefits offered by the Employer through the Administrator through an agreement.

Plan Participant – employees, dependents and retirees of the Employer who are eligible to receive their health benefits under the Plan.

Population-based Payment – a comprehensive payment to a group of providers to account for all or most of the care that will be received by a group of patients for a defined period of time.

Primary Care Clinician – a Provider focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant's diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Administrator.

Provider - primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the Administrator's network for the purposes of this Plan.

2015 Healthy Futures Program Timeline Workgroup Recommendation

In an effort to improve the participation and health assessment completion rates for the Healthy Futures Program, the Healthy Futures Workgroup recommends changing the timeframe for members to complete their health assessment and restructure the timing of the program process and incentive for the 2015-16 Plan Year.

Required Action	**Completion Date(s)**
Register for HF Program	August 15 – September 15 (Open Enrollment)
Complete Health Assessment(s)	August 15 – September 15 (Open Enrollment)
Attest that Two Healthy Actions will be completed by August 15 of the following year	August 15 – September 15 (Open Enrollment)
Complete/Report Health-Supporting Activities	August 15 of the following year.
Receives lowered deductible for participation	October 1 of that plan year, with the possibility of reverting to the higher deductible

OEBB members will be required to elect whether they are going to participate in the Health Futures Program and complete their health assessments during Open Enrollment (August 15 – September 15). Upon electing to participate, members will be required to attest they have or will complete their health assessment by September 15; and attest that they will complete two healthy actions by August 15 of the following year. Members who do this during Open Enrollment will be enrolled in an OEBB medical plan with a lower deductible starting that October 1st. OEBB will verify whether the member completed the health assessment either in late October or early November. If the member did not complete their health assessment as attested, the member's medical plan deductible will increase to the regular plan level (or return to the normal plan copayments) the first of the next following month.

The following Open Enrollment members who completed their health assessment as attested will be required to report the two healthy actions they completed. If the member does not complete and report their healthy actions, the member will not be eligible to participate in the Healthy Futures Program the following plan year and will not qualify for the $100 lower deductible, or reduced copayment medical plan options, for one full plan year.

Pros

- Reduces member/entity confusion over Healthy Futures process by aligning deadlines for program registration and completion of the health assessment
- Members learn of any health risks and suggested activities to reduce those risks much earlier in the plan year, allowing more time to participate in or complete their two healthy activities
- Members receive incentive much sooner, rather than being required to wait twelve or more months

For Reference Purposes Only

Current Healthy Futures Program Timeline

Required Action	Completion Date(s)
Register for HF Program	August 15 – March 31
Complete Health Assessment(s)	May 31
Complete/Report Health-Supporting Activities	August 15 of the following year
Receives lowered deductible for participation	October 1 of the next following plan year

Fitness Facility Membership Cost Support Program Options

At its December 2, 2014, meeting, the Strategies on Evidence and Outcomes Workgroup (SEOW) reviewed a member request and recommendation of staff and consultants relating to reimbursement of monthly fitness facility membership costs as part of the 2015-16 medical plans. SEOW agreed with the recommendation to forward this to the Healthy Futures Workgroup as a possible option to reward members who exercise regularly and encourage others to begin an exercise program. Both could increase participation in the Healthy Futures Program. The Healthy Futures Workgroup is currently considering ways to increase member participation in the Program. Following are options for the Healthy Futures Workgroup to consider:

Program Option #1 – Reimburse Fitness Facility Membership Costs

Modelled after the current Public Employees' Benefit Board (PEBB) Gym Membership Benefit, OEBB subscribers and spouse/partners ages 18 or older who went to the gym eight or more times during a month would be eligible to receive an individual reimbursement for $15 of the monthly fee paid to a qualified facility.

Program Option #2 – Discounted Fitness Facility Membership

OEBB members have access to discounted fitness facility memberships at select facilities through OEBB medical plans. Members covered under one of the Kaiser health plans currently have access to the CHP Active & Healthy Program which offers discounted fees for select fitness facilities and other recreational, cultural, fitness and wellness-centered resources. Moda will be adding the availability of discounted fees for fitness facilities for OEBB members covered on one of their medical plans on October 1, 2015. While the details of the program through Moda won't be available until a later date, it is believed that the discount would be similar to those available to Kaiser members. An example of the discount available through the current Kaiser program is Epic Fitness (located in Salem), which waives the $50 joining fee and provides a 15 percent discount on the monthly fee of $36 per month for 12-month memberships.

Program Option #3 – Reimbursed Fitness Facility Membership Costs tied to Overall Entity Healthy Futures Program Participation & Discounted Fitness Facility Membership

Members at OEBB entities that have 80 percent of their members completing health assessments and healthy activity attestations will be reimbursed $30 per month for fitness facility costs. Enrolled subscribers and spouse/partners ages 18 and older who went to the gym eight or more times during a month would be eligible to receive a reimbursement of $30 of the monthly fee paid to a qualified facility. If an entity that qualifies due to the participation requirement does not have a fitness facility available within a 30 mile radius, or if an otherwise eligible member lives 30 or more miles from a fitness facility, OEBB will provide the member(s) with a wellness kit (estimated value of $100) to support at-home exercise, upon request, limited to once per Plan Year.

Program Options Analysis

Staff analyzed all three of the program options based on their potential pros and cons to members, entities and OEBB. All three options share the following pros and cons:

Pros

- Alignment with the goals of the OEBB Healthy Futures Program
- Reduce financial impact on members associated with use of a fitness facility
- Promote regular exercise
- May help reduce future health and employer costs by potentially improving members' overall health through exercise

Cons

- Limiting the reimbursement amount to less than the full facility costs may not remove all barriers for some OEBB members. The reimbursement or discounts available will likely not cover all costs associated with fitness facilities.

Below are the pros and cons specific to each program option and audiences

- **Program Option #1**

Cons

- Doesn't support members who exercise regularly outside of a fitness facility or don't have access to a fitness facility.
- Doesn't necessarily incentivize greater participation in the Healthy Futures Program
- Reimbursement and administration costs for OEBB are estimated to be just over $277 thousand annually. The cost estimate is based on costs and utilization experienced during the first 10 months of the PEBB Exercise Rewards© Program.

- Requires the addition of staff resources to administer. The estimate above includes costs for the additional OEBB staff required for administering the program internally rather than using a third party administrator representing an estimated savings of $182 thousand.

➢ **Program Option #2**

Pros

- No OEBB staff resources are required for administration. Programs are administered through carrier-contracted vendors.

Cons

- Access is limited to those facilities participating in the fitness facility discount programs contracted by carriers
- Doesn't support members who exercise regularly outside of a fitness facility or don't have access to a fitness facility
- Doesn't necessarily incentivize greater participation in the Healthy Futures Program

➢ **Program Option #3**

Pros

- Incentivizes greater participation in and completion of Health Futures Program requirements
- Provision for members to be eligible for the discounted membership program regardless of Healthy Futures completion rate
- Supports members who don't have access to a fitness facility through the provision of a wellness kit

Cons

- Reimbursement and administration costs are estimated to be just over $460 thousand **if all** OEBB entities meet the 80 percent Healthy Futures participation target.
- Reimbursement and administration costs are estimated at just over $277 thousand **if OEBB entities representing 50 percent of OEBB eligibles** meet the 80 percent Healthy Futures participation target.
- Requires the addition of staff resources to administer. The estimate above includes costs for the additional OEBB staff required for administering the program internally

rather than using a third party administrator representing an estimated savings of $182 thousand.

