Washington State
Health Care Authority

Public Employees Benefits Board Retreat

January 12th, 2011 Meeting

Washington State
Health Care Authority

Public Employees Benefits Board Meeting

January 12th, 2011

8:45 a.m. – 4:30 p.m.

Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Table of Contents

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board

January 12, 2011
8:45 a.m. – 4:30 p.m.
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

8:45 a.m.	Welcome, Introductions, State Budget Update	Doug Porter, Chair
8:55 a.m.	State Budget & PEB Budget Updates	Doug Porter, Chair
9:15 am	PEB Funding and Self-Insured Experience Trends	Tim Barclay, Milliman
10:00 am	PEB Portfolio Redesign Project Overview	John Williams, PEB
10:30 am	Break	
10:45 am	UMP Redesign Proposal	John Williams Janet West, Regence Lorraine Mayne, Milliman
11:45 am	Lunch Break	
12:30 pm	Kaiser Redesign Proposal	John Williams, PEB Hilary Getz, Kaiser Tim Barclay, Milliman
1:30 pm	Break	
1:45 pm	GHC Redesign Proposal	Nicole Oishi, PEB Fred Armstrong, GHC Tim Barclay, Milliman
2:45 pm	Medicare Redesign Proposal	Mary Fliss, PEB Lorraine Mayne, Milliman
3:30 pm	Value-Based Purchasing – Pharmacy	Elizabeth James, PharmD, PEB Nicole Oishi, PEB Thad Mick, PharmD ODS
4:00 pm	Discussion and Next Steps	Doug Porter, Chair
4:30 pm	Adjourn	

The Public Employees Benefits Board will meet Tuesday, January 12, 2011, at Washington. The board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW. Direct e-mail to: board@hca.wa.gov. Materials posted at: http://www.pebb.hca.wa.gov/board/

Washington State Health Care Authority

PEBB Board Members

Name	Representing
Doug Porter, Administrator Health Care Authority 676 Woodland Square Loop SE PO Box 42700 Olympia WA 98504-2700 V 360-923-2829 portejd@dshs.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Phil Karlberg* Arlington Public Schools 315 N French Ave Arlington WA 98223 V 360-593-6275	K-12
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Lee Ann Prielipp 29322 6th Avenue Southwest Federal Way WA 98023 V 253-839-9753 leeannwa@comcast.net	K-12 Retirees
Eva Santos, Director Department of Personnel PO Box 47500 Olympia WA 98504-7500 V 360-664-6350 evas@dop.wa.gov	Benefits Management/Cost Containment

Washington State Health Care Authority

PEBB Board Members

Name	Representing
Margaret T. Stanley 19437 Edgecliff Dr SW Seattle WA 98166 V 206-484-9411 mtstanley@comcast.net	Benefits Management/Cost Containment
Yvonne Tate Human Resources City of Bellevue PO Box 90012 Bellevue WA 98009-9012 V 425-452-4066 ytate@ci.bellevue.wa.us	Benefits Management/Cost Containment
Harry Bossi* 3707 Santis Loop SE Lacey WA 98503 V 360-689-9275 hbossi@comcast.net hbossi@spipa.org	Benefits Management/Cost Containment

Legal Counsel
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PO Box 40109
Olympia WA 98504-0109
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melissab@atg.wa.gov

*non voting members

Washington State
Health Care Authority

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2011 Public Employee Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, The Sue Crystal Center Conference Room, 676 Woodland Square Loop S.E., Lacey, WA, unless otherwise noted below. The meetings begin at 1:00 p.m.

January 12, 2011 (board retreat)

February 16, 2011

March 16, 2011

April 20, 2011

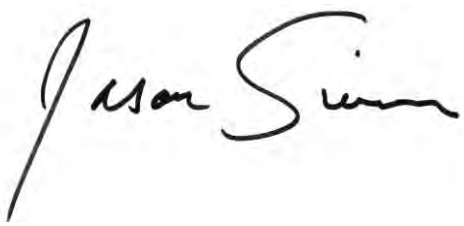
May 18, 2011

June 15, 2011

July 6, 2011

July 20, 2011

If you are a person with a disability and need a special accommodation, please contact Shelley Buresh 360-923-2829.



Jason B. Siems
Washington Health Care Authority
Rules Coordinator

Washington State Health Care Authority

PEBB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

January 12, 2011 PEB Board Retreat

HCA STRATEGIC INITITIATIVE: PEBB PORTFOLIO REDESIGN

Scope:

A. Provide a plan to proceed with redesigning the PEBB program, including identifying needed legislation to support the redesign. Include in the redesign elements that address:
   1. Enhancing wellness programs;
   2. Improving targeting of specific diseases and keeping patients on effective therapies;
   3. Using a combination of financial carrots and sticks to influence behavior and outcomes;
   4. Pooling insurance – teachers, local governments.
B. Support recommendations of the DRS Pension Review Committee on matters relating to retirees.

Desired Outcomes:

A. The PEBB program offers an array of affordable health-related insurance products that supports participating members to improve and maintain individual health status, access effective quality health care services consistent with individual needs, and provide a financial safety net against catastrophic acute incidents and chronic health conditions.
B. The redesign addresses the short-term need to manage annual expenditure increases over a one to five year period and begins moving PEBB toward the long-term goal to achieve lasting reduced cost trends for the future through fundamental health care reform.

Focus: For purposes of focusing the redesign effort to maximize positive impact, the initial effort will deal with employer-sponsored medical and pharmacy benefit plans.

