Washington State
Health Care Authority

Public Employees Benefits Board

March 16, 2011 Meeting

Washington State
Health Care Authority

Public Employees Benefits Board Meeting

March 16, 2011
1:00 p.m. – 3:00 p.m.

Health Care Authority
Sue Crystal Center
Lacey, Washington

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Washington State Health Care Authority

AGENDA

Public Employees Benefits Board

1:00 – 3:00 p.m.

Health Care Authority
Sue Crystal Center
676 Woodland Square Loop Southeast
Lacey, Washington

Conference call-dial in 1-877-597-2663, conference ID 9771860

1:00 p.m.	**Welcome and Introductions**	Doug Porter	
1:05 p.m.	**Approval October 20, 2010 meeting minutes**	Doug Porter	Action
1:10 p.m.	**February Projection Update**	Annette Meyer	Information
1:20 p.m.	**PEBB Redesign**	John Williams	Information
2:45 p.m.	**Public Comment**		
3:00 p.m.	**Adjourn**		

The Public Employees Benefits Board will meet March 16, 2011, at the Health Care Authority, Sue Crystal Center, 676 Woodland Square Loop Southeast, Lacey, Washington. The board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: board@hca.wa.gov

Materials posted at: http://www.pebb.hca.wa.gov/board/

Washington State Health Care Authority

PEBB Board Members

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

Washington State Health Care Authority

PEBB Board Members

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

Legal Counsel
Melissa Burke-Cain, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40109
Olympia WA 98504-0109
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2011 Public Employee Benefits Board Meeting Schedule

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

January 12, 2011 (board retreat)

February 16, 2011

March 16, 2011

April 20, 2011

May 18, 2011

June 15, 2011

July 6, 2011

July 20, 2011

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

Jason B. Siems
Washington Health Care Authority
Rules Coordinator

Washington State Health Care Authority

PEBB BOARD BY-LAWS

ARTICLE I
The Board and its Members

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

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

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

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

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

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

ARTICLE II
Board Officers and Duties

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

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

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

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

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

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

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

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

ARTICLE V
Meeting Procedures

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

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

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

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

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

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

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

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

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

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

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

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

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

Washington State Health Care Authority

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

October 20, 2010
Health Care Authority, Sue Crystal Center
Lacey, WA
1:00 p.m.

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

Members Absent
Harry Bossi

Call to Order

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

Approval of September 15th, 2010 PEBB Meeting Minutes

Margaret Stanley requested that the minutes from September 15 be formatted to a traditional paragraph format for approval. Melissa Burke-Cain seconded the request, all agreed. Melissa Burke-Cain, John Williams, and Shelley Buresh will work on the changes.

Board By-Laws

Melissa Burke-Cain commented that she had not received any changes or comments to the Board By-Laws. Lee Ann Prielipp commented on Article 1, Number 5, Privileges of Non-Voting Members, asking if this was the normal process and Margaret Stanley commented on whether or not the chair can vote and that she was not aware that this was the normal process. Melissa Burke-Cain commented that every voting member has a right to vote on every issue and she needed to make some changes for clarity to the by-laws.

UMP Redesign Update

John Williams gave an update on the HCA PEBB redesign looking towards calendar year 2012. This project was undertaken in July. A core development team was formed with three elements of the PEBB portfolio; UMP, GHC, and a development team specifically looking at Retirees and PEBB's health care benefits for that population. In addition, John Williams is having conversations with Kaiser getting their ideas on how to participate with PEBB in the future and will be meeting with Executives on Friday, October 22, 2010 for further discussions. All three cores of the development team are operational and moving forward. The way it is structured is to have the three development teams form a workgroup that involve HCA staff and staff of the respective vendor contractor for the health plan, Regence (*UMP*), and Group Health.