Staff Recommendation

OEBB staff recommends the Healthy Futures Workgroup consider recommending the Board implement Option #3 effective October 1, 2015. Program Option #3 addresses the goals of incentivizing greater participation in Healthy Futures at the entity level and rewarding members who exercise regularly and encouraging others to do so. It also recognizes that not all OEBB members have fitness facilities within a reasonable distance and provides those members with tools to use at home.

Healthy Futures Workgroup Recommendation

The Healthy Futures Workgroup recommended this topic be discussed with the full Board. There are concerns about the costs associated with Options 1 and 3, especially in light of the lack of evidence that subsidizing gym memberships is effective in improving overall health of a population. The Workgroup believes there may be more effective ways to use OEBB's limited funding in promoting and supporting OEBB members' health and well-being.

The Workgroup also felt the 80 percent threshold used in Option 3 was too high and if selected should be set at 50 percent.

Attachment 5
February 3, 2015

2014 OEBB Member Survey Results

Executive Summary

In the fall of 2014, OEBB had its seventh Open Enrollment period followed by the annual member survey. As you'll see in the following pages:

- ✓ Satisfaction levels across all areas remained very similar to 2013, deviating less than two percent in any category.

- ✓ OEBB maintained high customer service marks, not just during Open Enrollment, but throughout the plan year. Across all areas, an average of 82 percent of respondents rated their satisfaction with OEBB "good" or "excellent," and on average less than four percent rated their satisfaction "poor".

- ✓ Member experiences with commonly difficult areas in the MyOEBB system notably improved, with decreased reports of problems in the following categories:

    - Updating or Changing Benefits – down eight percent from 2013
    - Saving/Finalizing Benefit Selections – down four percent from 2013
    - Logging In/Registering – down three percent from 2013
    - Password – down three percent from 2013

- ✓ Satisfaction with OEBB's communications remained high with over 90 percent "satisfied" or "very satisfied".

- ✓ Member satisfaction with OEBB Medical, Dental and Vision benefits remained high with 92 to 97 percent of respondents indicating they were "satisfied" or "very satisfied" with Access and Quality of the medical, dental and vision plans.

- ✓ Of those respondents who reported waiving dental or vision coverage, the survey showed an increase in those who had other coverage through a spouse/partner or other source (dental up 14 percent, vision up nine percent), as well as a decrease in those who went without coverage due to cost (dental down six percent, vision down five percent).

- ✓ For the first time, the survey assessed member satisfaction with OEBB's wellness efforts with 81 percent of respondents reporting they were "satisfied" or "very satisfied" with the Healthy Futures program and 86 percent reporting they were "satisfied" or "very satisfied" with the wellness activities offered, such as Weight Watchers, Healthy Team Healthy U, and MoodHelper.

Methodology

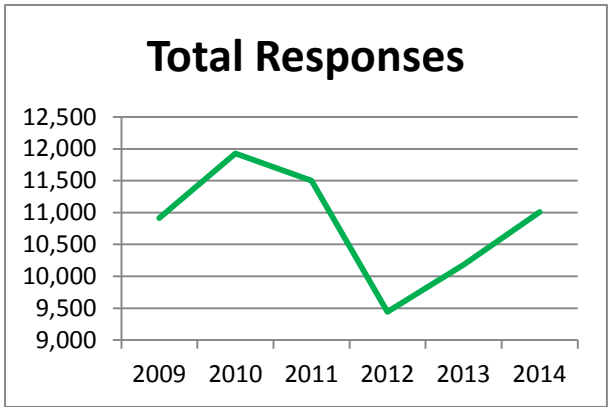
OEBB's 2014 Member Survey was conducted using an online survey tool called Survey Monkey. On October 17, 2014, OEBB staff sent an email invitation containing a link to the survey to the 57,282 members who had an email address in the MyOEBB system, which equaled almost 94 percent of all subscribers. The survey remained open through November 12, 2014.

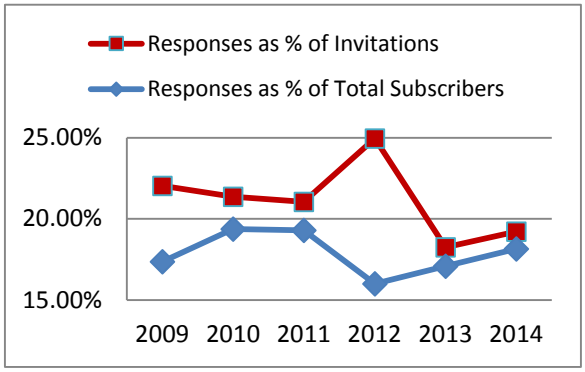
Results

The response rate in 2014 increased one percent from the year before, remaining slightly lower than all previous years with just over 19 percent of those invited to participate in the survey responding. The demographics of those who responded remained consistent with previous years and with the overall OEBB population.

SURVEY YEAR	Total Subscribers	Total Survey Invitations Sent	Total Responses	Response Rate	% of Total Subscribers
2008	61,899	unknown	10,900	unknown	17.61%
2009	62,859	49,527	10,915	22.04%	17.36%
2010	61,573	55,848	11,931	21.36%	19.38%
2011	59,600	54,629	11,500	21.05%	19.30%
2012	58,979	37,845*	9,444	24.95%	16.01%
2013	59,593	55,793	10,180	18.25%	17.08%
2014	60,645	57,282	11,008	19.22%	18.15%

** In 2012, the survey invitation was mistakenly sent only to members who had selected email as their preferred communication method in the MyOEBB system. All other years, the invitation was sent to every subscriber with a personal or work email address in the MyOEBB system.*





Satisfaction with OEBB: October 2013 - September 2014

ORS 291.110 requires all state agencies to develop measurable performance measures consistent with and aimed at achieving Oregon benchmarks. To ensure continuity throughout the Oregon Health Authority (OHA), OEBB inserted new questions identical to those used by OHA at the beginning of the Annual Member Survey starting in 2013. This data gets incorporated into the OHA annual Key Performance Measures report due each September. The 2014 results show satisfaction levels remaining fairly consistent, deviating less than two percent from the year before.

Note: This question captures members' experiences throughout the entire 12-month plan year and not just the Open Enrollment period.

How would you rate your satisfaction with OEBB during the past 12 months on the following?

Percentage of those reporting experience who indicated Excellent or Good

	2013	2014
Timeliness of the services provided	84.5%	82.9%
Ability to provide services correctly the first time	83.6%	82.6%
Helpfulness of staff	84.1%	84.0%
Knowledge and expertise of staff	83.1%	82.6%
Availability of information	78.7%	77.0%
Overall service	83.0%	81.5%

Open Enrollment Presentations

The percentage of respondents who reported attending an Open Enrollment Presentation in 2014 remained similar to 2013, dropping just one percent. This is somewhat surprising, given that 2013 was a mandatory Open Enrollment and 2014 was not. One factor that may have contributed to this relatively high attendance was the introduction of the new Moda Health Synergy and Summit plans.

Eighty-seven percent of those indicating they attended a presentation found the information useful, and 71 percent reported the information helped them decide which plan to select. These percentages were also similar to 2013, up one and two percent respectively.

