Washington State Health Care Authority

Public Employees Benefits Board

March 21, 2012

Washington State Health Care Authority

Public Employees Benefits Board Meeting

March 21, 2012

1:00 p.m. – 3:00 p.m.

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

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Washington State Health Care Authority

AGENDA

Public Employees Benefits Board

March 21, 2012
1:00 p.m. – 3:00 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

Conference call-dial in: 1-888-450-5996, Participant Passcode: 546026

1:00 p.m.	**Welcome and Introductions**	Doug Porter	
1:05 p.m.	**Approval July 13, 2011 Minutes** **Approval July 20, 2011 Minutes** **Approval October 19, 2011 Minutes**	Doug Porter	Action
1:20 p.m.	**Fiscal Update**	Annette Meyer	Information
1:30 p.m.	**2012 Open Enrollment Summary**	Mary Fliss	Information
1:45 p.m.	**2013 Wellness Benefit Design Change Proposal**	Scott Pritchard	Information
2:30 p.m.	**Public Comment**		
3:00 p.m.	**Adjourn**		

The Public Employees Benefits Board will meet March 21, 2012, at the Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. 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

PEB 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

PEB Board Members

Name	Representing
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

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Health Care Authority

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2011-2012 Public Employee Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Apple/Peach Conference Room, 626 8th Avenue SE, Olympia, WA 98501, unless otherwise noted below. The meetings begin at 1:00 p.m., unless otherwise noted below.

October 19, 2011

January 11, 2012 (Board Retreat) 9:00 a.m. – 3 p.m.

March 21, 2012

April 18, 2012

May 23, 2012

June 27, 2012

July 11, 2012

July 18, 2012

July 25, 2012

October 17, 2012

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-923-2625.

Jason B. Siems
Washington Health Care Authority
Rules Coordinator

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 16, 2011
TIME: 9:04 AM

WSR 11-17-066

Washington State Health Care Authority

PEB 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.

Washington State Health Care Authority

D*R*A*F*T
Public Employees Benefits Board
Meeting Minutes

July 13, 2011
Health Care Authority, Apple/Peach Rooms
Olympia, Washington
1:00 p.m.

Members Present:
Doug Porter
Greg Devereux
Phil Karlberg
Gwen Rench
Lee Ann Prielipp
Yvonne Tate
Harry Bossi
Margaret Stanley
Melissa Burke-Cain

Members Absent:
Eva Santos

Call to Order
Doug Porter, Chair, called the meeting to order at 1:00 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Approval of April 20, 2011 PEBB Meeting Minutes
It was moved, seconded, and carried to adopt the April 20, 2011 PEBB Board meeting minutes as written.

Finance Update
Annette Meyer, HCA: Hello everyone. My update today is going to be short. I wanted to just preface this by saying, we are still in the process of doing our calculations on the impact to the procurement on the reserves so we hope that will be ready for the meeting next week on the 20th, but we cannot guarantee that. There are still a lot of things to be done; and since we have had changes in our plan this year with the CDHP/HSA, it is just taking us a little bit longer to do those calculations. If they are not ready for next week, we will have them in time, obviously, for the next board meeting. We don't anticipate significant negative impacts from this procurement. Actually, our bid rates have come in favorably so we will also take a look at things like experience and that sort of thing when we are doing that update. Any questions on that piece at all? Then the update that I have today, essentially, I think is something that you already know but just to make sure. During the legislature, they passed a funding rate of $850 per employee for fiscal years '12 and '13. The retiree subsidy is $150 for the calendar years 2012 and 2013 and K-12 remittance is $66.01 for state fiscal year '11-'12 and $67.91 for fiscal years '12 and '13. That is the update that we have that was finalized in the budget in the legislature this year.

Open Enrollment Update

Renee Bourbeau, HCA: Good afternoon, members of the Board. I am pleased to be with you this afternoon. For the record, my name is Renee Bourbeau and I am the Deputy Assistant Administrator for PEBB. Mary Fliss isn't available today. I am also the PEBB Open Enrollment Project Manager. Typically, we do this presentation in the spring. However, given the Board's schedule, this is our first opportunity to make a presentation about what happened during last year's open enrollment. As we reach open enrollment, we have a number of initiatives.

National Healthcare Reform eliminated PEBB student and adult dependant coverage. Effective 1-1-11, the National Healthcare Reform laws required us to offer coverage for married and unmarried children up to age 26. The second bullet we have is the retro-termination processes, again effective 1-1-11. The affordable care act prohibits rescissions in certain circumstances. For example, if an employee ceases to be eligible for benefits; but the employer mistakenly continues to collect premiums and pay claims, the coverage cannot be canceled retroactively. The flexible spending account changed in 2011. The flexible spending account reimbursement for over-the-counter drugs, such as allergy medications, cold medicines, required a prescription from a provider. This was in the year 2011.

Dependant Verification Project, Phase 2. PEBB worked with HCA staff and agencies to implement an ongoing verification process in which employees and non-Medicare retirees must verify their dependants' eligibility before enrolling them in PEBB coverage starting 1-1-2011. This effort built on the DB Project, Phase 1, which was conducted in 2009 for the 2010 plan year.

The new Premera Plan F. Federal laws prohibited new enrollment in Medicare Supplement Plans E and J in mid-year; and provided a new plan, Plan F. Plans E and J were eliminated from the PEBB portfolio, leading to 7,000 people with an average age of 79 being transferred to Plan F. As part of this transition effort, PEBB staff coordinated with the Medicare Supplement Plan administrator, Premera Blue Cross, to communicate this change to current and new retirees.

Transition of self-insured products, which is the last bullet on our page. The elimination of Aetna required that we created and implemented a communication effort and members account transition plan. Those on Aetna who did not choose a plan were defaulted to the Uniform Medical Plan. We also supported the transition of the new TP provider, Regence Blue Shield, as the new administrative services provider for the Uniform Medical Plan. Do you have any questions on this page before we move on? Thank you.

Greg Devereux: I do have a question. Have there been any concerns raised with the transition to the new TPA? I know there were a lot of concerns raised before it went live. Has the Health Care Authority received any comments?

Nicole Oishi, HCA: We are working with a few issues. I think most of those that came up prior to the implementation have been resolved. Those were related to provider networks. Those issues have since been resolved. There are two issues that we are currently dealing with related to behavioral health and Medicare cost-over claims that we are actively dealing with; and the new TPA has been active at hiring staff for training, so we are feeling really good about where we are going. But there were a few bumps in the road.

Phil Karlberg: I have a question. With regard to dependent eligibility verification, you mentioned that activities are occurring before enrollment. Are there ongoing efforts for verification for members that are currently enrolled?

Renee Bourbeau, HCA: In 2009, we verified 148,000 members and we verified all the members who have dependants up to September 2009. We are currently doing a sweep. So, we pulled the data from September 2009 through December 2010 to capture the people who have enrolled new dependants. We are currently doing a verification for this group of people. Basically, we will have verified everybody. So, effective 1-1-11 we are only capturing new dependant, newly enrolled, so everyone will have been verified for active employees and non-Medicare retirees.

Phil Karlberg: What's the outcome of that verification? Have you realized a savings with regard to the verification process; and if so, can you categorize it as a percentage or something?

Renee Bourbeau, HCA: Yes, out of 148,000 that we verified, we removed 6,600 dependants out of the coverage. My understanding is we have a 20 million cost avoidance in terms of savings. I do not know from the current sweep, because we are in the process of doing the verification. This sweep has to do with 15,000 dependants at this point.

Any other questions? The next line has to do with employees and non-Medicare retirees. As you can see from the chart, it is Section 5, as you can see from this chart Aetna and Kaiser Permanente Value were eliminated in 2011. Both plans had very low enrollment. The chart also indicates the continued growth of Group Health members in the Value Plan compared to the Classic Plan. Any question about this chart? The next chart has to do with the Medicare enrolled retirees. In 2011, the Health Care Authority no longer offered Aetna, the Kaiser Value Plans, Medicare Supplement Plans E and J, and Secure Horizons Value. These plans also had very low enrollment. Of the Group Health members, Group Health Classic continues to have the majority of the enrollment for the Medicare retirees.

Annual Rule Making

Jason Siems, HCA: Good afternoon. My name is Jason Siems. I am here as the rules coordinator for the Health Care Authority. The purpose of this briefing today is to give you a high-level overview of our intended annual rule making. This is something we do every year, to review our rules and determine what amendments, if any, are necessary. We will also provide you with information regarding a policy proposal, however we won't be asking you to act on that proposal until the next board meeting. Regarding the scope of the rule making, PEBB will be writing rules to implement federal regulations. The rescission provision was part of the Federal Healthcare Reform Legislation and the piece we will be implementing prohibits retroactive cancellation or discontinuation of coverage in certain circumstances. Termination of coverage will be limited and will align to refunds of premium. Responsibility for premium payments will also be clarified. Additional change will be the implementation of the PEB Board Policy that I will cover in a future slide. Additionally, the rule making will include a number of technical corrections and clarifications including the retiree eligibility rule. The current rule for members of a higher education retirement plan lacks clarity because it refers only to the plans age requirement rather than referring to the plans eligibility criteria for receiving retirement. This was a point of confusion for one of the higher ed employers this past year. The requirement will be dissatisfied; the retirement plans eligibility for retirement, as well as the PEBB imposed procedural requirements.

Additionally, we will be clarifying the long-term disability rule; we will clarify when employer contribution toward basic long-term disability coverage will end. We will also be clarifying the surviving spouse rules. We will clarify that the PEBB program will treat the receipt of premiums from any source as notice of the surviving spouse or surviving dependant child's intent to elect to continue enrollment in PEBB coverage. Additionally, surviving spouses of emergency service personnel killed in the line of duty can add newly acquired dependants. This is something that is required by HIPAA and we will be clarifying in our rule. We will also clarify the rule that addresses premium payments and refunds so that it is clear. We will clarify how overpayment errors will be corrected, how underpayments will be resolved, and make some technical corrections related to the process for appealing premium refunds.

Finally, the policy proposal that we will be asking the board to act on at the next meeting will modify the Administrative Code 182-08-197(1)(a) and this rule will specify that the Uniform Medical Plan Classic Product will be the default medical plan, as opposed to the UMP CDHP/HSA. Currently the rule indicates that the UMP is the default plan when a person is newly hired and doesn't select a plan. They are defaulted into the UMP and this will clarify that the Classic Plan will be the default rather than just UMP. Finally, our next steps, we will ask the Board to take action on that policy proposal, most likely at the next meeting. In September we will actually have the draft rules published and our anticipated public hearing will be in October, with an effective date for the rules as January 1. Are there any questions I might be able to answer?

Harry Bossi: Jason, will we see the actual changes before the next meeting?

Jason Siems, HCA: We will have the policy proposal ready for the next meeting. As far as the actual writing of the rules, we haven't completed that yet. We will certainly circulate that to the Board members, as well as other stakeholders, well in advance of filing the CR 102 and actually publishing the draft.

Greg Devereux: You are asking us to vote on these the next time; and typically, in the past we've seen them in the context of the actual rule.

Jason Siems, HCA: What we will be asking the Board to vote on is in making the UMP Classic the default.

Greg Devereux: Ok, that's the only thing.

Jason Siems, HCA: That's the only thing. The actual language of the rules will come later and will be based on the Board's decisions.

Greg Devereux: All these other things, you are not asking us to do anything.

Jason Siems, HCA: No. You are welcome to make input. They are mostly technical corrections, clarifications, and implementation of federal regulation changes. You are welcome to provide input, but we don't need policy decisions on that.

Greg Devereux: Ok. Thank you.

PEBB Proposed Portfolio for 2012

Nicole Oishi, HCA: Anticipating that we may have some financial questions, I asked Ben to join us as well.

For the record, my name is Nicole Oishi. I am the Deputy Director for the PEBB Division. I am honored to provide you with the procurement information for today.

Doug Porter, HCA: And I should also hasten to say that for the record, it was my sad duty to accept Nicole's resignation earlier this week and to send out an announcement that she will be leaving us at the end of this month to join Regence in the Administrative Services Director position.

Elin Meyer, HCA: While we are waiting, for the record, my name is Elin Meyer. I work for the PEBB Division with the Health Care Authority.

Nicole Oishi, HCA: And this is Ben Diederich with the firm Milliman.

I will start by going through the agenda. I will cover for you the proposals for the non-Medicare plans. Elin will go through the Medicare plans. Ben and I will talk through the budget and premiums; and then Elin will go through the dental overview, as well as life and long-term disability. Please feel free to ask questions, interrupt me if something isn't clear. I am happy to provide any information that I can. Second page, or third page according to the numbers, is a list of what our purchasing goals are. It is pretty consistent with what we have always done, which is just to maintain comparable benefits with other private and public employers, design benefits that encourage members to improve their health, and seek quality and efficient care, manage within our fiscal limits, which is set by the legislature, improve access to affordable care, and then obviously manage our underlying cost trends. I am going to try not to read absolutely everything on the paper to you. I think what I will most importantly identify for you are the changes. Looking at the UMP active and non-Medicare retiree option, we are referring to this as the UMP Classic Option, which you just heard Jason refer to as the default plan as well. Really, the only change to this plan is that we will be adding a value tier to the pharmacy benefit. Those generics that are considered to be most costly, effective, and efficient will be at the 5% coinsurance. With the other change, we will be removing our mail order pharmacy to align with the retail as a coinsurance instead of copayment. Any questions on the Classic UMP? I'll move right along. Yes. Absolutely Margaret.

Margaret Stanley: On the prescription drug, do you expect the mail order to be cheaper than the retail?

Nicole Oishi, HCA: Actually if I can, I will turn to Elizabeth James and ask her, she runs the pharmacy benefit and she would be able to answer that.

Elizabeth James, HCA: From a contractual perspective, I am actually going to defer that to ODS. From the member's perspective, the cost will change for some of the drugs because some of those Tier 2 and Tier 3 drugs - the cost will increase because the cost is going to the percentage rather than the flat co-pay. However, we have done an analysis of the most commonly utilized drugs at our mail order pharmacy; and both Tier 2 and Tier 3 options have multiple generic options and other alternatives from other tiers, so from the market perspective. . .

Thad Mick, ODS: I would say that both the retail and the mail order benefit will align from a cost stand point. There really won't be one channel that is less expensive or cheaper.

Nicole Oishi, HCA: So, in essence they will be equal now instead of the way they were before. There were some incentives and disincentives to go one way or the other and we are just aligning them to be equal.

Margaret Stanley: So, the drug costs for the mail order are about the same as they are for a retail pharmacy?

Thad Mick, ODS: There are some differences between grade and generics, but they are about the same.

Nicole Oishi, HCA: For the record, that was Thad Mick, who was the director of the ODS Program for UMP. Any other questions about UMP? I will move on to the Group Health Classic Product and again I am just going to highlight the changes rather than reading everything on the slide. In order to be consistent with UMP, Group Health will be changing their out-of-pocket maximums for the family to $4,000. It was $6,000 and it's now going down to $4,000, so that is an improvement for the members. There is some changing to the office visit co-payment structure to encourage people to utilize primary care physicians. So you will see that as well, they are going down to $15 with the specialists visit's going up to $30 for the co-payment. Harry do you have a question?

Harry Bossi: How does this encourage them to use primary care as opposed to the past?

Nicole Oishi, HCA: Because, before they had a primary care visit at $25 and a specialty care visit at $25, and now it is $15 and $30.

Harry Bossi: OK. I thought you were trying to make a correlation on a network and a non-network which doesn't exist here so that is why I was confused.

Margaret Stanley: What is the financial impact of moving from the $25 co-pay to the $15 and $30?

Nicole Oishi, HCA: Financial impact – Ben or Patty?

Margaret Stanley: How it affects the premium.

Nicole Oishi, HCA: We can certainly get that information for you. It doesn't look like either of our experts…we can get that for you. Ok, go ahead.

Ben Diederich, Milliman: Overall, the total change is a financial wash. There may be a piece specific to the physicians; but it may not be, because we have other benefits that are changing.

Margaret Stanley: You mean the overall premium is a wash.

Ben Diederich, Milliman: The overall benefit relatively is a wash, but on a physician specific side of the question there is probably a change from a $15 and $30 average to a $25 overall.

Harry Bossi: If I can jump in again. I understand and encourage people to use a primary care physician when they need one; but I guess the concern I would have is maybe over-encouraging, over-utilization potentially, once the deductible is met. It's not much of a thought process to go there. It's just an observation. I would be really interested to see how the impact might affect the premium.

Nicole Oishi, HCA: We can certainly get that information.

Margaret Stanley: I kind of question the wisdom of reducing co-payments when we always struggle with health care costs. If people are accepting the $25 co-payment now, I don't understand why we would make it less when we are adding co-payments in other areas.

Nicole Oishi, HCA: We can do some research and certainly get back to you on that. I would say one of the things that Group Health has made it clear to us about is that they are really trying to move to a value-based benefit design; and one of the things that value-based benefits do is decrease or remove barriers, provide incentives to get people to make a good choices, and put more barriers or more costs to make a choice that may not be as good. I think Group Health, in this year's products, are really trying to begin that process of stepping into value-based benefit design. And I'll turn to Patty to see if you have anything to add.

Patty McKeon, GHC: I would just add that value-based benefits are really to encourage people to do the right thing, to take care of their chronic conditions, to see primary care doctors when they can, so to encourage the high value care and reduce barriers. We have seen that and this change has helped that, helped people with their chronic conditions and to go see a primary care doctor when they need to.

Nicole Oishi, HCA: Other questions, or shall I go on?

Margaret Stanley: I would be interested in any evidence or experience that you have on that. I just had some question in encouraging primary care when maybe a specialist is what is needed and it seems like it makes more sense to have an equal cost because maybe the specialist is going to get to the source of the problem, rather than repeated visits to a primary care physician.

Doug Porter, HCA: Other questions or comments?

Nicole Oishi, HCA: The next change I will talk about is the change on the inpatient co-payment decreasing to $150 per day. However, increasing to $750 and changing it to per admission instead of per year. Ambulatory surgery centers increasing the co-payment for those types of services to $150, $100 co-payment for MRIs, CTs, and PET Scans. Also, adding the retail and mail value similar to UMP for those medications identified as being most costly and efficient, changing to a percentage for ambulance and increasing the emergency room co-pay to $150.

Doug Porter, HCA: I am sorry, Nicole, did you say most costly or most cost effective?

Nicole Oishi, HCA: I may have said most costly out of nerves, but I meant most cost effective. Most cost effective. Are there any questions about the Group Health Classic Plan?

Lee Ann Prielipp: I actually have a comment more than a question. It looks like Group Health again is trying to bring the plan a little bit more into line with what UMP is, is that on some of these factors what I'm seeing?

Nicole Oishi, HCA: Yes. Their first indication to us was that they are trying to move towards the value-based incentives and that sort of plan design, and I think also aligning a lot of it with UMP. Yes.

Lee Ann Prielipp: Ok.

Harry Bossi: Was there any discussion about the diagnostics, to limit the out-of-pocket on the co-pays to $300, $400, or $500 for example?

Nicole Oishi, HCA: Well, the out-of-pocket maximum is $2,000.

Harry Bossi: Isn't that just specifically on the diagnostics?

Nicole Oishi, HCA: I didn't participate in any conversation about that in particular. I'm not sure if they considered that.

Margaret Stanley: As we've discussed, Nicole, I am concerned about the co-payment on the MRI, CT, and PET Scans; and I do understand that doctors feel under pressure from patients to order these scans sometimes, and may do so when they may not think it is necessary, like an MRI for instance on a headache. All of the ordering is done by the doctors, and they are the decision-makers. Group Health has more ability than other plans to have this kind of discussion with their doctors and they have good data on what the problems are with over-utilization. I'm sure doctors vary. My concern is that you have some patients who would be over-utilizing and we don't know how many there are; but we also have a lot of patients who are really sick who have to get repeated CT Scans. As far as I know, the only people who get PET Scans are cancer patients; and I just worry that this, in addition to special co-payments on radiation and chemotherapy, is sort of targeting sick people when the idea of health insurance is to spread the cost over a large population so the people with the high costs can be paid for by all the healthy people. I understand the logic of this. It doesn't sit well with me to have these kind of co-payments, and I know you told me earlier that other plans are doing it; but if the co-pay on MRI, CT, and PET Scans saves only a quarter of 1%, I think that's not very much money for having this impact on people who I think are mostly sick. I think we ought to consider whether we really want to do this, some of these co-payments. I also worry about the confusion to the employees and retirees if we add all these different co-payments for different services. Health Insurance is hard enough without making it so complicated.

