

Health Care Authority Strategic Plan

2007-09

VISION:

Shaping the Future of Health Care

MISSION:

HCA is a leader in health care policy, purchases quality health care and other benefits, and provides excellent service for its programs.

June 1, 2006

Health Care Authority

Strategic Plan to 2009

June 1, 2006

INTRODUCTION

Over this past year, leadership has discussed the vision for the Health Care Authority (HCA) and where it needs to go as an organization over the next several years. The Health Care Authority's Strategic Plan reflects the health care and economic challenges that our state faces. The following steps were completed to develop the roadmap to HCA's future directions:

- Reviewed data and information about external environment; including issues facing the agency, Governor priorities, and initiatives from Legislature;
- Reviewed agency Vision and Mission, updating to reflect current and upcoming environment;
- Completed employee survey, incorporating results into strategic planning process;
- Conducted self-assessment with extended management members, identifying area of strengths and opportunities for improvement;
- Conducted a 360 Leadership Survey with senior management members, discussed results to strengthen overall leadership of agency; and
- Held a variety of management discussions to review goals, ensure clear understanding of expectations for future, the objectives and strategies, and identifying the performance measures which measures progress.

The approach and process listed above have set the stage for identifying the agency's strategic direction. The steps included developing measurable strategies that will help meet goals, in addition to monitor performance in those efforts. This strategic plan speaks to how the agency will accomplish its goals, in addition to be meaningful to staff in the organization and align to common goals.

COMMON THEMES SURFACE DURING MANAGEMENT SELF-ASSESSMENT EFFORTS

In preparation for strategic planning efforts, self-assessment focus teams consisting of agency managers identified what is working well and any gaps that need attention. The outcomes resulted in building a base level of knowledge, completing the assessment, compiling data/information, and discussing the strengths and opportunities in preparation of developing an effective strategic plan. These efforts and investment of time contributed to desire for maintaining a high performance environment. The following represents common themes that surfaced during focus group discussions:

Working Well:

- Agency focus and direction: Administrator and Deputy Administrator's leadership and agency direction (stabilizing focus and priorities)
- GMAP: Round 1 great, Round 2 continue with measuring performance related to goals

- Transparency of information: customer access to information and staff

Room for Improvement

- Communication efforts: create consistency, share information internally, obtain feedback, cross division/program planning and problem solving, communications efforts to all levels within agency
- Recognition efforts: consistently recognize agency successes and staff contributions
- Leadership/Staff development: develop staff for current and/or future roles, provide growth opportunities, action plan for meeting training needs
- Proactive planning: strategically plan agency business direction and focus, communicate priorities, appropriate allocation of resources (FTE/\$), decisions for benefit of HCA and its customers – goal of being proactive vs. reactive in business initiatives
- Data collection and management: confirm business need and value added in data collected, plan for immediate and future data needs (need internally and externally) – need for consistency throughout HCA environment
- Human resource management: staff training to meet business needs (\$ and opportunities); clear expectations of roles; ensure staff accountable for work results and behaviors; provide coaching to foster respectful workplace; maximize Performance Development Plan tool to manage, recognize, and identify expectations of staff; identify the knowledge, skills, and abilities within agency to help complete agency business
- “HCA Team”: continue to build a cohesive HCA team working to achieve mission for the benefit of all customers (avoiding silos)

Gap Areas

- New employee orientation: orient to agency business, priorities, mission (outside of on-payroll paperwork)
- Data management: who (who manage data), what (what data), how (how manage, store, retrieve data); need for consistent and reliable system; build internal capacity

BUSINESS PLAN STRUCTURE REFLECTS GOALS, OBJECTIVES, STRATEGIES, AND PERFORMANCE MEASURES

The Health Care Authority Strategic Plan marks a departure from previous plans. The development process and resulting structure of significant components are key to successful progress. The 2007-09 Strategic Plan:

- Aligns with and supports the Governor’s priorities,
- Reflects a connection to our agency budget activities,
- Organized by goals directly relative to Vision, Mission, and core business of agency,
- Works towards creating a sustainable, affordable, high-quality health care system and make Washington’s people the healthiest in the world,
- Reflects strategies and performance measures that align with and support agency goals – ensuring accountability by identifying Executive Sponsors, and

- Reflects a commitment to and emphasis on improving cost and quality of health care.

The above aspects of the plan reflects a “planning drives budget” approach to our business and is intended to link financial, program, and management information.

STRATEGIC APPROACH AND ALIGNMENT

HCA’s leadership approach is to build a plan of action that maximizes resources, taking proactive steps in managing the current and future health care environments in Washington State. Strategic planning efforts reflect a performance-based approach to management of HCA business and initiatives.

HCA’s planning efforts reflect and align with Priorities of Government (POG) and Government Management, Accountability and Performance (GMAP) reviews at the Governor’s level. This approach is a logical alignment of the Office of Financial Management (OFM) and HCA business initiatives, ensuring accountability for identified performance measures. HCA is working to incorporate changes and improve existing practices that will:

- Ensure strategic initiative efforts are aligned with budget planning;
- Build capacity within HCA leadership to effectively review performance outcomes and measures;
- Review initiatives and performance measures on consistent basis to ensure accountability, creating opportunities to recognize successes and manage issues that surface;
- Continue to manage resources that support HCA’s Strategic Plan.

HCA is working across boundaries within the agency and with other agencies/organizations to make an impact in an ever changing health care system. The plan reaches across divisions to provide an integrated, agency-wide vision for the future.

IMPROVING COMMUNICATIONS AND DECISION-MAKING EFFORTS

In an effort to increase communications and incorporate strategic planning as an ongoing part of agency business, periodic reviews of identified strategies and resource allocations is done – this forum is called ‘*HCA Internal GMAP*’. This process supports the Governor’s GMAP focus on improving the results of state government. GMAP is a success in HCA, agency managers value the dialogue and ability to problem-solve program and/or business challenges. After initial few monthly report outs, it was evident for need to discuss what is not working as well as celebrating what is. Outside of improving cross-program communications, GMAP enables leadership to better manage issues, take a proactive approach, and to stop doing things that don’t make sense.

APPRAISAL OF EXTERNAL ENVIRONMENT (Health Care Marketplace Issues)

Even though the United States spends more per capita on health care than any other nation, safe, quality and affordable care is not always available to consumers. Cost growth for United States health care significantly outpaces that of both real wages and business revenue. In 2000, 69% of employers offered coverage to their employees, now only 60% do so.¹ In Washington State, annual state spending on health

¹ Kaiser Family Foundation’s [2005 Employer Health Benefits](#) survey.

care rose \$1.8 billion since the year 2000, with Medicaid and state employee health care costs doubling in this time. By 2006, over \$700 million that could have gone to public safety, transportation, or other priorities in 2000, will instead be spent on health care.

Yet, rising costs do not guarantee health status improvements even for those able to afford care. Consumers are presented with a barrage of information via the internet or advertising. Yet resources to evaluate the reliability of such information remain insufficient. Outcome data for treatments and facilities is limited. A 2004 study ([Donohue and Berndt](#)) notes that direct to consumer advertising (DTCA) spending increased from \$266 million in 1994 to \$2.6 billion in 2002. Patients increasingly ask for advertised drugs by name, even though the advertised drugs may be more expensive and no more effective, and riskier than older drugs. Still, DTCA is still not the industry's preferred marketing method. A 2002 study ([Rosenthal et al.](#)) notes that, as of 2000 over 80% of the industry's advertising funds were spent on direct promotion to providers. Troubling questions about attempts to influence provider behavior through published literature are raised by [Ridker and Torres](#), who report that industry funded trials appear more likely to report positive findings than those funded by non-profit organizations.

Emerging Conceptual Trends

Strategies to overcome the challenges posed by our health care system often focus on directly changing the behavior of providers and consumers through a variety of incentives. However, strategies aimed at changing how information flows through the market are emerging.

On the provider side, strategies often focus on using evidence-based guidelines (to reduce uncertainty in decision making), and available health information technology (HIT) (to improve care efficiencies and outcomes). Medical information kept on paper is not easily transmitted. About 30% of medical testing is unnecessary, and occurs only due to poor communication between doctors. Integrated HIT systems allow electronic transmission of data to the point of care and simplify access to evidence-based protocols.

On the consumer side, strategies include educating patients about real health care costs and the consequences of their lifestyle choices. Only patients with access to information on treatment options, costs of care, provider and hospital quality and outcomes data can make rational care choices accounting for medical and economic factors. Benefit designs incentivizing healthy behavior and prudent choices (for example, generic drugs) are also increasingly being offered.

