Washington State
Health Care Authority

Public Employees Benefits Board

October 19, 2011 Meeting

Washington State Health Care Authority

Public Employees Benefits Board Meeting

October 19, 2011
1:00 p.m. – 3:00 p.m.

Health Care Authority
Cherry Street Plaza
Apple/Peach Rooms
626 8th Avenue SE
Olympia, WA

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Washington State Health Care Authority

AGENDA

Public Employees Benefits Board

October 19, 2011
1:00 p.m. – 3:00 p.m.

Health Care Authority
Cherry Street Plaza
Apple/Peach Rooms
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**	Elizabeth James	
1:05 p.m.	**Value-Based Benefit Design**	Geoffrey Brown	Information
	Oregon and Value Based Benefit Design	Joan Kapowich	Information
2:05 p.m.	**Increasing Efficiency**	Fred Armstrong	Information
3:00 p.m.	**Adjourn**		

The Public Employees Benefits Board will meet October 19, 2011, at the Health Care Authority, Apple/Peach Rooms, 626 8th Avenue SE, Olympia, WA.

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

Washington State Health Care Authority

PEB Board Members

Name	Representing
Margaret T. Stanley 19437 Edgecliff Dr SW Seattle WA 98166 V 206-824-2228 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

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Melissa Burke-Cain, Assistant Attorney General
7141 Cleanwater Dr SW
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Olympia WA 98504-0109
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*non voting members

Washington State
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.

Value Based Benefit Design

A presentation to Washington PEBB
by Geoffrey N. Brown, CCP

October 19, 2011

TOWERS WATSON

The Need for Change

- BRFFS:
  - 2010 Washington State, obesity = 25.5%
  - 2010 Washington State, smokers = 19.2%
  - 2008 Washington State, engage in no leisure activity = 19.4%
- Institute of Medicine:
  - 2011 Nationally, $700,000,000,000 spent on unnecessary procedures and tests each year
- Towers Watson research found that between 2008 and 2010:
  - The percentage of employees who considered managing their health a top priority dropped 10 percentage points, from 69% to 59%
  - The percentage of employees who took action to significantly improve their health declined from 65% to 59%

Value Based Plan
A Working Definition

A plan whose goal is to encourage the provision of optimal (best value) 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.

Benefit provisions are constructed to:

- Encourage effective health behaviors
- Reduce economic barriers for chronic illness
- Provide economic protection for unplanned accident and illness
- Encourage patient-provider dialogue and shared decision-making
- Increase personal responsibility and risk for treatments:
  - of unproven or diminished benefit, and/or
  - where less invasive treatment options exist, and/or
  - where lower cost options of equal or greater quality are available

Behavioral Economic Insights

- Insight #1 We hate to lose more than we love to gain
- Insight #2 We like certainty more than uncertainty
- Insight #3 We interpret economic gains or losses based on context
- Insight #4 We like what's already ours
- Insight #5 People are overly optimistic
- Insight #6 We abhor unfairness
- Insight #7 We remember powerful stories

The Value Based Approach

- Key elements:
  - Wellness program
  - Health care plan
  - Prescription drug plan
  - Communication program

The Value Based Approach

- Wellness Plan
  - Programs to encourage healthy behaviors
    - Discontinue unhealthy state
    - Maintain healthy state
    - Achieve improved health
    - Tools and resources to support healthy objectives
- Health Care Plan:
  - Tier 1, Preventive services
  - Tier 2, Chronic disease care
  - Tier 3, Accident and sickness coverage
  - Tier 4, Special treatment coverage
    - ✓ Pre-authorization
    - ✓ Evidence based eligibility
    - ✓ Additional cost sharing

The Value Based Approach

- Prescription Drug Plan
  - Tier 1 Chronic
  - Tier 2 Generic
  - Tier 3 Preferred brand
  - Tier 4 Non-preferred brand
  - Tier 5 Specialty

The Oregon Experience…

Oregon and Value Based Benefit Design

Presented by:

Joan M. Kapowich
Administrator
Public Employees' and Oregon Educators Benefit Boards

October 19, 2011

Oregon Health Authority

The Board's Vision

- The Vision
  - An innovative delivery system
  - Focus on quality and outcomes
  - Promotion of health and wellness
  - Alignment of incentives
  - Accessible and understandable communication
  - Affordable benefits to state and members