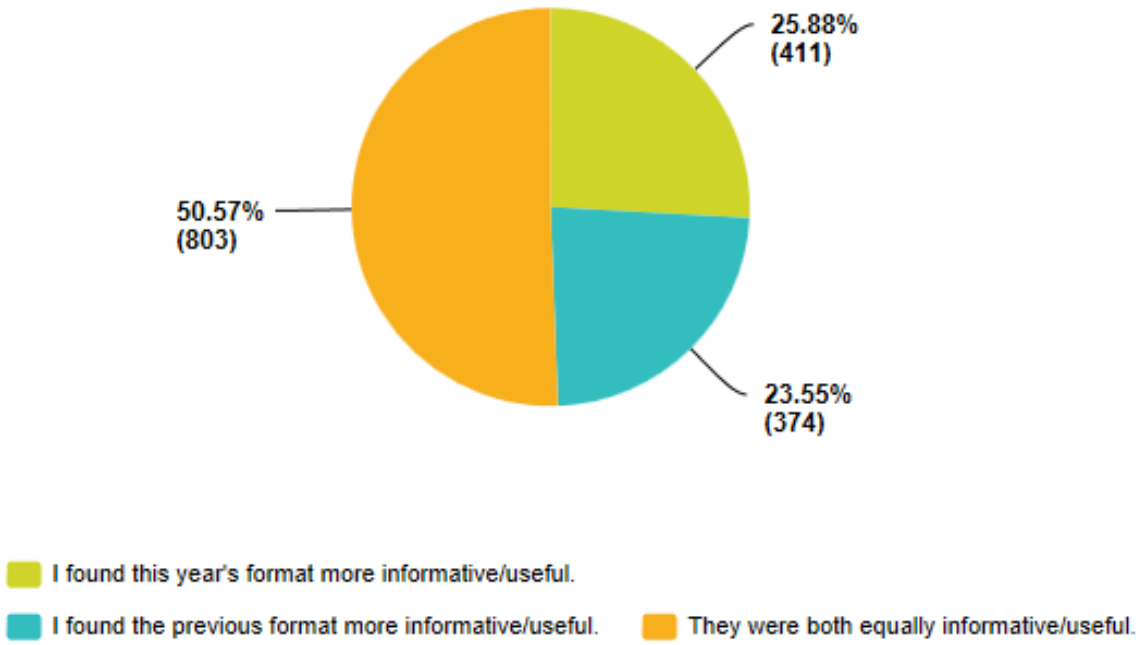
	2009	2010	2011	2012	2013	2014
Attended an OEBB Open Enrollment Presentation	21%	24%	24%	15%	22%	21%

Of those who reported attendance above,

Reported the Information Useful	84%	85%	85%	90%	86%	87%
Reported the Information Helped with Plan Selection	70%	76%	76%	73%	69%	71%

In 2014 the presentation format changed a bit from previous years. In the past OEBB would present an overview, then each carrier would present information on their specific plans. In 2014, carrier presentations were limited and OEBB presented the bulk of the information. The 2014 survey asked members who attended a meeting how they felt about the new format. Of those respondents who had attended a presentation both in 2014 and at least once in a prior year, the response to the new presentation format was nearly evenly mixed with just over 50 percent reporting they found both formats equally informative/useful, 26 percent reporting they preferred the new format and 24 percent reporting they preferred the old format.

In previous years, OEBB would present an overview, then each carrier would present information on their specific plans. This year carrier presentations were limited and OEBB presented the bulk of the information. How did you feel about this change?



MyOEBB System

If a member reported experiencing a problem with the MyOEBB system, the survey asked them to identify the nature of the problem(s) they experienced. In 2014, 20 percent of respondents who reported enrolling online also reported experiencing a problem during that process. This is the same percentage as reported in 2013. However, when asked to identify the nature of the problem(s) they experienced, four of the five standard categories showed improvement. The most improvement was noted in "Updating or Changing Benefits" down from 46 percent in 2013 to 38 percent in 2014. This may be due in part to a system enhancement implemented in 2014, where the plan selection interface was changed to display radio buttons rather than drop-down menus. The categories of "Logging In/Registering", "Saving/Finalizing Benefit Selections", and "Password" all showed improvement as well, with their reported percentages down three to four percent compared with 2013. "Adding, Enrolling or Certifying Dependents" remained at the same 11 percent as 2013. In the "Other" category, of those who said they experienced a problem, four percent expressed difficulty choosing a plan (not system-related), three percent noted their problem was in reporting their healthy actions for the new Healthy Futures program, one percent reported problems dropping dependent coverage or changing dependent information, and one percent indicated difficulties related to understanding the new Synergy and Summit plans and/or making a medical home selection.

Of the respondents who reported using the online enrollment system (MyOEBB) during the 2014 Open Enrollment period, how many experienced a problem?

	2009	2010	2011	2012	2013	2014
Reported experiencing a problem	2,785 of 10,915 (26%)	1,996 of 11,931 (17%)	1,856 of 11,500 (16%)	1,226 of 9,444 (13%)	1,986 of 10,070 (20%)	1,841 of 9,368 (20%)

Nature of MyOEBB problems reported above
(shown as a percentage of those who reported a problem)
Note that each respondent above was able to report more than one problem type below.

Updating or changing benefits	1,557 (56%)	956 (48%)	773 (42%)	515 (42%)	912 (46%)	705 (38%)
Logging In/Registering	920 (33%)	662 (33%)	504 (27%)	400 (33%)	701 (35%)	595 (32%)
Saving/Finalizing benefit selections	804 (29%)	526 (26%)	542 (29%)	294 (24%)	576 (29%)	455 (25%)
Password	768 (28%)	502 (25%)	424 (23%)	339 (28%)	532 (27%)	437 (24%)
Adding, Enrolling or Certifying Dependents	765 (27%)	328 (16%)	238 (13%)	147 (12%)	225 (11%)	204 (11%)

Common categories written in for "Other":

- **Choosing a Plan** (not system-related) **– 66 (4%)**
- **Reporting Actions for Healthy Futures - 57 (3%)**
- **Dropping Dependent Coverage or Changing Dependent Information – 27 (1%)**
- **Understanding Synergy/Summit plans, medical home selection – 26 (1%)**

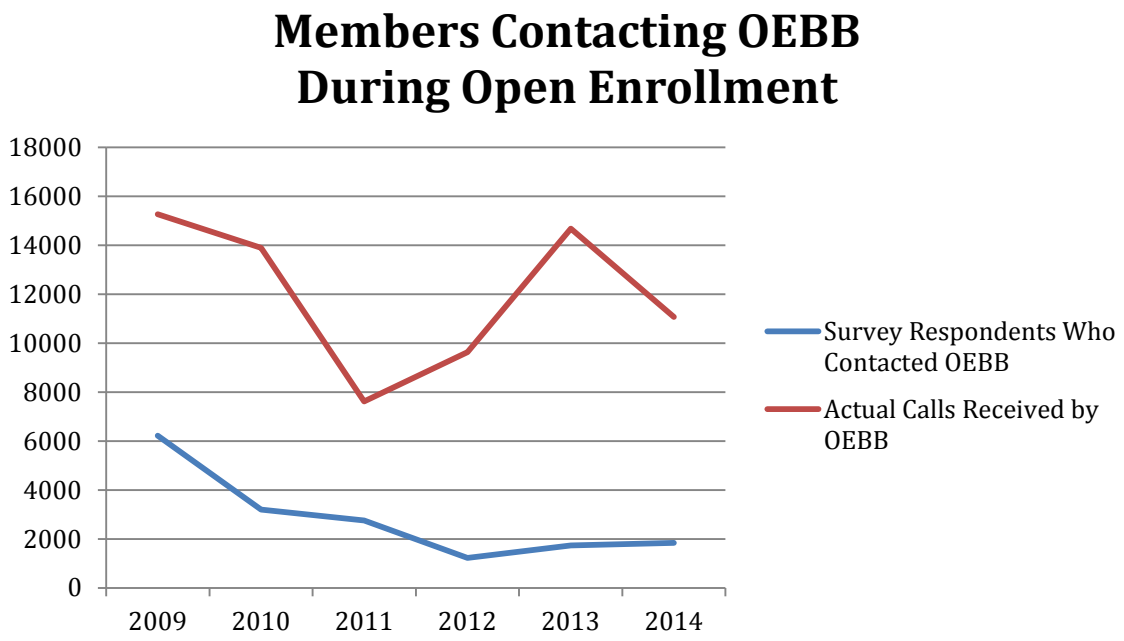
Customer Service

The number of survey respondents reporting they contacted OEBB customer service during Open Enrollment remained at 17 percent in 2014, the same as the previous year. However, the actual number of calls received by OEBB during Open Enrollment 2014 was significantly lower than 2013.