These issues are closely linked with the provision of needed information to policy makers. HIT adoption aids transparency efforts by simplifying reporting of clinical data for public health, or quality improvement efforts. Third parties without a financial interest in emerging technologies or pharmaceutical treatments can bring integrity to reviews of their efficacy. Such information made public, empowers patients and providers to work together toward informed care decisions.

Governor's Strategy

Governor Gregoire recognizes that affordability predicates access to health care. As defects and inefficiencies in care drive costs, her strategy aims to increase access by improving care quality. Its five points are practically embodied in a set of directives and request legislation:

- 1) Emphasize evidence-based health care: In 2006, the Legislature passed [ESSHB 2575](#) establishing the State Health Technology Assessment Program (SHTAP). This program will evaluate the efficacy of medical devices, procedures, diagnostic tests, and services.
- 2) Promote prevention, healthy lifestyles, and healthy choices: Governor Gregoire has issued [Directive 06-03](#) creating the Washington State Employee Health & Productivity Committee. Among other duties, the committee will identify state agency resources to implement “wellness programs for state employees, retirees, and their families”.
- 3) Better manage chronic care: Governor Gregoire has issued [Directive 06-02](#) directing HCA, Department of Social and Health Services (DSHS), and Department of Health (DOH), to collaborate on an initiative to improve chronic illness care in Washington State and develop a new patient-centered model of disease management.
- 4) Create more transparency in the health system: Governor Gregoire has issued [Directive 06-01](#) directing the creation of a Health Outcomes Advisory Committee to evaluate performance measure data, incorporate evidence-based measures in contracts, and examine the feasibility of collecting fee-for-service performance measures.
- 5) Better use of health information technology (HIT): In 2006, the Legislature passed [SHB 2573](#) which directs HCA to promote HIT adoption through pilot projects, purchasing, and reimbursement strategies.

Legislative Scan

In addition to the Governor’s request bills described above, a number of legislative efforts have focused on health care issues. Some bills directly affecting HCA include:

- [HB 2517](#): Did not pass. Would mandate a minimum corporate spend on health care benefits (“fair share”). Expected to again be addressed next session.
- [ESHB 3079](#): Passed. Directs HCA and DSHS to create a report to identify those employers who could be seen as shifting their health care costs to the state.
- [ESSHB 2572](#): Passed. Subject to available funds, directs HCA to create a Small Employer Health Insurance Partnership to subsidize coverage for small business employees.
- [ESSSB 6459](#): Passed. Created the Community Health Care Collaborative Grant Program.
- [SSHB 2583](#): Passed. Expands Public Employees Benefits Board (PEBB) eligibility for part-time community college staff with an average workload of more than 50% over the period of an academic year.
- [EHB 1383](#): Passed. Directs HCA to offer a Health Savings Account compatible high deductible health plan.

DISCUSSION OF MAJOR PARTNERS

- **Interagency Collaboration on Prescription Drug Purchasing:** HCA is leading an interagency project for consolidation of prescription drug programs. Initially, the project involves establishing a mail order pharmacy option for Health Resource Services Administration (HRSA) fee-for-service clients; collaboration with the state of Oregon on a preferred drug list; and joint procurement of pharmacy benefit management (PBM) services for HCA/Uniform Medical Plan (UMP) and HRSA fee-for-service programs beginning January 2004. The Department of Labor & Industries (L & I) may also participate

in some aspects of this project. The consolidation will give state agencies better leverage in negotiating reduced administrative fees, better drug prices, and improved rebates. This will also permit consolidation of data, as well as improved utilization and clinical management.

- **Washington Wellness Works:** In collaboration with DOH, HCA is the lead on the Governor's Directive on Employee Wellness. The goal of the directive is to implement a program that will assist in improving the overall health and fitness of our state employees, retirees, and their dependents. HCA is in partnership with all other state agencies, universities, community and technical colleges and, retiree associations to identify models and opportunities for on-site wellness initiatives; encourage the use of a health risk assessment; coordinate wellness fairs and activities; and encourage appropriate health screenings for state employees. Plans are underway to develop an evaluation effectiveness process and set goals and measurers. Developing collaborative partnerships throughout the state will be a major component of the success of this program.
- **Health Care Procurement:** HCA and HRSA collaborate health plan procurement for the Basic Health (BH) and Healthy Options Programs. Each agency develops the requirements for its programs. The agencies develop common criteria and standards covering quality improvement programs, provider network access, financial status, and information reporting. The agencies also coordinate stakeholder activities, include joint meetings with health plans, health care providers, and other interest groups.
- **TEAMonitor:** HCA, HRSA and DOH, through an interagency agreement, work together to monitor health plans that contract to provide coverage for PEBB, BH, and Healthy Options Programs. The Medical Directors and a team from each agency work together to monitor plan compliance with the quality standards established in the procurement process. Activities include on-site audits of health plans, a detailed evaluation of each health plan's level of compliance and development of a corrective action plan to address areas of concern.
- **Basic Health Program:** HCA and HRSA work together to coordinate the enrollment of children into the Healthy Options Program through BH. Families may apply for BH for the parents and Basic Health Plus for the children. HRSA reviews the eligibility of the children for Basic Health Plus. This process allows families to apply for coverage for all family members at one time and have all family members enrolled in the same health plan and see the same group of health care providers (wherever possible).

HCA and HRSA coordinate the provision of maternity services for subsidized BH enrollees through Healthy Options. BH enrollees are transferred to Healthy Options during the time they receive maternity services. Basic Health also partners with various community groups who provide application assistance and/or serve as financial sponsors for BH members.

- **Public Employees Benefits Board Program:** PEBB works closely with state agency and higher education payroll and benefits offices to coordinate training, communications, program changes, and open enrollment. PEBB staff coordinate with the Department of Retirement Systems (DRS) on a Quality Improvement Team to better serve the agencies common customers, state retirees, including all K-12. The team works to streamline communications from both agencies to retirees. Also, HCA staff participates in DRS pre-retiree seminars to provide information and answer health insurance

related questions. Over 150 political subdivisions, Educational Service Districts, and K-12 school districts also participate with PEBB on a voluntary basis to provide their employees insurance products.

- **Community Health Services (CHS):** HCA's state grant program for community health clinics provides access to health care for low-income residents who do not qualify for any other coverage such as Healthy Options and BH, in conjunction with various agencies including the federal Public Health Service, HRSA, and DOH. CHS, through its work with providers and other stakeholders, collects, analyzes and disseminates health clinic data. CHS is a principal source of financial and utilization information on community health clinics in Washington State.
- **Clinical Outcomes Assessment Program (COAP/ SCOAP):** HCA, in conjunction with various state health agencies, providers and other stakeholders, including the Foundation for Health Care Quality, is collecting, analyzing and disseminating health care outcome data to improve quality for the entire state population in certain high-cost and/or high-frequency clinical procedures (i.e., Coronary Bypass Surgery, appendectomy, etc). The programs' goal is to promote mechanisms for providers to develop and evaluate quality improvement programs and reduce safety concerns using outcome data, while maintaining patient confidentiality.
- **Prospective Payment Systems:** HCA coordinated a project with HRSA and L & I to develop and implement the Resource-Based Relative Value Scale, a uniform system for reimbursement of physicians for use by UMP, L & I, and the HRSA fee-for-service program. UMP continues to provide analysis to HRSA and L & I for the development of fee schedules using this methodology.

HCA, HRSA, and L & I recently completed an interagency project to implement a prospective payment system for reimbursement of outpatient facility costs for UMP, L & I, and HRSA fee-for-service program. Objectives include providing uniformity in state reimbursement methodologies and providing agencies with data to analyze outpatient utilization. UMP and L & I implemented services beginning January 1, 2002. The overall impact on UMP claims costs is expected to be a reduction of more than \$3 million per year.

- **Customer service and quality indicators:** HCA and HRSA have worked with other state and national organizations to develop and implement a standard survey tool to measure consumer experience and quality outcomes with health care plans. The agencies are currently working with health plans that contract with PEBB, BH, and Healthy Options to assure that each plan will be using the survey tool and the information will be made available to the enrollees of all three programs.
- **Integrated Provider Network Directory (IPND):** HCA participates in a project in coordination with HRSA to provide a directory of all health care providers that contract to provide health care services to PEBB, BH, and Healthy Options. The directory cross-references each provider by program and by the health plans with which they participate. The HCA, HRSA, and the Office of the Insurance Commissioner (OIC) are in the process of standardizing provider network data submissions from the health plans.
- **Washington Health Information Collaborative (the Collaborative):** The collaborative is a public-private partnership of First Choice Health, HCA, Qualis Health, and the Puget Sound Health Alliance to

provide \$1 million in technology awards that will be available to help doctors deliver better care. First Choice and HCA are each funding \$500,000 in awards to various entities to assist them in the development of innovative technology to improve safety and quality of care through the use of electronic medical records and aggregate data for improved decision making. The award recipients will be announced in the fall. More information can be obtained at <http://www.wahealthinfocollaborative.org/>.