- The Oregon Health Authority focus is the Triple Aim

Oregon Health Authority

Innovative Delivery System

- Free evidence based benefits – preventive services
- Medical homes – small groups and a pilot
- Free Value meds for chronic illnesses
- Free tobacco cessation/weight management
- Health screenings, flu shot clinics, public health StayWell coordination

Oregon Health Authority

Align Incentives for all

- Member, provider and plan incentives
- Low co-pays for HMO and medical homes
- Cost sharing and Premiums vary
- Physician pay for performance
- Plan alignment – flat administrative rates
- Case rates, DRGs, and global budgets

Consumer Education and Informed Decision Making

- Newsletters – articles & success stories
- A quarterly PEBB/OEBB Digest
- Communications Toolkits – Using Information to Get Quality Care - National Business Group on Health, Q Corp
- Shared decision making - Plans websites and pilots
- Pushing members to the website

Oregon Health Authority

Outcomes to date

- HEDIS measures improved steadily
- Increased utilization of preventive services
- Tobacco use 13% in 2005, 10.4% in 2010
- Tobacco quit rates 47% in 2009, 53% 2010
- Weight management – 9 -14% signed up at 100s of work sites
- $2 mil. return on investment (ROI) year one

Oregon Health Authority

Affordable benefits and value based benefit design

- PEBB premium increase lowest ever - 2009
- OEBB premiums – experience and design
- Both boards weighed changes to value based designs
- Tiered benefits – low tier for high value and high tier for preference sensitive or overused services

Oregon Health Authority

Value Based Design Choices

- Essential benefit package – developed in Oregon based on the prioritized list –four tiers
- Health Leadership Council – three tiers
- Benefit boards - areas of high cost and overuse – musculoskeletal and sleep studies
- Kept a simple design for members focused on their claims experience

Oregon Health Authority

Low Value Top Cost Tier

- A $500 co-payment in addition to the deductible & out of pocket maximum
- Spine surgery, hip and knee replacement, shoulder/knee arthroscopy, gastric bypass, sinus surgery
- $100 for MRI, CT, sleep studies, upper endoscopy and spinal injections
- Exclude cancer and emergency treatments

Tiers are nothing new

- It is already in place – formulary tiers
- Top tier – specialty cost tier, shared cost tier, the additional cost tier
- Member reaction – walked through benefit experience and premium information
- A change that impacts a small percent of people but saves money for the group
- Shared decision making emphasis

Oregon Health Authority

Reactions and Responses

- Prepared websites with frequent questions
- Small number of member complaints
- Majority of members understood design
- Still excellent benefit coverage
- Members have a financial reason to speak with their physician

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Experience to date

- Started October 1,2010
- Expanded in April 2011 for PEBB
- Utilization impact on outcomes
- Member comments
- Claims processing complexities
- Provider responses and actions

Oregon Health Authority

Next

- PEBB – Health Engagement Model to begin in 2012 health risk assessment, e-lessons
- Alignment of additional cost tier criteria, tier growth – between benefit boards
- Continue member education on design and insurance coverage and the OHA Coordinated Care Organizations

Oregon Health Authority

A Success Story

I learned about the Weight Watchers benefit just after my brother died of cancer. He was very concerned about my health and weight.

I joined Weight Watchers in his honor and lost 98 pounds!

I ride my brother's bike and log 50 to 80 miles per week, even in winter.

My doctor says that with the help of my brother's memory, I have given myself the gift of life.

Oregon Health Authority


Oregon
Health
Authority

PEB Board Meeting

Group Health Presentation

October 19, 2011

GroupHealth®

Agenda

GroupHealth

- Health Care Trend
- Value Based Insurance Design – VBID
- Clinical Evidence - VBID
- 2012 Incentive Requirements for 2013

Health Care Trend

GroupHealth

PriceWaterhouseCoopers or PwC Health Research Institute published the following national health care cost trend figures earlier in 2011:

2010 - 7.5% (actual)
2011 - 8.0% (actual)
2012 - 8.5% (projected)

PwC cites the following contributors to increasing 2012 trend:

- Higher levels of utilization
- Provider consolidation
- Cost shifting from Medicaid and Medicare
- Deferred care from recession

Milliman Medical Index – costs increased 48% from 2005 to 2010

CMS states health care spending increased from 7.2% of GDP in 1970, to 17.6% in 2009 and is projected to increase to 20.3% by 2018