The workgroup would develop a feasible approach to redesigning their specific element of the portfolio and provide enough substance about their select approach before taking it to a larger forum for input. These teams are working diligently to get the basic approach they are proposing to redesign and be able to describe it. In the next couple of weeks, meetings will be held with larger groups including representatives of the Board. There will be representatives from the labor groups that participate in PEBB, representatives from the Governor's policy office, and stakeholders; i.e. organizations that represent the retirees. The purpose of these meetings will be for the smaller development teams to present their work and engage in a meaningful discussion with the additional participants. This will be structured to have a lot of feedback that will include legislative staff involved with PEBB and with legislators. The goal is to complete this in December and bring a well developed redesign proposal to work through and make necessary modifications at the January 12th, 2011 Board retreat. The retreat will be the critical point to have the final plan designs set so that they have what they need for procurement starting in March of 2011

Greg Devereux commented that the redesign is very scary to him and is concerned about what will be taken away from the employees. He hopes that the process continues to be very open and the redesign is not to lower benefits. John clarified that they are focused on what PEBB needs to look like in the future so that it is affordable to members, the State, and National Health Care Reform.

PEBB needs to be sustainable. They will look at how to make it sustainable in a way that it does not shift cost to the members, but does increase accountability by all involved from HCA, purchaser, vendors, payers, members, and the providers.

Hospital Unit Cost/High Cost Center Utilization & Variations in UMP

There are three things that we are doing with UMP:

Looking at UMP as it exists today, continue the current UMP product into the future, and how it will look in 2012. We will continue to work with Milliman, OFM, and our Finance staff to project cost trends into 2012. Continue to work with Doug Porter and the Governor's office on the funding rate proposal that will be in the Governor's budget and in recognition of 8812 in place

today as the cost sharing arrangement between employer/employee and we will design around it until the environment changes.

Develop a high deductible health plan with an HSA (*health savings account*). This option would be in the UMP portfolio in addition to the current UMP/PPO. It is intended to be an option and is being designed as a second alternative of choice to members. This work is moving forward with Regence and most of the work is around the design of a high deductible health plan and overcoming a lot of barriers that have been identified operationally in implementing a health savings account with our current financing system.

Designing of a second PPO option within UMP where there are incentives in place for members and providers to get engaged in the participation in using the UMP benefits in an effective and efficient way. This is an accountability approach where there will be incentives; and in some cases, disincentives for activities that unnecessarily add cost for reduced quality because of the way people are engaging in UMP. This will be an option, and in 2012, the UMP portfolio will be the umbrella health plan for the three products.

Greg Devereux commented on the Health Savings Account and by spending time and money putting it together now. John Williams said that this is part of the redesign and he is working with Regence and Milliman to price out the high deductible plan as part of the redesign process. They will have answers to the Board in January for discussion on moving this option forward.

Greg Devereux asked for examples on disincentives. The disincentives occur more on the provider side and looking at identifying where there is excess money in the system that we cannot justify in terms of contributing to the value of health care to the members. Controlling the network and how it is used to get the care members need in a cost effective way by using the right provider network.

Margaret Stanley commented on the high deductible with the HSA option and asked if they are only looking at the high deductible. She suggests that when you present the finances with various options, look at it in two ways, with or without the HSA. John Williams said that the statute as its written directs HCA to implement an HSA with a companion high deductible health plan, the statute targets us doing an HSA.

Public Comment

Comment was invited from the public.

Melinda Murphy–Jones is representing many state employees and she works in a Tacoma office. She said that we are facing many concerns regarding employee shared cost increases by 26%. It is going to price health care out. There are many single parents, there are those that have pre-existing conditions, and many of us are at the top of our salary range after five years and we no longer get wage increases. Every time health care increases, we are losing money. We are supporting our community and paying taxes. It will impact health care and our ability to be at work and getting the health care needed for our family. There are many single families with increased deductibles pricing health care out of reach. There are letters from

other employees stating that they have to choose between medications, going to the doctor, or going to work. There have been studies done that when health care is out of reach they cannot continue to work. In the long run, the cost is greater because problems become much greater and treatments become more expensive. Please look at this seriously when we already as state employees have given up cost of living increases and many other things. We are looking at huge expenses and are asking you not to consider these increases at this time.