Greg Devereux: I would like to second Margaret's comments. I followed the e-mail string earlier in the week. I just have a lot of concerns with Group Health Classic when you combine the MRI, CT, PET, Scan increase with the jump from $0 to $30 or $15 for radiation or chemo. All of a sudden, folks are going to have serious costs. As Margaret said, I think within the Group Health model they have much more ability to regulate than in other situations. I think we ought to seriously look at the MRI, CT, PET Scan because I think a lot of those are required in certain situations and folks can be going from $0 to $500 without blinking when it's really necessary in any given year. So, I think the Board should seriously look at this.

Doug Porter, HCA: I just want to ask if there was consideration given to the folks that Margaret is talking about being very sick, perhaps having a cancer diagnosis. Aren't these folks today hitting their out-of-pocket maximum anyway?

Nicole Oishi, HCA: Many of them do, yes. Yes, absolutely. Most of the people with a cancer diagnosis are getting lots of services, both radiation and chemo or having to have repeated PET Scans, would be meeting their out-of-pocket maximums very quickly. So, yes, the answer is to your question.

Doug Porter, HCA: I know on the Medicaid side we are starting now to have a lot of conversations about introducing co-payment structures which we have never talked about having before and I think you are not really targeting the sick folks in that regard, in the Medicaid program, but rather giving the caregiver, the prescriber some talking points about if you insist on this course of treatment this is what it is going to cost you out-of-pocket. Where today there isn't that type of disincentive in the Medicaid program. I am an endorser of this approach and I think that there are adequate protections built for folks who are very high utilizers just given the out-of-pocket maximum protections they get on that.

Lee Ann Prielipp: I agree basically with what Margaret and Greg were talking about. It is such a big jump and so fast to go from having nothing, having it covered, to where it is going to put people when there should be some built in ways in which to regulate the costs.

Nicole Oishi, HCA: I would just add that I agree with you that there should be some way to prevent unnecessary imaging, unfortunately, the community, the physicians, the standards, there isn't that protection in this environment; and so we don't have a lot of those protections in play. For Group Health, half of their members are not part of their network. They are actually in their extended network if you will and so are not their physicians using their epic system and that sort of thing. To be able to offer the breadth that they do, they do have physicians that do not have access to some of the tools that help manage more efficiently - radiology and high-end imaging.

Greg Devereux: I have to respond to Doug. Unfortunately, I have seen a lot of people recently who have had both chemo and radiation; and I agree they would meet their out-of-pocket maximum quickly, but I have also seen a lot of variations, some people have radiation, some people have chemo and they wouldn't necessarily meet the out of pocket maximum. They would incur hundreds of dollars in MRI, CT, and PET Scans that they wouldn't otherwise. I think there is quite a variation out there.

Doug Porter, HCA: Other comments from the Board?

Nicole Oishi: I will move on to the Group Health Value Plan unless there are other questions. The Group Health Value for Non-Medicare members. Again, I am just going to go through and highlight the changes. Again the decrease in the maximum out-of-pocket to $4,000, a similar style to what we saw in the Classic with a lower cost co-pay for primary care visits, and the higher cost co-pay for specialty care visits, the same with the admission for inpatient changing from a per year co-payment to a per admission co-payment, an increase in the ambulatory surgery center, the co-payment for MRI, CT, and PET Scan, as well as the value tier being added for those cost effective medications. Increase in the ER co-pay as well. Other questions related to the Value Plan or comments?

Doug Porter, HCA: I'm noticing that the labeling here, Nicole, on the inpatient hospital co-pay, it says $300 a day / $900 per year. Is that $300 per admission or $300 per hospital day?

Nicole Oishi, HCA: The way that it used to work, it was $300 per day up to $900 per year.

Doug Porter, HCA: So under the 2012 column that should say $200 per admission?

Nicole Oishi, HCA: $200 per day, up to a $1,000 per admission instead of per year.

Doug Porter, HCA: So, you could be admitted and stay in the hospital five days and have a limit of $1,000?

Nicole Oishi, HCA: Correct and if you stayed in the hospital in that admission for six days, you would still pay $1,000; but if you went back you would start over again with $200 up to five days.

Doug Porter, HCA: Gotcha.

Margaret Stanley: I was just wondering on the Group Health changes, in total, how much do they impact the premium versus keeping the benefit design as it was?

Ben Diederich, Milliman: We can ask Patty to comment; but as far as I know, both benefit design changes were a wash financially, so there would be no impact.

Nicole Oishi, HCA: I am going to try to say that in a different way, then I will ask Patty. I think what he is saying is that essentially, because there is the decrease in the out-of-pocket maximum, and because of some of the increases in benefits, that it is essentially exactly the same cost as the pre-2011 benefit design. That the value of the benefits for Group Health Value are the same as the value of the benefits for the 2011 Group Health Value. They are tweaked but they are not tweaked in a material way in terms of cost.

Harry Bossi: I would like to ask a question and there is probably an answer that I have been presented before; but because of lack of experience, I haven't heard it. These are looking more and more like each other, the Group Health Value and the Classic. The question to me is longer range does it make sense to have two separate plans if they have to be administered separately with the same system but different mechanics involved behind it. The cost to do all that, to maintain two separate programs, couldn't somehow be combined into something where the premium could be adjusted where it would be attractive to the same people whether they were currently in the value or the classic.

Nicole Oishi, HCA: I think I will respond to that by saying I think the Board knows that we were hoping to provide what we are referring to as the UMP 2 product; and as a result of that, Group Health was also planning to provide a different plan design under their Value Plan. Because we decided to defer that product until 2013, I think that Group Health had very little then to decide how they wanted to re-tool their product offerings for 2012. I think all the points that you just made are things that Doug is going to need to sit down with the procurement team and evaluate exactly what is our strategy for 2013 and what does that look like for Group Health. Other questions related to the Value Plan for Group Health before I move to Kaiser?

Kaiser will be offering two products this year, their Classic Plan, which I will go through now. They did not offer the Value Plan last year and I think Renee talked through that change

already. Really, the only changes to the Kaiser Plan this year is the introduction of a deductible of $150 / $450 for families and then changes to how they cover inpatient hospital care, ambulatory surgical centers, and ambulance to a 15% coinsurance instead of the co-payment they had prior. Questions about Kaiser?

All right, I am going to move onto the Consumer Directed Health Plans. So, the board, if you look in the back of your packets, I provided you with five different examples of UMP, current UMP members, all HIPAA protected information redacted that if they had the Consumer Directed Health Plans, it shows exactly how their benefits and what would have happened to their out-of-pocket maximum. I am not going to go through those today. A few board members had asked for those, which I sent them out and I found them to be helpful and a few other people said that they were really helpful. We do have staff that is happy to answer questions related to those. I think it provides information to show how this Consumer Directed Health Plan works; and if you have certain different services, at the end of the day, what does your out-of-pocket amount look like if you stayed in the Classic Plan, or if you moved to the Consumer Directed Health Plan. I will go ahead and talk through the plan designs.

UMP, Group Health, and Kaiser are all offering a Consumer Directed Health Plan with a Health Savings Account for 2012. The state will be providing a $700 employer contribution to the Health Savings Account. It will be put into those accounts on a monthly basis, so it will be prorated and monthly. The benefit designs are similar and a lot of them controlled by the IRS. There are some very strong stipulations about how Consumer Directed Health Plans and HSAs have to be administered, including limits on coinsurance and co-payments and out-of-pocket maximums, so they are pretty consistent across the board. For UMP, a single person will have a total out-of-pocket of $4,200. A $1,400 deductible and the rest of that $4,200 are the coinsurance and co-payment. Again, the deductible of $1,400, they are getting the $700 in their Health Savings Account to offset that. So, it really changes the deductible to $700. Coinsurance is varied across the board, but 15% for UMP and Kaiser, and then 10% for Group Health within their network, and then they are also offering a broader network that members can have a choice to select from and those coinsurances are at 30%. Preventive care in a Consumer Directed Health Plan is equally the same as in any other health plan. It is covered at 100% and not subject to any of these deductibles. Office visits, and again I am not going to read through each step for you, but I would be happy to answer any questions.

Doug Porter, HCA: Any questions from the Board?

Harry Bossi: I have one question, I don't recall from several months ago when we first started talking about this earlier this year, there was a projection, a planning percentage, I don't recall what it was.

Nicole Oishi, HCA: A switching assumption?

Harry Bossi: Yeah, 6% or 4%, something like that. I just don't recall what it was.

Nicole Oishi, HCA: So, we changed our switching assumptions, based on the fact that we are deferring the UMP 2; and I believe that the switching assumption for UMP is about 10% for this year. Other questions about the Consumer Directed Health Plan I can answer?

Phone Question: Would you be able to repeat that last question and answer.

Nicole Oishi, HCA: The last question and answer, I believe was from Harry Bossi. It was what our switching assumptions would be, so how many from UMP, Harry, I am assuming I am getting this correct. How many people from UMP Classic do we think would switch to the Consumer Directed Health Plan? The answer I gave was that we had to re-tool our switching assumptions because we are deferring the UMP 2 option, and we believe our switching assumption for the Consumer Directed Health Plan for 2012 to be around 9 or 10%.

Doug Porter, HCA: Can I ask the caller to identify himself or herself for the record?

Phone Question: Yes, this was Carrie Zambrano from Regence Blue Shield.

Doug Porter, HCA: Thank you.

Nicole Oishi, HCA: So, if there are no further questions related to…Margaret?

Margaret Stanley: Could you take us through one of these examples, please?

Nicole Oishi, HCA: Absolutely. As long as you bear with me, I didn't create these examples. Bettina Maki did a fantastic job. Margaret are you interested in the single, is it easier to go through a single or there are three single people and then there a couple family.

Margaret Stanley: Just pick one, whatever is fine.

Greg Devereux: Before you do that, I asked you this question earlier in the week. It is $700 for a subscriber, a member; it's $1,400 for a subscriber and a spouse or dependant?

Nicole Oishi, HCA: Correct. There are only two tiers on the contribution from the employer. It is $700 for a single, $1,400 for two or more.

Greg Devereux: Thank you.

Nicole Oishi, HCA: Absolutely. So, I will just go through the first one, since it is relatively easy. What Bettina did was capture, obviously by month, the allowed charges that this person had. This person is a relatively healthy member that had few services outside of their preventive care services. The last two columns are what the member would pay if they were in UMP Classic; and the very last column is what the member would pay if they were in the UMP Consumer Directed Health Plan with the Health Savings Account. Bettina just walked through. The doctor billed $49. Under UMP Classic, the member would have paid $5; and under the Consumer Directed Health Plan, the member would have paid $49. So, she just went down each month. Again, these are actual real life examples for services and then at the bottom totaled. The total of what the member paid out-of-pocket was $421 for the UMP member, sorry in the UMP Classic, and then $1,000 in the UMP Consumer Directed Health Plan. When you then take into account the difference in premiums, which is the next line, and the $700 that gets funded into the members Health Savings Account, you come out with that the person with the UMP Classic would have spent $1,489, where as the person in the Consumer Directed Health Plan would have spent $615. Each example is built that way and so what she tried to do was to pull a variety of different types of members so that the examples would be meaningful. Does that help you, Margaret?

Margaret Stanley: Yes, thank you.

Ben Diederich, Milliman: We should note that the premium assumption for this was preliminary, so it is a little bit different than what was finalized.

Harry Bossi: Help me a little bit with the June services. Because the member didn't pay the full $961, I think there must be some preventative in there, would that be a good assumption? Don't you have to meet the deductible before any plan payments kick in?

Nicole Oishi, HCA: You do, absolutely and it could be coinsurance as well, if it was inpatient care or pharmacy amounts, because the pharmacy amounts also apply. I didn't get into that level of detail with Bettina on specifically what those services were, $961 represented what our allowed amount would have been for that service and $377 was the member's coinsurance for that visit.

Harry Bossi: Right, my understanding was that the member had to reach the high deductible threshold before any benefit kicked in.

Nicole Oishi, HCA: They have to meet the deductible, correct.

Harry Bossi: Which is $1,400, correct?

Nicole Oishi, HCA: Yes, $1,400, correct.

Harry Bossi: I still don't understand why they would only pay $562 versus $961.

Ben Diederich, Milliman: It's the mix of services, so the deductible is not directly applicable to preventative, so we actually, Bettina actually, created this model to go through and look at the specific type of service rendered. I think it also captures the fact that the claim was in June, so there had been six HSA cash payments; and I believe she took the credit of the HSA cash against the deductible that had been received up until that point. So, we are assuming that members full spend their HSA fund; that they don't save. Had the member been modeled to fully save their HSA fund; then yes, it would have been $961. I am assuming that there is some preventative in there too. It's a preventative and a deductible interpretation issue. I think the option 2 and 3 are interesting to look at side by side because those are different spend rates of pharmacy versus medical. So, number 2 is 87% of total spend came through the pharmacy business and option 3, 77% of total spend came through the medical benefit.

Nicole Oishi, HCA: Harry, if you have additional questions that I am obviously not able to answer, I would be more than happy to have you connect with Bettina. She can walk you through all of these examples.

Doug Porter, HCA: I thought this was very helpful for the discussion to actually see some real life member experience in these different scenarios, so I appreciate the extra work that Bettina did pulling this together.

Greg Devereux: I agree, I think it was extraordinarily helpful.

Nicole Oishi, HCA: I'll make sure she gets that feedback. I am going to turn it over to Elin now to go through the Medicare products if everyone is ready to move.

Elin Meyer, HCA: Thank you, Nicole. Going to your slide 11, we are going to go look at UMP Medicare Plan design; and similar to Nicole's review, I am going to just focus on those changes that are being recommended. The first change is the out-of-pocket maximum recommending that it be increased from $2,000 to $2,500, and the inpatient hospital $200 a day / $600 per admittance with the same professional 15% coinsurance. Similar, to the non-Medicare pharmacy aligning the prescription drug across all products to a coinsurance for both retail and mail. Any questions on the UMP Medicare? Thank you.

Doug Porter, HCA: I don't know if it shows up in the materials, but I was struck by our projection of how much the Medicare premium was going to go up absent some of these changes.

Elin Meyer, HCA: Thank you for bringing that up, Doug. Absent these changes, the projection was that the Medicare premium would have gone up 31.3%.

Doug Porter, HCA: And with these changes, our estimate is…around 7%?

Elin Meyer, HCA: Correct. We will be going through the premiums very shortly. I didn't want to steal Ben or Nicole's thunder.

Doug Porter, HCA: Well, I did.

Elin Meyer, HCA: On the Group Health Medicare Advantage Plan design, slide 12, we talked to the Board previously that Group Health was going to consolidate their Medicare products into a single Medicare Advantage Plan. There was very little difference in terms of the premium or benefit design of those two plans; and so what's being proposed for 2012 is an increase of the out-of-pocket maximum to $2,500, very consistent with the UMP Medicare Plan. Many of the co-pays, as you will see, are very closely aligned with the Value Plan. The office visits at $20, the inpatient hospital has not changed from the Medicare Advantage Value Plan, neither has the ambulatory surgical; and the ambulance also remains the same as the Medicare Advantage Value Plan. What has changed is again the pharmacy, similar to UMP, we are recommending aligning the pharmacy across all of their products, so that will become $20 and $40 up to $250 for retail; and $40 and $80 up to $750 for mail order. The other increase you will see is the emergency room being raised to $65. Are there any questions on the Group Health Medicare Advantage Plan? Thank you. The next slide. I apologize, without those changes the increase was anticipated to be about 7.2% and I won't go into any detail, but with these changes there will be a decrease in the premium.

Greg Devereux: In the non-Medicare world, the benefit changes were a wash really. In the Medicare world, we were using them to bring down the overall cost.

Elin Meyer, HCA: Correct.

Ben Diederich, Milliman: The reason for the drop in the benefits is to compensate for the reduction in the explicit subsidy. So, we went from $189, I think, came down to $150. So, we lost $30 in state funding.

Elin Meyer, HCA: The Kaiser Permanente Medicare Advantage Plan design. What is being recommended is an increase in the out-of-pocket maximum from $600 to $1,500. Similar to the Group Health design, differentiating if you will, some of the co-payments for office visits, those office visits being increased to $30 from $20 with the exception of urgent care being at $35.

The inpatient hospital co-pay is recommended to be $500 admission and the prescription drug benefit both mail order and retail is being realigned to be similar to their non-Medicare product at $20 and $40 for retail and $40 and $80 for mail order. Without those benefit changes, the anticipated increase would have been 28.3%; and you will see shortly with these changes, there will be a decrease in the premiums. Any questions regarding Kaiser? Thank you.

Ben Diederich, Milliman: We are now on to slide 15 which is the presentation of the non-Medicare rates. These are the single employee bid rates which are the cost that's been normalized for any risk adjustment differences between the plans. Group Health Classic, Value, and CDHP were all developed by them corresponding to the plan designs that they quoted. Same story for Kaiser Classic and CDHP and Milliman models, the UMP Classic as well as the CDHP impacts. The overall percentage, weighted average increase after we apply the switching assumption that was 10% of UMP discussed earlier, is a 4.4% change. Questions?

Greg Devereux: Yes. Do the numbers here currently reflect the switching or not?

Ben Diederich, Milliman: Yes, they do.

Greg Devereux: They do. So, why, if the three major plans with the most people in them are above 5% and Kaiser Classic is pretty small, how does it come out to 4.4?

Ben Diederich, Milliman: The cost relativity of the CDHP Plans on a bid rate basis is influencing that total average. So, if we look at UMP for example, it is $529 for the Classic Plan and $484.

Greg Devereux: I see.

Ben Diederich, Milliman: What is not shown on here is the total spend in 2011. When we take the total spend in 2011, compare that to the projected spend for 2012, it is a 4.4% increase. We are getting a savings to the program through the enrollment in the lower cost CDHP Plan. The lower cost CDHP Plan is mostly a function of switching of healthy individuals. So, the healthy individuals are going to see that high deductible, not be afraid of it, switch into the UMP high deductible plan which is going to raise costs a little bit on the population that stays, and lower costs for those on average for those people that come into the CDHP. That is why the bid rate is lower.

Greg Devereux: Your switching assumption, the 10%, is that CDHP as well? So, 10% total of the total population will switch to something else?

Ben Diederich, Milliman: No, I don't know what the composite average switch worked out to be. Do you know that off the top of your head, Kim, for grand total population? Kaiser and Group Health switching were around 2%-3%. UMP was the highest at 10%.

Greg Devereux: Switching to UMP or away from UMP?

Nicole Oishi, HCA: Switching to the Consumer Directed Health Plan.

Ben Diederich, Milliman: We had no inter-plan switch. We took the total UMP population in 2011, we switched off 10% of the enrollees to UMP high deductible for 2012.

Greg Devereux: So, there is no inter-plan switching built into this at all?

Ben Diederich, Milliman: No assumed inter-plan switching.

Greg Devereux: But haven't we had inter-plan switching forever?

Ben Diederich, Milliman: We always do and it is always a function of something that gets corrected after the open enrollment, so we set the contributions now and then we experience open enrollment. The effective contribution rate is always not going to match the 15% that's been bargained.

Nicole Oishi, HCA: But historically, switching is very, very small, of people that leave UMP to go to Group Health or leave Group Health to go to UMP. Those numbers are very, very small.

Ben Diederich, Milliman: Mostly driven off of situations like 2011 where the Aetna plan gets eliminated and those people have to find a home somewhere else. But most of the time, the UMP enrollment stays within UMP and Group Health enrollment stays within Group Health.

Harry Bossi: If I could jump in, I guess this is common because that same stability that you talk about in the normal year - will that reluctance to move somewhere else, will that be a barrier to overcome to move 10% to the high deductible? So, there is a lot of work, communications-wise.

Ben Diederich, Milliman: Yeah, we have a very sticky population that tends to stick with the plan they like. The 10% is a stretch target to try and achieve. But we are optimistic that we have put the right incentives in place. I mean a $700 differential in Bettina's example, that's a significant reduction. And I am talking about the premiums, I am not talking about the cash. In Bettina's example, it was $1,068 in annual premiums for the Classic versus $312.

Greg Devereux: Is there any explanation that jumps out, why the Consumer Driver Health Plan, all of them are within $4 of each other? All three of them are within $4 of each other.

Ben Diederich, Milliman: The thing in my mind that jumps out is that you have a range of enrollees in each of the three plans that's fairly similar, so I think at some point, we were looking at the classic HMO argument that they are being selected against the individuals that are looking for the least out-of-pocket. I think the population now is a little bit more diffuse within the Group Health population, so that there is that opportunity to draw out the healthiest people from each plan. We don't have an aggregation of all the sick within one plan so that we don't have a selection dynamic. I think what happened in the pricing of the three high deductible plans is that you have to make a guess of what that relative cost is versus the relative risk score. These are all bid-normalized rates, so I think everyone kind of assumed the same order of magnitude on what the risk score of the population that was going to switch over to the high deductible and what the total cost of that person was going to be.