OEBB received 11,072 calls during the 2014 Open Enrollment period compared to 14,682 in 2013, a reduction of approximately 3,600 or 25 percent.

Survey results regarding member satisfaction with OEBB customer service can be found on page 4.

	2009	2010	2011	2012	2013	2014
Survey respondents who reported contacting OEBB Customer Service during Open Enrollment	6225 (57%)	3206 (27%)	2760 (24%)	1227 (13%)	1742 (17%)	1836 (17%)



Phone Call Reasons
During Open Enrollment

Open Enrollment Call Reasons	2009	2010	2011	2012	2013	2014
Help Enroll Online	8.81%	19.60%	24.00%	10.00%	9.02%	14.05%
User Name/Password	40.06%	11.68%	17.25%	13.30%	8.21%	12.52%
Plan Details	4.61%	7.10%	15.31%	13.00%	8.19%	9.86%
QSC Assistance - Entities	5.77%	9.43%	7.78%	10.10%	9.32%	13.56%
Explain Policy			7.02%	1.40%	4.94%	
Do I Need to Enroll?	14.22%		5.31%	4.10%	4.75%	5.12%
Confirm Enrollments		7.10%	6.07%	2.90%	4.80%	4.40%
Dependents	1.66%	10.10%	3.06%	6.90%	7.50%	6.44%
Rates	3.72%	5.58%	3.06%	14.20%	7.96%	2.74%
Medicare Eligibility	0.79%	6.47%	1.66%	7.90%	6.71%	6.53%
COBRA	1.00%	3.64%	0.99%	1.30%	5.76%	1.26%
HB2557			0.54%	0.10%	1.51%	0.31%
Plan Comparison				8.30%	7.96%	8.96%
Plan H/HSA					8.16%	
All Other Calls	19.36%	14.87%	7.92%	4.20%	5.21%	14.25%
Total Calls	**15265**	**13888**	**7625**	**9635**	**14682**	**11072**

Communications

The 2014 survey results continue to show high levels of satisfaction (90 percent or more satisfied or very satisfied) with OEBB's communication materials. This does reflect a three percent drop from 2013 in the satisfaction with "Information Sent to You by OEBB". This decrease is most likely due to the printing/distribution delay experienced during the production of the hard copy 2014 Open Enrollment materials. This resulted in USPS materials reaching members in the middle of the Open Enrollment period rather than arriving prior to Open Enrollment, as they had in previous years. In an effort to get the information to members as quickly as possible, OEBB sent electronic versions of the materials to all members with an email address in the system at the start of Open Enrollment, then the hard copies were mailed as soon as they were available.

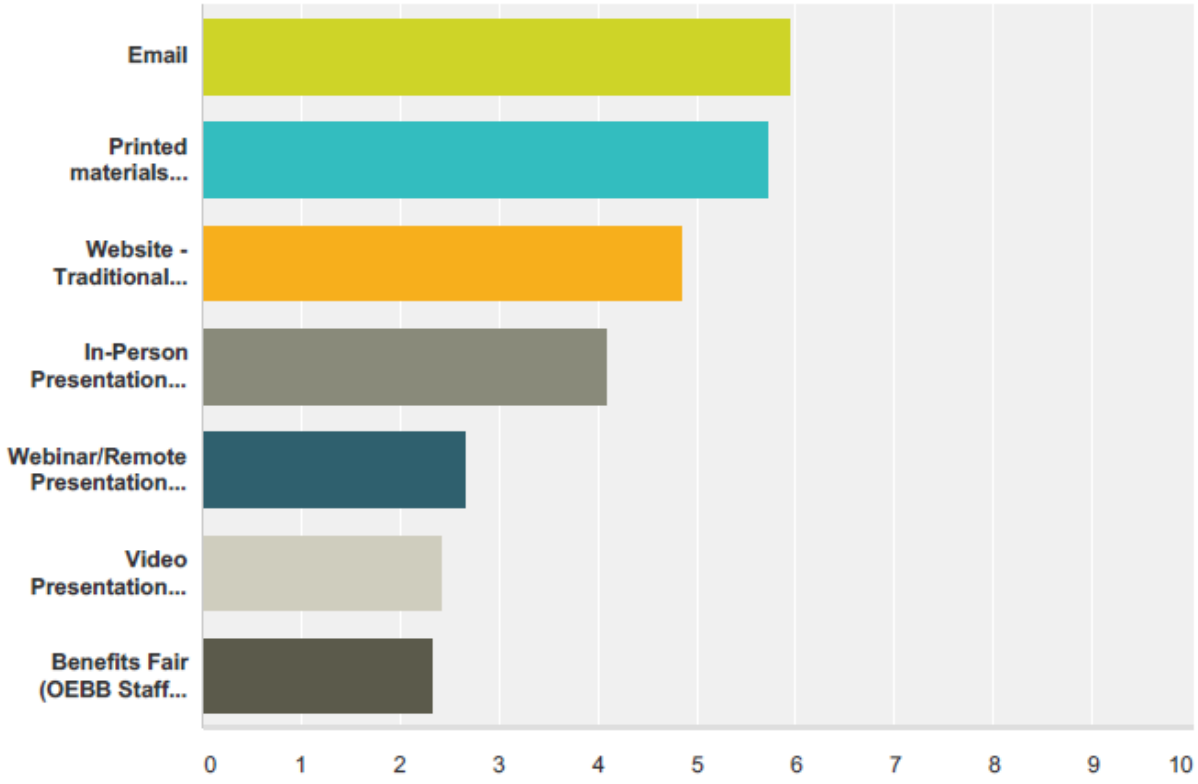
Satisfaction Level with Communication Materials

	2009	2010	2011	2012	2013	2014
Information Sent to You by OEBB (mailings, emails)	81% rated good or excellent	87% satisfied or very satisfied	94% satisfied or very satisfied	95% satisfied or very satisfied	94% satisfied or very satisfied	91% satisfied or very satisfied
OEBB Website		89% of Web users satisfied or very satisfied	91% of Web users satisfied or very satisfied	93% of Web users satisfied or very satisfied	91% of Web users satisfied or very satisfied	90% of Web users satisfied or very satisfied

In prior years, the survey asked members to select from a list of seven options any/all communication methods they preferred to access or receive information about their benefits. In 2014, this question was changed to instead ask members to rank those seven communication methods in order of preference, 1 indicating their most preferred and 7 indicating their least preferred. Consistent with previous years, email remained the most preferred method with USPS mail a close second and a traditional website a distant third.

The following chart displays a weighted average of the ranked responses, where weights are applied in reverse. In other words, with seven choices, the option the member ranked as #1 received a weight of 7, the option the member ranked as #2 received a weight of 6, and so on until the option the member ranked as #7 received a weight of 1. The average of all weights are then reflected as that answer's "score" and the score is displayed visually in the chart to make it easily recognizable which option was preferred overall.

How do you prefer to access or receive information about your benefits? Please rank the following communication methods with number 1 indicating your most preferred method and number 7 indicating your least preferred method.