Objectives: The redesign project will strive to:

A. Address the existence of three member groups: active employees, retirees not eligible for Medicare, and Medicare-eligible retirees, and takes into account similarities and differences among the three groups.
B. Favor high value services, high value products, and high value behaviors on the part of the State as the purchaser, the contracted PEBB vendors as the payers, the in-network and out-of-network providers as the care delivery system, and the plan members as the consumers. Conversely, the redesign removes or reduces low value services, products, and behaviors.
C. Provide a balanced approach to effectively and efficiently serving members across the spectrum of health status from the healthy individual to the individual experiencing advanced stages of illness and disease.
D. Provide a balance between an acceptable level of employer financial investment in the health and productivity of public employees (State, K-12, local jurisdictions, etc,) and an acceptable level of member investment in managing individual health and effective financial management of the health plans.
E. Proactively address the health literacy of PEBB members to enable meaningful understanding of the medical plans and products offered and the associated benefit design features and to create an awareness of the need for members to be actively engaged health care consumers.
F. Integrate with other State efforts to improve employee wellness and productivity.

Redesign Approach:

A. The Uniform Medical Plan will be the single PEBB self-insured medical plan for this redesign and may have multiple product variations within the plan.
B. Regence BlueShield of Washington will serve as the Uniform Medical Plan third party administrator through the term of its current contract with HCA. The contract will cover all products created within the Uniform Medical Plan under this redesign.
C. The Group Health Medical Plan will be a primary PEBB fully-insured medical plan for this redesign and may have multiple product variations within the Plan.
D. The Kaiser Medical Plan will be a primary PEBB fully-insured medical plan for this redesign and may have multiple product variations within the Plan.
E. A separate redesign activity will be completed for the PEB Medicare portfolio.

UMP REDESIGN STRATEGY

PEB's Guiding Principle: The PEB Program strives to provide health plan members the highest quality health care services that can be purchased within the funding level provided by participating employers and employees.

PEB Strategy Outcomes:

- Health status improvement
- Cost trend management
- Positive member experience & satisfaction
- Health care quality improvement

PEB Strategy Approach:

- High **engagement** by HCA, PEB members, PEB network providers, PEB contracted health plans, and PEB participating employers
- Shared **financial accountability** for cost trend management by HCA, PEB members, PEB network providers, PEB contracted health plans, and PEB participating employers

UMP REDESIGN STRATEGY

PEB Strategy Timeline:

2012: Introduce new PEB culture of Engagement and Financial Accountability through introduction of new medical portfolio products that incorporate elements of member and provider engagement tied directly to financial accountability. Accompany introduction with aggressive communication, education and decision support.

2013: Aggressively move forward with increased use of premium sharing arrangements and benefit design changes to incentivize behavior change on the part of all parties to bend cost curve.

2012 Redesign Objectives

- Introduce a "NEW PEB" culture beginning in benefit year 2012.
- Introduce PEB members, providers, payer, and purchaser to fundamentals of accountability under the NEW PEB culture (shared responsibility for effective and efficient health insurance benefit plan – design, service utilization, payment, outcome, etc).
- Demonstrate ability to effect positive behavior change by targeted groups.
- Demonstrate ability to improve PEB medical cost trend management.
- Demonstrate ability to promote behaviors shown to positively impact health status, safety, and productivity.

ENGAGEMENT AND FINANCIAL ACCOUNTABILITY

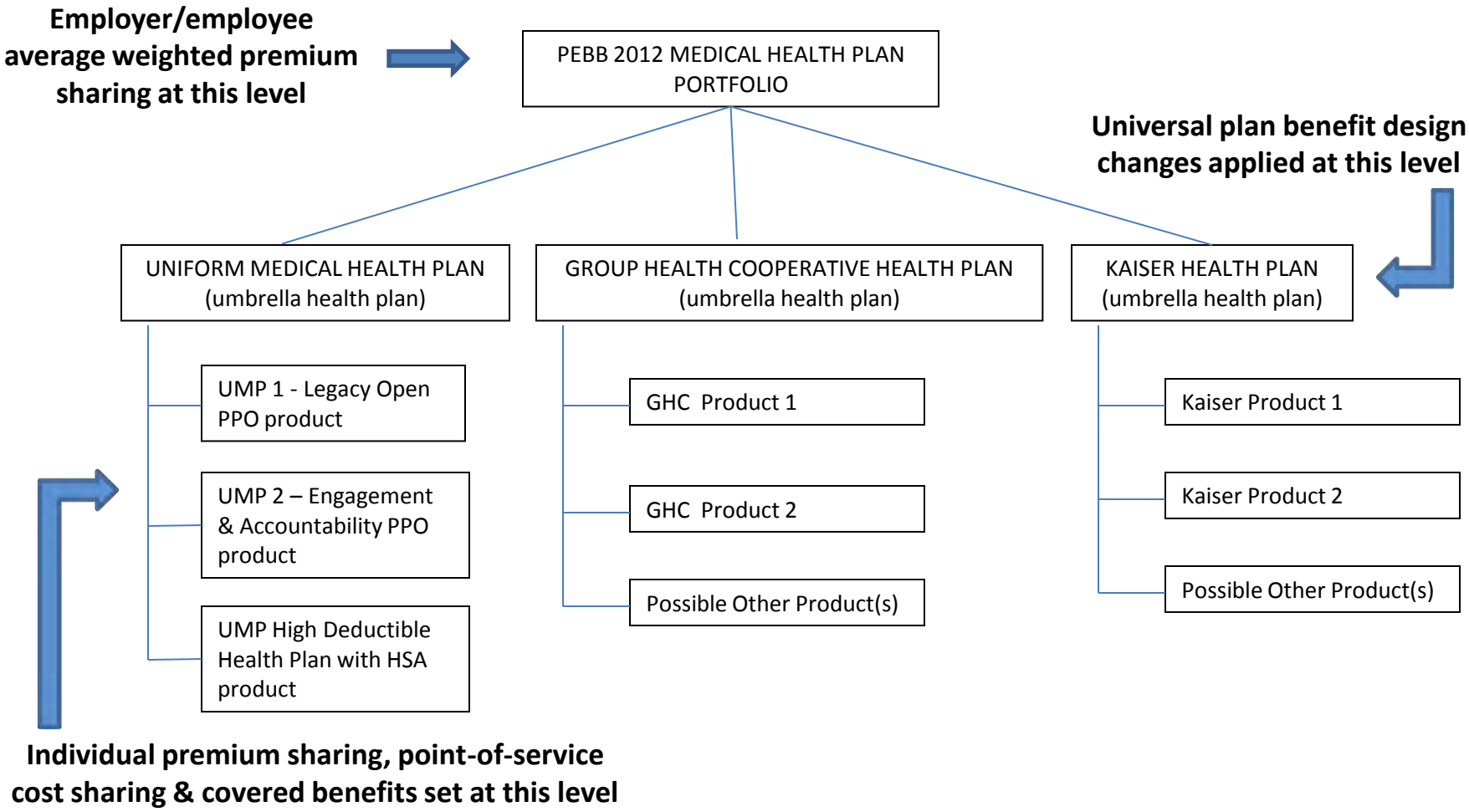
ENGAGEMENT: The level of involvement in lifestyle behaviors and benefit utilization behaviors that impact the PEB outcomes are achieved.