Nicole Oishi, HCA: Does the fact that the benefit design, also that they are all very similar in terms of the benefit design…

Greg Devereux: They are not all that similar though…

Ben Diederich, Milliman: The deductible levels are all the same.

Greg Devereux: But the out-of-pocket are very different.

Nicole Oishi, HCA: We have very few people that meet out-of-pockets even under our regular plans, so really looking at the deductible, getting that the cash of the $700 was the similarity that I was referring to.

Greg Devereux: So, really all the plans are looking at that data when they are making their bids.

Ben Diederich, Milliman: Each plan's looking at their data of their population that they have enrolled.

Greg Devereux: So they know how many folks have come to the out-of-pocket, reached the out-of-pocket when they are bidding?

Ben Diederich, Milliman: That was one of the key inputs when we priced the UMP high deductible plan - is to look at that range of population within the individual buckets of claims spent.

Greg Devereux: I just find it interesting that it is that close when they don't have similar information.

Ben Diederich, Milliman: I think it goes back to the similarity that the plans are now getting to. I think Kaiser is so small they didn't have any real…we also did a very transparent procurement on the high deductible health plan which may have had an influence there. But Kaiser aside, Group Health, I think has a very similar range of population between the two plans in aggregate that UMP is covering in totality. We are both dealing with the same type of person; and I think when you go to pull from those two pools, you are going to get a very similar answer because you have healthy people that you are drawing out with similar incentives.

Margaret Stanley: Could you remind us on the non-Medicare retirees and other self paid people on the CDHP, how the employer funding works. Is the $700 built into the premium in some way?

Ben Diederich, Milliman: Yes, I guess we have to go two slides ahead but we will get to that when we get to slide 17.

Margaret Stanley: Ok.

Ben Diederich, Milliman: Slide 16 is the active employee contributions calculated by tier. I am not sure if anyone has any questions on the methodology to get to these figures. Go ahead, Greg.

Greg Devereux: I would love to see, and I know you won't have it now, but I would love to see the difference, because I will be asked by members, state employee members, the difference between the 4.4 weighted average versus the 12%-15% employee increase. So, if there is a way to see that across the tiers, I would love to do that.

Nicole Oishi, HCA: Kim Grindrod will provide that. We should be able to get that to you tomorrow.

Greg Devereux: Thanks, very much.

Margaret Stanley: Will you send that to all of us?

Nicole Oishi, HCA: Absolutely. So, are there any other questions?

Ben Diederich, Milliman: One thing that I would like to point out, for the high deductible health plan, we are using the same exact tier ratios as the non-high deductible plans. So, even though the cash contribution is two times, we are still varying the employee contribution by 1.75 and 2.75 for the tiers of employee and children and full family.

Nicole Oishi, HCA: I will move to the next slide where I think is where Margaret had a question, so I am going to let Ben talk through this slide, too.

Ben Diederich, Milliman: This is the retiree contribution. We have the same tier ratio comment that I closed the last slide with where the CDHP Plan is the multiple of the same tier ratios as the non-CDHP Plan; and then we have the additional spouse surcharge. So these retiree contributions include several components beyond the bid rates that were presented a few slides back that include the administrative expense for the Health Care Authority that they need to charge these individuals, the ERRP reduction that was collected through the federal government program, and…anything else?

Nicole Oishi, HCA: You got it. Questions about this slide?

Gwen Rench: If I could clarify, so the state for retirees on the CDHP Plan will contribute $700; whereas if you are just on Uniform Classic, there is no contribution.

Ben Diederich, Milliman: No, the employee contributes the $700.

Gwen Rench: Oh, the employee does. Ok, thank you.

Ben Diederich, Milliman: It is embedded in this premium rate that is shown on this slide. So, the $480 single retiree rate is the premium that has to be paid for the high deductible health plan portion and a required HSA contribution of $700.

Nicole Oishi, HCA: Again, it is prorated, so it would come out monthly.

Gwen Rench: I guess my confusion comes from the little asterisk where it says the employer's annual contribution $700 per subscriber.

Nicole Oishi, HCA: That makes sense. We should take that off of this slide. That, in fact, does not apply. You are absolutely correct. Good catch. I am going to turn it over to Elin to talk about the Medicare Retiree Premiums.

Elin Meyer, HCA: Moving on to slide 18. The Board may recall that the Medicare Retiree Premiums are tied to the explicit subsidy approved by the legislature, which for 2012 is maximum $150; but it is $150 or 50% of the plan premium, whichever is less. This slide actually reflects those premiums that I mentioned; Group Health and Kaiser will have a premium reduction. Uniform Medical Plan will go up to $213.87 in 2012. We did not talk about the Premera Medicare Supplement F Plan Design because that plan design is dictated by federal regulations; but it has been approved by the Office of Insurance Commissioner. It will become $99.77 for the retiree population and $175.93 for the disabled population.

You do not see Secure Horizons on our premium slide because we will not be contracting with them in 2012. Members who do not choose an alternative plan during open enrollment will default to UMP. Just as an FYI, Secure Horizons has now approximately 2,400 members, not subscribers, but members; and they are primarily located in Thurston, Snohomish, Clark, and King Counties. So, those members would have a choice during open enrollment of either a managed care plan or the Uniform Medical Plan. We always caution the Board that the Group Health and Kaiser Medicare Advantage rates are subject to federal review and approval; and that normally does not occur until a later date, September or October. We've mentioned that this is an estimated premium. The Board will vote for the explicit subsidy rather than the actual premiums on the 20th. Are there any questions on the Medicare Retiree Premium slide? Yes, Margaret.

Margaret Stanley: I think that it is important for us to recognize that the gap between say Group Health and the UMP has grown from $60 a month to $84 a month. I think we could expect more switching based on that difference; and probably a fair amount of comment from people not understanding why Group Health is going down and UMP is going up. I kinda wonder if some of the increased co-payments on the Group Health Medicare Advantage are really so necessary. I think you may get some switching that maybe you didn't want.

Nicole Oishi, HCA: For the Medicare portfolio, what we did this year, we actually convened a group of stakeholders, and Lee Ann participated in that; and I am speaking on behalf of Mary Fliss from the Health Care Authority who shored up that project. But the Group Health and Kaiser plans we made the decision to utilize the same plans that they take to the market, very similar plan designs in order to purposely, so we could have those premiums go down, because what we heard in that stakeholder meeting consistently was that the premiums were too much. So, that was one of the big reasons why that change was made. The difference, if you will, between Group Health, Kaiser, and Uniform Medical Plan, a lot of it speaks to the difference in the benefit design because Uniform Medical Plan provides an additional benefit, if you will, that is different than what those advantage plans offer and they are subsidized by CMS. There are definitely differences. I think it will be on us to be able to describe those during open enrollment to say, "here's what you are signing up for" so that people are clear. I don't know if you want to add anything.

Lee Ann Prielipp: I think you explained it well and during those meetings one of the comments I remember clearly was the fact that retirees are looking at, of course, the change in explicit subsidies. So already they are going to be paying more from that aspect, no matter which retiree plan they have. The other part was they didn't want to make changes to such things as hearing and vision and the kinds of things that it appears more retirees use than some of the active members do. So, there was quite a bit of discussion about how that goes about; and the input I am receiving from members who belong to both Group Health and Uniform, is they are committed to the type of plan that they are in, either one of those. For the UMP, they feel very strongly that they seem to have more choice and they like that and want to be able to continue doing that. Those that look only at the premium don't seem to have the commitment to whatever plan it is and they probably tend to be a little more healthy than some of the others. I think that is how much of our discussion went.

Nicole Oishi, HCA: I think also to the previous comment about strategies for 2013, I don't think that the work we are doing to shore up our Medicare offerings is done. I think that we have just barely started the work to figure out what our Medicare portfolio should look like, and I think that

those strategies are going to be developed as we move forward. Other questions? I am going to turn it over to Elin to talk about what I refer to as the others.

Elin Meyer, HCA: If we could turn to slide 20 we will spend a little bit of time talking about long-term disability and the life insurance procurement at a high level. Very good news - long-term disability. The employer paid basic coverage. There is no increase in the premium and we did negotiate a 25% reduction in the premium for the employee paid supplemental coverage. Any questions on LTD? So, moving right along.

On life insurance, very similar, favorable trends, the employer paid basic coverage will be reduced by 19.5% and the employee paid supplemental. There are two bullet points here. You may recall that our current design has two supplemental plans which historically have been somewhat confusing. We will be collapsing those into a single supplemental plan. No person, no member will lose any coverage. All coverage that they currently have in both plans will be combined into the new supplemental. In addition to that, members will receive a 15% reduction in their employee paid supplemental premiums due to the favorable trends starting in 2012. The retiree paid basic will be $6.57 per retiree per month. You may recall that it is a very limited benefit; but last year we implemented a new product for employees that were leaving state service giving them the ability to apply for what they call portability, porting their active coverage into either retirement or leaving state service. Any questions on the life insurance?

Greg Devereux: Any explanation for the dramatic favorable trends?

Elin Meyer, HCA: We've actually had good trends for approximately 3-5 years; but because of the unpredictability of claims trends, we wanted to wait another year before we actually implemented premium reduction. What you will actually see in the contract is the opportunity for a multiple year reduction because the trends have gone long enough that from an actuarial perspective we think that it is safe to reduce the premiums at least for one year, but possibly for two to three years.

Greg Devereux: Because of experience?

Elin Meyer, HCA: Because of experience, yes. Not very many people going out on LTD or dying.

Doug Porter, HCA: That is good news!

Elin Meyer, HCA: That is good news, yes. That's because of our good medical benefits. Dental premiums, moving right along, slide 21. Again, very good news experiencing favorable trends. Uniform Dental Plan, you will see that premium has been reduced to $45.20 from $47.63. That's where most of our population is enrolled. Delta Care, what you will see is a flat rate, although you do not see it on this slide, we have a two year rate guarantee of no increase; and again, part of what is behind these very favorable rates is the Washington Dental Service rebasing their reimbursement rates. Willamette Dental, again a very modest increase going from $40.74 to $42.68. Just a reminder that the employer pays for the employees and the family. The retirees self-pay the full premium. Any questions on dental? I am going to turn it back to Nicole to talk about next steps.

Nicole Oishi, HCA: It looks like we made it through the slide deck and we are all still here. We are hoping to have our next meeting next Wednesday, same time; and we will ask then for the

Board's votes on the 2012 Medical Plan Benefit Designs that we talked through today. We will ask for your vote on the 2012 active employee premiums and we will ask for your vote on the 2012 explicit employer Medicare contribution.

Margaret Stanley: I have a request for information by next week before we vote on this. I am still not convinced that the changes in the Group Health design are necessarily beneficial; and it may be that the Board is getting briefed kind of late on the concept of the value-based benefit design; but if there is some evidence from Group Health implementing this previously or of some studies on these changes, I think that would be helpful. Particularly like lowering the office visit co-pay from $25 to $15, and then the diagnostic co-pays, and the radiation and chemotherapy.

Nicole Oishi, HCA: What I can do is we can certainly get some of that information from Group Health. I can also share with you studies and things that have been done in other states. Oregon is very active in their value-based insurance plans. We will include the entire Board when we get that information for you and we will try to get it done this week.

Doug Porter, HCA: Other comments or questions from the Board? Thank you very much.

Public Comment

Susan Burns, Nancy Ellison, and Lisa Jaenisch, United Health Group: Thank you, Mr. Chair. For the record I am Nancy Ellison, I work in Government Relations for the United Health Group. Lisa Jaenisch, I am a Strategic Account Executive designated to the PEBB account. I am Sue Burns and I am the National VP of Client Management for UnitedHealthcare's retiree business.

Nancy Ellison, United Health Group: I brought reinforcements because these are the folks who actually know what they are talking about, but thanks for the opportunity to come. We will be very brief. United has been offering, and before us Pacificare, the Secure Horizons product to our members, your retirees for about a dozen years and it has been a positive relationship. We have had a good working relationship with your staff and consultants. So, these are not in any way personal comments about the folks that we have worked with. A few weeks ago, we received a two-line notice from the consultant that the Secure Horizons product was being recommended to be dropped. It appears that we are the only plan that was recommended to be dropped; and perhaps the only one that didn't get an opportunity to offer a revised rate and a restructured plan design. We would respectfully request that you revisit this recommendation and here in a nutshell are our reasons. As Nicole said, or Elin, we have about 2,400 enrollees. It is a modest amount, but they have been very loyal folks. Half of them have been with us more than ten years; the other half, almost that long. They have clearly found some value with the product. The average age is close to 78, a number of them are quite a bit older than that. We think we are the only Medicare offering that is statewide as far as our network goes, our open network. We have looked at where our folks receive their care, at who their providers are. It appears that most of them will either need to join an HMO to get the full Medicare advantage benefits and have to change providers in the process; or keep the provider the same and go into the UMP and give up some benefits, kind of the trade-off that Lee Ann was talking about. Even though we weren't invited to, we took the liberty of submitting to staff a reduced rate product that we think is sensitive to your concerns about both affordability and choice. I'd like to ask Lisa to very briefly discuss that.

Lisa Jaenisch, United Health Group: Actually what you see in front of you is a little bit off. When we came early, I saw some of the numbers, so I penciled in some revisions. Based on

now the 2012 proposed subsidy of $150 for a retiree from PEBB, and our proposed rate of $324 per member per month, which is about $100 decrease, same plan benefits as 2011; but at a reduced premium would cost the retiree about $174 a month, which is actually a decrease of just over $73 per month in premium. Now when I compare that to the Uniform Medical Plan, so I am going to assume that the retirees would want to keep the same provider, their choice would be the Uniform Medical Plan. If we compare that to the 2012 rate, the members are going to see an increase of about $40 per member per month in cost. Again, our rate was based on the same plan design; and when Elin reviewed today the Kaiser Plan and the Group Health Plan, there were some changes in benefits. If we were given the opportunity, which we would welcome, to give a quote for those same benefit plan changes, we could even see a further reduction in the premium for 2012. Again, ours was based on the same plan design as 2011. Just very briefly, our out-of-pocket max is at $750, which will compare now to an increase of about $2,500 to the UMP. The plan designs are a little bit different, but still feel like the Secure Horizons plan from 2011, was a richer plan than what is being proposed for 2012. Thank you.

Nancy Ellison, United Health Group: We would be glad to answer further questions, or just have you contact us through staff after this to get additional information. But we do feel that retirees ought to have at least one Medicare Advantage Product that has a broad network with a lot of choices, especially in the areas where most of our members reside. Thank you very much.

Margaret Stanley: I have a question. Actually, I have two questions. The first one is, why do you think your enrollment has only been 2,400; and the second question is, how could you bring down premium $100 per month with the same plan design, you know that's a lot. It kind of makes you wonder if you have been charging too much before. So, I would be interested in hearing responses.

Lisa Jaenisch, United Health Group: Margaret, to answer your first question regarding the enrollment, and I have been on this account for about 2.5-3 years, so I have gone with a couple of open enrollment cycles; and I think some of things that you heard earlier from the staff is that retirees don't make changes, they stay very true to the plans. As Nancy mentioned, we have had members that have been in the plan for ten years; and I think being that there isn't an active UnitedHealthcare Plan, you see retirees when they move from active coverage to retiree coverage they will stay in the same plan that they are. Now you do have retirees, because I have been to your open enrollment meetings and participated in them. You do have retirees that are looking for choice and that will come and talk to us about how do the plans work. I think those retirees that are very astute, worried about cost. In the past our plan has not been as competitive. In working with Elin and the staff, and then going back and working with our underwriting team, we really challenged them to have a very sharp pencil knowing that PEBB has been an important client for us and wanting to retain that membership and being concerned about our 2,400 members who are potentially going to see provider disruption and have to make plan choices. We just worked very diligently with our underwriting team to come out with a very good rate and really trying to reduce our administrative costs internally. Thank you.

Lee Ann Prielipp: The provider service or network that is available to people at Secure Horizons, is it all over our state or how dense is it?

Lisa Jaenisch, United Health Group: We have, and this is something that I can follow up and provide to you, but we do have a service area in most of Washington and also in Oregon. We did increase our service area to include Spokane, I believe effective in 2011. It wasn't

previously a service area. So, we have worked to increase our service area; but what we see in looking at and preparing to come here today is where our retirees reside. They will have some limited offerings. It is really to go back to more of a traditional Medicare product which is the UMP where they would have Medicare primary or they are going to have to switch providers and go to a staff model, either Kaiser if that is being offered where they reside or the Group Health plan.

Doug Porter, HCA: Other comments or questions from the Board? Thank you very much.

Nancy Ellison, UnitedHealthcare: Thank you for the opportunity.

Doug Porter, HCA: Anybody else in the audience who didn't get the chance to sign in on the sign-in sheet wishing to make public comment? Seeing that, let me ask if there are any folks on the telephone that would like to make a comment.

The meeting was adjourned.

Washington State Health Care Authority

D*R*A*F*T
Public Employees Benefits Board
Meeting Minutes

July 20, 2011
Health Care Authority, Apple/Peach Rooms
Olympia, Washington
1:00 p.m.

Members Present:
Doug Porter
Greg Devereux
Phil Karlberg
Gwen Rench
Lee Ann Prielipp
Yvonne Tate
Harry Bossi
Margaret Stanley
Melissa Burke-Cain

Members by Phone:
Eva Santos

Call to Order
Doug Porter, Chair, called the meeting to order at 1:00 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Approval of July 13, 2011 PEBB Meeting Minutes
Verbatim minutes were requested for the July 13, 2011 PEB Board meeting. Approval of these minutes will be postponed until the next PEB Board meeting.

Annual Rule Making Resolution
Mary Fliss, HCA: Good afternoon Chairman Porter, Members of the Board. My name is Mary Fliss and I am the Deputy Director in the PEBB Division. This afternoon I will be reviewing the resolution we are asking you to vote on. This is in follow up to Jason Siems presentation last week to this Board around our annual rule making. For purposes of clarity, we are asking that the rules be revised to designate that employees who are newly eligible for benefits and fail to choose a medical plan within their allotted timeframe, be defaulted to UMP Classic. Currently the rules just read the UMP and now that the UMP will have two products, we would like to create that clarity in the rule itself. We will also be updating for clarity the portion of the rule that relates to the defaulted product, as well to clarify that it is the UMP Classic.

Doug Porter, HCA: Any questions for Mary from the Board? Before, and this would require a vote to set this in motion, so before the Board takes a vote, I would like to ask if there is any public comment. Hearing none.

MOTION: It is resolved that employees who fail to choose a medical plan within the required timeline will, by default, be enrolled in UMP Classic.

Moved. Seconded, and Approved.
Voting to Approve: 6
Voting No: 1

Doug Porter, HCA: We have a series of ten resolutions related to the procurement and I think, in the sake of time efficiency, I will open the floor for any public comment on any or all of the resolutions that we have here. State your name for the record and let us know which of the resolutions you would like to comment on.

Public Comment

Katie Nelson: My name is Katie Nelson. I am going to be speaking specifically on the co-pay increases for diagnostic testing, specifically to Group Health, which is my plan; but it would relate to any of them, and also the creation of the consumer directed health plans. I have great concerns about both of those. I am a public employee and will be affected by them. First, I would like to talk about the diagnostic testing. Diagnostic testing is part of preventative health care and I think that we have all agreed in the health care debate and looking at costs that one of the ways of keeping down costs is early diagnosis and treatment. Diagnostic testing is definitely one of those pieces to help keep costs down in the future. When you put a $100 co-pay on a diagnostic test, you will price many state employees out of the market. They simply will not be able to make the choice to get that testing. Their children will need food and they will put food on the plate for their family and forego the testing that they need. They will go on until they reach a crisis and then we will spend more money because they will be in crisis and it will cost us more to treat them, possibly even reach the point where they cannot treat them. We will lose some of our valuable public servants or their family members, all because we priced them out of an early testing. I find that to be unacceptable. I have MS. Every once in awhile my Neurologist wants to do an MRI to see if my medication is doing its thing. It's preventative, because if they can figure out that my medication needs adjustment early on, they can prevent future physical disabilities. That's going to save the state money because they aren't going to have to do any accommodations for me; and it's going to save my insurance company money because they are not going to have to deal with further complications. Pricing me, pricing my co-workers, out of diagnostic testing is simply penny-wise and pound-foolish. I would urge you to seriously reconsider that option and see if there are better ways to make long-term savings. That is my idea on diagnostic testing.