Brad Samples - He stated that with the current climate we know there is limited funding and adequate health care is a necessity. What was imposed in January 2010, state employees saw deductibles increase and their co-pays by 150%. What is being proposed is undoable for a number of individuals. Brad Samples read a letter (anonymous) from a fellow employee with a Master's degree and a long-time state employee.

Steve Siegel – Disability Adjudicator with DSHS and a member of the WFSE. A lot has been said publically about health care negotiations and the way state employees are suffering. In order to get us through this biennium, the state has dipped into its premium stabilization account to keep the cost level in 2011. We believe that the hardships will continue as we look into subsequent years and those reserves should be used again. We ask for your support to move forward together in this legislative session.

Greg Devereux – Acknowledged all the state employees that came who not only are enduring furloughs, foregoing cost of living, but they used leave to be here today. We will look at these things very seriously.

Adjourned

The meeting was adjourned.

Respectfully submitted,

Doug Porter, Chair

PEB PORTFOLIO REDESIGN PROPOSAL

March 09, 2011

This document presents an interim scenario for the HCA PEB Portfolio redesign project and as such is a work in progress. All features of the health plan products described herein are based on partial PEB 2010 financial experience available to the participating design teams as of February 2011. Final design features and cost-sharing arrangements and levels are contingent on approval of the PEB funding rate by the Legislature and Governor, analysis of 2011 legislation impacting the PEB program, and thorough reviews by the involved Health Plans of all current and 2010 patient claims, administrative costs, and membership forecasts.

PEB PORTFOLIO REDESIGN PROPOSAL

BACKGROUND INFORMATION

UMP REDESIGN STRATEGY

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

PEB Strategy Outcomes:

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

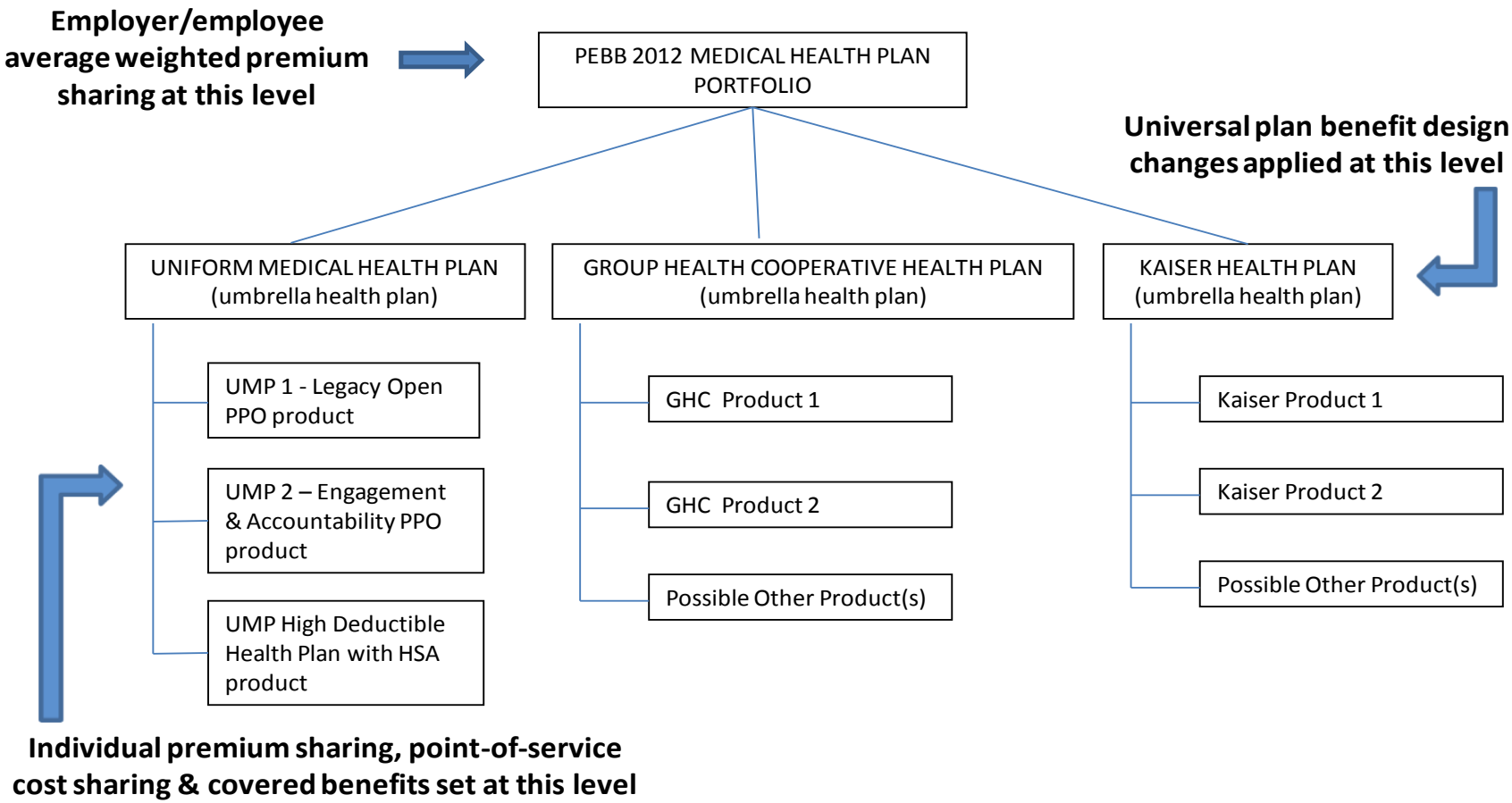
PEB Strategy Approach:

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

2012 Redesign Objectives

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

PEBB MEDICAL PORTFOLIO 2012



PEB PORTFOLIO REDESIGN PROPOSAL

HEALTH PLAN PRODUCTS

Uniform Medical Plan Proposal

	UMP-1	UMP-2	UMP HSA
Annual Deductible	$250/$750	$200/$600	$1,400/$2,800 Family deductible must be met in full before any benefits are paid by health plan for any family member except preventive services.
Medical Coinsurance	15%	15%	15%
Annual out-of-pocket maximum	$2,250/$4,500	$1,950/$3,900	$4,200/$8,400
Employer contribution to Health Savings Account	NA	NA	$700/$1,400
Emergency department copayment	$75 per event	$75 first visit $150 second visit $350 third + visits	none
Inpatient Hospital Services	$200/day ($600 max/year per person) + 15%	$200/day ($600 max/year per person) + 15%	15%
Network	Expanded use of Centers of Excellence/Efficiency	Expanded use of Centers of Excellence/Efficiency	Expanded use of Centers of Excellence/Efficiency
Projected single employee contribution	Recommended: $89.00 [Alternative: $85.00]	Recommended: $58.00 [Alternative: $64.00]	Recommended: $26.00 [Alternative:$30.00]
Projected enrollment as a % of UMP total (median estimate rounded to nearest percent)	Recommended: 66% [Alternative: 73%]	Recommended: 24% [Alternative: 20%]	Recommended: 9% [Alternative: 7%]
Applicability of Deductible and Coinsurance	All non-pharmacy services except preventive care and inpatient hospital are subject to deductible and coinsurance	All non-pharmacy services except preventive care and inpatient hospital are subject to deductible and coinsurance	All services except preventive care are subject to deductible and coinsurance