	1	2	3	4	5	6	7	Total	Score
Email	**46%** 4,638	**30%** 3,031	**11%** 1,073	**6%** 627	**3%** 326	**2%** 186	**2%** 229	10,110	5.95
Printed materials mailed to my home (U.S. Postal Service)	**39%** 3,906	**32%** 3,251	**14%** 1,398	**5%** 547	**3%** 329	**2%** 212	**5%** 463	10,106	5.73
Website - Traditional format (read information on web page or download PDF documents)	**6%** 557	**20%** 2,032	**48%** 4,878	**13%** 1,284	**8%** 799	**3%** 331	**2%** 230	10,111	4.84
In-Person Presentation (OEBB Staff comes to your worksite and makes a formal presentation with the opportunity to ask questions)	**7%** 667	**10%** 984	**12%** 1,249	**47%** 4,761	**12%** 1,183	**7%** 672	**6%** 593	10,109	4.09
Webinar/Remote Presentation (scheduled event you can participate in via your computer with the opportunity to ask the presenter questions even though they are in another location)	**1%** 64	**1%** 148	**3%** 313	**9%** 896	**47%** 4,768	**21%** 2,120	**18%** 1,802	10,111	2.65
Video Presentation (watch and listen at your convenience, no interaction with presenter)	**1%** 66	**2%** 179	**4%** 451	**10%** 973	**15%** 1,528	**53%** 5,338	**16%** 1,576	10,111	2.42
Benefits Fair (OEBB Staff comes to your worksite and sits at a table where you can "drop in" informally, ask questions and pick up materials)	**2%** 214	**5%** 487	**7%** 749	**10%** 1,022	**12%** 1,177	**12%** 1,252	**52%** 5,208	10,109	2.32

OEBB Benefits

Over the years, cost has been the area where customer satisfaction has been the lowest. Although satisfaction with cost decreased slightly (two percent) in 2014, this is still the second highest satisfaction level recorded over the life of OEBB plans, with 56 percent of respondents reporting they were "satisfied or very satisfied" with cost, versus the high of 58 percent reported in 2013.

Satisfaction with Benefits and Coverage remains just two percent below the all-time high of 80 percent reported in OEBB's first year, 2008. And overall satisfaction with OEBB remains within one percent of the all-time high reported in 2012 and 2013. Satisfaction with Access and Quality of the medical, dental and vision plans remained high with 90 percent or more respondents reporting being "satisfied or very satisfied", and overall satisfaction with the dental and vision plans remained high at 90 percent. Overall satisfaction with the medical plans remained within two percent of the highest levels reported (82 percent in 2014 versus 84 percent in 2013).

In 2014, the survey also assessed satisfaction levels in two new areas: The Healthy Futures Program and Wellness Activities Offered (e.g., Healthy Team Healthy U, MoodHelper, Weight Watchers, etc.). Eighty-one percent of respondents reported being "satisfied or very satisfied" with The Healthy Futures Program in its first year (2014) and 86 percent of respondents reported being "satisfied or very satisfied" with OEBB's wellness activities.

Percentages of respondents "satisfied" or "very satisfied"*

	2009	2010	2011	2012	2013	2014
Benefits/Coverage	80%	66%	69%	77%	78%	78%
Cost	NA	45%	45%	52%	58%	56%
Overall OEBB	81%	74%	77%	83%	83%	82%
Healthy Futures	NA	NA	NA	NA	NA	81%
Wellness Activities	NA	NA	NA	NA	NA	86%

Medical	2009	2010	2011	2012	2013	2014
Access	88%	89%	91%	93%	93%	92%
Quality	NA	92%	94%	95%	95%	94%
Overall		76%	77%	83%	84%	82%

Dental	2009	2010	2011	2012	2013	2014
Access	NA	92%	95%	95%	96%	95%
Quality		95%	97%	97%	97%	97%
Overall		85%	88%	90%	91%	90%

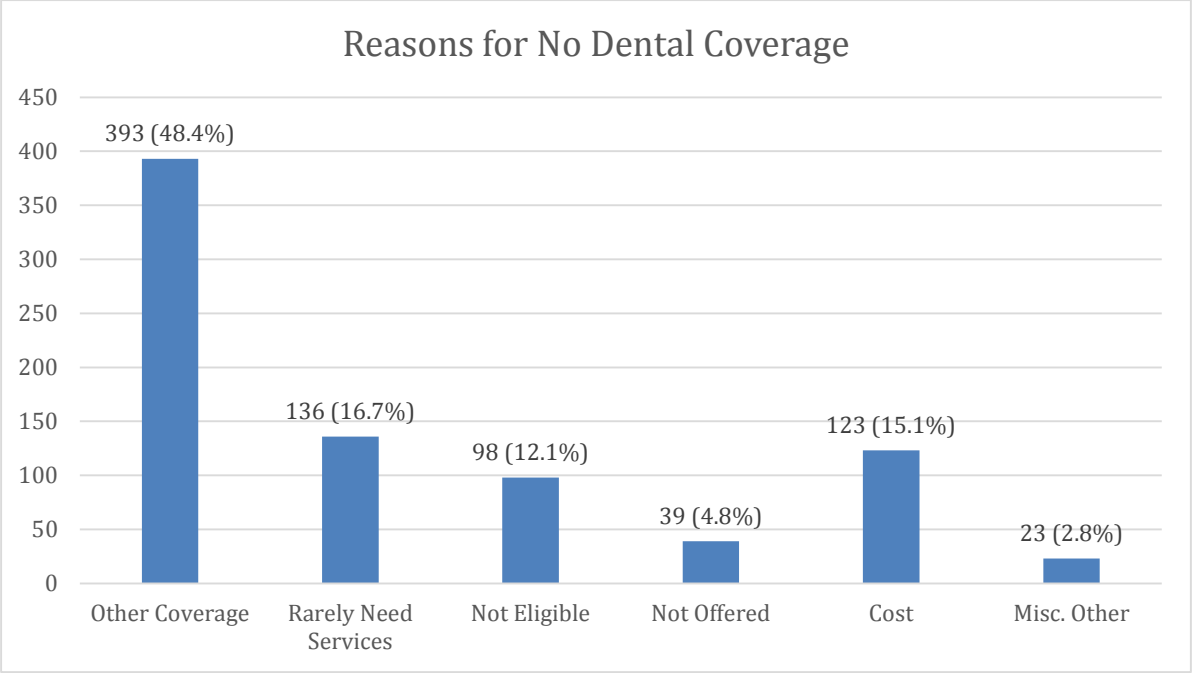
Vision	2009	2010	2011	2012	2013	2014
Access	NA	94%	96%	97%	97%	97%
Quality		95%	97%	97%	97%	97%
Overall		86%	88%	90%	91%	90%

**In the 2009 survey, the categories offered were Excellent, Good, Fair and Poor. In 2010, the categories changed to Very Satisfied, Satisfied, Dissatisfied and Very Dissatisfied. The 2009 percentages above reflect responses of "Good" or "Excellent".*

Declining Dental Coverage

The top three reasons for declining dental coverage were consistent with past years, although the balance of responses in two of those categories shifted significantly. The percentage of respondents reporting they had other coverage through a spouse or partner increased 14 percent (48 percent in 2014 compared to 34 percent in 2013). The percentage of respondents reporting cost as the reason they chose to go without dental coverage decreased six percent (15 percent in 2014 compared to 21 percent in 2013). Those reporting they rarely need dental services remained similar to last year, increasing just two percent (17 percent in 2014 compared to 15 percent in 2013).