- **Puget Sound Health Alliance:** The Puget Sound Health Alliance is a regional partnership involving employers, physicians, hospitals, patients, health plans, and others working together to improve quality and efficiency while reducing the rate of health care cost increases across King, Kitsap, Pierce, Snohomish, and Thurston Counties. Alliance participants agree to use evidence to identify and measure quality health care, then contribute to and produce publicly-available comparison reports designed to help improve health care decision making and provision of quality health care services.
- **Washington Health Foundation (WHF):** This is a non-profit organization that has been active in the promotion of quality health care for the state of Washington. The organization believes that health systems and healthy living lead to improved health care outcomes. WHF initiated the “Healthiest State in the Nation Campaign” for the state of Washington; HCA and DOH are leading partners for progress on this initiative. Recognizing that prevention is better than cure – and is cheaper for the health care system, the campaign was kicked off last year by Governor Gregoire in conjunction with the American Heart Association’s Puget Sound Health Walk. WHF has chosen to track key indicators of illness, disability, and death. There are six measures of a healthy system and six measures to gauge healthy living. Washington ranks 35th in summary measure of health system quality and 29th in preventive care. In collaboration with WHF’s educational efforts, HCA and DOH are leading the efforts for a program titled: Washington Wellness Works. HCA’s contribution to this effort includes distribution of WHF’s Thrive! Magazine to state employees as well as a regular column written by the HCA medical staff in conjunction with other state agencies medical directors.
- **State Health Technology Assessment Program (SHTAP):** Authorized by ESSHB 2575 in 2006, the SHTAP is an effort by the state to employ evidence-based medicine principles to its purchasing of health care. The program will determine (in collaboration with the affected agencies) which health technologies to evaluate, contract with an evidence based practice center or similar entity to conduct the technology assessment (which includes gathering, reviewing and evaluating all the scientific and medical evidence regarding that technology), establish, staff and manage a health technology clinical committee that will then take that technology assessment and make a coverage recommendation to the state agencies. Participating agencies include the HCA (self-funded program), DSHS (Medicaid fee-for-service), and L & I.
- **Leapfrog Group:** This group’s first members were 50 Fortune 500 entities and HCA. This initiative is now driven by 170 organizations that buy health care who are working to initiate breakthrough improvements in the safety, quality, and affordability of health care for Americans. Leapfrog provides the voice and resources to help health care purchasers drive higher value into health care. It is a voluntary program aimed at mobilizing employer purchasing power to alert America’s health industry that big leaps in health care safety, quality, and customer value will be recognized and rewarded. HCA is the Greater Washington Regional Roll Out (RRO) Leader (Boeing is the RRO for the Puget Sound

Region). As the RRO Leader, HCA is working with hospitals outside the Puget Sound Region to take the voluntary Leapfrog Hospital Quality and Safety Survey. HCA works collaboratively with Leapfrog members and RRO Leaders (Boeing and Intel [RRO in Oregon]) on Leapfrog initiatives and issues, particularly as they relate to Washington State. HCA also participates in the Regional Medical Advisory Committee for the group. More information can be obtained at <http://www.leapfroggroup.org>.

- **Washington Patient Safety Coalition (WPSC):** This Coalition is a voluntary organization of which HCA was one of the founders. This group of diverse stakeholders, including the Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), Qualis, Washington Rural Health Care Network, Virginia Mason, Washington State Nurses Association (WSNA), League of Women Voters, WA State Pharmacy Association, Swedish Hospital, Group Health, First Choice, and Washington Health Foundation are committed to improving quality and reducing errors both in the inpatient and outpatient setting. The WSPC is recognized by DOH as a *Coordinated Quality Improvement Program* (CQIP). The current initiative on outpatient error reduction in prescriptions, being lead by HCA, is in partnership with Bartell Drugs. In addition to increased costs due to incorrect drug dispensing, errors in prescriptions may also lead to unnecessary and costly patient complications.
- **Washington Health Care Forum:** This is a coalition of health plans, physicians, hospitals, and purchasers that have joined together in an attempt to improve the health care system. Their vision is to devise creative, cost effective solutions to increase efficiency of the health care financing and delivery system. Leaders of the organization initially identified two key areas to address: administrative simplification and electronic medical records. These areas represented significant opportunities to reduce paperwork, unnecessary costs, and frustration. The group also works with public officials and community leaders on public policy issues in the health care arena. The resultant standards of claims payment/submission and referrals have been adopted by the Uniform Medical Plan. The standards for credentialing are in the process of implementation. Most recently the group has been looking at ambulatory care issues and quality initiatives in the hospital setting. HCA is an active participant in the latter work group.
- **National Quality Forum (NQF):** This is a non-profit organization composed of over 350 diverse health care entities, representing almost every aspect of the health care system. The organization was created to develop and implement a national strategy for health care quality measurement and reporting. NQF's mission is to improve American health care through endorsement of consensus-based national standards for measurement and public reporting of health care performance data. It is envisioned that utilization of such national standards will provide information about whether care is safe, timely, beneficial, patient centered, equitable, and efficient. Many of the standards produced to date are being used by the Centers for Medicare and Medicaid Services (CMS), Leapfrog, Joint Commission on Accreditation of Health Care Organizations (JCAHO) and other diverse users, providers, and purchasers of health care. HCA has served on several committees including the steering committee for standards for deep vein thrombosis (number one complication in hospital setting) and palliative care (as the population ages, this becomes more of a priority). The HCA, as member of both the purchaser's council and the provider's council, has input into priorities for consideration for consensus-based standards, ability to help develop standards, comments on all standards produced, and has voting rights for all consensus-based standards. These quality standards are at the forefront of national efforts related to quality improvement and elimination of avoidable costs.

- March of Dimes (MOD):** This is a national, non-profit organization committed to the reduction of premature infant births. Every day 1,280 babies are born prematurely and another 411 babies are born with birth defects. Prematurity is a silent crisis in America and one of the biggest threats the health of our babies in the 21st century. The March of Dimes, through its partners, spreads the word about cost-effective interventions that improve infant health. Two examples include smoking cessation and folic acid intake before and during pregnancy. The MOD five-year campaign goal is to increase the awareness about prematurity to 60% of women of childbearing age and 50% for the general population by 2010. While the prematurity rates in Washington are low compared to many other states, serious disparities exist; especially with Native American and African American populations. HCA, partnering with MOD through the grants program, is exploring efforts to pilot projects in the Native communities with interventions aimed at reducing premature infants in this population. Other MOD educational efforts help ensure that practitioners and pregnant women have the latest information related to healthy pregnancies. MOD is participating in the “Healthiest in the Nation Campaign” with the Washington State Health Foundation.
- American Heart Association (AHA):** This is a national organization whose mission is to decrease the risk of cardiovascular disease and stroke 25% by 2010. Cardiovascular disease is one of the top five cost drivers in health care. Many of the incidents and complications can be reduced or eliminated through education about symptoms, prevention, nutrition, and exercise. HCA has partnered not only with the King County branch of the AHA, but also with ten state affiliate programs in their strategic planning and implementation of the Heart Healthy Campaign. HCA has been an active participant in the GO RED CAMPAIGN held annually in February to educate women about the prevalence and significance of heart disease in women, where the incidence of dying is 1 in 2.5 compared to an incidence of 1 in 30 deaths from breast cancer. Most recently, DOH has also actively partnered in the GO RED CAMPAIGN to increase the awareness of heart disease. These partnerships have resulted in increased educational outreach, participation in the heart walk, and distribution of information about stroke prevention. It is an integral part of the DOH State Health Plan and one of the expected quality improvement efforts for the state contracted health plans. This two-pronged effort is aimed at prevention of disease as well as healthy living.
- National Committee on Quality Assurance (NCQA):** This is an organization dedicated to improving health care everywhere. It is the source for information about quality in managed care. There are multiple programs that include accreditation, certification, pay for performance, physician recognition, and other quality efforts. NCQA’s standards include measurement, transparency, and accountability. HCA collaborates with NCQA, both utilizing their accreditation tool for monitoring of our contracted health plans (PEBB and BH) and active observation during the NCQA on-site portion of the accreditation process that occurs for participating HCA contracted plans.