Additional detail regarding the Umbrella Uniform Medical Plan

- The above UMP portfolio redesign proposal contains two Employee Premium options for PEB Board consideration. For each option, the degree of migration from the 2011 UMP health plan to the 3-product 2012 UMP health plan is modeled as a % of the total UMP 2012 enrollment. The modeling assumes no switching between UMP and other health plans (GHC and Kaiser) from 2011 to 2012. **HCA's recommended option is identified first and the alternative is presented in brackets. HCA believes the recommended option best achieves the goals and objectives established for the PEB Portfolio redesign by the Governor and HCA Administrator.**
- HCA is proposing a 2012 pharmacy benefit plan design change that will apply to both the UMP-1 and UMP-2 products within the umbrella Uniform Medical Plan. The proposed changes will standardize pharmacy cost-sharing provisions for all aspects of the UMP pharmacy benefit, impose additional restrictions on a select group of high cost generics and establish greater adherence to a previous PEB Board policy decision to not cover prescription drugs for which safe and effective over-the-counter medications are available.
- All products within the umbrella Uniform Medical Plan will incorporate increased use of documented Centers of Excellence/Efficiency for a select set of high cost elective surgical procedures.

Additional detail regarding UMP-1

- UMP-1 retains the same Deductible, Co-insurance, Out-of-pocket maximum, and Emergency Department copayment levels as the 2011 UMP health plan.

Additional detail regarding UMP-2

- The National Business Coalition on Health (NBCH), in partnership with the federal Centers for Disease Control (CDC), has offered technical and financial support to HCA to develop a set of Member Engagement activities for UMP-2. NBCH will arrange for the UMP claims data to be analyzed using industry recognized data analytics software to identify UMP-specific opportunities to improve member health status, increase utilization of effective health care

services, and increase use of cost-effective providers. Based on the electronic data analysis, NBCH will provide clinical experts to work with HCA clinical staff to identify a combination of approximately 10 health conditions, health care procedures, and health status risk factors to target for improvement within the UMP-2 membership over a 3-year period. During the period March-October 2010, the NBCH/HCA joint clinical team will define the consumer engagement requirements UMP-2 members will have to complete during the 2012 benefit year in return for the reduced monthly employee premium and out-of-pocket cost sharing levels of UMP-2. This cooperative effort will continue for the UMP 2013 and 2014 benefit years. NBCH will also contract for an independent evaluation and reporting of the effectiveness of the member engagement activities in progressing toward the desired outcomes.

Additional detail regarding UMP HSA

- Members who select the UMP HSA plan will be able to use direct payroll deductions (pre-tax dollars) to deposit additional funds into their individual health savings account on a voluntary basis. The anticipated monthly premium savings ($756), in combination with the $700 employer contribution to the HSA, are sufficient to enable a member to establish a HSA balance that approximates the full deductible amount of the HSA product if the member chooses to voluntarily deposit the premium savings to the HSA on a consistent basis.
- Members who select the UMP HSA plan will have access to the same provider network as members in UMP-1.

Group Health PEBB Proposal

	Classic	Value			HSA	
		Tier 1	*Tier 2*	*Tier 3*	*In-network*	*Out-of-network*
Annual Deductible (without incentive)	$400/$1,200	n/a	$500/$1,500	$650/$1,950	$1,500/$3,000	$1,500/$3,000
Annual Deductible (with incentive)	$250/$750	n/a	$350/$1,050	$500/$1,500	n/a	n/a
Coinsurance	n/a	n/a	n/a	20%	10%	30%
Annual out-of-pocket maximum	$2,000/$6,000	n/a	$2,000/$6,000	$4,000/$12,000	$5,100	$10,200
Office visit copay	$15/$30	First 4 visits copay waived, then tier 2 pricing $0 – Preventive Care Office Visit	$30/$50	$30/$50	After deductible, $10 plus coinsurance	After deductible, $20 plus coinsurance
Hospital inpatient copay	$150 per day up to 5 days ($1050 Per Admit)	Tier 2 coverage	$200 per day up to $1,000 (Per Admit)	$200 per day up to $1,000 (Per Admit) then coinsurance	Deductible/ coinsurance	Deductible/ coinsurance
Hospital outpatient surgery copay	$200	n/a	$200	$200, then coinsurance	Office cost shares apply	Out-of-network cost shares apply
Emergency care	$150	Tier 3 coverage	Tier 3 coverage	$150, then deductible & coinsurance	Deductible/ coinsurance	Deductible/ coinsurance
Urgent Care	Same as Primary	Tier 2 coverage	Same as Primary	Same as Primary	Deductible, coinsurance	Deductible, coinsurance