- Assumes large degree of choice and control by individual member and individual provider.
- In terms of members, the primary redesign targets are: (a) individual health status (lifestyle habits and management of risk factors) and (b) entry into the health delivery system (health plan selection and primary care.)
- In terms of providers, the primary redesign targets are: (a) shared decision making with patients and (b) individual prescribing habits.
- Cost control is a core element of the primary targets for member and consumers.

FINANCIAL ACCOUNTABILITY: The nature and degree of individual financial responsibility tied to the cost of care incurred.

- Directly ties financial responsibility to behavior – Individual has control of the behavior but is locked into the associated financial responsibility for the cost of health care associated with the behavior choices.
- In terms of members, the primary redesign targets are: (a) plan selection, (b) treatment selection, and (c) treatment adherence.
- In terms of providers, the primary redesign targets are: (a) service pricing, (b) treatment selection, (c) treatment follow through, (d) absence of errors and other undesirable events, and (e) detection of fraud and abuse.

PEBB MEDICAL PORTFOLIO 2012



UMP Redesign Concept

PEB Board Retreat

January 12, 2011

Approach

The Health Care Authority will develop 3 products under the umbrella of the self-funded Uniform Medical Plan to enable members to obtain necessary health care through a plan design of choice that best balances individual responsibility for cost-effective decision making with the level of personal financial liability.

UMP Products

UMP- 1: The current 2011 UMP health plan will be retained with its current deductible level, co-insurance rate, and out-of-pocket maximum level. Other targeted plan changes will be implemented as appropriate.

This product serves as the legacy plan for 2012 and 2013.

New UMP product designs will deviate from the legacy plan in terms of the level of required consumer engagement and the corresponding level of financial accountability.

UMP Products

UMP-2: A new UMP PPO product (UMP-2) with a reduced premium level in exchange for increased consumer engagement tied to HCA specified cost-effective service utilization management.

The proposal anticipates consumer engagement responsibilities will involve such features in 2012 as:

- Complete a Health Risk Assessment (HRA), including self reporting of height and weight to produce a BMI index with feedback.
- Commitment to participate with care management in cases of:
  - High risk pregnancy
  - Chronic illness
  - High use of Emergency Room/Department services for non-emergent conditions.
  - Use of multiple medications involving targeted drugs (narcotics, etc.)
- Agreement to obtain all A & B rated USPSTF services.
- Identification of a network primary care physician for consultation and treatment as needed during the benefit year.
- Targeted plan design changes associated with identified areas of high cost avoidance potential (e.g., ER use, brand drug use, advanced imaging procedures, specialty care without a primary care referral, etc.)

Engagement responsibilities will be adjusted in future plan years based on cost experience.

UMP Products

UMP-HSA: A new Consumer Directed Health Plan/Health Savings Account product with a reduced premium level and defined contribution to the HAS.

Member assumes responsibility for increased consumer financial accountability under higher deductible and out-of-pocket maximum cost sharing levels.

Requires member access to a much greater level of service and provider level quality and cost information and decision supports to support informed service selection and utilization .

Universal Value-Based Purchasing Modifications

Universal Design Changes
Emergency Room copayment tiers
Pharmacy Benefit changes (To be discussed later in agenda)

Universal Provider Reimbursement Changes
Exclusive Centers of Excellence designation for specified procedures

Provider Network Restrictions
Preferred provider network designation

Discussion

UMP REDESIGN CONCEPT

The Health Care Authority will develop 3 products under the umbrella of the self-funded Uniform Medical Plan to enable members to obtain necessary health care through a plan design of choice that best balances individual responsibility for cost-effective decision making with the level of personal financial liability. The three proposed products are:

1. The current 2011 UMP product (UMP-1) with possible limited targeted plan design changes. This product serves as the legacy plan against which new UMP product plan variations in consumer engagement level and financial accountability level modifications will deviate.
2. A new UMP PPO product (UMP-2) with a reduced premium level in exchange for increased consumer engagement tied to HCA specified cost-effective service utilization management (See below).
3. A new Consumer Directed Health Plan/Health Savings Account product (UMP-HSA) with a reduced premium level and defined contribution to the HSA in exchange for increased consumer financial accountability for cost-effective service utilization under higher deductible and out-of-pocket maximum cost sharing levels.