AGENCY STAFFING LEVELS

Evaluating workload (existing and upcoming) against staffing levels indicates there is not the staff capacity to meet our organizational needs. In particular, HCA has a shortage of skills in the areas of project design/management, analysis, and supervision of people. Some of this can be developed but anticipate a need to hire. HCA continues to face recruitment and retention problems in Seattle office, less in Lacey. It

is anticipated to see greater difficulties in recruiting (as will most employers) over the coming years as the demand/supply for quality employees becomes more competitive. Any new hires (permanent and/or temporary) will require close attention to monitoring space within existing facilities (Seattle and Lacey). Based on some anticipated temporary project staff, the space forecast is expected to be near capacity.

AGENCY TECHNOLOGY STATUS

A key component to HCA's strategic planning and performance management efforts is the need for appropriate technology resources. Information Services leadership has developed a strategic plan in support of the agency plan. The high-level strategies are:

- Build a modern help desk
 - Build a process based on Information Technology Infrastructure Library (ITIL)/Information Technology Service Management (ITSM) best practices around incident, change, and problem management
 - Purchase software to automate these processes
 - Implement organizational practices to increase learning at the first tier support level
- Invest in infrastructure
 - Identify and replace end-of-life/at-risk systems
 - Implement a security strategy to decrease risk and increase functionality
 - Leverage existing Department of Information Services to achieve greater economies of scale
- Ramp up for the Benefits Administration and Insurance Accounting System (BAIAS) Project
 - Build an implement modern practices around software configuration and release management
 - Hire additional resources and expertise in support of the effort
- Mature the methodology for information technology (IT) project management
 - Provide training on project management principles
 - Define and institutionalize a methodology for management of IT components of agency initiatives
- Invest in staff development
 - ITIL/ITSM framework for managing IT systems
 - Management and stewardship training for IT managers
 - Identify budget for reoccurring IT training to maintain relevance of knowledge

FINANCIAL PLAN ASSESSMENT

Health care costs for the Public Employees Benefits Board (PEBB) Program are currently projected to increase at 10 to 12 percent per year in the 2007-09 biennium while cost increases for the Basic Health (BH) are likely to be in the 7 to 9 percent range. HCA is working cooperatively with its actuaries and plan providers to aggressively contain costs. At this time, the agency anticipates being able to offer the current PEBB benefit design and support the current BH baseline enrollment in the upcoming biennium.

HCA is funded by a mixture of appropriated, budgeted non-appropriated and non-budgeted funds. Funding for benefits, direct administration, and a proportionate share of program support related to PEBB come from the non-budgeted Public Employees and Retirees Insurance Account. The PEBB Plan is funded through member premiums and state and other public agency employer contributions. Employee benefit costs are paid directly from this account. Administrative activities are paid through one of three budgeted sub-accounts: Health Care Authority Administrative Account, Uniform Dental Plan Benefits Administration Account, and the Uniform Medical Plan Benefits Administration Account.

HCA receives premium revenue from enrollees in the subsidized Basic Health Program to cover the portion of medical premiums not paid (subsidized) by the state through the Health Services Account. Enrollees in the lowest cost or state benchmark plan are charged on a sliding scale based on income. HCA receives premium revenue from enrollees in the non-subsidized BH to cover the full cost of their health care premiums. For adults, \$10 per member per month is also charged to pay the HCA's administrative costs for the non-subsidized program. Other agency administrative costs related to BH are paid with Health Services Account funds, with some revenue from the Medicaid Program for the costs of administering the accounts of clients eligible for Medicaid.

HCA GOALS AND PERFORMANCE MEASURES

GOAL 1: Cost: Make Public Employees Benefits Board (PEBB) and Basic Health (BH) more affordable for participants and the state.

Performance Measures:

- Annual percent change in PEBB medical premiums compared to annual percent change in state fiscal growth
- Annual percent change in BH medical premiums compared to annual percent change in Health Services Account revenues
- Annual percent change in PEBB medical premiums compared to benchmark group of large Washington public and private employers (adjusted for demographics and benefit design differences)

GOAL 2: Quality: Improve the quality of care delivered through the PEBB and BH programs.

Performance Measures:

- Percent of Uniform Medical Plan (UMP) members selecting providers from UMP High Performing Network [2008 and beyond]
- Annual Consumer Assessment of Health Care Providers and Systems (CAHPS) survey of PEBB and BH health plans with focus on overall rating of personal doctor, specialists, and health care
- Percent of increase in utilization of PEBB preventive services after implementation of health risk assessments and wellness initiatives

STRATEGY: Enable members and citizens to make healthy, cost effective choices.

Performance Measures:

- Percent of BH enrollees who rated our communication tools excellent to superior
- Percent of PEBB enrollees who rated our communication tools excellent to superior

STRATEGY: Purchase health care based on quality and efficiency.

Performance Measures:

- Percent of UMP members with select chronic conditions enrolled in care management programs
- Percent of total PEBB medical expenditures in UMP High Performing Network
- Annual HCA HEDIS survey of PEBB and BH health plans

INITIATIVE A: Effectively manage the PEBB and BH benefit portfolios.

Performance Measures:

- Annual increases in PEBB and BH medical benefit costs

INITIATIVE B: Implement authorized evidence-based purchasing.

Performance Measures:

- Increase the number of technologies submitted to program from three the first year to eight the second year

INITIATIVE C: Improve our communications with members through Plain Talk.

Performance Measures:

- Improve enrollee level of understanding and perceived usefulness of our communications

INITIATIVE D: Implement Washington Wellness Works for all state employees, retirees and their dependents.

Performance Measures:

- Increase number of participants who engage in physical activity and healthier eating
- Increase number of participants who participate in tobacco cessation

GOAL 3: **Leadership:** Lead in the statewide expansion of access to quality, affordable care.

Performance Measures:

- **Affordability:** Percent of trend of healthcare relative to personal income (Mercer/Millman index)
- **Access:** Percent of uninsured in state (OFM, DOH)
- **Quality:** Washington State performance on AHRQ quality measures

STRATEGY: Collaborate to leverage resources, information, and influence.

Performance Measures:

- Increase the number of people/groups in the community database
- Increase the percent of providers using Electronic Medical Records
- Increase the number of Tribal governments involved in Tribal workgroup

STRATEGY: Develop affordable options to expand access to target groups.

Performance Measures:

- Increase the percent of children who have access to health care
- Increase the percent of small businesses who have access to health insurance

INITIATIVE E: Implement authorized small business assistance program and develop alternatives to expand small business access.

Performance Measures:

- Key milestones reached compared to plan

INITIATIVE F: Implement authorized dental, community clinic, and RX purchasing collaboratives.

Performance Measures:

- Increase percentage of target population participating in the RX consortium
- Increase number of patients served in community clinics
- Increase number of dental residents and impact in communities they serve

INITIATIVE G: Lead in formulating state policy on Health Information Technology and use of Electronic Medical Records.

Performance Measures:

- Key milestones reached compared to plan

INITIATIVE H: Engage partners in collaboratives that support HCA and state priorities.

Performance Measures:

- Improve satisfaction of partners for HCA/state priorities and leadership as a result of our activities

INITIATIVE I: Lead in formulating state policy on health planning and Certificate of Need.

Performance Measures:

- Key milestones reached compared to plan

Goal 4: **Performance:** Build a high performance HCA organization.

Performance Measures:

- Overall HCA employee survey performance of 4.0 for 2007
- Percent of HCA in "green status" relative to their programs performance measures
- Percent of all HCA programs in "green status" with their customers

STRATEGY: Build capacity in organization, skills, and tools needed to achieve our goals.

- Increase the percent of employees in compliance with Performance Development Plan training plan and performance
- Increase the percent of business processes improved
- Achieve DOP's Performance Management confirmation
- Increase percent of employees who say they have the tools they need to do their job

INITIATIVE J: Adopt best practices in employee performance management.

Performance Measures:

- Key milestones reached compared to plan
- Improve employee satisfaction with performance development plans

INITIATIVE K: Develop HCA employees to build knowledge and skills needed to achieve goals.

Performance Measures:

- Increase percentage of employee development plans established and implemented
- Improve recruitment and retention performance measures

INITIATIVE L: Improve service delivery and support processes focused on customers.

Performance Measures:

- Improve customer service adherence and quality
- Key milestones reached compared to plan

INITIATIVE M: Improve PEBB eligibility rules by clarifying and resolving outstanding issues.