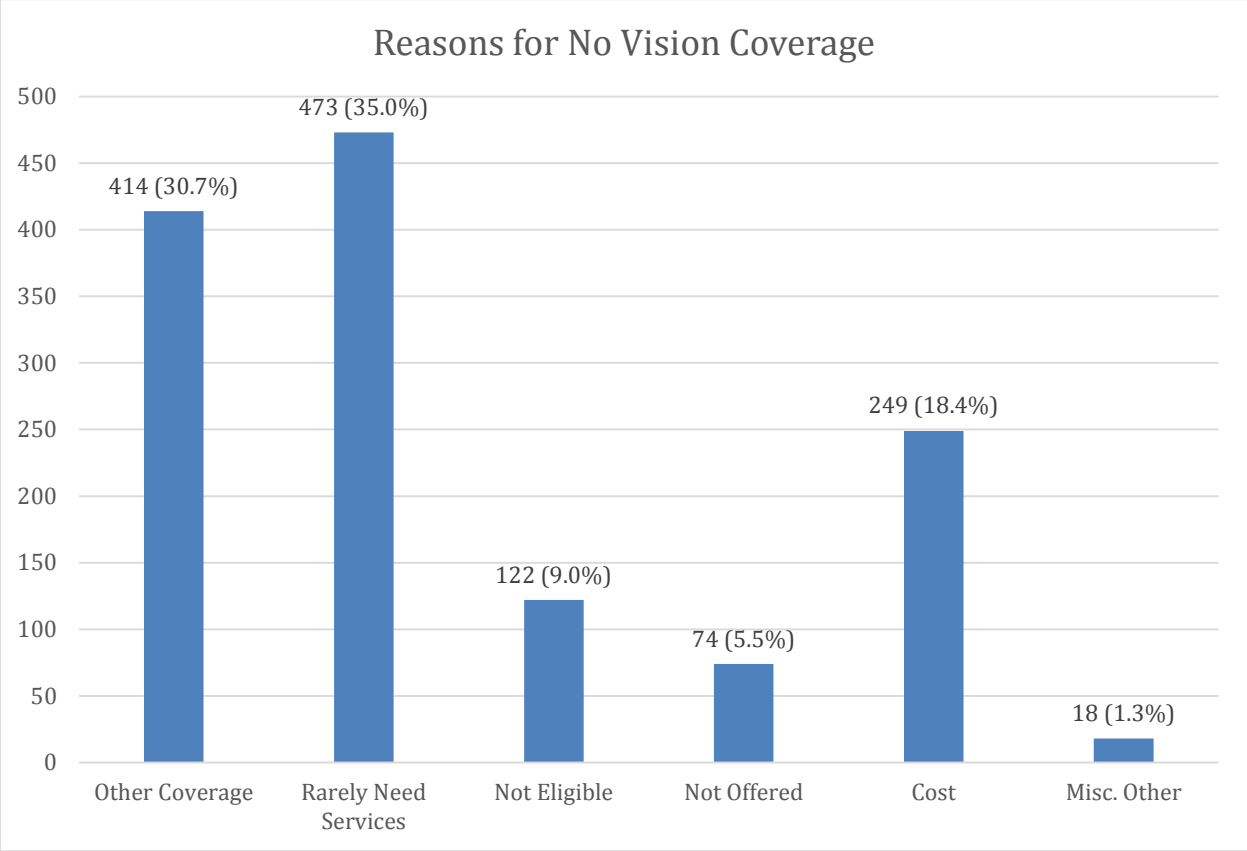
Reason for No Dental Coverage	2012	2013	2014
Other coverage through spouse/partner or another source	32%	34%	48%
Rarely need services / chose to go without coverage	15%	15%	17%
Cost (Write-in)	21%	21%	15%



Declining Vision Coverage

Much like those waiving dental coverage, respondents who waived vision coverage reported the same top three reasons as years past, and reflected a similar (although somewhat smaller) shift in the "Other Coverage" and "Cost" categories. The percentage of respondents reporting coverage through a spouse or partner increased nine percent (31 percent in 2014 compared to 22 percent in 2013). The percentage of respondents reporting cost as the reason they chose to go without vision coverage decreased five percent (18 percent in 2014 compared to 23 percent in 2013). Those reporting they rarely need vision services remained similar to last year, increasing just two percent (35 percent in 2014 compared to 33 percent in 2013).

Reason for No Vision Coverage	2012	2013	2014
Rarely need services / chose to go without coverage	33%	33%	35%
Other coverage through a spouse/partner or other source	21%	22%	31%
Cost (Write-in)	22%	23%	18%



Staff Proposed Next Steps

Based on the satisfaction levels reported, as well as the additional supporting comments, OEBB staff propose the following steps for improving OEBB's service to participating entities:

- ✓ Continue to develop and implement effective strategies to promote the Healthy Futures program and the various wellness activities.
- ✓ Assure timely, high quality print materials are available prior to Open Enrollment.
- ✓ Include more detailed information on medical homes and Synergy/Summit plans in Open Enrollment materials, explaining what a medical home is and how the plans work.
- ✓ Ensure drop-down list of medical homes in MyOEBB is complete and accurate, or make selecting a medical home directly with Moda Health the only option in the MyOEBB system.
- ✓ Include more detailed instructions about the Truven Plan Comparison tool in the Open Enrollment materials to aid members in plan selection.
- ✓ Hire additional temporary staff during Open Enrollment to assist Member Services with timely responses to calls and emails.

Through daily contact working with members, OEBB staff have also gathered and propose the following suggestions to improve the MyOEBB Member Module:

- ✓ Simplify beneficiary page to make the designation and change processes easier.
- ✓ Expand dependent eligibility verification questions to more clearly distinguish eligibility from coverage. For example, "Is your dependent NOT eligible, or is your dependent eligible but you do not want to enroll them in any benefits?"
- ✓ Update member communications and materials to include any MyOEBB system enhancements.
- ✓ Reduce the number of screens where possible (e.g., unnecessary introductory screens).
- ✓ Merge residential and mailing addresses to reduce confusion and simplify the update process.
- ✓ Include browser compatibility instructions in Open Enrollment materials as well as in the MyOEBB system.

Attachment 5a
February 3, 2015

2014 OEBB Entity Survey Results

Executive Summary

In the fall of 2014, following OEBB's Open Enrollment period, OEBB staff surveyed the Benefits Administrators, Business Managers and Superintendents of participating entities.

- ✓ Satisfaction with the MyOEBB system's navigation capabilities and ease of entering/updating data both increased eight percent compared to 2013.
- ✓ The Benefit and System Analyst team maintained their usual high ratings with the highest number of responses rating them "Excellent" and 90 percent or more rating them either "Excellent" or "Good" in all categories (timeliness of response, willingness to assist, and ability to answer specific questions).
- ✓ The OEBB Management Team also retained high marks with 92 percent of respondents rating their responsiveness and timeliness either "Excellent" or "Good".
- ✓ OEBB's Financial Services Team maintained high ratings similar to 2013 with approximately 85 percent rating them either "Excellent" or "Good" in their efforts to help resolve issues related to invoicing, monthly invoicing/reconciliation processes, and the effectiveness of financial reports and 95 percent rating the timeliness of their premium payment reconciliation as "Excellent" or "Good".
- ✓ Satisfaction with OEBB communications dropped in 2014, particularly with the documents that detail the plan offerings (dropping from 86 percent in 2013 to 70 percent in 2014). A number of factors contributed to this change including an unexpected printing/distribution delay with hard copy Open Enrollment materials, the redesign of the benefit details in the Open Enrollment Guide, the Summary of Benefits spreadsheet on the website being difficult to print and/or read (as had been expressed in years past, leading to the redesign in the Open Enrollment Guide), and a desire to have more detailed information about the new Synergy and Summit plans.
- ✓ Over 95 percent of respondents reported interest in OEBB creating an information booklet similar to those used for Open Enrollment but specifically for newly benefits-eligible employees. Of those, 69 percent said they would prefer an electronic version they could customize to their employees, while 31 percent said they would prefer hard copies showing all of OEBB's offerings.
- ✓ Responses to the new Open Enrollment presentation format were fairly evenly mixed, with the majority of respondents (42 percent) saying both the new and old formats were equally informative/useful, 39 percent preferring the new format and 18 percent preferring the old format.