Now I want to talk about the consumer directed health plans, which I think of more accurately as I call them, health insurance lottery. I understand that these came about because of legislation. I don't think we can overlook or forget how dangerous these plans are both to the physical and financial well-being of public servants. They are actually predatory. They prey on the innocence of our youngest employees. They prey on the fact that, like us, young people think they are invincible and they are not going to need that health insurance. The problem is they are younger and they are actually more likely to get in a serious car accident and need that health insurance. A trip, a broken bone, or a broken bone from driving for a long drive can happen to anyone, cancer doesn't care about age. But we lull these people into a plan because we offer them a cheap premium. It's really a bait and switch and they don't understand the realities. It will take seven years, seven years of never going to the doctor to save up enough money to cover the maximum out-of-pocket expenses that they will have to have if they get seriously ill. Again, it is penny-wise and pound-foolish. It dissuades people from going to the

doctor. It actually gives them incentive to not seek health care. Again, little symptoms go untreated, and again we end up in crisis and more expensive for everybody because they wanted to save that money. That's what it's about, it's not about health care, it's about saving money. If you think that a health insurance lottery is a good idea, then I also think that you should be investing my retirement in lottery tickets, because it's the same thing. These plans prey on the young, the ones that think they will never get sick. My best friend was young, healthy, never a health care in the world until the day they diagnosed her with breast cancer. I was young and healthy, never a care in the world until I went into the eye doctor because I thought I had a scratched eye. I came out with Multiple Sclerosis. If we had the health care lottery as our health insurance, we, like every other lottery player out there, would have lost and lost big. Please, please look at how serious it is and what you are doing to our potential next generation of workers. You are leaving them without the health care that they need to be productive. Thank you.

Doug Porter, HCA: Any questions from the Board? Thank you very much.

Procurement Resolutions

Greg Devereux: Would you prefer the Board spoke, if we have comments, spoke in general, after each one, or before each one?

Doug Porter, HCA: I look to the pleasure of the Board; I am open to either approach. We can have a discussion right now as we invited the public to do.

Greg Devereux: I guess some of it might be repetitive so I would offer some comments to several of them. Probably, my comments would be directed primarily toward 1-3 and 7-9. I have always had a lot of concerns, I have voiced them throughout the legislative process with the consumer driven health plans. I am concerned. We had a good labor coalition meeting this week on them and I am concerned that folks have to have money up front. You know you are going to get it monthly, the $700 month by month or the $1400, there is a cash flow problem with them. I am concerned about the higher out-of-pocket cost and I am just really very concerned about how they will work. I understand they passed the legislature, I understand we are moving forward with them. I guess we will see how people vote with their feet about the products.

I am also concerned about the increase. The Health Care Authority, the staff, has done a tremendous job regarding the rates this year. It is just amazing to me, leaving aside the CDHPs, the lowest rate increase is, I think 5.3%. We are in the second worst, if not the worst depression in this county's history; and I just don't know how, and I am not asking you to explain, I don't know how you explain to state workers who are taking a 3% salary decrease where, if they are in Group Health Classic, their family plan is going up 28%. If they are in UMP Classic, their family is going up 26%. I don't know how we explain to them that 5% or 6% increase is due to productivity gains or due to increases for providers. I don't know why providers need to get increases during this time period. It is just surprising to me and I ultimately think there will be a tremendous backlash. If the recession / depression continues, I think there is going to be a tremendous backlash because of that. Folks can handle increases when their salary balances it out or their salary offsets it; but during this period, it is incredible the impact that folks, state workers, are going to have with a $150-$200 a month decrease in salary and benefits. To someone making $28,000 working at GA or L&I, that's a huge impact, that's a tremendous impact. I understand. I appreciate that the overall weighted average is 4.4 compared to 7, that's tremendous. But I am amazed that in this period, the inflation, however

you explain this increase, it really says to me that other folks in the community are not taking the same sacrifice. I do think that is going to have an impact in the end.

Gwen Rench: I also have a lot of concern, even in looking at some of the information that was forwarded to us in the University of Michigan Study, the value-based. They had questions that people will not get the right medications that will prevent the major health problems. I have heard from people at the retiree picnic yesterday, they were certainly upset about the different increases in costs. Also, they are offended by the idea of people having to pay for chemotherapy, a co-pay for such things. Also, I received an e-mail this morning from someone whose income is going to go down by more than $100 a month because of the difference of how prescriptions will be covered. When you are a retiree without any increase in income coming because the cost of living adjustments have been taken away, it becomes unbearable. He doesn't have the choice to go to generic. He has chronic obstructive pulmonary disease and high blood pressure. He is taking lots of medications and he knows he is going to hurt, hurt too much.

Lee Ann Prielipp: I'd also like to add to what is being said here. The retirees in particular have had their subsidy reduced to $150, which means they have an automatic increase of $32 on top of the premium increase and on top of the medications. When we come down to doing percentages and we change the retail mail so that it is a percentage rather than an amount of money, it is going to cost them a tremendous amount of money and those are the concerns that I have heard and would like to relay to everyone.

Margaret Stanley: I have a question on the radiation and chemotherapy where it says $30/$15. I realize I don't understand what that means.

Nicole Oishi, HCA: It's a $30 co-payment for radiation therapy and a $15 co-payment for chemotherapy.

Margaret Stanley: Ok, I also have a question about the timing on this procurement. My impression is that we are running later than usual and there might be a bit of a jam in terms of getting ready for the open enrollment. Is that right?

Nicole Oishi, HCA: In terms of procurement, we were a little bit behind because of some of the changes that we made that we talked about with the Board, the deferral of the UMP accountability plan, which then changed what some of our other vendors wanted to offer. We are on track without concerns for open enrollment this year or for the plan designs for implementation. The teams that are working on both of those products have not indicated that there's any risk that we won't be ready to go live on 1-1-2012.

Margaret Stanley: If you had additional delay would that cause you problems?

Nicole Oishi, HCA: Additional delay. I think the timelines and the project plans are set up to deliver by 1-1-2012. Honestly, I don't know what the ramifications, I think some of it would depend on what was delayed and what we were doing so I think there are a whole lot of variables in there. I do think there is some significant risk, for example the certificates of coverage or the benefit booklets that are given to members so they know what is covered, those are being written right now so if the benefits were going to change there would be things that would be at significant risks for not being prepared for those members at the time of open enrollment when they need to make choices. I believe this year one of the big things that we

are focused on at HCA and PEBB is to make sure that we are doing the absolute best job that we can to engage consumers and educate people about these products so people know what types of members do better with consumer directed health plans versus members that might choose to stay with Group Health Classic or the Value Plan. Those efforts would definitely be compromised if we had to wait because once the Board votes, we are raring to go to have those types of conversations so we make sure that members pick the best plan for them.

Greg Devereux: Timing-wise the Board has made decisions later than this.

Nicole Oishi, HCA: I don't think I am saying that it couldn't happen. I think what Margaret asked or what I was responding to was the risk and I think the risk is that we would not be able to educate members in the same fashion that we hoped. I also think that if there were significant changes, then we may not have a benefit booklet for the member to understand what the benefits are on January 1, 2012. In terms of if it happened, I do believe that you are correct that it has happened in the past. I was just answering Margaret's question about risk.

Margaret Stanley: I was prepared to vote for these benefit packages because of concern about the timeline; this has come to us fairly late. I am still very bothered by the Group Health Classic benefit package. We know from research that has gone on from the 1970s on that if you add a co-payment that you will reduce utilization for both needed services and unneeded services. People just respond that way. The co-payments on the MRI, CT, and PET scans would discourage unnecessary utilization; but as a speaker from the union said, it will also discourage people that need those services and it could have bad results. I know that the Oregon State Employees plan adopted it, but it wasn't clear to me that they have any experience with it yet. I didn't see anything in the research that was sent to us that looked at an experience with adding this kind of co-payment on imaging. I am really bothered by the co-payments on radiation and chemotherapy because it targets the people that are unfortunate enough to have cancer. A breast cancer patient will go in everyday for radiation for weeks and chemotherapy goes on for months or years. I realize that there is an out-of-pocket maximum and it has been pointed out that the out-of-pocket amount is the same approximately as it would be on the Uniform Medical Plan, but the Uniform Medical Plan treats all diseases in the same way. It doesn't target cancer patients. I think that's the thing that bothers me about this and I don't think there is anything in the literature on value-based purchasing, that talks about adding special co-payments for people who have cancer. I've been thinking a lot about this and I will certainly go along with what the other members of the Board want to do, but I think it is going to hit people badly when they read these benefit changes. As Gwen said from the picnic, it just seems kind of mean. It comes across that way to me.

Eva Santos: I just want to endorse and veto in advance what Margaret so eloquently just said. As I was reading this stuff, I'm away, I'm in Mississippi right now, it hit me hard. One, because I am a cancer patient and I just felt very personally targeted. When you have to go through these procedures and these screenings and using imaging when you are on your last leg of your life, it is very hard to say that now I have to pay a weekly fee to receive treatment that I have been receiving for twelve years. I can probably make it because I am at a salary level that I can save the dollars to do that and it's a matter of priorities. But I think about my employees that don't have the ability to do that and it is truly a targeting mechanism. So I am extremely concerned about that and how it is coming at us, especially on those two fronts - the screening – on imaging, and the co-payment for the treatment pieces especially in the Group Health Plan. The other thing that I am concerned about is that it takes away from our long-term view of the well-being and lifestyle of our employees and trying to change behavior. I think we cannot drive it.

The opposite of what we want to end up doing, which is trying to get people healthy and yet, dealing with the chronic diseases that will face us regardless because we do have an agency workforce and we cannot deny that. That is not going to change. We are only going to get older. I am extremely concerned about these two pieces. Yet I am also concerned that if decisions are not made we are not going to do justice to the education piece to get our employees to understand the real options they have and the decisions that they need to make and that is even a greater concern to me that people will just default to the out- of-pocket option, the lower out-of-pocket portion, just because of this grave economic situation that we are facing today. Thank you.

Doug Porter, HCA: Thanks Eva. Other board comments?

Yvonne Tate: One thought I had was, is there an exchange that could be made from lowering those co-pays? Keeping them where they were and then making an adjustment to the chemo and the radiation and diagnostic co-pays? It was just a thought I had in the Group Health Classic Plan.

Margaret Stanley: Can I just butt in here a minute? I think last week it was said that the Group Health Classic changes were awash with the current years benefit design, so if you just kept Group Health Classic the same, it sounded as if it would be the same premium. It is mainly because I think of the out-of-pocket maximum going from $6,000 to $4,000 and maybe the primary care co-payment. I don't know. Staff would maybe be able to advise on that.

Nicole Oishi, HCA: What I can tell you is, that the cost, on average, it was almost awash; but what Ben Diederich from Milliman went back and did, there was a modest cost change of 1%. So, there was a little bit of change there. I don't think that Group Health can go back, given where we are right now and say that they can't make changes. I don't think that we can do a re-tooling of all of our products at this point, to go back and make a bunch of changes to the plans. I am not saying that they can't be tweaked, but I am saying in terms of re-tooling an entire product, it would not be something that we could do and meet our timelines for open enrollment if we had to go back and start over with procurement again and go back to Group Health and say, please provide us with something different than what you have offered to us. From a complete start over/do over, I am not sure that we have enough time to meet our open enrollment timelines to do a complete do over. I also think that part of the issue, part of the concerns, were related to the value-based benefit design and introducing that to the culture as we move forward to instituting that throughout our portfolio as we have been communicating with the Board since January. Your point about the radiation and chemotherapy, I don't think those are value-based benefit designs. Absolutely not. They are not chronic diseases and the consideration of value-based benefit design and so introducing the 5% value tier for insuring that people can get their medications for low costs to treat chronic disease. Those are the value-based benefit designs and enhancements that have been made to the benefit package to really encourage people to make the right choices. Take your chronic disease medications. So, a lot of the changes that you are seeing in here are really pushing us or starting us on the path of where we are going. What we all know is the benefits as they are right now are not sustainable. I think it is trying to start going down that path.

Greg Devereux: It seems to me with the Group Health Classic, it is less about that and it's more about Group Health wanting to maintain market share. They are lowering their co-pay; they are lowering their out-of-pocket max to be more competitive with UMP and I am not sure why in a week or two at most why Group Health couldn't tell the Health Care Authority why they couldn't

look at the same benefit design from last year or something more similar. I mean they moved pretty quickly from the time their accountability plans were in place to come back to this plan. Nicole Oishi, HCA: Which was before procurement, and so when we go through the procurement efforts, it impacts the rates for not only Group Health, but it impacts the rates for UMP. We had not gotten to that stage when we decided to change the product, when we decided to defer UMP, the accountability plan that was prior to anything going to the actuaries or the rate-building model, to come up with the premiums. That has now taken place and so it is completely a do over because of the way the process works that we would have to re-do UMP. It impacts everything. So that is why I am saying that the timeline would take longer. The reason why it took, I think we had three weeks from the time that we deferred and I could be wrong about that but part of the reason was because, we hadn't gotten to that stage of procurement yet. We didn't have Group Health's offer, if you will, when we said we are deferring UMP 2. We now have all of the offers in, that modeling has been done, and the procurement cycle has gone through, so we are at a different place. Group Health Classic's rates are not…it requires all of those to go back in and for that whole procurement and remodeling effort to be done.

Greg Devereux: I understand that and I appreciate what that would take. I don't do your work in your world every day, but I would be surprised if it took a month to have Group Health Classic re-look at their bid and then to plug that into everything else. I'd be surprised if it took a month to do that.

Nicole Oishi, HCA: What I am saying is that I don't honestly know the answer to that because we would have to go back to the actuaries, we would have to talk to our internal staff. So I don't have an answer for you but I know that the process is bigger than what it was before given where we are in procurement. So, without talking to Tim Barkley or Ben Diederich from Milliman, I don't feel like I could answer that question with any assurance in terms of a timeline.

Greg Devereux: Is it possible, Doug, to take a short break and allow Nicole to talk to those folks and see what it might entail?

Doug Porter, HCA: It's possible and I would certainly entertain that motion. I would like to say a couple words in response to the comments and I respect the points of view that were expressed today, both from the public as well as from the Board members here. I really think our challenge is to strike a balance and I'll start with the comments about the Health Savings Account and the Consumer Directed Health Plan. It was clear, and it was a legislative mandate. I think two or three bills have passed directing us to offer this choice to employees and I don't know how we can maintain the one size fits all UMP structure that we have when there is an opportunity; and as the board has seen with real life examples from UMP subscribers and beneficiaries, there are people who make out a lot better under a Consumer Directed Health Plan with a Health Savings Account, substantially reducing their out-of-pocket liability.

Greg Devereux: Even though I think there are concerns around those plans, I don't hear anybody saying, requesting changes of those plans. Most of the concern I've heard, and my own concern, is around Group Health Classic, some of the changes it that.

Doug Porter, HCA: I understand that and I think what will make to the public comment point about people needing to understand what their profile is relative to the benefits of either a UMP Classic or a Health Savings Account approach. It is incumbent upon us to do a good job educating folks as to how to make that kind of a choice. I just wanted to say that about the

Consumer Directed Health Plan. I feel strongly that it is a choice that we are obliged morally as well as legally to offer employees. I think, as you yourself made the point, Greg, the premiums are getting unaffordable in the standard packages and I think there has to be at least some effort to offer an alternative. To the co-pay issues, I have said this before to you, Greg; but I want to say it publicly here, it's been driven home to me in the Medicaid program that an absence of any kind of co-payment is an invitation to over-utilization. We've got scores of examples of both diagnostic testing and treatments and surgeries and prescriptions that have not only been not necessary for Medicaid clients to have; but in fact, and don't improve their health; but in fact jeopardize their health. While I understand that the Rand Studies talk about how co-payments are a double edge sword, but no co-payments and no skin in the game and no involvement on the part of the consumer is what, to a large measure, has brought us to where we are today with unsustainable health care costs, every year escalating. So, I think we need to find some balance where the patient has got to think twice about the economic realities of the course of treatment that they are asking for.

Greg Devereux: I think that's true generally with office visit co-pays when you have a headache; but you can't really say I think I'll do 20 radiations instead of 30 and having a co-pay on every single one of them. I think makes a huge difference.

Harry Bossi: Can I jump in here for a second? I would like to see the verbatim because I think a lot of the comments I made last week speak to some of the issues that are coming up today. I guess I just feel compelled to say, I didn't understand why the co-pays were reduced generally across the board. I mean I think if I was a consumer, I would say that's a good deal, it's an invitation to an office visit. For those who are healthy don't necessarily need an office visit. So, I was a little troubled that we were lowering those, yet at the same time raising those for those that are really sick, that is with the chemo and the specialized testing. So, I agree there Doug, there is a balance that can be found. I just don't think that the Board was given an array to discuss or to select. I think it would be worth everyone's effort to try to re-strike a balance. There is clearly a limitation with the dollars. We know that. It is going to be a sharing by the subscribers and the state, or the plan. I think just a little bit more work would be worth the time spent doing it.

Yvonne Tate: One other comment, as I think about this. We all know that in any health care plan, somewhere around 15% of the enrollees are driving 85% of the cost; and I know we have struggled with this issue in Bellevue. So, the question is: Do you cover increased cost by having the higher utilizers of the plan pay more, or do you have the folks who don't utilize it as much continue to subsidize the high utilizers at a greater amount? To me, that really is a dilemma here when you look at it. With our health care costs escalating so, this issue just becomes more and more demanding. I know the plan design changes we made for 2011 for Bellevue did shift to having high utilizers paying more rather than having the lower utilizers subsidize. I can't honestly tell you what is best, but we all know playing around with the premiums will never get us what we want because all the cost is in the utilization. To me this is the dilemma which we are struggling.

Doug Porter, HCA: Back to Greg's suggestion about maybe taking a break and having Nicole consult with Tim. It just seems to me that if we were to consider continuing with the Group Health Classic benefit package from this year, that would not be a hard thing for Group Health to rate because there is no change. It would just be their trends and there aren't that many plans in terms of working out the risk adjustment, you know they've been reduced. You've essentially got UMP and Kaiser to manipulate given the new premiums that would be quoted by

Group Health. So, I think it is worth considering given the level of concern that the Board has expressed, or some members of the Board have expressed, about the co-payments that are being suggested.

Nicole Oishi, HCA: Can I just share with the Board one other statement that I think may conceptualize some of the concerns about just saying let's go back to what happened in 2011. Because the programs themselves experienced lower costs this year than previous years, it appears in terms of the increases, speaking directly, Greg, to your point about trend of 5.3%, that has not been historically where our trends have been, and part of the reason why they are lower this year is because all of the things that you talked about, there is a recession going on and those sorts of things. The concerns I honestly have is without introducing some of the value-based benefit designs, is that our trend next year is going to be unsustainable, and that is how we base our rates. So I think I would just add caution to the Board in thinking about not making changes and saying ok, it was a wash for this year, that we could potentially be setting ourselves up for huge risks for next year in terms of trends by not doing something in moving to a more value-based benefit design. I think that the premiums will continue to grow; and again, one of things that we also hear at the Health Care Authority is feedback from our members about how the premiums are not affordable. So I just want to put that out there and caution that our actuaries are actually concerned that may, in fact, be what happens if we are just offering the same plan designs next year. We may find ourselves in a far graver situation next year financially.

Eva Santos: Nicole, let me ask you, do we have a projection as to what we expect most movement from plan to plan would be, kind of percentage-wise?

Nicole Oishi, HCA: Yes, we do and I can share those, but go ahead.

Eva Santos: What I was thinking, one of the worst case situations that we might have is that we do a heck of a job with educating our workforce and our retirees from all these options; and aside from people making decisions around out-of-pocket, they decide, no I need the care, I need the support, I need the coverage; therefore, I am going to go with UMP and so my concern is what will that do to UMP if the trend is that the majority of people leave Group Health and go with UMP.

Nicole Oishi, HCA: We do risk adjustment altogether, Eva. We do a non-Medicare risk adjustment across all plans; and then we do a Medicare risk adjustment, so that would take into account they're not risk adjusted independently.

Eva Santos: Ok, got it.

Nicole Oishi, HCA: We do have switching assumptions when we put the rates together; and I believe for UMP, the switching assumption was about 10% would go to the Consumer Directed Health Plan with Health Savings Account. Historically, what I can tell you is that people appear to be very satisfied with the style of plan they select. Usually, there are very, very few people that switch from Group Health to UMP. That people pick which style of plan they like, the UMP with more choices, but higher out-of-pocket expenses because those members are already paying the percent for the high cost imaging and the percent for the radiation and chemotherapy to the more Group Health structure of a co-pay. So we don't typically see a whole lot of switching between products. Did that answer your questions?