Health Care Trend

GroupHealth

PwC's Health Research Institute's report on "The Price of Excess" states more than half of U.S. health care spending is wasteful. Major contributors include:

- Defensive medicine
- Lack of emphasis on prevention

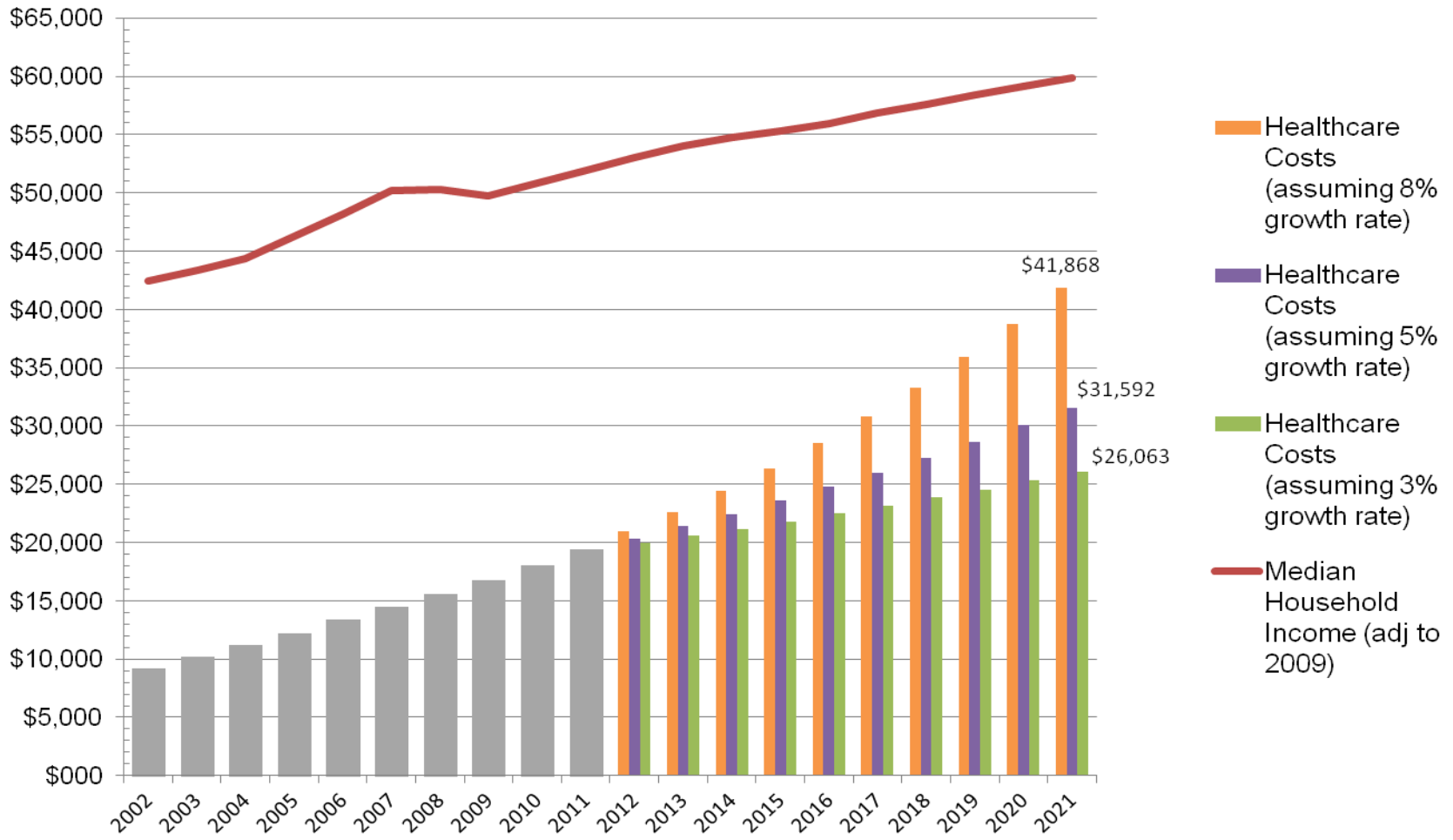
"Traditional" tactics to reduce health care costs often result in "shifting" costs from health plans to participants