The proposal anticipates the UMP-2 consumer engagement responsibilities will entail involve one or more of the following utilization management features in 2012 and the engagement responsibilities will be adjusted in future plan years based on cost experience.

- Complete an Health Risk Assessment (HRA), including self reporting of height and weight to produce a BMI index with feedback.
- Required use of Centers of Efficiency for selected procedures such as orthopedics, spinal procedures, transplants).
- Additional restrictions for pharmacy cost sharing beyond UMP-1.
- Commitment to participate with care management in cases of:
    - High risk pregnancy
    - Chronic illness
    - High use of Emergency Room/Department services for non-emergent conditions.
    - Use of multiple medications involving targeted drugs (narcotics, etc.)
- Agreement to obtain all A & B rated USPSTF services.
- Identification of a network primary care physician for consultation and treatment as needed during the benefit year.
- Targeted plan design changes associated with identified areas of high cost avoidance potential (e.g., ER use, brand drug use, advanced imaging procedures, specialty care without a primary care referral, etc.)

PEBB Redesign

2012-2013

Tentative Group Health Proposal

for Health Care Authority

January 5, 2011

GroupHealth

Group Health Philosophy

GroupHealth

Essential Ingredients for Success:

- Improved member health education, awareness & engagement
- Improved provider education, awareness & engagement
- Reduction in no-low value “preference sensitive” care
- Network strategy & management
- Providing health plan options members value & want to purchase
- Recognition of unique characteristics of PEBB members
- Visible support by all levels of management to promote employee wellness and program participation

2012/2013 Group Health Offering

GroupHealth

Key Factors:

1. Multi-benefit tier Value Based Insurance Designs (VBID) replace current single tier deductible/co-pay plans
    - Retain current nomenclature (Classic & Value)
    - One option modeled after GHC employees' Total Health plan
    - One option modeled after Oregon Health Plan Value Based Essential Benefits Package (3-tier)
2. Introduce a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA)
3. Networks
    - VBID options offered on either GHC HMO or GHO Alliant Select network
    - HDHP option offered on GHO Choice network

2012/2013 Group Health Offering

GroupHealth

Value Based Insurance Design Concepts

- Increasing member engagement
    a) Incentives for compliance
    b) 2012 – Health Risk Assessment completion, health status identification, website registration/ID verification
    c) 2013 – 2012 requirements plus compliance with health coaching
- Focus upon Preference Sensitive Conditions
    a) Member education
    b) Reduced benefits for low-no value services (3-tier VBID)

VBID Highlights

GroupHealth

Total Health Type Plan: Integrates medical care with a wellness program

- Focus on preventive care and managing chronic conditions using evidence based treatment protocols
- Cost sharing encourages members to use high value services and avoid low value services.
- Low cost VBID drug tier

3-Tier Plan: Three tiered level of benefits established according to proven effectiveness for health, chronic care management and preference sensitive treatments. Cost sharing based on value not price.

- Tier-1: Most attractive benefits and low or no cost shares (preventive, chronic care)
- Tier-2: Primary benefits subject to deductible & copays (evidence based treatment, medically necessary)
- Tier-3: Higher deductible and cost shares for treatments that are “Nationally recognized as overused or driven by preference rather than sound medical evidence”

Scenario – Total Health Plan

GroupHealth

Tentative 2012 Changes:

- **Total Health benefit design that integrates medical care with a wellness program**
- **Focus on preventive care and managing chronic conditions coordinated through Primary Care**
- **Value based pharmacy design**
- **Financial incentives to encourage employees to engage in healthy behaviors**

Scenario – 3-Tier Plan

GroupHealth

Tentative 2012 Changes:

- **Three tiered level of benefits established according to proven effectiveness for health, chronic care management and preference sensitive treatments**
- **Focus on preventive care and managing chronic conditions coordinated through Primary Care**
- **Value based pharmacy design (4-tier)**
- **Financial incentives to encourage employees to engage in healthy behaviors**

Scenario – HDHP w/HSA Plan

GroupHealth

New offering:

- Qualified high deductible health plan with upfront coverage for preventive care
- Health Savings Account through Health Equity employer funding via premium that enables:
    a) Provider payments direct from HSA account
    b) Self reimbursement for qualified expenses
    c) Create and manage future payment schedules
    d) Record & store medical claim records

Your Partner in Health

Washington PEBB and Kaiser Permanente

January 12, 2011

KAISER PERMANENTE® thrive

Your Partner in Health

- We share common goals and challenges
- Partner to meet needs of PEB and our mutual members
- Recognize State budget crisis means change
- Common values: quality care, health improvement, sustainability, affordability
- Changing for the better, together

KAISER PERMANENTE® thrive

Your Partner in Health

Quality and Value

Integrated evidence–based care

Disease Management

Medical Home / Complex Medical Home

Consumer Engagement

Creating a culture of health

KAISER PERMANENTE® thrive

KAISER PERMANENTE®

2009 Member Activity on kp.org

WA PEBB, PID1983
Northwest

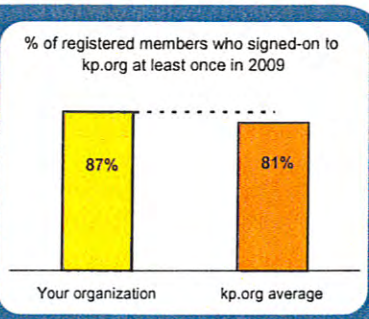
Kaiser Permanente's Commitment

Providing tools and information to help members stay healthy is an important goal for Kaiser Permanente, and kp.org is a key channel for achieving that goal. Last year your employees used kp.org to communicate with their health care team, order medications, look at their lab test results and access a wide variety of information to help them achieve total health. Studies show that ease of access to health care is associated with improved health, and good health is associated with lower absenteeism and increased productivity. In short, using kp.org benefits your employees and your organization.