Eva Santos: Yes, yes.
Doug Porter, HCA: How much time would you need in order to consult and answer the Board's questions? Would a ten minute break cover it? Let's take a break for ten minutes.

TEN MINUTE BREAK

Doug Porter, HCA: Bring our Board back to order. Eva was going to call back in ten minutes. Eva, are you there?

Eva Santos: I'm here.

Doug Porter, HCA: Excellent. Thanks, Greg. Nicole let ask you to inform the Board of the deliberations over the last ten minutes.

Nicole Oishi, HCA: I think I will start by saying that I miss-spoke and need to make sure that I clarify that truly the efforts that we are doing now are to be closed out by November 1st. So, when we talk about open enrollment, we are not talking about the plans going live on January 1st, we are really talking about November 1st that we have to have everything completely done because that is the first day of open enrollment and when members will be making selections. So, I just wanted to make sure that I didn't miss-speak to the Board about the timeline and what we were working with. There are a couple of additional things that I want to clarify and then I can talk about what we feel like we can do at this point. One of the things that we heard from the board was a concern that we were unfairly or singling out people that had cancer or radiation and I think that I want to make sure that the Board is aware that, in actuality, what we had been doing was singling out radiation and chemotherapy all this time because any other service that members had or any other chronic disease people paid co-pays to have those services done. So, if they had MS or Cerebral Palsy or had to meet with a physician for COPD, they would have had to pay a co-pay for those services. So, some of this was to make sure we weren't singling out specific diseases or putting any priority, if you will, or any statement to that and for UMP members.

Doug Porter, HCA: Said another way, treating cancer the way we treat all of the diseases.

Nicole Oishi, HCA: Correct.

Nicole Oishi, HCA: And that has been consistent with UMP and so that decision was really made to make sure that we were being consistent and treating all things equal. What we were able to come back and offer to the Board is going to change a couple of things. We, right now today, believe that we can make the change of decreasing the high cost imaging co-pay which is for MRI, PET Scans, and CT Scans specifically, to the specialty co-pay for Classic and Value which would be $30 in the Classic Plan and $40 in the Value Plan, so aligning it with the specialty co-payment. That will cause the premiums to change. It will be less than a $2 change, so we would ask today that the Board vote on the premiums with the understanding that there will be a small increase in premiums, under $2, to the plans to make that change. We don't have the ability to tell you right now exactly what that change will look like, but it will cause an increase, so we wanted to make sure that you knew that.

Greg Devereux: Can you go back over what it would, the specifics, did you say $40? I did not hear you clearly.

Nicole Oishi, HCA: Currently in both the Value and Classic Plan for Group Health, we would change the co-payment to match the specialty co-payment for each plan. So, for the Classic Plan, the specialty co-payment is $30, so if you got an MRI, you would pay a $30 co-pay. If you were in Value, right now it says $100, the specialty co-payment is $40, so if you received a PET Scan you would pay $40.

Doug Porter, HCA: Questions from the board for Nicole?

Eva Santos: Let me ask a question. Doug, Eva here. Nicole, what I understood you said is that, because I think you're making your initial point of equal treatment of chronic diseases is, I think an important one. What you are saying is that for other diseases, diabetes, MS, you name it, these co-payments have always been there, or some kind of co-payment has always existed, but not for cancer payments.

Nicole Oishi, HCA: Correct. Cancer, chemotherapy and radiation therapy were both excluded from co-payments, while every other disease paid a co-payment for visits. Yes, correct.

Eva Santos: Were those co-payments equal, over time, to what this specialty co-payment has been?

Nicole Oishi, HCA: We didn't have the designation of specialty co-payment and primary care co-payment historically, so it was whatever the co-payment was for that service. In the Classic Plan, I believe the co-payment was $20, I'm sorry it was $25 last year. So, whether you were receiving a primary care visit with your doctor for an earache or if you were receiving treatment for your diabetes or treatment for your MS, you would have paid a $25 co-pay for that service.

Eva Santos: Ok, thank you.

Margaret Stanley: I'm not sure that I think it is really an analogous situation because if you are being treated for something like diabetes or MS, you have periodic visits with your specialist or with your primary care physician. What's different about radiation and chemotherapy is that it is frequent and repetitive. So, it is not like an office visit.

Greg Devereux: That was my question. Out of ignorance I didn't know with diabetes and dialysis. I wasn't sure if it was as frequent as radiation. I don't know enough about it.

Nicole Oishi, HCA: I don't think I could comment. I mean, there are diseases, especially along the respiratory line where people are in trouble on a real regular basis. For COPD, they can't breathe and they are frequently seeing respiratory therapists and their physicians. So, I think each chronic disease, each acute disease, has a real different disease process. Without knowing everyone's treatment plans, I don't know that I could comment.

Doug Porter, HCA: Isn't it fair to say that consideration was given to that situation in the reducing of the out-of-pocket maximums?

Nicole Oishi, HCA: That certainly makes a huge impact in reducing the out-of-pocket maximums.

Yvonne Tate: Well, I just wanted to say, I do appreciate what you did. I think it will make a huge difference lowering the co-pay like you did. I just want to say thanks for the effort.

Doug Porter, HCA: Any further discussion on any of the resolutions before us? One through ten?

Greg Devereux: I guess I do, Doug. I do appreciate very much taking the time and going back and looking at the diagnostic change. I don't know. It feels to me we had some accountability plans before us, at least the Labor Coalition did before, and they seemed very complicated and they were drawn back till next year which we appreciated very much. It just seems in place of that we are going part way with Group Health this year. I would almost prefer to wait and really have a whole year to really go through what the accountability plans are, vet them, have constructive criticism from every angle. I guess I would ask if there is any further, even aside from this meeting, taking breaks in this meeting, is there any value in going back and looking at what could be done on chemo and radiation, say in the next week or two. I understand that could change other parts of the design and/or the premium.

Nicole Oishi, HCA: So that was part of our conversation, what would it look like, obviously with the Board's direction, of re-tooling or a kind of do-over. I think if we start making additional changes, we will need to do a do-over. There is no more that I will be able to do on a fast track to make changes to the plan design that won't impact premiums enough that we will have to re-tool all of the premium products and re-do our risk adjustment process. Given that, we will not make the November 1st deadline. That was the path we went down. There is not enough time for us to basically start over from scratch. So this is what we can do essentially right now, today to make sure that we meet our deadline and also hearing the Board's feedback.

Doug Porter, HCA: Any further discussion or questions? I'd like to move us along then and turn to the resolutions behind section 5.

Lee Ann Prielipp: Will we do these individually, Doug?

Doug Porter, HCA: We will.

Procurement Resolution 1: Resolved that the PEB Board endorses the Uniform Medical Plan (UMP) and Consumer Directed Health Plan (CDHP).

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1

Procurement Resolution 2: Resolved that the PEB Board endorses the Group Health Classic (GHC), Value, and CDHP.

Moved, Seconded, Approved.
Voting to Approve: 4
Voting No: 3

Harry Bossi: I apologize. I don't want to get confused. I know Melissa. Can you re-explain who votes on these and who doesn't? I think there is some confusion, at least with me, whether you can make a motion and second it, but not vote for certain members.

Melissa Burke-Cain, HCA: Going back to our bylaws, a non-voting member can do everything except vote. They can participate in the discussions, can make a motion, can second a motion,

all of that is spelled out in the bylaws. The only thing they can't do is participate in the vote. I think non-voting members know who they are.

Harry Bossi: Thank you, but I don't think the tally reflected the non-voting members. How many non-voting members are there?

Melissa Burke-Cain, HCA: Two, I believe.

Harry Bossi: Ok, I'm sorry. I didn't hear Phil.

Melissa Burke-Cain, HCA: So, did we add up correctly? I didn't hear the tally vote.

Doug Porter, HCA: Seven voting members.

Margaret Stanley: I have a question on the radiation and chemotherapy where there is now going to be a co-payment on the Group Health. Those are treatments and I am wondering since they said that the co-payment applies to all treatments, but in the past it hasn't applied to radiation and chemotherapy, does it apply to physical therapy, massage therapy, etc.? Because, it is not listed here.

Nicole Oishi, HCA: Yes, the only things that are listed there are changes. That's why the radiation and chemotherapy are spoken there. Yes, those other therapies do.

Margaret Stanley: Ok, I think you might give some thought in terms of communication in how this might be displayed for the employees. You might, for example, say treatments and then it would list all those things. I think it might make it more logical to them.

Nicole Oishi, HCA: Thank you.

Greg Devereux: So, I guess I have one question. It seems to me, and I could be wrong, that redoing the Group Health Classic Design Plan is separate from the premium setting. I don't know why, for example, you couldn't, why the actuaries couldn't, go back and say for a $20 office visit co-pay that would yield this amount that you could use toward diagnostics.

Nicole Oishi, HCA: Benefits aren't built that way. I mean that's the short answer. That it is a benefit package, and there is a design attached to it and they are not built that way. That's the short answer. Any time we make significant changes, it changes everything for that particular benefit package, as well as the bid rate for all of the rest of the benefit packages. So, making one small change, like I said, is less than a $2 change to all of the premiums, including UMP's premiums. It's not just Group Health's premiums that it changes; and so to go back and start doing those pieces, it changes the entire package because it changes what services people receive. It assumes then a person may get this service instead of that service. There is a whole lot more to it than just saying there is a $20 co-pay. What the Group Health assumption is, in this design, is that that primary care co-pay and that specialty care co-pay are essentially even because they decreased primary care and increased specialty care. But when Ben was here last week, he said it was essentially a wash, it was spending the same amount of money, but splitting those two. So, if we start making those changes, it changes the actuary value of the benefit plan itself.

Phil Karlberg: Doug, I have a question. Nicole, can you confirm that the issues that we are discussing will turn off in the event that an out-of-pocket maximum is reached?

Nicole Oishi, HCA: Yes, once the out-of-pocket maximum is reached, as long as you are seeing network providers for covered services, the services are covered at 100%. So, for a family in Group Health now, where it would have been once they reached a $6,000 out-of-pocket, 100% of their services are covered, they now once they reach a $4,000 maximum out-of-pocket, 100% of their services are covered.

Phil Karlberg: And that includes all of the characteristics within the design of the policy, is that correct?

Nicole Oishi, HCA: Maybe, say that question again.

Phil Karlberg: That includes all of the provisions that we're discussing…

Nicole Oishi, HCA: Correct.

Phil Karlberg: All of those factors will be turned off once the out-of-pocket maximum is reached.

Nicole Oishi, HCA: Correct. Let me make sure, Elin just pointed out to me, I am not talking about prescription drugs, because prescription drugs, except for Consumer Directed Health Plans, don't apply to the out of pocket maximum. So, I point that out. But, yes, the answer is all medical services, as long as they are a covered service and they are from a network provider, once you reach the maximum out-of-pocket, 100% of the services are covered. So, your maximum liability for any medical service with Group Health is now $4,000 for a family, instead of $6,000.

Phil Karlberg: Thank you.

Procurement Resolution 3: Resolved that the PEB Board endorses the Kaiser Classic and Consumer Directed Health Plan (CDHP).

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1

Procurement Resolution 4: Resolved that the PEB Board endorses the UMP Medicare Plan.

Moved. Seconded. Approved.
Voting to Approve: 4
Voting No: 3

Procurement Resolution 5: Resolved that the PEB Board endorses the GHC Medicare Plan.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 6: Resolved that the PEB Board endorses the Kaiser Medicare Plan.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 7: Resolved that the PEB Board endorses the UMP Classic and CDHP employee premiums. (With the qualifier that Nicole has issued that there will be a nominal adjustment, under $2.)

Gwen Rench: How is that motion different from number one?

Nicole Oishi, HCA: Number one is the plan design, number two is the premiums.

Doug Porter, HCA: I guess that qualifier goes for all three of these if you are voting on these. All these premiums could change by something less than $2.

Nicole Oishi, HCA: Correct, for seven, eight, and nine.

Moved. Seconded. Approved.
Voting to Approve: 5
Voting No: 2

Procurement Resolution 8: Resolved that the PEB Board endorses the GHC Classic, Value, and CDHP employee premiums. (With the qualifier that Nicole has issued that there will be a nominal adjustment, under $2.)

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1

Procurement Resolution 9: Resolved that the PEB Board endorses the Kaiser Classic and CDHP employee premiums. (With the qualifier that Nicole has issued that there will be a nominal adjustment, under $2.)

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1

Procurement Resolution 10: Resolved that the PEB Board endorses the maximum $150 Employer Medicare Contribution set forth in the legislative budget appropriation.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Doug Porter, HCA: I want to thank the Board for a very thoughtful and engaging discussion on all these resolutions. I know this has not been easy and I want to acknowledge the Health Care Authority's role in contributing to a last minute change in direction as we reconsidered our accountability plan and caused Group Health and others to have to go back to the drawing board. I, for one, am glad that we finally got to this resolution, but I do appreciate the thought and hard work that went into this. This is not always a dispassionate discussion of the facts; there are a lot of very personal stories that affect people's feelings about these issues. I respect the way in which the Board has gone about discussing this in a very professional way. So, thank you very much for that hard work.

Greg Devereux: I also, Doug, appreciate you taking the time to take a break and reconsider some of the options. I also, before we leave today, I'd like to on behalf of current state employees, honor Nicole for her work at the Health Care Authority. I think she has been incredibly professional, she has a great sense of humor as well that goes along with that, and she will be missed.

Doug Porter, HCA: Can I ask you then to do me a favor?

Greg Devereux: Certainly.

Doug Porter, HCA: Can I ask you to present this to Nicole. Thank you, Greg. That was unrehearsed by the way.

Nicole Oishi, HCA: Before you close, can I make my one last humor statement, is that there is one more agenda item and that is to discuss the future PEB Board meetings and get feedback from Board members not necessarily here, but please see those. It is the last page of your binder for the next Board meeting schedule for the next 12 months. Thank you.

Eva Santos: I just want to say thank you for accommodating my absence from Washington to be an active participant in the meeting. I really, really appreciate it and all the work that your staff did to get me the facts so that I could be educated and ready for today's meeting. I just want to encourage you to come along and play with me in the education piece with the Workfirst. It is an area that I am passionate about. I just want to extend a thank you to the Health Care Department and the Department of Personnel in making this happen for our people. So, let's work together on it.

Doug Porter, HCA: It's a deal. Thanks Eva. All right. We will see you later next week.

Nicole Oishi, HCA: No meeting next week, unless you want to have one. Greg, if you'd like one, we can hold one. We will send an e-mail out to the Board, to let you know what those premiums do change to, so that you have that information. We'll update that one slide and send that out as soon as it is done.

Doug Porter, HCA: Anything else for the good of the order? We stand adjourned. Thank you very much.

The meeting was adjourned.

Washington State Health Care Authority

***D*R*A*F*T**
Public Employees Benefits Board
Meeting Minutes

October 19, 2011
Health Care Authority, Apple/Peach Rooms
Olympia, Washington
1:00 p.m.

Members Present:
Greg Devereux
Gwen Rench
Lee Ann Prielipp
Yvonne Tate
Margaret Stanley
Eva Santos
Melissa Burke-Cain

Members by Phone:
Phil Karlberg

Call to Order
Eva Santos, Acting Chair, called the meeting to order at 1:00 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

There is no decision today, but it is mainly a meeting on getting us briefed on some activities that are happening in our neighbor state of Oregon.

Value-Based Benefit Design

Elizabeth James, HCA: Today's presentation is to help us understand a little bit about value-based benefit design. This is something that you have heard in the media. Value-based benefit design is a real concept and it is an important concept. We also have Group Health here, as well, to present today on value-based benefits. So, without further ado, I would like to turn it over to our friends from Oregon. Thank you for being here.

Geoff Brown: My name is Geoff Brown. I am a Senior Consultant with Towers Watson.

Joan Kapowich: And I am Joan Kapowich. I am the Administrator of the Oregon Educators and Public Employees Benefits Boards.

Geoff Brown: I would like to start off by thanking you for inviting us here for us to share our experience in developing value-based benefits in Oregon. My specific involvement was with the Oregon Educators Benefits Board and Joan oversees both boards so her experience is even broader. My role is to lay down some basics in setting the stage for the actual experience in

Oregon. I'll briefly lay down some of those basics, the problems that provide impetus for the new way of addressing benefits, a working definition that is more process oriented, some behavioral insights, plan design framework, and then Joan will follow up with a case study or two.

On page 2, traditional medical and PPO plans were designed to remove barriers to health care treatment and now after 50 plus years in that model, along with some others, but primarily addressing those, we have arrived at today. I thought I would give you a few statistics to round out the landscape today. According to the latest BRFFS study, Washington State has an obesity rate of a quarter and the smokers about 20%. Interesting that about 20% of the adults report that they do not engage in any leisure activities. That fits into the picture, actually of value-based benefits as well. The institute of medicine reports $700,000,000,000 spent annually on unnecessary procedures and tests. Our firm's research between 2008 and 2010 reported that the percentage of employees who looked at managing their health to be a top priority dropped 69% to 59%. Those who took action to improve their health declined between those two years 65% to 59%. All of this sums up into behavior both on patient/employee side and also the provider side when you look at how much is spent.

Greg Devereux: Can you tell us what BRFFS is?

Joan Kapowich: It is a public health study, a research study every other year in Oregon and it is called Behavioral Risk Factors Surveillance Survey. They call and ask about your health habits, exercise, and tobacco.

Geoff Brown: We offer a working definition. The goal of a value-based plan is to encourage the provision of optimal health care for members so that good health outcomes are achieved and inappropriate treatments are reduced and ultimately eliminated. Through education and alternative approaches to reimbursement, the plan engages patients and providers in seeking this goal. Necessarily plan design becomes a bit more robust or complicated - more elements to its structure. Because as you get into the data of the population that you are designing a plan for, you set out certain conditions, whether that is to drive health, encourage healthy behaviors, whether it's to reduce economic barriers to chronic illness to make sure the compliance is there and reduce the number of complications that go with that. To provide the more traditional economic protection of unanticipated or unplanned for accident or illness, which is where the genesis of health insurance began. And then also from a behavioral standpoint, to encourage patient/provider dialogue and shared decision making. This is really a key component of value-based plans from our point of view and we are really trying to drive people's interaction with their own care. And finally, to increase personal responsibility and risk for treatments. This is an area where I believe the Oregon experience has been out ahead and that the total package is not only the incentives that often put into commercial programs, but also to look at how to mitigate the unnecessary care or the less effective care and build that into plan design as well. Because behavior is actually an ingrained part of establishing a value-based plan, I've listed a number of insights from a paper that I brought along. In the interest of time, rather than going through all seven of those, I am just going to pick out two and then you will be able to read the article rounding out the other seven.

One principle or insight is that people like certainty more than uncertainty. Socially you will run into people who will say that they would rather pay more for monthly coverage and know exactly what I am going to spend than have a co-pay. They are easier, in fact, to manage within a budget; but at the same time just having co-payments and not having to become engaged in the

process of care leads to not necessarily using good judgment or the best of judgment, I should say in terms of what kind of care you want to access and how frequently. On the other hand, having certainty plays a positive role in addressing those people with chronic illness in terms of them staying the course and being on top of their treatment so that they avoid unwanted consequences. So you have kind of a dual aspect of this principal where people need to be encouraged. It serves one purpose and where they need to be engaged, you need to structure the benefit differently.

The other one that I would like to talk about briefly is insight number four, we like what is already ours. Time and time again, we see that once people have made a choice, whether that goes back to the early '90s and cafeteria plans or wherever choice is available, we see the most active choosing the first year that the choices are available. And then as long as the choice is there that people selected the first time, there is very little movement. In today's environment where things are rapidly changing, it's often difficult to think about how we encourage people to completely evaluate the choices and decide what plan is right for them today. You see in the literature that sometimes that could go so far as to say that we need to discontinue one choice that we have evaluated not to be as efficient and effective. Those are always difficult decisions to make.

In the value-based approach, typically we are seeing care being addressed through four somewhat discreet areas. The wellness program typically is the non-insurance type of program like Weight Watchers or a tobacco cessation therapy. The health care plan would be treating chronic illness, accident, and sickness. The prescription drug plan has to be in concert with the health care plan. Finally, and probably one of the most challenging areas is designing a communication program that fully supports and one could say, enables the other elements to work well. Let's walk through those in a little bit more detail. A sample of that would be a wellness program to encourage healthy behaviors, to discontinue the unhealthy state, like smoking, to maintain health where that exists, to achieve improved health, such as weight loss and tools and resources to support those healthy objectives. Last night in my office, I was going over this, trying to shorten it up a little bit and I was thinking about tools. I looked over at my bookcase and back in the 1970s, there was a movement to give out these self-help books. They went through about three different publishings. Most of the books ended up looking like mine does here; it's pretty yellow around the edges and occasionally would be used. At the end of the day if you talk to a young mother who has a child with an ear infection, they really wanted someone to tell them that they were doing the right thing and not just strictly rely on a book so to speak. We've had to come a long way in developing tools and helps that address the apprehension that patients have; but also, to encourage them to have meaningful dialogue with their physicians and care-givers.