- e.g., significant growth in CDHPs and HDHPs

"Traditional" across the board cost share increases do provide a one-time health plan expense reduction, but do little to:

- Reduce health care trend
- Reduce wasteful or low value health care spending

Health Care Trend



Sources: Household healthcare costs 2002-2011 courtesy of the 2011 Milliman Medical Index, which measures the total cost of healthcare for a typical family of four covered by a PPO. Extrapolations 2012-2021 assume a constant growth rate of 3, 5, or 8% annually. Median household income courtesy of 2009 US Census Table H-8, “Median Household Income by State: 1984 to 2009 (Households as of March of the following year; income in current dollars).” Data extrapolated through six-year moving average of annual rate of income change to forecast median income 2010-2021.

Value Based Insurance Design

GroupHealth

The U.S. spends nearly twice as much per-capita on health than other industrialized nations without a corresponding gain in clinical outcomes.

Value Based Insurance Design programs as defined in the American Journal of Managed Care –

- Decrease cost-sharing for interventions that are known to be effective and increase cost-sharing for those that are not. Cost-sharing amounts are set in relation to the clinical value, not the cost, of a specific intervention.
- Explicitly guide patients to use high-value, and avoid low-value, interventions

Value Based Insurance Design

GroupHealth

Two general approaches to VBID programs:

1. Using incentives or lower cost shares to target high value services with the objective of improving patient compliance – “carrots”
    - Emphasis on prevention and targeted chronic conditions
    - Example – Group Health employees Total Health program
    - Cost reduction in the future
2. In conjunction with incentives for high value services also use disincentives or higher cost shares to target low value services with the objective of reducing use of these services – “carrots & sticks”
    - Emphasis on prevention and targeted chronic conditions
    - Emphasis on reducing low value or wasteful spending such as inappropriate ER utilization and preference sensitive conditions
    - Example – Oregon PEBB
    - Immediate cost reduction

Clinical Evidence - VBID

GroupHealth

What is “Value” in health care

Not all health care is the “right care at the right time”

Over and unnecessary utilization is not just costly, it can also results in poor quality

What clinicians advise to reduce health care costs without affecting quality

GroupHealth

How do we Measure Value?

$$\frac{\text{Service+ Quality of Care}}{\text{Cost}} = \text{Value}$$

Developing programs that improve ***service*** and ***quality of care*** have long-term impacts on health care outcomes and member satisfaction

Measures to ***decrease cost*** should also enhance application of evidence-based care and/or decrease unnecessary care

Right Care at the Right Time

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Not all health care is evidenced based, examples include:

- Pharmaceutical and biotechnology Industries – very effective at convincing the public and physicians to purchase new products
- Over reliance on specialty physicians, in place of primary care physicians - adults who report having a primary-care physician rather than a specialist as their regular source of care had lower subsequent five-year mortality rates and lower health care costs, regardless of their initial health or demographic characteristics.
- Emergency Department utilization increasing – inappropriate use of ED's and growth in stand alone ED's

Right Care at the Right Time

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The Dartmouth Atlas of Health Care documents variation in the practice of medicine

- Variation can be expensive – 30% estimated savings
- Quality issues - many patients with chronic illnesses do not receive care that is proven effective (Evidenced-Based Medicine)

Drivers of variation:

- Preference Sensitive Care
- Supply Sensitive Care

Preference Sensitive Care

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For both Commercial and Medicare consumers, the most prevalent PSCs are Hip Conditions, Knee Conditions, Back Conditions, and Cardiac Cath/Revasc

Rates of hip surgery across all regions of Washington are well above the national average.

Rates of back surgery across nearly all regions of Washington are well above the national average.

Surgical discharges per 1,000 Medicare enrollees							
Hospital Referral Region	Coronary Angiography	Hip Replacement	Knee Replacement	Mastectomy for Breast Cancer	Percutaneous Coronary Interventions	Transurethral Prostatectomy for BPH	Back Surgery
US-United States	21.61	3.36	8.36	1.07	11.54	4.16	4.28
WA-Everett	12.87	3.60	7.90	1.27	7.47	5.28	4.12
WA-Olympia	16.48	4.01	8.29	1.54	10.06	3.40	4.32
WA-Seattle	13.54	4.10	7.37	0.87	7.76	3.31	4.93
WA-Spokane	14.12	4.48	10.13	1.08	9.25	5.96	6.83
WA-Tacoma	14.73	4.20	8.81	0.78	8.44	5.45	5.43
WA-Yakima	19.28	4.01	6.87		9.87	5.31	5.47

Note: Blank cells denote fewer than 12 events; not reported to protect patient confidentiality.