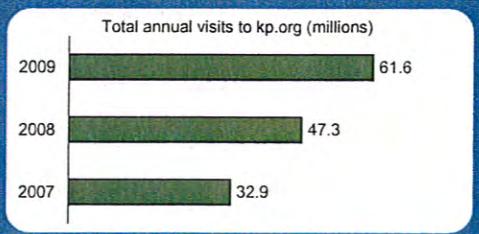
Your organization summary

Metric	2009 Total
Subscribers and dependents covered by KP	7,291
Number registered on kp.org as of 12/31/09	3,170
Sign-ons to kp.org	67,754
Number of members signing-on	2,756
Online prescription refill orders	8,671
Total prescription refills	14,969
Number of members refilling prescriptions	1,117
Appointments made online	1,138
Lab test results viewed online	23,214
Number of members viewing lab test results	2,097
E-mail messages sent to health care providers	9,207
Number of members sending e-mails	1,646

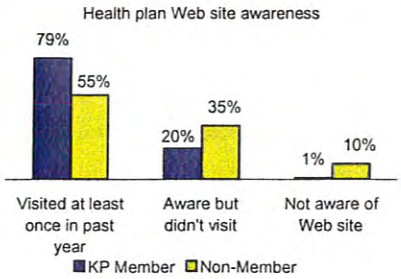
Of your 3,170 employees registered on kp.org, 87% signed-on at least once in 2009.



Total visits to kp.org by all members exceeded 61 million in 2009.



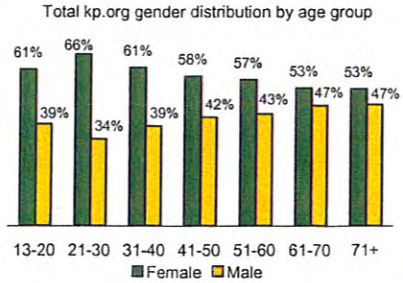
Kaiser members visit kp.org more often than non-Kaiser members visit their health plan Web sites, according to a 2009 survey.



Top visited kp.org features by all members in 2009

1. My test results
2. Online appointments
3. E-mail my doctor
4. Online prescription refill
5. Facility directory
6. Health encyclopedia
7. Past visit information
8. Medical staff directory
9. Act for a family member
10. My prescriptions

More women than men are registered on kp.org in all age groups; however, the gap narrows as age increases.



WA PEBB, PID1983
Northwest

Methodology

This report contains employer group-specific aggregate information about KP members and their activities on kp.org. To preserve the anonymity of members and comply with the Health Insurance Portability and Accountability Act (HIPAA), reports can only be created for employer groups with 50 or more members registered on kp.org as of 12/31/09. If any metric contains fewer than 11 units, the exact count will not be displayed on the report.

Metric definitions

Subscribers and dependents covered by KP —The number of Kaiser Permanente members and their dependents as of 12/31/09.

Number registered on kp.org as of 12/31/09 —Members who have completed the online registration process on kp.org, and also completed the activation process by either using Single Visit Activation or entering the temporary password that was sent to them in the US mail. These members are able to access *My health manager* activities on kp.org such as viewing lab test results, making online appointments, and e-mailing their doctor.

Sign-ons to kp.org —A count of successful sign-ons to kp.org by members. Once members sign-on successfully by correctly entering their user name and password, they can access *My health manager* features on kp.org

Number of members signing-on —The number of unique members who signed-on to kp.org in 2009.

Online prescription refill orders —Prescription refill orders processed through the online prescription refill service on kp.org. An order occurs when a member requests to refill one or more prescriptions for personal use and/or other dependents in a single online transaction. Prescription refill orders processed through other channels, for instance by telephone or in a pharmacy (Kaiser Permanente or other), are not included in this metric.

Total prescription refills —Number of prescription refills processed through the online prescription refill service on kp.org. The total number of refills ordered within a given timeframe will usually be larger than the total number of orders because a member can request to refill multiple prescriptions within a single order.

Number of members refilling prescriptions —A count of unique members who submitted a prescription refill order via the online prescription refill service in 2009.

Appointments made online —Requests for appointments with KP medical staff by using the schedule appointment feature in *My health manager,* the online appointment real-time system (available in Northern California only), or by submitting a secure form using the appointment request feature on kp.org.

Lab test results viewed online —The total number of lab test results viewed online for the first time via the *My test results* feature on kp.org. Members can view their lab test results online an unlimited number of times, however this metric is only counting the first time a result is viewed online.

Number of members viewing lab test results —A count of unique members who viewed a lab test result via the *My test results* feature in 2009.

E-mail messages sent to health care providers —The total number of e-mails sent by members via the *E-mail my doctor* feature on kp.org.

Number of members sending e-mails —A count of unique members who sent an e-mail via the *E-mail my doctor* feature in 2009.