Then in the more traditional health care area of it, we have broken that into four tiers. It is not necessarily four tiers but I present this as an example where the preventative services are treated in one way and traditionally this is becoming 100%, especially with some of the elements of health reform. Then how do you deal with chronic disease care, so usually building in some incentives. I will just give you a brief illustration here. I have been a Type 1 Diabetic for 28 years. A year ago, I went on an insulin pump and for the last year, until last night, every time I went to get test strips, I was being limited by the health plan to those limits that were aligned with Type 2 Diabetes. When you are on a pump, you actually have to test before you eat and then two hours later to keep that pump calibrated and moving correctly. It has taken me a year to work that out with the health plan, and certainly my experience has enabled me to be more forthright with people at the health plan. The idea is that if people are not doing simple things

like that, they can end up in the hospital; and I guarantee you that one night in the emergency room with low blood sugar, or excessively high blood sugar, would more than pay for the number of strips I was asking for or my doctor was suggesting that I do. Again, getting those things to work smoothly so that those people challenged with chronic disease can focus on managing that disease is in everybody's best interest. Tier 3, accident and sickness, is the area where it is not planned for, so there is some cost sharing involved in that and typically you want to retain cost sharing so that people think through the alternatives of care that are presented to them. And lastly, Tier 4, in terms of special treatment coverage, can be addressed in a number of ways. This comes from the data being studied, where are the areas where the evidence shows that these conditions are being over-treated or that treating professionals are going to higher levels of care than what the evidence supports and perhaps patients are asking for care that they don't need; and so additional cost sharing might be used. It is very difficult in a very short time to give you specifics and the bandwidth in each of these areas, but they all do play a part in terms of designing an overall plan.

From a prescription drug standpoint, we get a couple of different categories. We have the encouragement of the chronic disease treatment and then you have the generic, preferred brand and non-preferred brand; those are the three more traditional. But also emerging are specialty drugs; how those are being treated, and how those are being procured. I am looking through the data and discussing with your pharmacy benefit manager, what is the most effective way to deliver appropriate care would be part of the process in coming to a final design. With all that said, I will turn things over to Joan to share the Oregon experience.

Joan Kapowich: In Oregon, we have two benefits boards. We have one for public employees and university employees and one for educator employees and community colleges. Both boards work under a vision, that we have statutory language around this; but then they crafted from it a vision of what they would want to see the delivery system look like and these are those elements. We wanted to be innovative, focus on quality and outcomes, health and wellness, alignment of incentives, accessible communications for our members and then it be affordable. Under our new health authority, when we were working under that umbrella, we very much talked about the triple aim and the focus on improved member health. Starting with our innovative delivery system, first off, we do have free evidence-based benefits. These are benefits that members receive that are endorsed by the U.S. Preventive Services Task Force and we started out with a constellation of about 17 services, things like immunizations, mammograms, pap smears, those kind of things. There is going to be no reason for you not to have your mammogram that has to do with money anyway. You might have other reasons that you want to put it off, but money won't be it. From there, we started to look at this is what we value; this is what we want people to have so that they don't get sick in the long run.

One of the other things we asked of our carriers in our innovative delivery system when we went out to get carriers is that we wanted to have medical homes. We already had Kaiser; we had Kaiser for many years. We are very pleased with the integrated design and we wanted to have in other areas practices that were integrated, a team-based approach, focus on the member, so we started a pilot in 2006 with one of our carriers, Providence, to do a medical home. We now have 27% of our PEBB members in medical homes when you count Kaiser and Providence together. We expect that will grow. We are currently going under Open Enrollment and on the OEBB website, we have 21% in medical homes with Kaiser, ODS, and Providence. So, we see that as a growth area, good for our members and those are our least expensive plans, so they are cost effective. We also offer free value medications for our generics for cardiac disease, hypertension, consolation of chronic illnesses, depression. We have free generics for those so

that there is no barriers between what our members medications needs are in keeping them under control. We then offered free tobacco cessation and then free weight management to our members. In a little bit, I will tell you more specifics but those have been very popular. Free health screenings, flu shot clinics and we coordinate a lot of our wellness activities and things like that with our public health partners, as well as all of our state agencies; and now we are starting it on the school side. We try to have in each agency a wellness coordinator. Unfortunately, they are not a full-time wellness coordinator; they are an employee who says "I'll do wellness in my free time." It seems to be pretty effective in getting organizations interested in walking programs, speakers or getting that kind of thing going. We are also very focused on financial incentives and alignment in our vision, because we know that in our current system, on a fee for service basis, the incentive there is to provide more services to get paid more to do it. We wanted to make sure that our plans had the right incentives so when we go out to negotiate; we work very hard at negotiating our lowest cost admin cost, service cost. From the provider side, we ask our carriers to look at innovative programs in a more open, non-Kaiser type of environment. How can we pay physicians or do something to encourage physicians to do evidence-based care. So, one of our plans has a pay per performance, providers will be paid what they would usually be paid if they do evidence-based care on chart review that fits within a certain standard. There have been significant improvements in care, really high generic rates. That is one of the things that they put in evidence-based, pay per performance alignment. Flat administrative rates were some of the things that we negotiated with our carriers when we went out to bid. We don't want our admin rates go up for three years anymore than this amount or any at all. We are also working on case rates, flat rate for maternity whether it is a c-section or a vaginal delivery, diagnostic related groups, that's a perspective payment system, so again you aren't going to the hospital and charging every single line for those extra booties or the TV controller, that kind of thing. We are getting a flat rate if you treat pneumonia this way or you treat pneumonia that way. So, that is one of the financial things that we are working on, as well as global budgets. So we work within a budget not just looking every year at the budget going up. This is how much money we have, you will provide that service to members. So, again we are really trying to ingratiate into this very value-based system.

Consumer education is a very important piece of this. We want our members to be knowledgeable consumers. When they go to see their physicians, do you know the questions to ask? Did you write some questions down in advance? We have put a lot of toolkit type of information in front of members. Here are some simple questions you can bring with you. We have newsletters on various health topics, education on specific types of diseases, questions you might ask about your medications. We offer a quarterly newsletter online to our members that has longer articles, not just little newsletter articles, but longer, more in-depth articles come out in our digest.

We also have a great deal of focus and energy on decision making, which is where we send members to a website usually where they will get information about say, an MRI or a back surgery. It will go through the pros and cons of a back surgery or an MRI, the risks and harm you might see going through that and helps the member think it through, is this something for me, what are the risks and harms, how do I feel about the things on balance if I look at the pros and cons about it. So we really do everything we can to push members to our website for finances as well as anything else. We don't have a very big communications budget.

The outcomes to date on our preventative services, those 17 free preventative services and then tobacco and weight management, we have steadily seen our HEDIS measures increase, those are Health Employer Data Information Set numbers which are basically how does your

health plan compare on how many immunizations members get to other health plans in the country. We get these from our carriers, I believe, at least once a year and those measures for how we do processes, how many people get mammograms, have increased steadily since we put this in and we are now in about the 90th percentile or above for every one of those measures. So, really lowering or eliminating the cost share for members helped a lot, as did the carriers tracking it and knowing that it was of value. We know, because we survey members with public health how many of our members smoke. In 2005 13% of our PEBB members smoked and in 2010 10.4% of our members smoked. We will be surveying again in January and we hope that number goes down further. I will say that the teachers, because you can't smoke on school grounds in Oregon, they only have 5% of smokers, which we were thrilled by because that's just a great rate. You hardly ever see a rate that low. In terms of the quit rates that we encourage by having this be free, 47% quit rate in tobacco cessation is pretty much knock your socks off, so we were very excited that for people after 6 or 12 months, half of them successfully quit almost. The 53% figure in 2010 was with our Educators Board Members who went through tobacco cessation, so they even had a higher success rate with smoking which is really positive.

Under weight management what we offered was free weight management. You had to agree to go to three-quarter of the sessions, 10 of 13 sessions in a quarter period in order for it to be free and stay free. Between 9-14% of all of our employees attended those meetings. So, we pretty much had standing room only. We had huge demand for this particular service, very valued with members. In the first year, on the PEBB plan alone we had a $2 million dollar return on investment. What is the impact on the affordability? By giving away the free preventative services, those kinds of things, what we have really seen over time is that we have seen some moderation in our rates, we still have health care trend going up, unfortunately a higher rate than we would like every year. In 2009, PEBB had its lowest premium rate ever. Unfortunately, the following year we had a very high increase from what one of our carriers offered and it forced us basically to move to be self-insured. Which means, we still had a very low rate increase, because we took the risk on ourselves. You are going to see variability in benefits when you have high rate increases in the market. We believe when we are seeing costs, we are paying for the right things by paying for prevention in this way. It may mean that we will have to modify our benefit design, which I will get to.

We also have premiums that vary between PEBB and OEBB, but we really try to focus the design on the services that we want to see, the carriers, the type of plan we want you in, we are going to try to price that right and to see if there isn't some way that we can get more people in our medical homes or systems of care, like Kaiser. Both boards were looking at this value-based design and asking is there anything else we can do? All of these free services are one thing, but is there anything else that we can do in this area? When you go to look at it, one thing that you can do is charge more for services that are overused or preference sensitive. What we did with the boards is we brought two groups to the boards to show different designs you could use. The first was an Essential Benefit Package based on Oregon's prioritized list of services which puts treatments for prevention high on the list and treatment for warts is low on the list. What it did was basically put that into four tiers, a preventive tier and then each tier subsequently you would have maybe a 10% cost share, 20%, 30%, and 40%. It had not been and has not to date been used by anyone or employed. There are a lot of not yet priced options in this particular plan; it is more fully developed now. It has not yet been used commercially, but a lot of strengths in that kind of design. It fits the need of being evidence based.

There was another plan that the health leadership task force and business group put together with just three tiers, so a little simpler. The first tier was free or very low cost, preventative services. The second tier looked like any health plan today, maybe a cost sharing at 20%, something like that. Then a top tier that was much higher, 40%, 40-50% cost sharing and a different deductible and out of pocket max. That had more appeal, but still if you are going to tell someone that had pretty good insurance that they are going to pay 50% of cost sharing, that's kind of a gulp thing. The boards liked the idea, but wanted to make it a little bit more acceptable so they wanted a simpler design. What the boards wound up doing was instead of having that top tier, let's look at conditions that we see a lot of, treatments that we think are overused or preference sensitive, might have other options available and instead of a 50% cost sharing, let's just have a flat co-payment of say $500 in addition to what you are ordinarily paying. So, whatever cost you already paid, you are going to pay an additional $500. If you hit your out-of-pocket maximum, you are paying an additional $500. So, that's what we did. Spine surgery, hip and knee replacement, arthroscopic, sinus surgery, gastric bypass on the PEBB side; and then for lesser expensive ones, than say hip surgery like MRI or CAT Scans, sleep studies, upper endoscopy and spinal injections, those are $100. The reasons, for example, that sleep studies are in there, is in Oregon and maybe you don't have this in Washington, we have a lot of sleep studies being done these days, sleep clinics opening up. So, we were finding that when we look nationally on per member, per month, we spent maybe 50 cents for sleep studies. In Oregon, we were paying $6 per member, per month for sleep studies. Meaning, pretty much everyone who snored was getting a sleep study it seemed like. So, we just felt it was reasonable to put that $100 on there. Now, we do want to know, and we will talk about this in a bit, that the right people are getting sleep studies, people who have sleep apnea need a sleep study, need a c-pap machine probably. We don't want people to not get the right care, we want to put a little bit of a pause in for those to think about what are my other options. We also specifically excluded any diagnosis related to cancer or an emergency trauma.

Greg Devereux: I can't believe anyone would voluntarily sign up for sinus surgery and I am just surprised that that would be an area of overuse.

Joan Kapowich: There are two pieces to this, overuse and then surgeries for which there might be other alternatives or for whom the outcomes might not be as cut and dry, that every time you have a sinus surgery that is really going to help everybody. So, the idea is that you get an opportunity to really talk about what are the outcomes after surgery. If many people after surgery continue to suffer from sinus problems on an ongoing basis, just to make sure that a member would know the risks and harms for them. I would not say that that is one of our highest utilized surgeries, but it is one that falls into what they call in the medical community, preference sensitive. It is not a life-saving surgery and it is one that has outcomes that are sometimes not quite as good as we would like to see.

Greg Devereux: Regardless you prioritize a list and everybody pays $500 additionally.

Joan Kapowich: We are not technically using the prioritized list; that was one of the options to use the list. What we did was we developed a list of preference sensitive type procedures based on either things that were over-utilized or fell into the category of preference sensitive. There may be other ways to treat, for example, antibiotics or other courses of treatment. In spinal surgery, maybe it is physical therapy or weight loss, some of those kinds of things. Then the idea is that there will be people for whom sinus surgery is the appropriate treatment, absolutely. But there will be others for whom once they got more information about it, talked about it with their provider, may make a different choice.

Greg Devereux: Let's say someone who has tried all the alternatives to sinus surgery, but ultimately that is by all accounts the best treatment. Do they still have to pay the additional amount?

Joan Kapowich: They do.

Greg Devereux: To me, that's not very sensitive. I think we need to press even deeper to make sure that those folks, both in terms of pharmaceuticals and procedures, they shouldn't have barriers in front of them; and I would advocate for that. I've seen it too often in our situation.

Joan Kapowich: Again, one of the things that we were very focused on in this is that the numbers that are impacted by these particular procedures are fairly small. Our benefit, and you once again have to look at your own benefit, our benefit is still very generous. So even with some of these $500 co-payments or $100 co-payments, they still had very good coverage for the services provided.

Greg Devereux: We keep hearing that as they take away more and more and more and more.

Joan Kapowich: It is definitely one of the things you have to look at in your plan design. In talking about this, some groups might choose to make it say $100 or tie it somehow to completing a shared decision module kind of thing. This was the course that we chose in part because the board felt once you start opening everything to a potential prior authorization or if you really need it, then you were going to engender a more administratively complicated process. For example, some integrated systems like a Kaiser or a Group Health already have that integrated process within their structure. But in a world where many of our members are in a preferred provider organization, you don't have as good of controls as you would like to.

Greg Devereux: I am all for raising the cost of unnecessary procedures; I just don't want to throw the baby out with the bathwater. I don't want to penalize people who actually need certain drugs or certain treatments.

Joan Kapowich: Absolutely. As I go forward, I think you will be curious to hear what our members had to say about that, too, because I think that is important. The reactions; we very much expected to get a strong reaction about how we were doing this, about why we were doing it, we provided websites with frequently asked questions, we received overall a very small number of member complaints about this. We did a lot of education, going out and explaining to people that this is really no different than a pharmacy tier system where you start with a generic, and then you have a preferred, and then you have a non-preferred. There are people that will need a non-preferred; they will pay more for it. People sort of got that. There are still situations in which people say I wish you really didn't have to, but ok. What we said was that if we do this, then everybody's rates will be able to stay lower than they are now. People do get that. Ok, I see it, I don't like it and I don't like that it impacts me; but I understand why you are doing it and you are using the evidence to do it.

Our experience to date, I should clarify that we have not yet added, the sinus surgery, will be added in January of 2012, so I am speaking from all of the other things that were there already. We started in October of 2010. We had expanded in the Public Employees Benefit; they had not started with a $500 tier. That started in April of this year. We have been looking at the utilization impact and will be looking at the outcomes; for example did those people that needed sleep monitors because they had sleep apnea still get them. We are tallying things like member

comments. We have had some issues with claims processing complexities which we were able to iron out. That is basically making sure that all of the carriers that we use have the same diagnostic and procedure codes, so that everyone is treating it the same way. We have had some interesting provider responses and actions. We have had some flyers that members were getting on the teacher side that said "We like teachers so much, we won't make you pay that $100 additional cost payment," which by their contract, they can't waive that, so we had to talk to them about that. There were some providers who weren't very happy about that because they felt it was going to impact their business. Before I go to this next slide, the last thing that I do want to say about it is I have been very surprised by member reaction because I was very much prepared for people to be very angry about that kind of a decision or choice; the fact that it was going to impact me. Most people, when I talked to them, really just wanted it to be understood while they might have had that procedure or would need it, no one was maligning that or saying that was bad. We recognize there are people that will need these procedures; and as I nurse, I feel like that is always going to be the case. The message in talking about this is not that there is any completely wrong procedure, it is just do you need it, are we making sure that you are going to get the care that you need.

I do want to talk a little bit about the decision support because what we did is all of these procedures are linked on our website, the member goes out to a website and can get the pros and cons, the strengths and harms of that procedure, whether it is an MRI, back surgery, hip surgery, any of those. One of our plans is doing a pilot whereby if I go to my physician and I say, "My back has really been killing me for years, doc. I really think I need to have a surgery; it is at that point." My physician will give me an information RX and basically they will push me an e-mail to my web address and it will take me to the shared decision website where it will go through the risks and harms, pros and cons; and I will fill it in about the risks and how I feel about risk taking. That information is then generated back to my physician so that my physician and I, when I go back in again, can have a starting point to talk about what my feelings are, so they know exactly where we are starting in the conversation. It is a better use of their time. I can give some thought at home and they are then incenting the provider financially and the member financially for going through that module and that education and that's been very well received by members and providers.

The other thing that I did want to mention is that we have had some preliminary look at what happened to utilization. What happened to utilization is between the time we announced this plan design change, things that were maybe going to be hip replacement or spine surgery, we saw a lot of surgery. We kind of had a little run on the bank there. What we then saw was when the new plan year started, we saw a lot less surgery. It dropped off pretty dramatically. Then the things that really have stayed quite a bit lower were imaging, which was very high, over-utilized, sleep studies, again very much over-utilized, stayed down, and spinal surgery pretty much has leveled off, seems like that has been going in a reasonable direction, not climbing steadily. Some of the others, it's not something that we can say is definitive; it's what it is going to look like. It is very early days in looking at it, but we were pleased with the things that we felt really had over-utilization were in fact being impacted with the fact a member had a little higher cost share for that.

Greg Devereux: Have you ever looked at levying the fee on providers for prescribing the treatment?

Joan Kapowich: Well, in fact, some of when I was talking about provider pay for performance. That method of payment is in fact tied to the provider prescribing according to treatment

guidelines; and so in fact, that is trying to get to that very point. The member does not want to find themselves in a situation where the provider is encouraging something that might be questionable; because we have had that exact conversation. What is the provider doing, if the person really didn't need it? Why might they be prescribing it or encouraging it or something like that. We are really trying to take it from both sides, really trying to make sure the providers are working along treatment guidelines and getting some oversight for that, data and feedback for how they look according to peers and that evidence-based guideline. Also, trying to do what we can to encourage members to get more information themselves about it, think about it, and consider it before they move forward. Really, the important thing for this also is that both boards felt really strongly that this needs to be studied in terms of what is the impact on members. We don't want this to have a negative impact on member's health and so there is an independent study that will be going on to make sure that we are not going to see that. Next, once you do value-based design, it is sort of an ongoing thing.

The other piece of value-based design, although it is really not talked about and this is sort of my own version of value-based design, is that I think you need to look at contracts. I think we need to have in contract language, language that says, things like we put in, we will not pay for never events. If you leave a sponge in someone, we will not be paying for that. We want you to use surgical checklists. So our contracts with our carriers say you will find providers who use surgical checklists in the OR so they won't leave a sponge in you. We can reduce errors. We ask for things in contracts that really are promoting the values we want to see in terms of high quality care, so that our members have the best quality of care and it isn't just in plan design, but it is also in what you ask for from the carriers from whom they contract with.

Next, in terms of some of the things that we are looking at, is on the public employees benefits. We are introducing in January something called a Health Engagement Model which members will sign up for. They will get a $20 savings on their overall premium. They will complete a health risk assessment online and complete at least two e-lessons. We are not requiring lab values or biometric screening, but they have to take, the one mandated element they have to include is their waist circumference, which has not been popular with some people. If you are a female and your waist circumference is over 35, you will agree that you will take a weight management course, see a dietician, or work with your physician on a plan that is specific to you. It is over 40 inches for men because those are the risk factors for cardiac disease and diabetes. It has been somewhat contentious I will say because people feel there is that sense of being told what to do. The issue for the board is that we want to know what some risks of our members are so that we can better help address that with plan design. We are in Open Enrollment now and we have had about 88% of our members enroll in the Health Engagement Model. We think our members are seeing some value in it as well and there will be some coaching available in that. We are looking at additional ways, between our two benefits boards, to align the additional cost tier and again continue to study the impact on members, continuing to work on member education and design within the context of the Oregon Health Authority. In the future we are looking at Coordinated Care Organizations. We will be looking at that as we go forward as well.