Outpatient Advanced Imaging Elective MRI, CAT, PET	$100 copay	Tier 3 coverage	Tier 3 coverage	$200, then deductible & coinsurance	Deductible, coinsurance and a $250 copay	Deductible, coinsurance and a $500 copay
Retail pharmacy	$5/$20/$40/50% to $250	Tier 2 coverage	$5/$20/$40/50% to $250	$5/$20/$40/50% to $250	$20/$40/50% to $250	$25/$50/50% to $250
Mail order pharmacy	$10/$40/$80/50% to $750	$10/$40/$80/50% to $750	$10/$40/$80/50% to $750	$10/$40/$80/50% to $750	$10/$40/$80/50% to $750	$10/$40/$80/50% to $750
Network	GHC- HMO	GHC- HMO			GHO - Alliant Plus	OON
Employer Contribution to HSA Account	n/a	n/a	n/a	n/a	$750/$1500	$750/$1500
Projected Single Employee Contribution Per Month	$97.00	$41.00			$23.00	

Additional detail regarding Classic Plan

- Prior to 2012, each existing subscriber is required to take the Group Health Health Profile - Health Risk Assessment (HRA), and select a Group Health Primary Physician to earn the reduced deductible (above). If they fail to meet this requirement their deductible will be $150 higher - annual deductible without incentive.
- The new Classic plan applies principles of value based insurance design while maintaining a straight forward plan design. Plan changes include
    - Primary care copayment dropped from $25 to $15 per visit.
    - A separate specialty care copayment is introduced at $30 per visit.

- Hospital inpatient has changed from $200 per day with a $600 max per year, to $150 per day with a $1050 per admission charge.
- Emergency room copay has increased from $75 to $150.
- We have introduced a new pharmacy model. Instead of a $20/$40/$60 copay, we now have a $5 (value based)/$20 (tier 1)/$40 (tier 2) /50% to $250 per script (tier 3). The changes allow for better benefits for individuals with chronic diseases that are prescribed generic drugs.
- Elective advanced imaging (MRI, CAT, PET) now has a $100 copay.

Additional detail regarding Value Plan

- Prior to 2012, each existing subscriber is required to take the Group Health Health Profile - Health Risk Assessment (HRA), and select a Group Health Primary Physician to earn the reduced deductible (above). If they fail to meet this requirement their deductible will be $150 higher - annual deductible without incentive.
- The new Value Plan has moved to a 3-tier, VBID (Value Based Insurance Design) plan. The plan is designed to make the management of chronic disease and preventive care more financially feasible.
- Tier 1 preventive care benefits are covered in full.
- The first 4 primary care office visits each year are offered without a copay and are not subject to the deductible. These no cost visits are provided to remove barriers for members with chronic conditions and give them easy access to care needed for management of these conditions. This benefit applies to all members.
- The following elective outpatient procedures are included in the Tier 3 benefit- Advanced Imaging (MRI, CT PET); Spine surgery; Joint replacements; Coronary Artery Bypass Graft Surgery (CABG); PTCA/stents; Emergency room visits (unless admitted); Genetic testing; Jaw surgery; Varicose vein surgery; Breast reduction surgery

Additional detail regarding HSA Plan

- The projected PEBB contribution to the HSA is $750 for a single member, and $1500 for a family.
- The new plan utilizes the Group Health Alliant Plus POS (Point of Service) network which includes an out-of-network option.
- Note: Rx is subject to deductible (shared with medical benefits) in this plan.