Performance Measures:

- Improve number of rules reviewed
- Key milestones reached compared to plan

INITIATIVE N: Build a five-year strategic plan for information services.

Performance Measures:

- Key milestones reached compared to plan

INITIATIVE O: Complete the first phase of the Benefit Administration and Insurance Accounting System (BAIAS) project on time, on budget.

Performance Measures:

- Key milestones reached compared to plan

BUSINESS PLAN FOR CERTAIN PROPRIETARY FUNDS

PUBLIC EMPLOYEES BENEFITS BOARD FUND 721 2005-2007 BUSINESS PLAN

Fund 721 is formally the Public Employees' and Retirees' Insurance Account, and is frequently referred to as the PEBB fund. The PEBB Fund is established at RCW 41.05.120. Deposits into the fund include monthly employer and employee contributions, the remittance paid by school districts and educational service districts for funding K-12 retirees, dividends, and refunds. Payments from the fund include premiums for employee and retirees health, dental and other insurance benefits, and payments made by UMP for provider claims. The PEBB Fund is a proprietary fund, financing the services provided by the Public Employees Benefits Board program through user and employer charges.

PEBB Business Mission and Description

The Health Care Authority's (HCA) Public Employees Benefits Board (PEBB) program, established under RCW 41.05, purchases and coordinates coverage of insurance benefits and provides direct customer service for over 316,000 public employees, retirees and their dependents. State employees and employees of public higher education institutions, and retirees of each, have benefits through PEBB. Only a few school districts have elected to cover their active employees through PEBB but all of their employees are offered PEBB coverage at the time of retirement. Approximately 21,700 PEBB members are employees and retirees of participating counties, municipalities, or other political subdivisions.

PEBB sponsored insurance coverage includes medical, dental, life, and long-term disability. PEBB also provides access to group long term care, and auto and home coverage solely on a self-pay basis. In addition to providing health and dental benefits through fully insured private plans, PEBB also offers the Uniform Medical Plan and the Uniform Dental Plan, self-funded and self-administered preferred provider medical and dental plans. State and higher education employees also have the opportunity to participate in a PEBB sponsored flexible spending account (FSA) program that allows them set aside pre-tax earnings to help pay medical and dental expenses not covered by their health plans.

The purpose of the PEBB program is to provide high quality benefit options and customer service to employees and retirees, while striving to control cost increases for members and the State of Washington.

Marketing Plan

Enrollment Summary

PEBB members are classified into four main groups:

1. Active employees (state, higher education, participating K-12 school districts and other political subdivision groups) and their dependants

2. Retirees (state, higher education, K-12 school districts, and participating political subdivision groups) and their dependants
 - a. Retiree membership is further divided based on the retiree or spouse's Medicare eligibility status: 17,841 non-Medicare retiree members, and 51,266 Medicare retiree members. Health insurance options and funding mechanisms are different between the Medicare retirees and non-Medicare retirees.
3. Members who are on leave without pay (LWOP)
4. Members who choose to extend their benefits for up to 36 months after leaving a PEBB employer, as is their right under the Federal COBRA requirement.

Medical and Dental

Medical and dental insurance coverage is purchased by HCA for PEBB members through a competitive bid process and is available through several private insurance plans. The HCA also self-funds and administers a preferred provider medical plan--the Uniform Medical Plan (UMP), and a preferred provider dental plan--the Uniform Dental Plan (UDP) administered by Washington Dental Service.

The following table summarizes the number of members covered by each type of medical and dental insurance offered and administered by the PEBB program. Total members include actives, retirees, COBRA and LWOP participants, their enrolled spouses and dependents. Coverage is available in all 39 Washington counties, nationally and worldwide.

Table 1

June 2005 Enrollment Summary	# of Members
Medical Insurance Benefits	
Managed Medical Care Plans (MCO) (6 MCO plans)	171,770
Uniform Medical Plan (UMP) and UMP Neighborhood	145,002
Total Members	316,772
Dental Insurance Benefits	
Managed Dental Care Plans (2 managed dental plans)	55,239
Uniform Dental Plan (UDP)	197,734
Total Members	252,973

Life and Long-Term Disability

Active employees (those currently employed by PEBB state, higher education, participating K-12 and participating employer groups) also receive basic long-term disability (LTD) and life insurance as part of their overall benefits package. The table below summarizes enrollment for basic life and LTD insurance.

Table 2

June 2005 Life & Long Term Disability (LTD) – Basic Coverage	# of Members
State and Higher Education Employees	109,336
K-12	2,530
Political Subdivisions	4,712
Total	116,578

Active employee members have the option to purchase additional coverage for life, LTD insurance along with a long-term care insurance product, and auto and home coverage at group rates. The retiree members have an additional option of purchasing a basic life insurance package. The members pay the full price of these coverage options.

Program Growth

The PEBB program measures enrollment in two ways, subscribers and members. PEBB funding is based on the number of subscribers. A subscriber is an individual with direct entitlement to PEBB insurance coverage, such as an active employee or a former employee retired from state service. Members include both subscribers and dependents.

From 1996 to 2005, total PEBB enrollment grew by almost 5.2 percent while the retiree enrollment grew nearly 33%. Further, Medicare retiree enrollment grew by 41.5% during the same time period. The following chart shows the growth in retiree member enrollment.

Table 3

PEBB Retiree Members By non-Medicare - Medicare enrollment

Year	Retirees		Annual Percent Increase in Medicare	Total Retirees	Annual Percent Increase
	Non-Medicare	Medicare			
1996	15,742	36,223		51,965	
1997	15,946	37,971	4.8%	53,917	3.8%
1998	16,703	39,523	4.1%	56,226	4.3%
1999	17,667	40,991	3.7%	58,658	4.3%
2000	18,718	42,642	4.0%	61,360	4.6%
2001	19,459	44,266	3.8%	63,725	3.9%
2002	18,690	45,624	3.1%	64,314	0.9%
2003	18,195	47,412	3.9%	65,607	2.0%
2004	17,948	49,257	3.9%	67,205	2.4%
2005	17,841	51,266	4.1%	69,107	2.8%

Source: June enrollment reports

Customer Characteristics

The PEBB member population is aging. Generally, older members use more medical benefits than younger members. In 1997, 43% of the non Medicare population was over 40. In June of 2005, 50% of the non Medicare population was over 40. The following chart shows the steady increase in the over 40 non-Medicare population.

Table 4
Percent of Non Medicare Members over 40
Years 1997 thru 2005*

Year	Age		Total Non Medicare Members	Percent of Non-Medicare Members over 40
	0 thru 40	Over 40		
1997	144,870	110,890	255,760	43%
1998	144,224	115,209	259,433	44%
1999	146,450	119,934	266,384	45%
2000	145,874	123,654	269,528	46%
2001	139,277	126,727	266,004	48%
2002	133,857	125,726	259,583	48%
2003	132,331	127,849	260,180	49%
2004	132,722	130,705	263,427	50%
2005	132,252	132,943	265,195	50%

* Enrollment measured as of June each year

The PEBB non-Medicare member population is older than Washington State's general population. According to the 2000 Census published on the Office of Financial Management's website, the median age in Washington is 35.3. Half of PEBB's non-Medicare member population is over 40.

State employees who have other comprehensive medical coverage have the option of waiving PEBB medical coverage. Employees may choose this option to save the cost of the employee contribution. These employees still receive the employer paid dental, life, and long term disability coverages. As employee contributions rise, waivers are expected to rise. If employee contributions are lowered, it is expected that fewer employees will waive coverage. The following chart shows the number of employees waiving coverage since 1999.

Table 5
PEBB Waiver Subscribers

Year	Waivers	
	Waivers	Annual Percentage Increase
1999	825	
2000	995	20.6%
2001	1,644	65.2%
2002	2,248	36.7%
2003	3,669	63.2%
2004	4,619	25.9%
2005	4,881	5.7%

Source: June enrollment reports

The total number of subscribers has also grown since 1996 to 166,608. This is an increase in subscribers of 34,007 with an average annual increase of 2.6 percent. The following chart illustrates subscriber growth from 1996 through June 2005.

Table 6

Year	Active** Subscribers	Retiree and Other Self Pay Subscribers	Total Subscribers	Increase	Annual Percent Increase
1996	94,912	37,689	132,601		
1997	96,775	39,034	135,809	3,208	2.4%
1998	98,729	40,602	139,331	3,522	2.6%
1999	102,023	42,249	144,272	4,941	3.5%
2000	103,798	44,264	148,062	3,790	2.6%
2001	106,355	45,834	152,189	4,127	2.8%
2002	109,825	46,232	156,057	3,868	2.5%
2003	112,900	47,135	160,035	3,978	2.5%
2004	115,522	48,347	163,869	3,834	2.4%
2005	117,068	49,540	166,608	2,739	1.7%

Source: June PEBB monthly enrollment reports

** Active Subscribers includes enrollees from State, Higher Education, K-12 and School Districts and Political Subdivisions. Does not include state employees waiving coverage.