Eva Santos: What is your participation level in Health Risk Assessment?

Joan Kapowich: Right now it is 88% of our members who have enrolled that say they will participate and that will start in January. They will have six weeks to complete the Health Risk Assessment; and then if they didn't complete the Health Risk Assessment, their premium would go up, I think the following month. So there is some timing involved in that.

This is just an example of one of the things that we share with members about success stories, because everybody likes a good story. This is one about a woman who went to take care of her brother who was dying on the east coast. He did die and when she went back to pack up his belongings, his friends who went to help her do that told her how worried her brother had been about her health because she was very overweight. She took his bike back to Oregon with her, started riding it, took us up on the weight watchers program, and lost 98 pounds in his honor. As her physician said, through her brother's memory she had given herself the gift of life.

The one last story that I would like to leave you with in terms of our design is that it is really more than just benefit design. At our own board, we have under 40 people that do the benefit board administration; and we had our own wellness committee put together to say, what can we do different or better at our own site? Our employees came up with the idea of a healthy sharing food basket. So, instead of getting that Butterfingers in the machine downstairs, we had some healthy snacks in our kitchen. The first week that I went in there, out of the corner of my eye I saw a pile or something; and I look over and there's this basket that says "healthy sharing basket." Then there is this big banner over the top of this big pile and the banner said, "Start a movement. Eat a prune." The box was full of wrapped prunes by a woman whose husband has a prune farm. It has been one of my favorite stories because in fact this is really about a movement. It is about good humor and social support, doing the right things with each other and for each other to try to improve our collective health. In this effort, we will make some people unhappy; we will make some changes that as Geoff said, don't embrace. It is really for the right reasons and there are a lot of positives to be gained from it. I am very happy that I have had the opportunity to talk to you about it today. Thank you.

Eva Santos: Any questions from the Board?

Fred Armstrong: On behalf of Group Health, I want to thank the PEB Board for inviting us to make this presentation today. My name is Fred Armstrong, and I am in the Sales and Account Management Department, Director of a unit we call Complex Accounts with includes the state account and the PEBB. Sometimes I have to explain that. To my left is one of our Medical Directors. I am very pleased that Dr. Brenda Bruns has joined us today and I would ask you to introduce yourself.

Brenda Bruns: Brenda Bruns, I am the Executive Medical Director for the health plan. I am a practicing ER doctor, about 15 years, and then got a business degree and went into health plan management to try to save the health care system, although I really don't feel that I have quite succeeded yet. We are working on it.

Fred Armstrong: Our presentation in your agenda today is labeled Increasing Deficiency. What we want to talk about today is going into the future. How Group Health prefers to approach, if you will, designing benefits; and how we will try to manage health care going forward. What we want to do, and this is the agenda, to set some context, so we are going to spend a little time talking about health care trend. When we prepared this presentation, we didn't have the full benefit of what our previous presenters were going to talk about, so we are going to touch on value- based design; but we don't want to repeat everything that they did, so we will kind of fly through that. Then we want to spend more time talking about clinical evidence. That supports many of the concepts that you heard just previously. Lastly, wrap up with some Incentive Requirements for 2013. To set the context, what are we up against looking into the future, particularly as you look at the cost of health care in the country?

Noted consulting firm, PriceWaterhouseCoopers, each year publishes through their health research institute some data for national health care trend. They reported actual trend expense, and this is before plan design changes. Benefits are increasing each year in terms of cost shares that employees must pay; but if you look at what the cost of health care is before you make plan changes, in 2010 it increased 7.5% over 2009, and in 2011, 8.0%. They are predicting 8.5% to be the trend in 2012. Significant numbers. They cite a few things that are contributing to why it has gone up in the last couple years, higher levels of utilization, some provider consolidation, cost shifting from Medicaid and Medicare; and then some deferred care from the recession. Another consulting firm publishes some data and Milliman Medical Index is indicating that in the six-year period from 2005 to 2010, costs have increased 48%. CMS publishes numbers as a percent of GDP; and you can see what those are, and basically 1970 through 2009, we are looking at an average of 8% annual trend compounded. The cost of health care is significant.

PriceWaterhouse, in a report they called "The Price of Excess," indicates that more than half of what we spend in the U.S. on health care is wasteful. They cite defensive medicine, they cite lack of emphasis on prevention. What that means is insufficient spending to prevent disease leads to overspending treating diseases once they occur. If we look at how we have traditionally approached solving the health care cost problem, health plans and employers have in many ways been shifting costs to employees. A good case in point is the growth in CDHPs and high deductible health plans, a significant growth in the last three years for those. The problem is, those approaches really do little to reduce the rate of health care trends and they also do little to reduce wasteful or low value spending; you simply have employees pay more. What we want to do is focus on how we can improve those dynamics. This slide can be a little bit overwhelming because it is busy, but you can see from 2002 through 2009 and '10 where we have actual numbers, and then projected numbers going all the way out to 2021, what will happen with health care expenses if the trend continues at 8%. If we can get it down to 5%, which is not where we are today, or better yet, get it to 3%. Significant numbers particularly in relation to household income.

We want to spend just a little bit of time talking about value-based benefits; and we have, I think, one definition of what that is. One way of looking at health care in the United States is how much we spend per capita and what we get for that in terms of health outcomes. When you look at it that way, we spend twice as much and we don't get a corresponding gain in health outcomes. One definition of value-based insurance design coming out of the American Journal for Managed Care is "Decreased cost-sharing for interventions that are known to be effective and increased cost-sharing for those that are not." You do this based on the clinical value not necessarily the cost of an intervention.

We at Group Health are moving down a path of two general approaches to value-based insurance design. The first approach, which I am going to label here "carrots," has lower cost shares for preventive care and targeted chronic conditions; a lot of the things in terms of getting access for those people that need to maintain their health status. This is the plan that Group Health has today for its employees that we call the total health plan. One of the characteristics of this type of plan, where you are lowering cost shares to encourage certain types of behavior, is that you do not get a cost reduction immediately. The cost reduction is in the future when you will avoid more costly treatments for illnesses that were avoided.

Another approach is what I am calling “carrots and sticks.” You also have the emphasis on prevention and targeted chronic conditions with lower cost shares. But in addition to that, you have higher cost shares for those that have low value or wasteful spending. We heard the Oregon presentation define how they saw what those were. An example, again, is the Oregon PEBB Plan. With that type of approach, “carrots and sticks,” you will get an immediate cost reduction with the lower utilization on wasteful spending. I am going to turn it over now toDr. Bruns, who is going to talk about the clinical side of value-based insurance design and how we see that.

Dr. Brenda Bruns: I am going to talk a little bit about value. A lot of this I am sure you have already heard many, many times; but I am trying to set up for what we are going to talk about more. Sometimes in all of this, we lose track of why we are doing this. I think we all know why we are doing this; there is a financial urgency. Even within health care, there is often a lack of true belief that if you improve quality, you decrease costs. The hard part, and it gets a little to the sinus surgery example, is quality according to whom? That is what I am going to talk a little bit about. Who kind of figures out value in health care and how do we make sure that we get the right care at the right time? In whose eyes are we identifying the quality and the value?

We’ve talked about the right care at the right time includes not only the best care you should get, the right care; but it also includes not getting care that is unnecessary and that can actually cause worse problems. If you get a procedure you do not need, and you have a complication, that’s the worst thing because all procedures have a complication rate. What clinicians advise, to reduce health care costs that has to also be associated with how it impacts quality. We came to this definition of value and I think it is a pretty common one. Basically, it is the quality of care that you get and the service for that quality of care divided by the cost. What amount of enhancement do you get for the costs you pay? So, developing programs that improve either service or quality, obviously it increases the numerator and you have more value. Also though you can have measures that decrease cost, but they should also enhance the application of evidence-based care and decrease unnecessary cares. You can get value by either decreasing costs or increasing quality, but the best are the ones where you increase the quality and it results in decrease in cost. Those are really the ones that we want to emphasize and talk about today.

Not all health care is evidence-based. So, this is the challenge, it gets to the challenge of is the sinus surgery indicated, is the new drug indicated that you have. We have a lot of messages coming into all of us, both physicians and patients about what is the right care; the pharmaceutical, the biotech industries. We have to realize that these are industries and these are businesses, just like all of us are in some sort of business or industry. It is not that they are inherently evil, it is just that they are trying to develop product and save lives. In the process they also develop a lot of products that don’t have any significant impact on saving lives, but those are also presented to the public as being a panacea for something. You know all the ads on television about the drugs that you can never quite figure out what they are for, but have a lot of complications. I have noticed that everybody seems to be going through fields of flowers when they are getting these. The difficulty is that they spend thousands, hundreds of thousands, millions of dollars, convincing us all what we should do. So we get that input.

We also have a challenge in our country that we have an overreliance on specialty care. We have a higher ratio of specialty to primary care than many of the well-developed countries that have lower cost, France, England, etc. There is a lot of literature, Barbara Starfield, who was from Johns Hopkins, a really respected researcher, did a lot of research around primary care,

did surveys, backed up with outcome studies, that adults that report having a primary care doctor rather than a specialist as their regular source of care had lower subsequent five-year mortality, so lived longer and had lower costs of care, regardless of where they started out with their care. In our country, we don't have that right ratio so to speak. So that is another thing that is contributing to our challenge.

We also have a huge amount of emergency department utilization which is increasing; and I'm an ER doc, so I don't think this is necessarily bad; but a lot of it is inappropriate. There are a lot of studies that show 20%-30% of patients seen in emergency departments didn't really need to be seen there and it causes more discontinuity of care. We also have another phenomenon that is going on in our state and I am sure other states where we are developing stand alone emergency departments that are seeing patients and patients don't quite know the difference in this an urgent care clinic or an emergency department. When they get the bill, they will know the difference, because it will be at emergency department rates, regardless of what the situation was. There are lots of pressures on all of us to try to figure out what it is that we should be doing for our care. Again, right care at right time. The things you want to make sure of is that you are getting effective care; because that is the care that you want to make sure you get which is the preventive care and the care that is evidence-based and then not get the care that is not indicated or may not be indicated.

Dartmouth Health Care Atlas, which is a very well reputed organization which Jack Weinberg was sort of the discoverer of so to speak, of the concept of variation in care that was often provider and sometimes member motivated. Which was that you could be in a community that was right next to another community and have three times the rate of sinus surgery or tonsillectomies and it was because you had three times the number of ENT doctors. It was hard to believe that the two counties that were right next to each other had that much difference in their need for sinus surgery or tonsillectomies or hysterectomies or whatever, but they still had a huge variation. Through years of study around that issue of that variation in health care, which again is provider driven, but is also patient enhanced, there is an estimation that 30% of health care costs could be eliminated if we decreased that variation, so that people were getting what was indicated and also what made sense for them as individuals.

Effective care is not being delivered all the time. Effective care is the things that are being measured by HEDIS scores you may have heard about, which are if you have diabetes are you getting your blood test to have that checked. That's probably, unfortunately, according to many studies, only being done about 50%-60% of the time. Anything we can do to encourage that is really good; decrease the barriers for those. The drivers of variation which may lead to not necessary care we put into two categories, preference sensitive and supply sensitive. You heard about this a little bit from Oregon. Preference sensitive is not only care that has a different approach, sometimes depending on the physician; but what's also unique about it is that it is the type of care that should really have the patient's values put into the decision making. If you are considering having back surgery, or hip surgery, or knee surgery, you could have people that have exactly the same amount of arthritis in their knees; but one person will decide to have the surgery if they are fully informed and the other will decide not to have the surgery yet if they are fully informed. They will decide maybe if I lost 20 pounds, my knee would be so much better that I wouldn't have to have the surgery; and once you have the surgery, your knee is not going to be the same again ever as it was before. People going through what you heard referred to as the shared decision making process where the physicians give them information. I understand that they have a video, like you heard about from Oregon. It's interesting the research shows given that information, given that time to make the decision,

many patients, 20%-30% will choose to have more conservative therapy than their doctors would have recommended. So, that is actually preference sensitive. It is not so much that it is wrong or right to have the surgery; it is making sure it is in line with evidence and with the patient's preference.

So, we have a variation in health care in our own state just like the thing about the tonsillectomies that Jack Weinberg originally studied. If you look at this graph, in our state we have a big variation, you can see here, in that we have more than the national average in hip replacements. For some reason we get more hips done, not sure why and there isn't any good demographic reason.

Knees, we are a little high, only in Spokane and in Tacoma. Mastectomies. Cardiac, we seem to be doing pretty well in compared to the country, although there are parts of our state that are a little less than others. Prostatectomies, this is benign Prostatic Hypercom, not cancer we have a higher rate. Back surgery you can see we really are pretty red, especially is those counties. Why is this that we have this? It is probably not due to the fact that we have different kinds of backs or different kind of hearts. It is a combination of the way the physicians practice, the number of physicians, and the way that information is portrayed; and then those incoming messages that people or patients get about what they should or shouldn't be doing according to various pieces of information from advertising, etc. Here you see the rate of hip surgery and the rate of back surgery. Another type of potentially unnecessary care is supply sensitive care. So preference sensitive care is where given the right information for a patient and a good discussion with a provider that the patient may choose to, based on their preferences, to not or to have a procedure. That is what preference sensitive care is usually defined as. Supply sensitive care is that if you happen to have a lot of it around, use it. It's really true.

I am an emergency physician. When the hospital was really full and I didn't have any place to admit somebody, I would tend to find another thing to do than admit them if I could. When there were lots of beds available in the hospital and I was super busy, I admitted the patient. It is just sort of the way people behave and not something you consciously thought about. That is actually what supply sensitive care is. People aren't sitting around saying I'm going to make sure I make tons of money by using these pieces of machine, now some people do that, but it is often unconscious. It's because it's there, you do it. High-end imaging has really been escalating and probably a lot of this is because we have, I think I heard the number that we have more MRI scanners in the city of Seattle than the entire country of Canada. I don't know if it is exactly that, but I am sure that it is pretty close. You can practically barely walk down the street without getting a picture snapped of you by an MRI. It is not without risk. At least 1% of the cancer in the U.S. is thought to be due from radiation exposure. I had another chart that was very blurry that showed the amount of radiation exposure that all of us are getting from technology like this in the past ten years, it has more than doubled; just radiation from those types of sources. Again, they are not cheap. Here's a graph to demonstrate what I just mentioned, the amount of escalation.

Now this is something that Group Health started approaching awhile back where we have a decision tool that our physicians use, both our physicians in the group practice and in the network and we don't say no or yes to the physicians. We just ask them to fill out this decision tool before they fill out the test; and if they don't fill out the decision tool, then they may not be paid for the test, so they at least fill out the decision tool. We also had information for patients about this and you can see from the time that we implemented the program to now we have had a steady decline in our utilization. This is both in our group practice and in our network. This is

more prominent in our group practice than it is in our network simply because our physicians in our group practice have access to really great tools. They have it right on their electronic medical record and they are in a different payment system. They have different motivations; they don't own their own MRI scanner. They aren't as suspect to the supply sensitive issue.

The other way that their supply sensitive care is what I just mentioned earlier actually about emergency departments; and we did a whole project called the emergency department hospital in-patient project which we named EDHI which we put in place because we realized there were two problems we were trying to address around in-patient care, two key problems. One was and this was a quality issue more than anything, that patients were being re-admitted to the hospital too frequently. You have seen that probably in the literature that in the Medicare population up to 20%-25% of patients are admitted within 30 days back into the hospital after they are in the hospital. This is a quality issue, but it is also a supply sensitive issue in the sense that there isn't really a motivation to not use those beds again. So if somebody has a condition that they are admitted to the hospital for, there isn't currently a financial motive for most hospitals or providers to say how do I not use that bed again? I want to fill my beds, it's ok to fill it with a patient who is admitted or a patient who is re-admitted. It's not that people are evil or doing bad things, but what actually the whole issue of transition management and re-admissions brought up is that actually it isn't a good thing. It isn't a good thing for a patient to be re-admitted. There are risks to being in a hospital in the first place but why be re-admitted and besides very few people want to be re-admitted. I mean there are plan reasons for re-admission. Those are very valid, but these are unintended admissions.

The other way that we approached this was from the very beginning when a patient lands in the emergency department, which we also again feel is as I brought out in my example is somewhat supply sensitive. If emergency departments are under a lot of pressure, they are very busy, people are probably using them a little bit unnecessarily, so they are even busier than they should be. If you are in that ED and it's crazy and all the beds are full, you got to do something; you either admit the patient or you discharge the patient. Often patients are complicated and have multiple issues going on with them. We realized that there would be kind of this gravitational pull that once they landed in the emergency department to be admitted unless we could come up with counter measures. We developed a set of counter measures which we put into place over the past year which consists of a couple of things. We have our own Group Health Hospitalist in several of our hospitals. They go down to the emergency department now if it is a gray area so to speak as to whether the patient should really be admitted. One of the benefits is that we have access to their electronic medical records back from the clinic. We can kind of go through and make sure that patient really does need to be admitted. The other thing we put in place was what we call an emergency physician resource options. It is a physician and a nurse who are in our consulting nurse area at the phone service in Tukwila where the hospitalist, or even the ED docs, say this person doesn't really need to go to the hospital, maybe they could go to a skilled nursing facility, maybe they could go home if they have somebody to look after them. They will help them set up those services so that then instead of going into the hospital, we will find them a skilled nursing facility bed, or we will find them a home health care nurse that will see them in the morning. That has sort of been our counter measure against that supply sensitive type of care.

Yvonne Tate: Wouldn't your consulting nurse service also help in that regard?

Dr. Brenda Bruns: Well, yes. We actually encourage all members, if they have a question about whether they should go to their doctor, urgent care, or to an emergency department, to

call a consulting nurse if they have any doubt about it. We have urgent care centers that are quite large in some of our cities and so we then will ask them to go to that one because then at least all of their medical records are there. Yes, that is also another way to prevent that. What we found actually is that despite again what people often think when they say you are trying to keep me out of the hospital, or you are trying to do something, we found that when we actually put these things in place, we had a huge increase in patient satisfaction. This was at our pilot hospital which was Virginia Mason and then we found this similarly at other hospitals. This is a Press Ganey patient satisfaction tool.

In December 2009 we were in the 74th percentile for how happy are you with your physician and care team in the hospital. This was the same physicians and care teams, but they had put in place this new kind of standard work around transition management and around better disposition in the emergency department and it went up to the 91st percentile. So, patients were happier and we actually ended up across our entire system within a year saving $50 million dollars in patient costs by appropriate use of a very important resource, the hospital. The hospital is really important but it really needs to be used appropriately. The other part that we talked about, so we have talked about sort of kinds of care, the preference sensitive care, supply sensitive care, the kinds of care that can be if you have good systems put in place and you really educate your patients, you can avoid that unnecessary part of care.

The other thing that unfortunately we sort of alluded to, but leads to unnecessary care are incentives. There are provider incentive problems and there are individual or member/patient incentive issues. This literature that I have up here is actually from the Common Wealth Fund, which is a large organization that does a lot of research on health care, especially for the underserved and Medicaid populations. We actually had their president speak at our annual meeting recently and they did a lot of research to talk about what could Medicare spend or not spend if they put in place some of these kinds of things. There is the payment issue, so paying for volume is currently what many of our systems do vs. paying for value. I think the way that we pay our physicians at Group Health is much more towards paying for value; but if you thought about if we paid for value only and didn't just pay for volume, that might be a lot of waste right there that we could prevent.

The other thing that can reduce and lead to problematic situations is because of the way we pay for care. We pay for volume, we don't pay for value. We also produce through paying for a value a fragmentation of care. That's a real problem, because we pay for care in silos. We pay the physician, we pay an outpatient surgery center, we pay a specialist, we pay the hospital, we pay the nursing home. We pay those separately and they are all individually incentivized to optimize their type of payment. Again, it is not bad, it is what they are supposed to do as far as being business people. This fragments care and this leads to a lot of waste too, redundancy, getting multiple tests, getting more than one MRI for exactly the same problem. People don't always communicate with each other, the providers, so the patients are on different medications then they should be on. There is not clarity around what the real care plan is and that is especially a problem for patients at the end of life or who have complicated care because having a really well coordinated care plan is especially important for patients who have complex care. So, what the Commonwealth Fund said is one of the ways to overcome this fragmentation is to emphasize again, primary care which we talked about earlier. If we did a different approach to how we pay. With better payment for primary care, we could not only augment the coordination of care because you would have that primary care physician who is orchestrating your care, then it would de-fragment the care, get rid of some of that redundancy and lead to better quality. It could save CMS as much as $50 billion for their Medicare program in the next

five years. These two top things are sort of this extra waste and the fragmentation are sort of being driven by the way we pay right now for providers.