Retiree Redesign
PEB Board Retreat

January 12, 2011

Agenda

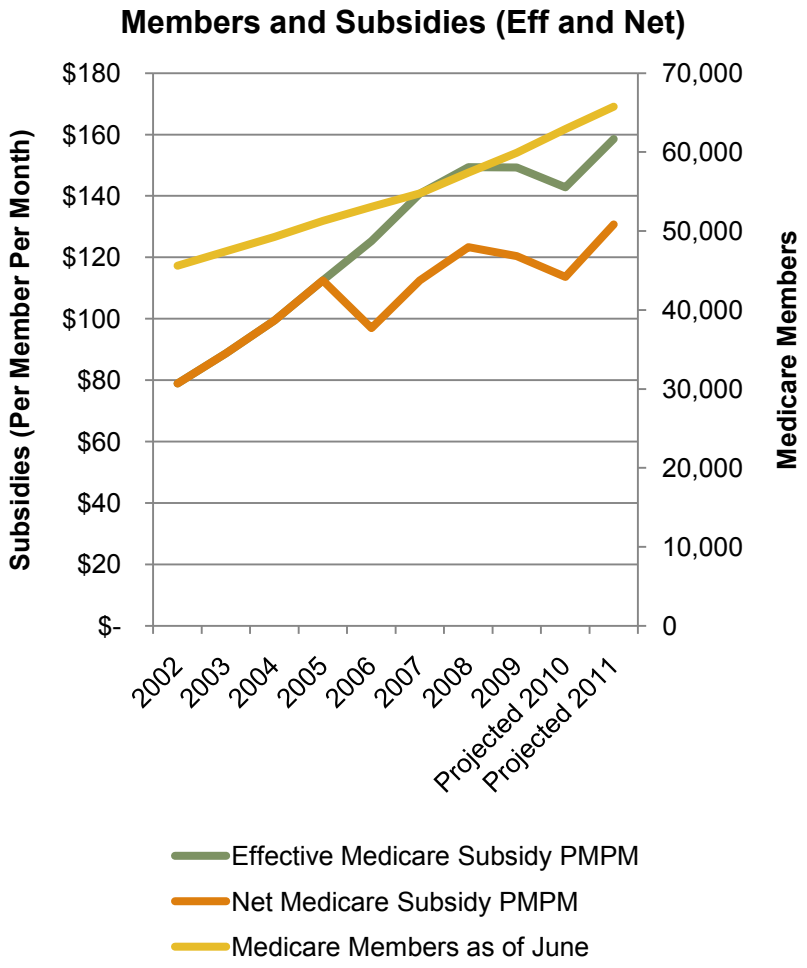
- Context
- Demographics
- Alternatives/Recommendation

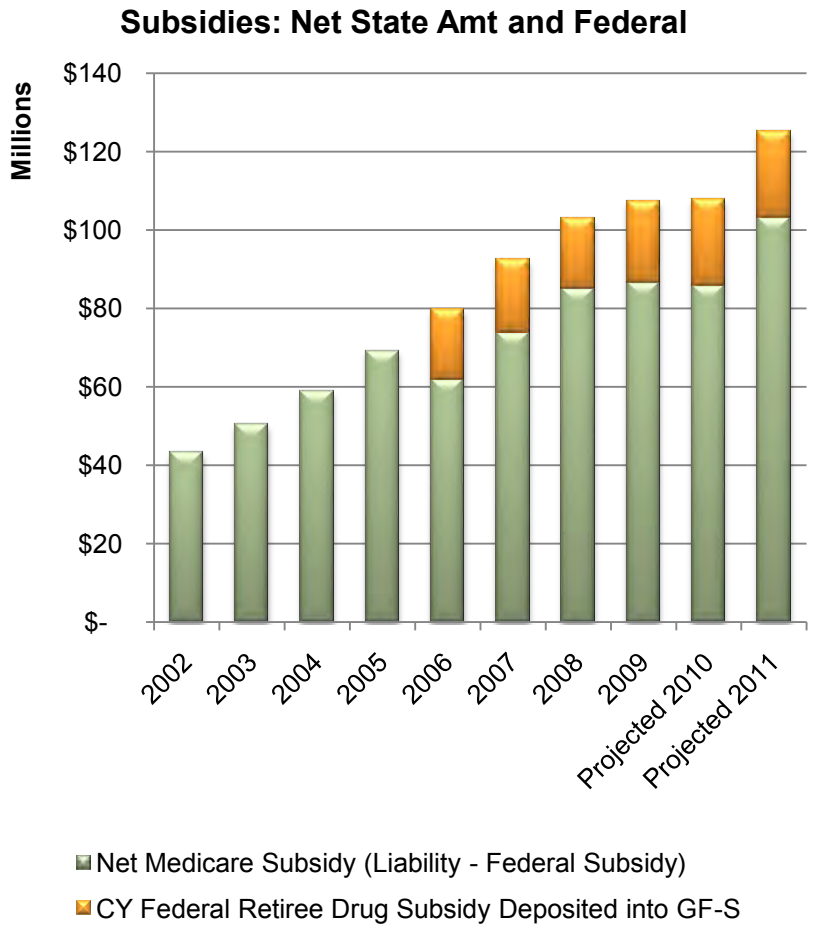
Context

- Role of PEB Board
  - Approve the explicit subsidy, not to exceed the amount set in Budget
  - Approve dependent access to the explicit subsidy
- Explicit subsidy set in budget process
  - 2011 explicit subsidy is half of the premium, not to exceed $183
  - 2012 explicit subsidy in proposed budget is half of the premium, not to exceed $150
- Problem Statement