Disclaimer

This document is an initial draft of the 2012 Group Health offering to PEBB employees. The purpose of this draft is to discuss all potential benefit offerings and monthly member contributions.

The finalization of benefit design and member contributions shall be determined after Group Health thoroughly reviews all current and 2010 patient claims, administrative costs, and membership forecasts.

Kaiser Permanente Proposal

	Kaiser Classic	Kaiser HSA
Annual Deductible	$150/$450	$1,400/$2,800 Family deductible must be met in full before any benefits are paid by health plan for any family member except preventive services.
Medical Coinsurance	15%	15%
Annual out-of-pocket maximum	$1,500/$4,500	$2,800/$5,600
Employer contribution to Health Savings Account	NA	$600/$1,200
Emergency department copayment	$75 per event	none
Primary Office Visit	$20	15%
Specialty Office Visit	$30	15%
Network	Permanente Medical Group	Permanente Medical Group
Projected single employee contribution	$71.00	$28.00
Projected enrollment as a % of UMP total (median estimate rounded to nearest percent)	95%	5%
Applicability of Deductible and Coinsurance	Preventive care, primary care, certain specialty care, lab/x-ray/specialty diagnostic tests, pharmacy and vision services (including hardware) are NOT subject to deductible or coinsurance. Services not subject to deductible and rider copays do not apply to out of pocket maximum.	All services except preventive care are subject to deductible and coinsurance

Additional detail regarding the Kaiser Classic Plan:

- Deductible also does NOT apply to Ambulance services, Chemical Dependency outpatient visits, Durable medical equipment (outpatient), Mental Health outpatient visits, Urgent Care.
- Deductible applies to: Emergency, Inpatient Hospitalization, Chemical Dependency care (inpatient/residential), Mental Health (inpatient/residential), Outpatient or same day surgery, Outpatient rehabilitation, Skilled nursing facility services.
- This proposal maintains existing pharmacy benefits.

Additional detail regarding Kaiser HSA

- Members who select the Kaiser HSA plan will have access to the same provider network as members in Kaiser Classic.
- Kaiser HSA plan follows Federal HDHP/HSA guidelines.
- Kaiser HSA plan includes Kaiser Classic plan pharmacy, vision hardware, hearing aid and chiropractic benefits.

PEB PHARMACY BENEFIT PLAN CHANGE PROPOSAL

Proposal:

The Health Care Authority is proposing a change to the Uniform Medical Plan pharmacy benefit design that will apply to all products within the umbrella Uniform Medical Plan. This package of recommendations positions our prescription drug benefit for long term sustainability. It represents a cost-effective, high-value approach, i.e., one that provides a greater overall benefit for the dollars spent by both the plan and the member. Collectively, these strategies promote the utilization of high-value medications, and necessitate a member dialogue encouraging safe, effective, and affordable medication use.

The proposed changes will:

A. Add a 5% coinsurance Value Tier to reduce member cost-share for high-value generic medications used to treat chronic conditions. Currently the lowest coinsurance tier is 10% generally covering low cost generics.

B. Simplify cost-sharing at mail order, specialty and retail pharmacies by adopting a standard co-insurance arrangement regardless of the dispensing location.

C. Move a targeted set of generic drugs from Tier 1 to Tier 2. These targeted generics are priced as high as some brand-name drugs and have more cost-effective alternatives that will remain at Tier 1.

D. Establish greater adherence to a previous PEB program policy decision to not cover prescription drugs for which safe and effective over-the-counter medications are available. Specifically proton-pump inhibitor drugs will no longer be covered.

Cost-Savings:

Adopting this proposed package as a whole is estimated to result in annual plan savings through cost avoidance of $16 Million for the 2012 benefit year. Continued savings through cost avoidance will accrue in future benefit years.

Plan Savings for Non-Medicare Risk Group: $9.2 Million
Plan Savings for Medicare Risk Group: $6.8 Million