The other area is all of us, as members, is how do you incentivize this and that's a lot of what we are talking about today with value-based benefit design. When the Commonwealth Fund looked at this, they said if there are incentives out there that all the health plans, Medicare, Medicaid instituted incentives that could promote healthy behaviors, this could save $19 billion alone across the nation and this was for all care, not just CMS. So, by promoting the healthy behaviors with incentives, we could save that amount, then if we also put in incentives that incorporated the relative clinical effectiveness and cost for alternative treatments a lot like what you hear with the shared decision making and the preference sensitive conditions. In other words, again pay more or have the carrot to incentivize having those discussions with your physicians, doing the shared decision making or having a higher co-payment that makes you think twice about is this preference sensitive condition something that I should choose or not choose or should I try the more conservative route first. That could lead to $368 billion in the next ten years in savings across the country. These are proven things that could help us with our costs. I am going to turn this back over to Fred. Are there any questions before we go back to bringing us back to the Group Health Plan?

Greg Devereux: If the Health Care Authority or the PEBB said to Group Health, instead of 8.5% trend, we will do zero next year. You laugh, but I am serious. If we said zero, do you think Group Health could come up with the incentives for both providers and consumers that could meet that target?

Fred Armstrong: Can I ask what you mean by zero percent trend? Are you talking about only the PEBB's portion of the cost or the total cost?

Greg Devereux: The PEBB's.

Fred Armstrong: We typically do that between plan design changes.

Greg Devereux: The whole point of this is that I am not talking about plan design. It could be plan design in terms of incentives; but I am just asking if Group Health, if you think Group Health could come up with that.

Fred Armstrong: It would be very, very difficult. I would say that. Could we eliminate trend just through plan incentives in one year? No.

Greg Devereux: Well, $368 billion is a lot of money. I know that is not all Group Health, but that is a lot of money.

Fred Armstrong: Correct, but that is also over ten years. What we are talking about is behavior changes and in order to…

Greg Devereux: Yeah but, to me, and I am not just focusing on Group Health. We are all talking about behavior changes; and when employees are expected to pick up 8.5% every year, I keep saying give me 8% pay increase for state employees and I will be happy. I will be incredibly happy every year. I mean it's like it's unbelievable. So, there needs to be dramatic behavior changes at all levels, I believe.

Fred Armstrong: I would think that we agree with you. So, at all levels I will refer to all stakeholders so there are employees as consumers, there are providers, physicians, hospitals, whomever provides care and health plans that help design and coordinate that. Each stakeholder has to have a piece in making this happen. So, there are tactics we as a health plan use to, and I think you mentioned some of the work that we do with physicians, basically to incentivize physicians to change their behavior. There are things we're doing as a health plan to look at how we do things and to get to an outcome we want to achieve. And we also need to work with employees to have them play their part.

Dr. Brenda Burns: I think as we have been developing what we want to do going forward; with PEBB our plan is to kind of phase in changes and work towards changing the incentives dramatically. So, part of it will be up to how fast people want to change incentives. The hard part, in the short term, is often to change people's behavior rapidly; it tends to have to be a little bit more stick-like than carrot-like, unfortunately. I think that these are our options. We have to educate people on the realities out there; and I think that all of us are going to have to get much more dramatic in how we change incentives to try to change people's behavior in the next several years, if we are going to keep costs down. Our trend, our clinical trend, and actually at Group Health, has been very reasonable. It hasn't been zero, but it has been in the 2%, 3%, 4%, 5% range for the past few years. It varies of course based upon our population. Some populations we have a much lower trend rate than with others. I think that doing these things that we are recommending are getting us on the road to there. It is just in a way how fast we can move. I don't know that we can move as fast as a year.

Fred Armstrong: Other questions? I have one more slide. In discussions with Health Care Authority, we wanted to make sure that the Board was aware of what Group Health plans to do in 2012 for 2013. So, this last slide addresses some incentives. Our benefits for 2012 are fixed. The PEB Board approved them; you know what those are. Benefits for 2013 are not fixed. What we want to accomplish, and I think you heard the Oregon presentation address some of this, is during 2012 we want Group Health PEBB members to complete a health risk assessment. Currently we have 8% compliance with that. Group Health has its own health risk assessment. It is an online tool. It will also be available on paper. It is, if you will, coordinated with a member's medical record if they see a Group Health physician. So the medical record will pull data, if you will, from the health risk assessment. We want them to do that. We also want them to designate a physician as their primary care physician. Currently, we had 93% compliance; and that includes not only those that see Group Health physicians in our medical centers, but also those that see our network physicians outside our medical centers. We will begin communicating for these requirements in early 2012. We don't know what the benefits are going to be in 2013, so I don't want to go there; but for those that are not compliant with these requirements, there will be a higher cost share in 2013 than those that are. Let me give you a little bit of an example. It might be like a difference of an additional $100 in terms of the calendar year deductible. So, I just want to be clear on that. We haven't decided on the benefits, but we want to put in place incentives for people to start doing things that will be able to promote engagement.

Gwen Wrench: What's the carrot for doing the health risk assessment?

Fred Armstrong: The carrot is that they will keep their cost shares as low as possible. If they don't, they will pay more in 2013 than someone that does not.

Gwen Wrench: Well, some people might see that as a stick. But, I mean is there going to be any $50 payment for having taken the assessment?

Fred Armstrong: Ok, there is no incentive to take the health risk assessment in that context.

Dr. Brenda Bruns: We actually have this with our Group Health employees, this kind of incentive and it's worked really well. We are up to, on the health risk assessment, 89% right now. The nice thing about the health risk assessment is it gives the physicians ahead of time a whole lot of information about each patient. It also triggers various coaching programs that we have for them, lifestyle coaching, or smoking cessation coaching, so we can know what our patients might need. It even may have it trigger a complex case management nurse call, so if we see the need in that; we will then ask the patient if it is ok for one of our nurses to contact them. So, it really helps us get them into the system and get things done even before they even get to the physician. So that is why it is very critical and really important.

Also, we are adding this year the coaching for preference sensitive conditions. Currently, what we do with these preference sensitive conditions, like the hips and the knees, all those kinds of conditions, is we have had for about two years now, is on the website you can get a streaming video that are these shared decision making tapes; or you can have the tape mailed to you if you are going to consider one of these kinds of procedures that are covered. And now what we are going to add to that this coming year for the PEB member is a coaching call by a nurse. So, that if you have an appointment scheduled to go see the back surgeon for back pain, then you will get contacted and asked if you want to have the tape sent to you; and then you will have a nurse that will say once you have watched the tape, call me and we will walk through the questions that you might want to ask your doctor. Sort of already starting to have you to start to think what are the pros and cons of whether you would like to consider having the surgery. So, by the time you go to see the doctor, you are more prepped than you would be. So, that is something that is being added. Thank you.

The meeting was adjourned.

Washington State Health Care Authority

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March 21, 2012
Fiscal Update

PEBB Funds 721 and 730 Account Balance Summary
As of FY 2012 2nd Quarter PEBB Financial Projection Model 2.0 2011-13 Biennium
(In millions)

Assumes $850 Funding Rate

	FY 2012	FY 2013	FY 2014	FY 2015
Projected PEB Ending Surplus/(Deficit) Position	**118**	**98**	**26**	**(135)**

Assumes $800 Funding Rate

	FY 2012	FY 2013	FY 2014	FY 2015
Projected PEB Ending Surplus/(Deficit) Position	**118**	**29**	**(111)**	**(342)**

Highlights:

- Projection based on claims experience through December 2011
- Calendar Year (CY) 2011 claims experience continues to be positive
    - Have begun researching service trends to identify spending patterns that differ from CY 2010
    - Preliminary efforts are focusing on:
        - Inpatient and Outpatient surgery
        - Radiology
        - Physical Therapy
        - Psychiatric
        - Private Duty Nursing/Home Health
        - DME and supplies
    - Data still not mature for certain services, especially hospital
    - As a result, will have a more complete analysis as data continues to mature

Washington State Health Care Authority

2012 Open Enrollment Summary

Mary Fliss
Deputy Assistant Director
Division of Public Employees Benefits
March 21, 2012

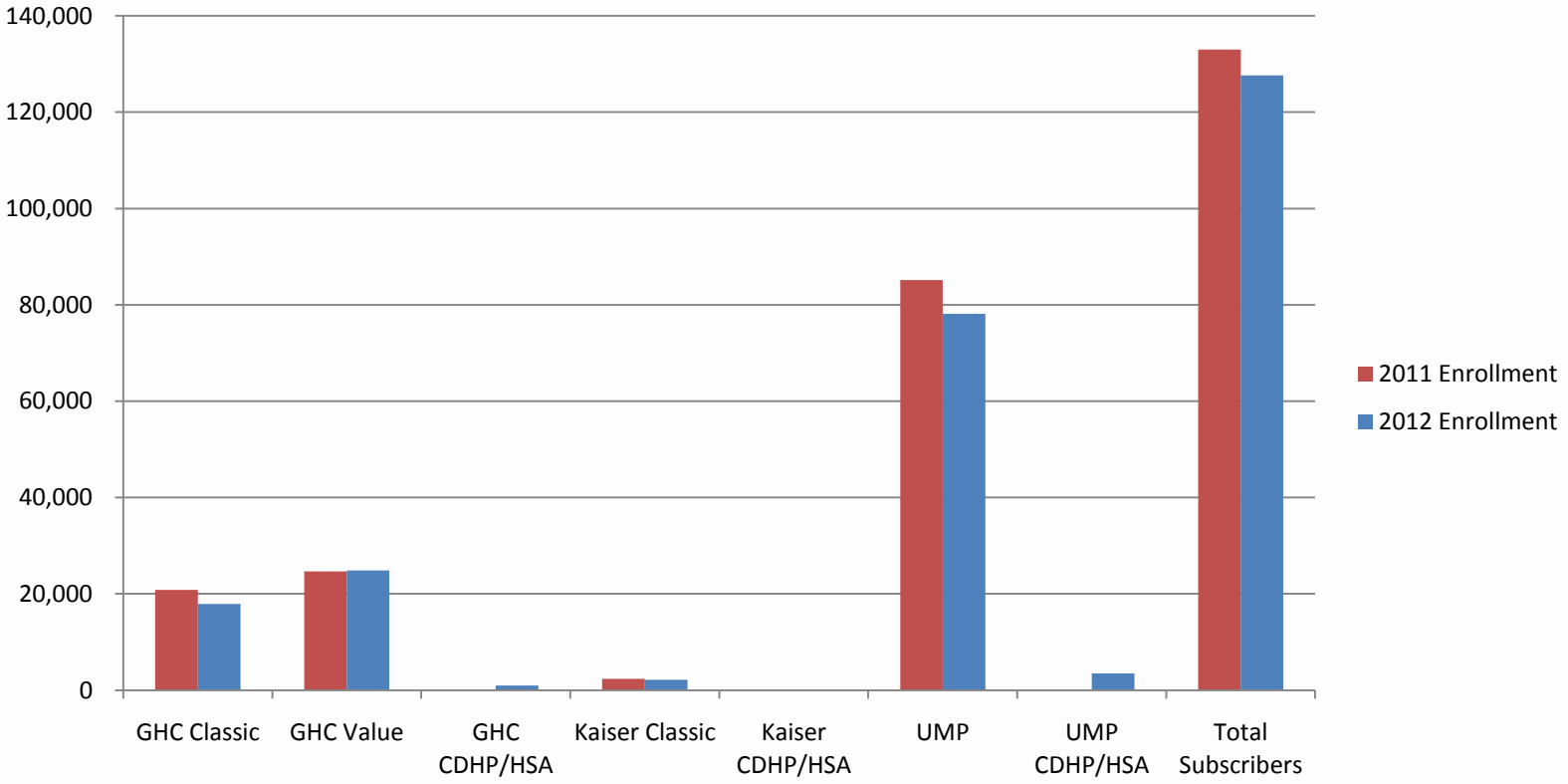
Open Enrollment 2012 Initiatives

- Consumer-directed health plans/health savings accounts
  - Implemented comprehensive communication strategy
  - Aligned to federal, state, and PEBB laws; tax codes; PEBB rules, regulations, and policies
  - Revised and developed operating systems and procedures within PEBB and the state's 8 payroll systems
- Medicare product changes
  - Eliminated SecureHorizons and Group Health Value
  - Revised members' cost sharing
- Email subscription service
  - Promoted paperless delivery of PEBB newsletters to members

Open Enrollment 2012 Results

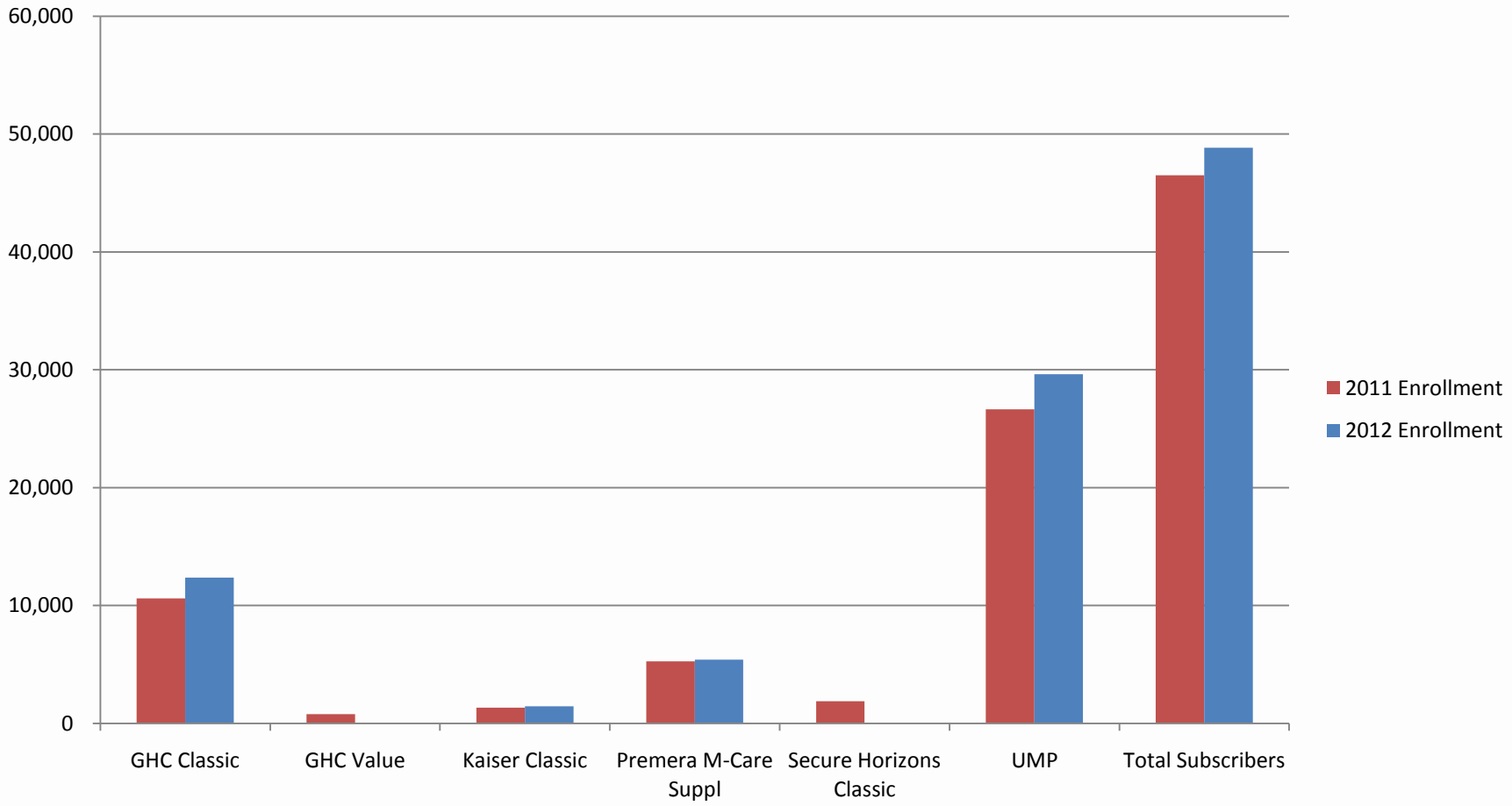
- Nearly 4,600 subscribers (11,000 members total) selected a CDHP/HSA.
- Keying cut-off on December 8 and go-live on January 1 met without incident.
- 70% of survey responders indicated having all or an adequate amount of OE information.
- More than 15,000 subscribers signed up for the email subscription service.

Employees and Non-Medicare Retirees (Jan. 2011 and Jan. 2012 subscriber counts)



Washington State Health Care Authority

Medicare-Enrolled Retirees
(Jan. 2011 and Jan. 2012 subscriber counts)



Washington State Health Care Authority

Questions?

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Washington State Health Care Authority

2013 Wellness Proposal
PEB Board

March 21, 2012

Scott Pritchard
Health Management
Division of Public Employee Benefits

PEB Goals

Continuously improve quality, cost and access to health care for PEB members

A comprehensive approach:

- **Supply side**—Provider initiatives
- **Demand side**—Member lifestyle and healthcare utilization
- **Value-based Benefit Design**– Maximize Health Outcomes within budget constraints set by the Legislature

- **Wellness Proposal**: Increase member engagement in healthy Lifestyle choices and Healthcare decisions

Supply Side—Provider Initiatives

Puget Sound Health Alliance

- "Community Check-up" report
- Cost transparency for selected procedures in 2012

Multi-payer primary care pilots

- Patient-centered medical home project
- Intensive Outpatient Care Program (aka Boeing model)

Demand Side
What

- **Engage members as partners**
  - Healthy Lifestyle choices
  - Value-based Healthcare decisions
- **Provide Tools to assist members**
  - Knowledge
  - Behavior change tools
- **Create a Culture of Health**
  - Powerful impact of culture

Demand Side—
Criteria / Constraints

2013 UMP Wellness Plan Criteria

- Components align locally and nationally
- Operational within PEBB IT systems
- Operational for vendors
- Fiscally feasible
- **Members likely to be successful**

Incentive for Participation

- Premium Differential **Incentive**
  - Qualify in 2013 by completing specific actions (subscribers only)
  - Pay lower premium in 2014 if successful
- Premium Differential **Constraint**
  - Conforms to cost share requirements in the collective bargaining agreement

Qualifying Actions: 2013

Subscribers (active pool) complete three activities* in 2013:

1. Take a Health Assessment
2. Identify Primary Care Provider
3. Do **one activity** from following list

   *Successfully complete **one** of the following:*

   - Smoking cessation program
   - A 6-8 week program selected from a broad menu of activities: physical activity, healthy diet, stress relief, healthy heart, get in shape, etc

* *Paper-based options available*

Component Selection
Evidence Based

- Health Assessment
  - Members: Assessment of own health status
  - PEB: Population health status
    - Target resources
    - Assess effectiveness of targeted interventions
- Primary Care Provider selection
  - Evidence that members with PCP have better health outcomes
  - Fits with "medical home" model
- Lifestyle change tools
  - Lifestyle behaviors strongly impact healthcare utilization
  - Lifestyle behavior change requires more than education.
  - Evidence-based behavior change **tools** are essential

Multi-Year Approach

- **Member Side**– Wellness Program / Member Engagement
  - Year 1: Begin the process (subscriber only)
    - Introduce the partnership concept
    - Introduce online tools and decision aids
  - Year 2+: Evaluate and enhance / expand
- **Provider Side**—Cost, Quality and Transparency
  - Year 1: Evaluate PCP pilot projects for broader rollout
  - Year 2: Continue to work with community partners to improve provider quality and cost performance
- **Value-based Benefit Design**
  - Apply to both Member (demand) and Provider (supply) decisions

Questions?

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Washington State Health Care Authority

PEBB PROCUREMENT CALENDAR

March 21	Board Meeting: Budget, Open Enrollment Summary, & Procurement Brief
April 16	Request for Proposals Issued to Fully-insured Plans
May 15	Proposals Due
May 23	Board Meeting: Initial Proposal Brief & Budget Update
June 27	Board Meeting: Procurement Update, Eligibility Scope, & Policy Brief
July 11	Board Meeting: Recommended Resolutions • Plan Design • Employee Premiums • Medicare Explicit Subsidy • Eligibility Policy (if needed)
July 18	Board Meeting: Resolution Vote

*May 25 and July 7 are tentative PEBB Meeting date placeholders.