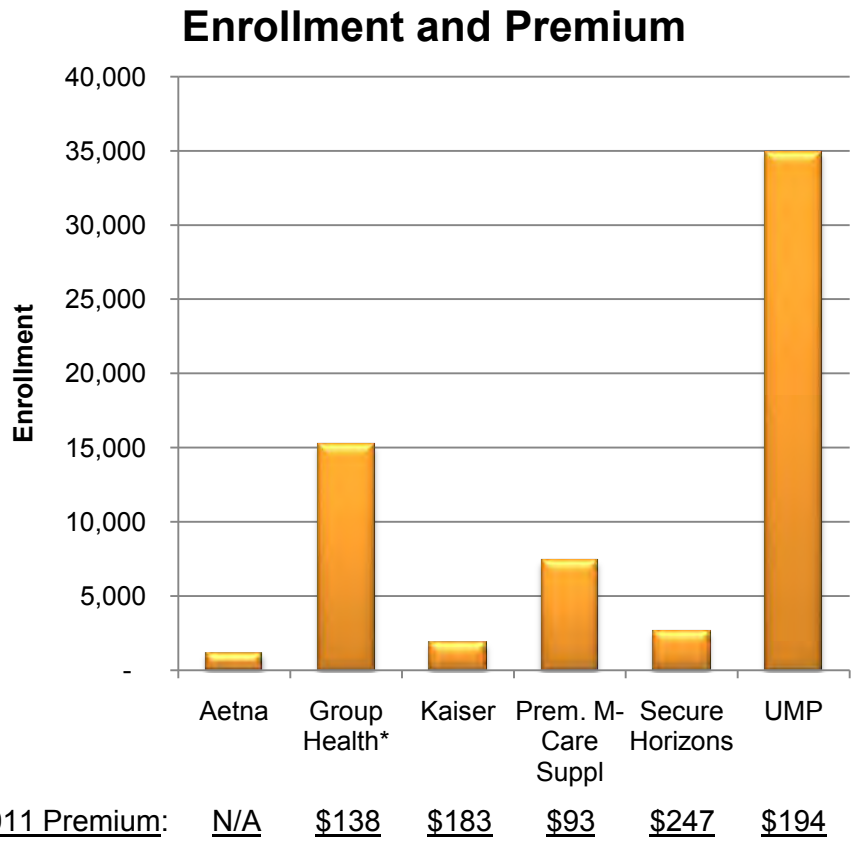
  “What changes should be made to PEB retiree health care coverage to make it more affordable and sustainable?”

Members and Subsidy Amounts

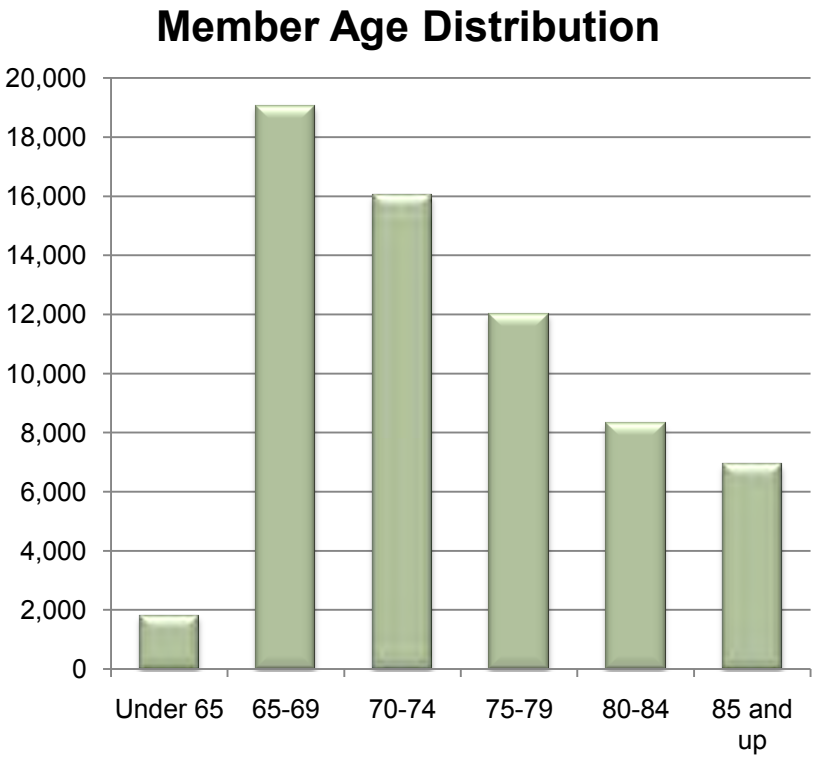




Information on Members



2011 Premium:	N/A	$138	$183	$93	$247	$194



**Premium for the GH Classic Plan with 93% of members*
Approx 1,000 GH Value members
Approx 2,000 non-Medicare Advantage GH members

Medicare Alternatives and Recommendations

- Core plans
  - UMP
  - Group Health
  - Kaiser
- Non-core plans
  - Medicare Advantage plans
  - Medicare Supplement plans
- Financing Options
  - Medicare Part D plan
  - Structure of the subsidy

Pre-Medicare Alternatives and Recommendations

- High Deductible Health Plan/Health Savings Account
  - Available in each core plan
  - Single product design

Washington State Health Care Authority

THE ODS COMPANIES

Proposed Value-Based Purchasing Strategy: Value Tier

Objective: Reduce barriers to specific generic medications known to prevent acute care needs and complications associated with common chronic conditions, such as high blood pressure, high cholesterol, diabetes and depression.

Recommendation: Create a 5% Coinsurance Value Tier

Estimated annual plan cost: $400,000

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THE ODS COMPANIES

Proposed Value-Based Purchasing Strategies for 2012

1. Addition of a value tier
2. Evidence-based change in cost-sharing for high cost generic drugs
3. Alignment of coinsurance cost-sharing at mail order, specialty and retail pharmacies
4. Limited coverage of proton pump inhibitor drug class
5. Addition of a discount tier

Note: Strategies included in these briefings are not mutually exclusive; therefore, simple addition of savings figures will not accurately reflect total savings.