Methodology

OEBB's 2014 Entity Survey was conducted using SurveyMonkey, an online survey tool. An email containing the survey link was sent to Benefits Administrators, Business Managers and Superintendents at participating entities asking for their feedback. The survey request was sent on October 17, 2014, and closed November 12, 2014.

Results

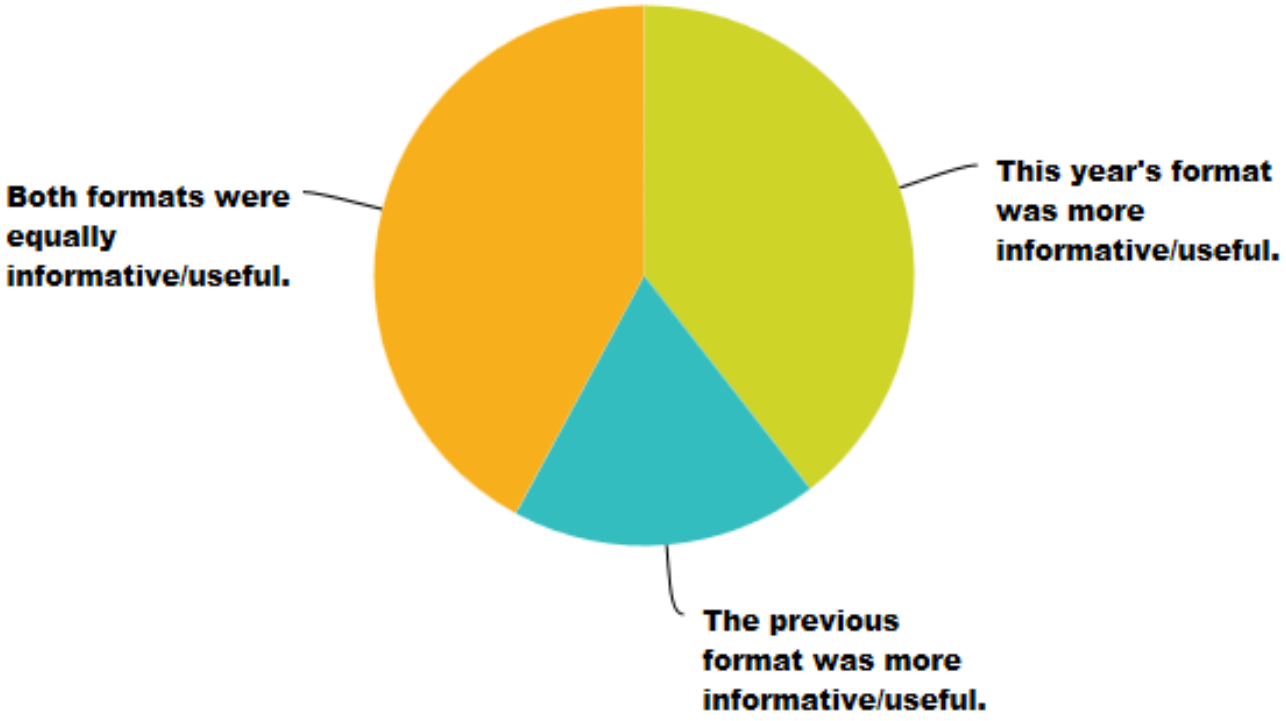
The 2014 entity survey received 117 responses, compared to the 2013 survey which received 81 responses. This higher response rate may be due to distributing the survey earlier in the year, prior to the Thanksgiving and Christmas holidays and winter break and the additional outreach reminding entities of the importance of the survey. (In 2013 the survey was distributed in December.)

The questions included in the survey and the resulting responses are shown below.

Please rate your experience over the past plan year (October 2013 – September 2014) with the following OEBB services.

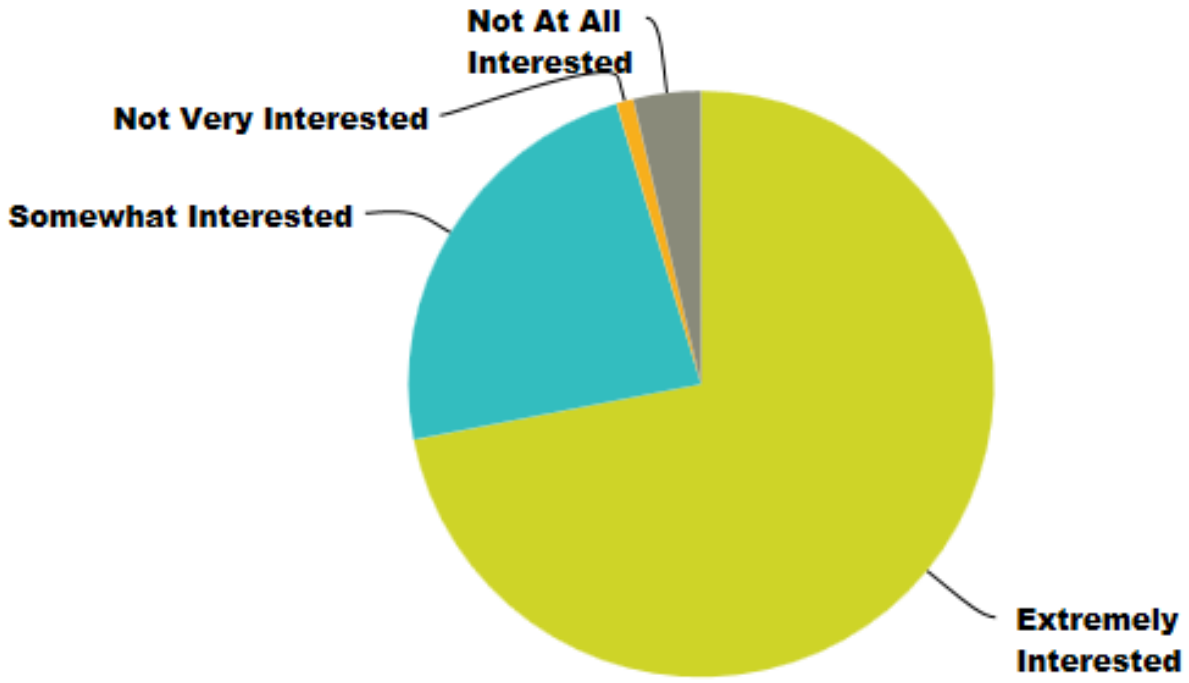
	Excellent	Good	Fair	Poor	2014 Total Excellent & Good	2013 Total Excellent & Good	Change from 2013 to 2014	Reported No Experience in 2014
The timeliness of OEBB Benefit and System Analyst team when you contact us	**47%**	44%	9%	1%	91%	90%	+1%	
The willingness of OEBB Benefit staff and System Analysts team to assist you when you contact us	**65%**	28%	8%	0%	93%	95%	-2%	
The ability of the OEBB Benefit staff and System Analysts to answer your specific questions	**49%**	43%	8%	0%	92%	92%	0%	
The responsiveness and timeliness of the OEBB management team	**46%**	**46%**	8%	0%	92%	96%	-4%	
Administrative coordination of the appeals process	**46%**	37%	11%	7%	83%	88%	-5%	**60%**
The ease of use of the MyOEBB Member Module	20%	**45%**	28%	6%	65%	61%	+4%	
The ease of entering/updating data in the MyOEBB administrative system	20%	**49%**	23%	8%	69%	61%	**+8%**	
The MyOEBB system's navigation capabilities	17%	**53%**	19%	11%	70%	62%	**+8%**	
The OEBB Financial Services team's efforts to help resolve issues related to invoicing	30%	**56%**	11%	3%	86%	87%	-1%	**46%**
OEBB's monthly invoicing/reconciliation process	25%	**61%**	9%	5%	86%	88%	-2%	
The effectiveness of OEBB financial reports in managing the reconciliation process	18%	**66%**	12%	4%	84%	83 %	+1%	
The timeliness of your premium payment confirmation from OEBB	**57%**	38%	6%	0%	95%	97%	-2%	
Your ability to access and receive data and reports related to benefit eligibility and enrollment	25%	**52%**	19%	4%	77%	81%	-4%	
The quality of information included on the OEBB website (not MyOEBB)	19%	**65%**	13%	2%	84%	92%	-8%	
The ease of use of the OEBB website (not MyOEBB)	12%	**65%**	18%	5%	77%	77%	0%	
The timeliness of information posted to the OEBB website	21%	**60%**	16%	3%	81%	80%	+1%	
The timeliness of OEBB communications and information sharing (emails, BIE meetings, etc.)	28%	**55%**	14%	3%	83%	89%	-6%	
The layout and structure of the OEBB website (not MyOEBB)	10%	**62%**	24%	4%	72%	72%	0%	
OEBB documents that detail benefit plan offerings	20%	**50%**	25%	5%	70%	86%	-16%	
Overall customer service provided by OEBB	31%	**58%**	9%	1%	89%	94%	-5%	