Marketing Strategy

PEBB has a two-fold marketing approach. PEBB works with participating employers to ensure appropriate information is made available to members and to help employer groups considering PEBB participation to understand what is available through PEBB, and conditions for participation. And PEBB does direct marketing to members.

- The HCA maintains a PEBB website with program information for members. This website includes information about the different insurance coverages available through PEBB, and in particular information about medical plans choices. In an effort to improve communications with members and increase efficiency, HCA increasingly encourages members to use the website as a primary source of information. The HCA continually assesses the web content and use and seeks to further develop the site to support PEBB members in understanding their benefits and making choices.
- The Health Care Authority creates nearly 100 publications annually that support new and ongoing PEBB members in plan choice and use, as well as documents that support employer groups in assessing PEBB participation.
- The HCA collaborates with the Department of Retirement Systems to hold retirement seminars to educate employees about PEBB benefits as they plan their retirements.
- The HCA and participating health plans participate in benefit fairs during the annual open enrollment period to provide members with a face to face opportunity to get information about PEBB or about particular plans.

Operational Plan

Business Functionality/Daily Operations

The PEBB program area has five primary areas of business functionality (enrollment, eligibility, member services, agency and employer group support, and risk adjustment), and works with support areas within the Health Care Authority to accomplish additional business functions (e.g. procurement, benefit design, and quality and contract monitoring). Funding for these activities comes from Fund 418. HCA has an administrative account, Fund 418, an appropriated fund with revenues transferred from Fund 721.

1. Enrollment

The enrollment process includes the development and distribution of quality, targeted program materials to various eligible populations; the establishment and maintenance of enrollment mechanisms for various eligible populations, account development and maintenance with participating employer groups, and customer service and problem resolution. To support enrollment, PEBB ensures accurate web content and publications, trains agency payroll offices, participates in benefit fairs, provides benefit presentations to interested employer groups, and manages enrollment files and coordination with 14 insurance carriers. PEBB facilitates individual enrollment, eligibility verification, and premium collection.

2. Eligibility

The PEBB (board) establishes eligibility for PEBB within the statutory framework established in RCW 41.05. The HCA PEBB program staff promulgates the Washington Administrative Code rules related to PEBB eligibility and supports payroll offices and employer groups in understanding and implementing the eligibility rules correctly.

3. Member Services

Starting with support during the enrollment process and continuing throughout PEBB membership, PEBB provides member services to PEBB members. PEBB uses both web and phone based communication for information delivery, and complaint resolution. PEBB member service staff are assisted by staff in other state agency payroll offices and, to some extent, other employer groups in providing the services to active (currently employed) subscribers. PEBB staff members are solely responsible for providing member services to retired employees and those on COBRA or in LWOP status. Contacts fielded by the member service staff include eligibility and benefit questions and complaints.

4. Agency and Employer Group Support

PEBB relies on its employer partners (state agencies, public universities, K-12, and political subdivisions) to correctly administer PEBB benefits. To maximize employer partners' ability to perform required PEBB related functions, PEBB supports them with training and materials. It is important for the 153 state agencies, 38 higher education institutions, and more than 280 participating school districts and employer groups to understand the plan options, covered benefits, eligibility rules, and enrollment processes.

5 Medicare Drug Subsidy

PEBB coordinates with CMS to track Medicare eligible members who choose to defer enrollment in Medicare Part D and retain their PEBB prescription drug coverage. Because PEBB health plans provide prescription drug coverage that is at least as good as Part D, PEBB qualifies for a federal subsidy for each enrollee who chooses to remain in his or her PEBB health plan rather than enroll in Part D.

Funds 438 and 439 are non-appropriated, but allocated, funds with revenues transferred from Fund 721. Funds 438 and 439 support benefits administrative functions for the Uniform Dental Plan and Uniform Medical Plan respectively.

Facilities

PEBB program staff, as well as HCA staff in support offices are located at HCA's central office and offsite warehouse. The Uniform Medical Plan, HCA's self-insured PEBB plan, has its office space in Seattle.

Central Office: 676 Woodland Square Loop SE, Olympia, WA 98504-2710

Warehouse: 3819 Pacific Avenue, Suite A, Lacey, WA

Uniform Medical Plan: 1511 3rd Avenue, Suite 201, Seattle, WA

PEBB Program Management and Staff

The PEBB program operates under the direction of assistant administrator supported by an operations manager, a training and outreach manager, a quality assurance manager, a Medicare specialist and an administrative secretary.

Operations Section—In the Operations Section, two teams totaling 23 FTEs provide direct member support. Each team is comprised of line staff that handle telephone calls and documents, a lead worker, and a supervisor. Both supervisors report to the Operations Manager.

Training and Outreach Section—The Training and Outreach Section operates under the direction of a manager who supervises four staff that provide support and training to more than 450 agencies, school districts and public employers. This section also provides information about the PEBB program to interested employer groups.

Program Improvement Section—The Program Improvement Section is staffed by the Manager of Quality Improvement and one staff person. This section is responsible for governor's office and legislative inquiries, WAC and RCW management, program eligibility and compliance issues, operational policy, procedure and quality control, and dental, life, long term disability and other ancillary procurements.

Medicare Strategy Specialist—This position is responsible for analyzing existing and proposed federal Medicare regulations to determine their impact on the PEBB program. The Medicare Specialist is PEBB's Medicare subject matter expert, external Medicare representative, and key contact with CMS for the submission and management of the state's Medicare employer subsidy which has the expected annual value paid to the Health Services Account of \$2.2 million.

Within the Health Care Authority, the PEBB program directly funds five accounting positions and one information services position. The program also receives support from the Health Care Authority's internal support division including budget, communications, health care policy, legislative relations, legal and contract services, administrative services and information services.

Financial Plan

Revenues

The PEBB program revenues include monthly premium for benefits' coverage from employers, employees, and retirees. They are received in the Public Employees and Retirees Insurance Account (revolving fund 721). From this fund, resources are transferred to three administrative funds: the Health Care Authority administration account (fund 418), UMP benefits administration (fund 439) and UDP benefits administration (fund 438). The remaining resources are used to pay for the health, dental, life and LTD benefit expenditures and support health quality initiatives.

Sources of Funding

The PEBB fund's revenue sources include: monthly contributions from state agencies and other PEBB employers; monthly contributions from employees and retirees of participating employers; monthly payments from COBRA/LWOP members; investment income and income from K-12 and Educational School Districts whose retirees participate in PEBB. The pie chart below shows the percentage of the 05-07 revenue from each source.

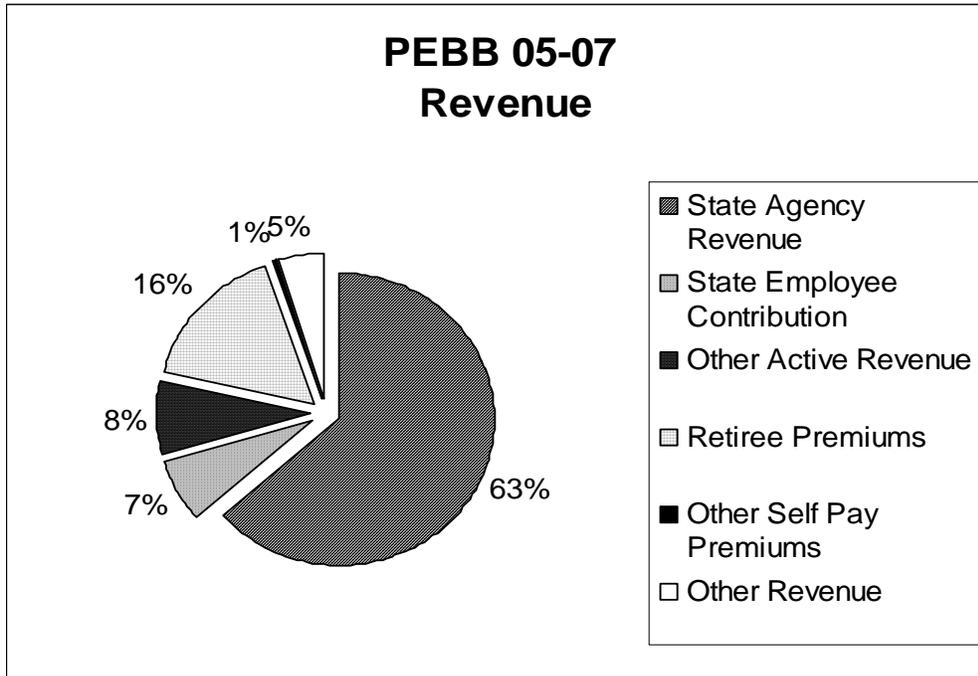


Table 7 below provides projected revenue amounts from each category for the 05-07 biennium.