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2011 UMP Pharmacy Benefit

Tier	Network Retail Pharmacy (up to a 90-day supply)	Mail-Order Pharmacy (up to a 90-day supply)	Specialty Drug Pharmacy (up to a 30-day supply)
Tier 1: Generic Drugs	10% coinsurance or $75 per 30 day-supply, whichever is less *No deductible*	$10 copay *No deductible*	$10 copay *No deductible*
Tier 2: Preferred Brand-Name Drugs	30% coinsurance or $75 per 30 day-supply, whichever is less *Deductible applies*	$50 copay *Deductible applies*	$50 copay *Deductible applies*
Tier 3: Nonpreferred Brand-Name Drugs	50% coinsurance *Deductible applies*	$100 copay *Deductible applies*	$100 copay *Deductible applies*

Proposed 2012 UMP Pharmacy Benefit

Tier	All Network Pharmacies[1]	Out-of-Pocket Cost Limit per 30-Day Supply
Value Tier	5% coinsurance *No deductible*	$10
Tier 1: High-Value Generic Drugs	10% coinsurance *No deductible*	$25
Tier 2: Low-Value Generic Drugs & Preferred Brand-Name Drugs	30% coinsurance *Deductible applies*	$75
Tier 3: Nonpreferred Brand-Name Drugs	50% coinsurance *Deductible applies*	$150 for specialty prescriptions; None for retail and mail-order prescriptions
Discount Tier	100% coinsurance *No deductible*	None

[1] *This benefit provides up to a 90-day supply of retail and mail-order prescriptions and up to a 30-day supply of specialty prescriptions.*

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Proposed Value-Based Purchasing Strategy: High-Cost Generic Drugs

Objective: Increase member cost-share for low-value prescription drugs.

Recommendation: Align high-cost generic drugs in Tier 2.

- High volume and/or plan paid dollar examples
  - Fentanyl and dronabinol (narcotic analgesics)
  - Valacyclovir and famciclovir (antivirals)
  - Claravis and amnesteem (oral medications for severe acne)
  - Itraconazole (anti-fungal)
  - Dextroamphetamine and dextroamphetamine-amphetamine combination (ADHD drugs/stimulants)
  - Desoximetasone (topical steroid)
  - Pantoprazole (proton pump inhibitor)
- This strategy has been successfully implemented by HCA's current pharmacy benefits vendor in a similar population and by other health plans across the nation.

Estimated annual plan *savings*: $1.2 million

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Proposed Value-Based Purchasing Strategy: Mail-Order & Retail Pharmacy Benefit Alignment

Background

- Approximately 10% of prescriptions are purchased through mail-order, representing nearly 30% of total plan payments.
- Approximately 0.5% of prescriptions are specialty drug prescriptions, representing nearly 20% of total plan payments.

Objective: Mirror coinsurance cost-sharing arrangement at retail, mail-order, and specialty pharmacies without creating cost-prohibitive cost-sharing for high-value prescription drugs.

Affected Membership

- Retail Pharmacy Users: Member impact will be limited to a **positive** impact resulting from the lower out-of-pocket maximum for Tier 1 drugs.
- Specialty Pharmacy Users: Virtually all users will have higher costs with the out-of-pocket cost limit shifted up from the 2011 specialty pharmacy flat copayments.
- Mail Order Pharmacy Users:

Medicare Status	Members[1] Positively Impacted	% of Total Prescriptions[2] Positively Impacted	Members[1] Negatively Impacted	% of Total Prescriptions[2] Negatively Impacted
Non-Medicare	6.6%	3.9%	7.7%	3.5%
Medicare	25.8%	8.0%	27.7%	6.2%

Anticipated Outcomes: Estimated annual plan *savings*: $6.5 million

[1] Percentage of average membership.

[2] Percentage of all prescriptions (retail, mail order and specialty) for the time period.

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Proposed Value-Based Purchasing Strategy: Proton Pump Inhibitor Drug Class Limited Benefit

Objective: Align the prescription drug benefit to promote member engagement in consideration of appropriate and cost-effective PPI use. This strategy presents an alternative to adding PPIs to the discount tier.

Recommendation: Provide a maximum plan contribution of $20 per 30-day supply.

1. The approximate cost of a 30-day supply of an OTC PPI is $20.
2. The table below provides approximate member out-of-pocket cost comparisons for a 30-day supply at a retail pharmacy:

Proton Pump Inhibitor	2011 Member Cost	Member Cost Under Discount Tier	Member Cost Under $20 Plan Contribution
omeprazole	$1	$12	$0
lansoprazole	$11	$110	$90
pantoprazole	$11	$110	$90
Aciphex®	$125	$250	$230
Nexium®	$95	$190	$170

Estimated annual plan *savings*: $3.8 million

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Proposed Value-Based Purchasing Strategy: Discount Tier

Objective: Rather than eliminate coverage, continue to provide members access to these drugs at a discounted rate.

Recommendation: Create a 100% Coinsurance Discount Tier

1. Members will save an average of 44% from the pharmacy cash price.
2. The table below provides examples of approximate out-of-pocket cost comparisons:

Drug Class	Drug	2011 Member Cost	Member Cost Under Discount Tier	Member Cost for OTC Alternative
Topical Acne Agents	Tretinoin 0.1% cream (Generic Retin-A®)	$10	$85	$5-25
Anti-Inflammatory Drugs	Naproxen	$1	$15	$5-15
	Celebrex®	$80	$160	$5-15
Proton Pump Inhibitors	Omeprazole (Generic Prilosec®)	$1	$12	$10-25
	Lansoprazole (Generic Prevacid®)	$10	$110	$10-25

Note: Projected costs are approximate and represent common 30-day medication supplies.

Estimated annual plan *savings*: $9.4 million

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