In previous years' Open Enrollment meetings, OEBB would present an overview, then each carrier would information on their specific plans. This year carrier presentations were limited and OEBB presented the bulk of the information. How did you feel about this change?



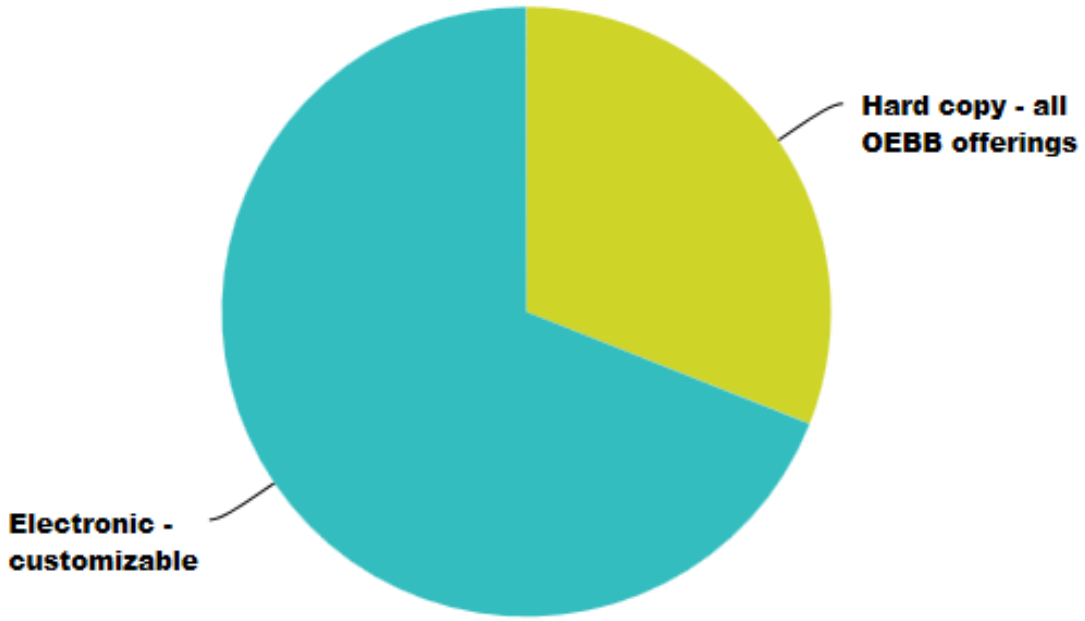
Answer Choices	Responses	
This year's format was more informative/useful.	39%	15
The previous format was more informative/useful.	18%	7
Both formats were equally informative/useful.	42%	16
Total		38

OEBB is considering creating a New Hire information booklet similar to the Open Enrollment Guide booklets we've created the past two years. If we were to create an information booklet like this specifically for newly eligible employees, how interested would you be in using/distributing it?



Answer Choices	Responses	
Extremely Interested	72.0%	77
Somewhat Interested	23.4%	25
Not Very Interested	0.9%	1
Not At All Interested	3.7%	4
Total		107

Would you prefer to receive New Hire booklets hard copy (printed by OEBB and showing all of OEBB's offerings), or would you prefer an electronic version you could customize to your specific plan offerings, which you could them post to your website, email to employees, and/or print yourself?



Answer Choices	Responses	
Hard copy - all OEBB offerings	31.00%	31
Electronic - customizable	69.00%	69
Total		100

Approximately how many new hires (newly eligible employees) do you onboard each plan year?
Please enter one specific number, not a range.

With 92 responses recorded, the **average number of new hires reported was 55**, with 39 percent of the entities reporting less than 10 new hires per year, 50 percent of the entities reporting between 10 and 99 new hires per year, and 11 percent reporting 100 or more new hires per year. The lowest number reported was zero and the highest number reported was 1,100.

Staff Proposed Next Steps

Based on the satisfaction levels reported, as well as the additional supporting comments, OEBB staff propose the following steps for improving OEBB's service to participating entities:

- ✓ Ensure timely distribution of Open Enrollment materials.
- ✓ Include more detailed information on medical homes and Synergy/Summit plans in Open Enrollment materials, explaining what a medical home is and how the plans work.
- ✓ Ensure drop-down list of medical homes in MyOEBB is complete and accurate, or make selecting a medical home directly with Moda Health the only option in the MyOEBB system.
- ✓ Develop a New Hire Guide and ensure timely distribution to entities in the preferred hard copy or electronic, customizable format.
- ✓ All state websites are in transition to redesigned templates to streamline content and make site more user-friendly. Part of this process is to work with staff and end users February - April 2015 to determine how best to organize and streamline content. OEBB must wait for all of OHA for the new design to go live (targeted for mid-2016), but content will be reorganized within the current structure in May 2015 to improve the user experience during Open Enrollment 2015, streamline current content and ease the transition from the current template to the new design.
- ✓ Explore alternative designs for Summary of Benefits to improve readability.
- ✓ Develop an electronic version of Summary of Benefits that entities can customize to show only the plan options offered to their employees.
- ✓ Provide training document to assist entities with monthly reconciliation process. Demonstrate the process in Benefits Information Exchange (BIE) Meeting.
- ✓ Perform a critical analysis of MyOEBB Member Module and reduce the number of screens where possible (e.g., unnecessary introductory screens).
- ✓ Continue to offer a separate phone line for entity administrators during Open Enrollment.
- ✓ Move all reports to ReportMart and categorize them to make it easier for entities to find the one they want.
- ✓ Rename reports to make contents and purpose more self-explanatory.
- ✓ Add School ID# back into the MyOEBB system and add this field to all applicable reports.
- ✓ Update the MyOEBB Admin Module to allow the member School ID# to change when a member moves from one entity to another.
- ✓ Create a report to help entities identify members whose life insurance premiums will change due to age.