Source: Dartmouth Atlas, Washington

Supply Sensitive Care

Supply of resources and not clinical evidence dictates utilization

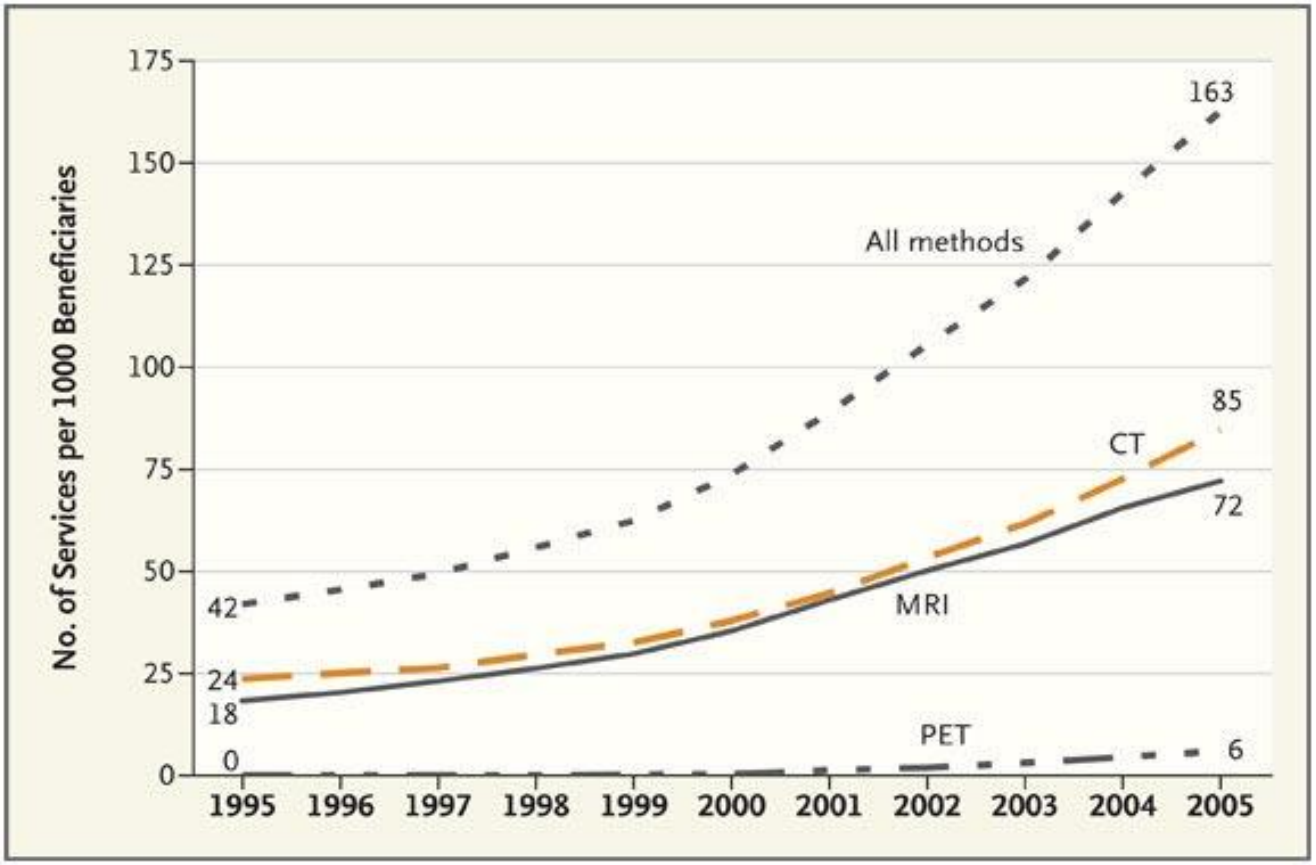
Example: High End Imaging

- The use of high end imaging (CTs & MRIs) at Group Health has more than doubled in the last 10 years
- Imaging is not without risk – at least 1% of the cancer in the U.S. is thought to be due to radiation exposure
- Costs associated with high end imaging are rising rapidly