Table 7

Projected Revenues	05-07 Biennium
State Agency Revenue	1,759,083,198
State Employee Contribution	189,789,966
Other Active Revenue*	226,797,394
Retiree Premiums	441,662,136
Other Self Pay Premiums**	15,913,273
Other Revenue***	130,730,758
Total REVENUE	2,763,976,725

* K-12 and Political Subdivisions

** COBRA, LWOP, RIP

*** Non PEBB K-12 Remittance and Investment Income

Expenditures

The PEBB purchases health, dental, life and LTD insurance products for its members. The pie chart below shows the cost of each insurance product and agency administration as a percentage of the total 05-07 budgeted expenditures. Payments for optional life and long-term disability coverage are made directly to the plans, not through the PEBB fund.

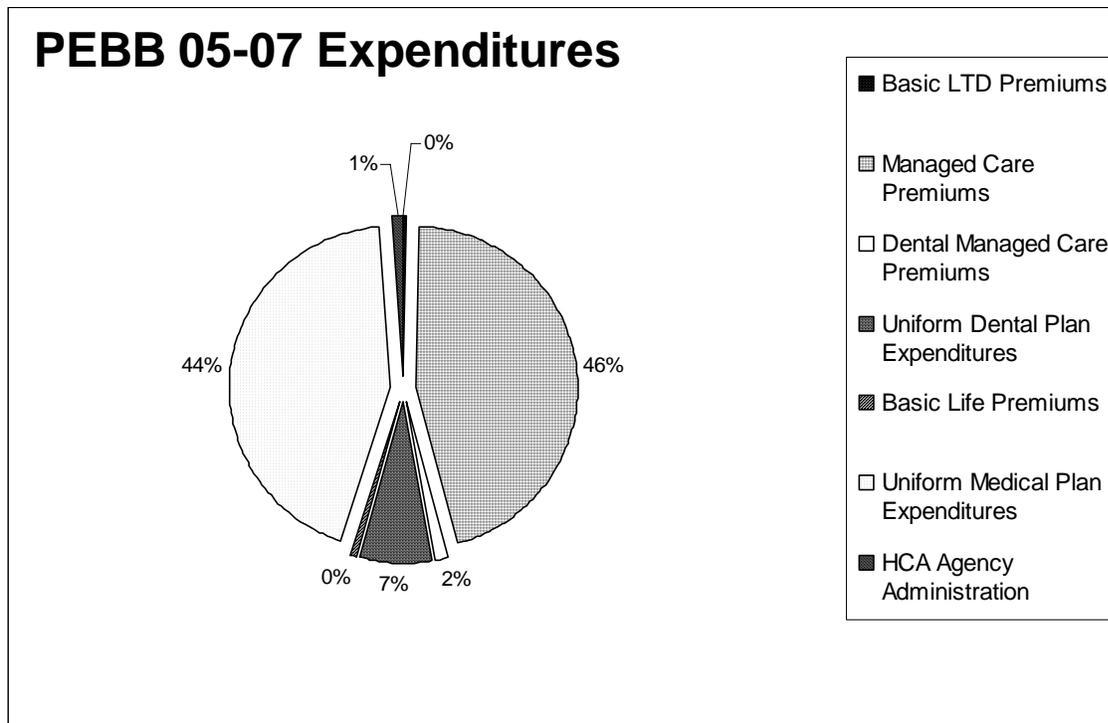


Table 8 below provides projected expenditure amounts for each category for the 05-07 biennium.

Table 8

Projected Expenditures	05-07 Biennium
Basic LTD Premiums	7,530,242
Managed Care Premiums	1,219,104,732
Dental Managed Care Premiums	41,776,030
Uniform Dental Plan Expenditures*	193,263,581
Basic Life Premiums	12,619,279
Uniform Medical Plan Expenditures**	1,182,804,073
HCA Agency Administration***	26,498,677
TOTAL EXPENDITURES	\$ 2,683,596,614

*UDP expenditures include claims, and administrative expenditures from Fund 439.

** UMP expenditures include claims, and administrative expenditures from Fund 438.

*** HCA Agency administration total includes monies from Fund 418, and some monies for UMP administration.

Pricing Structure

Rate Structure

Rates are calculated separately for two distinct risk pools: the active/non-Medicare risk pool; and the Medicare risk pool. Monthly rates are paid for each enrolled subscriber based on a structure that is tiered according to type of family enrolled. Tiered rates are calculated based on the “Subscriber Only” rate.

The tiered rates for family types reflect fixed multiples of the “Subscriber only” base rates. For most Active/Non-Medicare subscribers, the four tiers are as follows: subscriber only (base rate); subscriber and spouse (base rate X 2); subscriber and child(ren) (base rate X 1.75); and full family including subscriber, spouse, and child(ren) (base rate X 2.75). A similar but more complicated tiering structure is used for Medicare subscribers or Active/Non-Medicare subscribers with Medicare family members.

Strategic Assessment

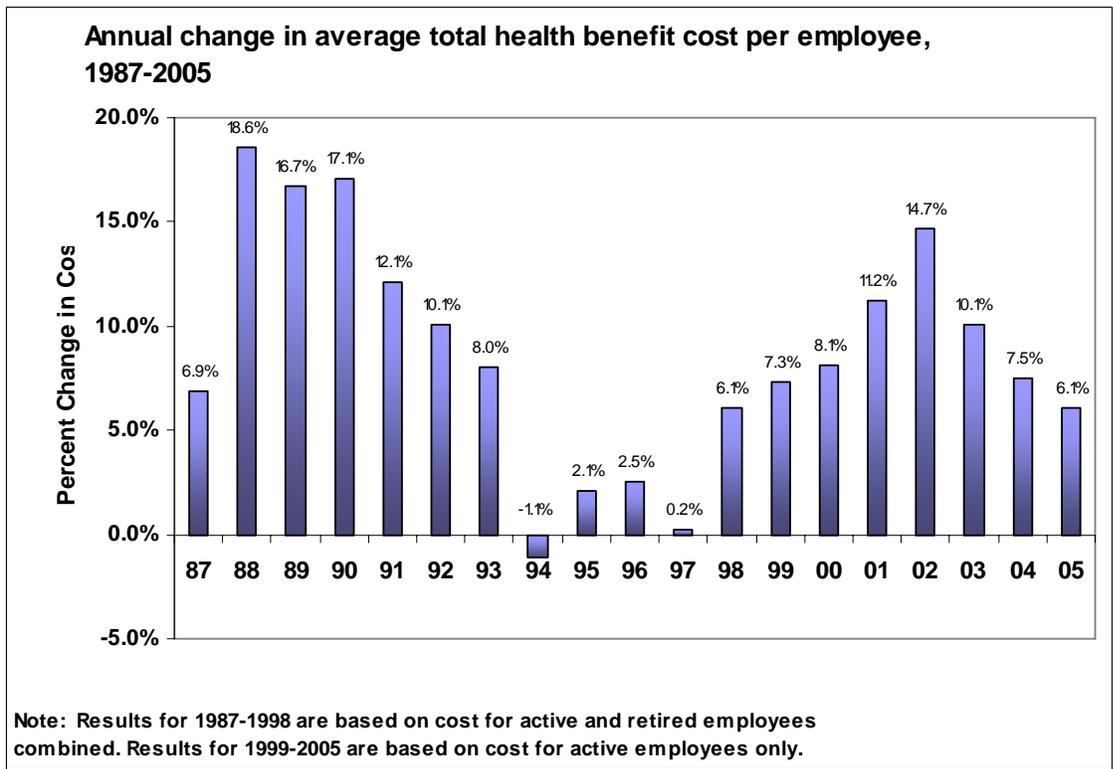
The rising cost of health care continues to be the critical issue for health care purchasers, elected officials and the general public. The last several years have seen double-digit medical inflation, and while the rate of increase is predicted to slow in 2006, it remains steep.