Supply Sensitive Care

GroupHealth

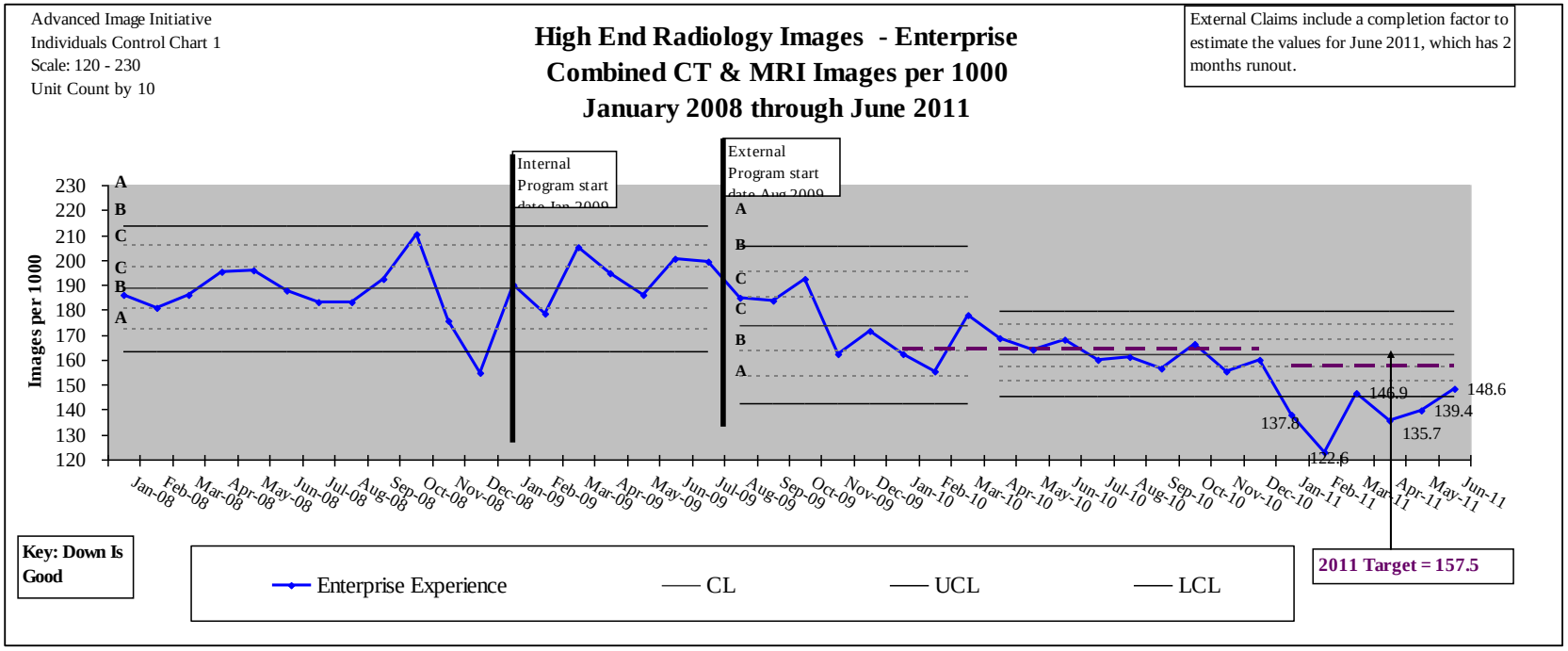
Growth in High End Imaging



Supply Sensitive Care

GroupHealth

How Group Health is impacting High End Imaging



Supply Sensitive Care

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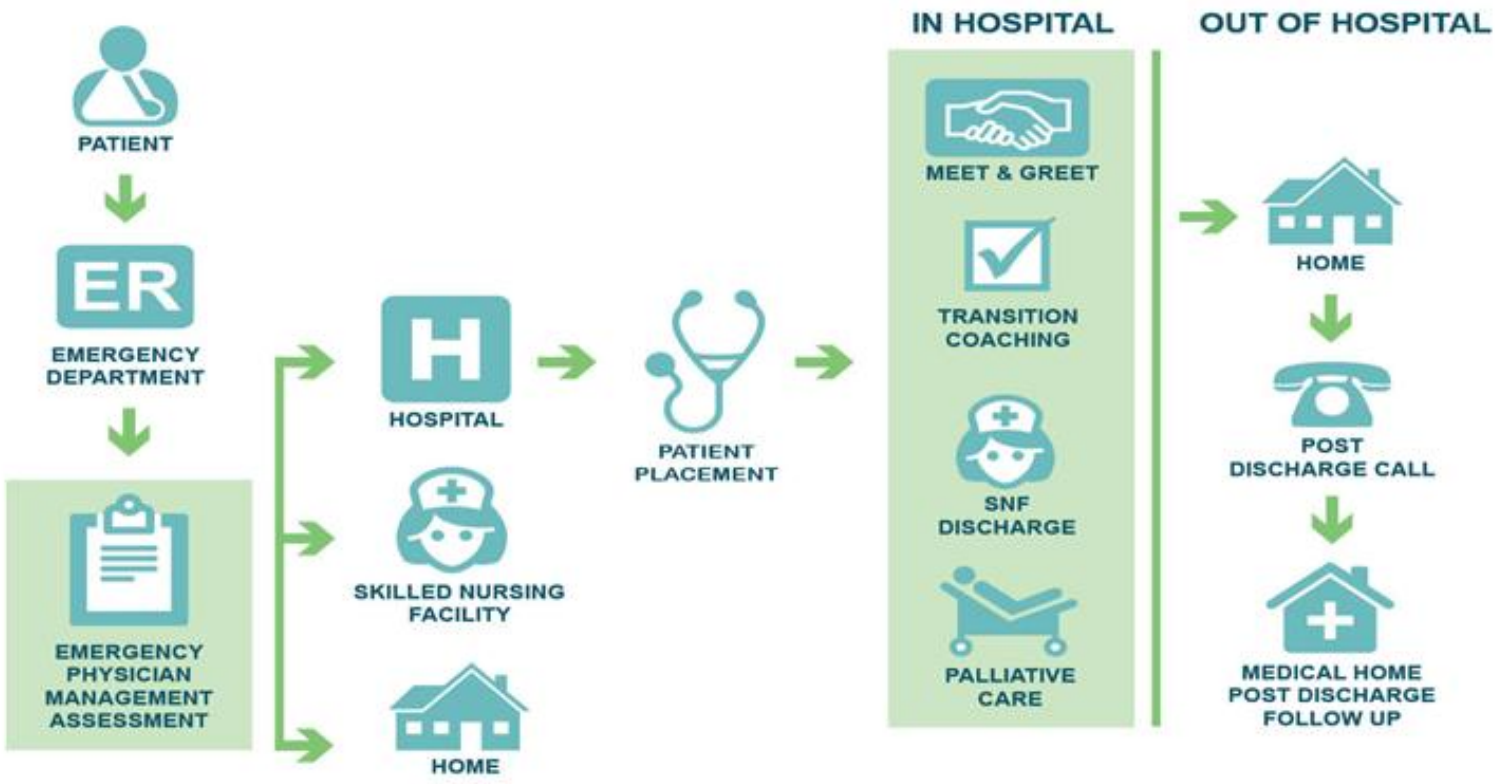
Emergency Department/Hospital Admissions - EDHI



Supply Sensitive Care

Emergency Department/Hospital Admissions – EDHI

Group Health Patient Satisfaction:

- December 2009 – 74th percentile
- September 2010 – 91st percentile

Reduced inpatient costs - $51 million

What Clinicians Are Saying

GroupHealth

Payment for Volume – Payment for Value = Waste

Fragmentation of Care – who is managing patients, especially at transitions and those with advanced illnesses and complicated care

- Strengthening payment for Primary Care Coordination could save $50 billion for CMS in next 5 years

Revising Incentives

- Incentives that promote healthy behaviors could save $19 billion nationwide in next 10 years
- Incentives that incorporate relative clinical effectiveness and costs for alternative treatments could save $368 billion in next 10 years

2012 Group Health Incentives

2012 benefits are set

In 2013 Group Health members can maintain lower levels of cost sharing provided in 2012 they:

- Complete Group Health's Health Risk Assessment, (currently 8% compliance) and
- Designate a network physician as their Primary Care Physician (currently 93% compliance)

Communication for the requirements to maintain lower levels of cost sharing in 2013 will begin early in 2012.

GroupHealth