The 2005 Kaiser Employer Health Benefits Survey noted that the 9.2% rise in employer health care costs for 2005 was the first in five years to come in within single digits. However, Hewitt Associates’ 2006 Health Care Expectations Survey anticipates a return to double digit health care inflation with an expected trend of 10%. PEBB’s non-Medicare risk pool increase of 8% for 2006 was lower than the national average, as is the approximately 6% increase projected for 2007 by PEBB’s actuary, Mercer HR. Along with well documented increases in prescription drugs, the aging population, dissatisfaction with the limitations imposed by managed care, expensive new technology

and providers demanding higher reimbursements, the projected increase in health care costs is further fueled by higher consumer utilization.

As the cost of providing health care services increases and society moves away from “managed care” as a means to control costs, most employers are increasing amounts paid by employees for their health care benefits. Some employers are dropping coverage for groups of employees entirely, while others are reducing funding for dependents or retirees.

The following chart illustrates national trends in employer costs for health care, as measured by the 2005 Mercer National Survey of Employer-Sponsored Health Plans.



Source: 2005 Mercer National Survey of Employer-Sponsored Health Plans

Health Plan Cost Issues

- 2006 health plan costs for state actives increased by an average of 8 percent.
- 2007 health plan costs for state actives will increase by an average of 6 percent.
- An aging population with a higher than average use of services.
- Rising prescription drug costs.
- Continued introduction of expensive new medical technologies and rising salary levels of healthcare professionals.
- Market trend toward cost shift to employees through greater cost sharing and “consumer directed health plans.”
- Market trend toward engaging consumers in better decision making regarding health care utilization and provider choice driving development of information resources to help consumers make better decisions.
- Market trend toward wellness, health promotion, and demand management initiatives.

Prescription Drug Cost Issues

- Nationally, prescription drug benefit cost increases are stable, but still in the double digits. According to a Segal Health Plan Cost Survey, costs increased 14.2 percent in 2006.
- New and expensive drug and biomedical therapies.
- Direct advertising to consumers and providers, as well as industry funding of drug studies and development of guidelines.

Provider Reimbursement Issues

- Low reimbursements driven by Medicare have heavily impacted medical specialists.
- Medicare reform increased payment to Medicare Advantage plans and creates additional financial incentives for increased participation and stability in the Medicare Advantage market.
- Market trend to align provider reimbursement strategies with quality goals through financial and non-financial incentive structures.

Collective Bargaining

Historically PEBB has had the authority to set policy regarding eligibility and benefits. In 2002, the Legislature passed legislation giving state employees collective bargaining rights, and the 2006 Legislature expanded benefits eligibility for the first time.

The new collective bargaining provisions included in RCW 41.80.020 were initiated in 2004 and implemented in the 2005-07 biennium. The bargaining agreement includes a per-employee dollar amount to be spent on behalf of each employee for health care benefits. The collective bargaining contract reflecting this new provision was implemented in July 2005. The impact of collective bargaining for benefits affects financial calculations used by PEBB to calculate the funding rate paid by state agencies on behalf of state employees.

Performance Assessment

The current PEBB scope of service was set in 1993 with the passage of the Washington Health Services Act of 1993 (Ch. 492 L1993), which included required coverage for K-12 retirees through PEBB, and the implementation of managed competition for health care purchasing. More recent initiatives such as RCW 41.04.208(2), which requires local governments to provide health coverage for their retirees, and RCW 41.05.050(4)(b), which requires PEBB to charge no more than the state agency funding rate to participating school districts, as well as rising commercial insurance rates, have created further incentives for school districts and other local governments to join PEBB.

Provided below is a brief assessment of the program's strengths, weaknesses, opportunities and threats.

Strengths:

- Continued balancing of price, quality and health care access
- Consumer interest in being more involved in health care decision making
- Annual review and implementation of benefit designs reflecting the latest medical developments
- Well developed health plan partnerships

Weaknesses:

- State agencies do not always correctly apply complex eligibility rules.
- Insufficient oversight of active enrollee eligibility.
- Complexities of eleven separate retirement systems with differing eligibility and rules governing PEBB retirees.
- Legal requirement to maintain PEBB benefits at a level "substantially equivalent" to those available in 1993 limits PEBB's ability to look at new benefit designs, and to respond to employee and retiree requests for lower cost options
- Inadequate insurance system
- Lack of data and resources to harness data to structure programs toward particular quality, cost, or health management goals

Opportunities:

- Focus on prevention and wellness programs for membership
- Improvement of quality assurance with enrollment and eligibility
- Refinement of risk adjustment methodology to more correctly calculate a relative risk index that reflects each enrollee's predictable use of health care services and ensures plans have incentives to provide appropriate care
- Expanded value-purchasing initiatives
- Expand and develop creative benefits such as Flexible Spending Accounts, while maintaining cost neutrality to the state
- Systematic collection of best practices and benchmarking of plan administration
- Collaborative purchasing efforts with other State agencies and private employers to create market leverage toward quality and cost goals
- New insurance system

- Improve customer information and information delivery to provide decision support and encourage self-management of health conditions.

Threats:

- **Benefit Financing - health care trend increases are projected to continue in the double digits – directly impacting the state budget, enrollee costs and customer frustration for both active and retiree members**
- A growing retiree population and an aging active population will impact the overall financing and rates for the program
- Negative program impacts of implementing a new insurance system
- Escalating customer demand for health services and corresponding increases in utilization

Goals and Initiatives for July 2005 – June 2007

Lifestyle Choices: Focus on Overweight & Obesity

Lifestyle choices of PEBB members regarding what they eat, how physically active they are, whether they smoke or not, use of alcohol and other drugs, and safety belt use are among many that PEBB can target for behavior change in members. Each of these behaviors represents an opportunity for PEBB and PEBB plans to moderate health costs by influencing member behavior. One of the areas PEBB will focus on in the coming biennium is the prevalence and impact of overweight and obesity.

The Centers for Disease Control recently released a report indicating that obesity will soon overtake tobacco use as the leading cause of preventable death in the United States. The affects of obesity are far reaching, including negative health consequences for the individuals, reduced productivity at work, and increased health care costs for all. PEBB, in participation with other HCA support areas, will review the current benefit exception to treatment of obesity, and existing evidence for various treatment of obesity to determine whether this exception should remain, or whether there should be consideration of coverage for treatment for obesity, or support for wellness programs within workplace settings that support employees in lifestyle changes.

Medicare Reform

In December of 2003, the Medicare Prescription Drug, Improvement and Modernization Act (MMA), P.L. 108-173, was passed and signed by President Bush. The legislation provides for many reforms within the Medicare program, several of which have direct impact to PEBB. The major reform within the Act is the creation of a Medicare drug benefit (Part D), which went into effect on January 1, 2006. HCA is working with PEBB enrollees who have Medicare to help them understand their options. The MMA also included required revisions to Medigap (Medicare Supplement) policy that required HCA to assess the Medicare Supplement plans being offered through PEBB and determine compliance with new federal policy, and identify any needed changes to current practice. PEBB will continue to monitor proposed and existing Medicare regulations for impact to PEBB programs.

Consumer Directed Care

Within the healthcare market place, many employers are using consumer directed care options to control the rate of growth of health benefit costs, and to engage employees/members in better decision making about health care utilization. Consumer directed care, and “consumerism”, refer to a

continuum of strategies that attempt to engage health care consumers as if they were purchasing health care in a retail environment. These strategies range from providing information (about health care, conditions, and treatments; about hospital and provider quality, about costs), to also structuring benefits to create significant financial incentives for members to pursue higher quality and efficacy, and lower cost care and providers. PEBB currently offers a relatively standard benefit through its health plan options. During the 05-07 biennium, PEBB will explore options for consumer directed care strategies and identify appropriate information to provide PEBB members, and explore benefit designs that increase consumer engagement around cost and quality.

Re-procurement of LTD and Life

PEBB plans to conduct a request for proposals process to re-procure the Life and Long Term Disability coverages effective January 2008, dependent on parameters of collective bargaining. The current vendors are ReliaStar and Standard Insurance for Life and LTD respectively.

FSA's

Flexible Spending Accounts (FSA) became available to all state and higher education employees eligible for PEBB benefits effective July 1, 2006.

In January 2003, the PEBB program began a pilot project offering FSAs to higher-education members. Individual universities and community colleges were invited to participate on a voluntary basis by signing an inter-agency agreement with the Health Care Authority. These institutions maintain payroll systems separate from the Department of Personnel's Central Pay System and their payroll systems were able to perform the necessary tracking requirements of this benefit.

The PEBB planned to offer FSAs to state employees beginning in January 2006, but the new state payroll system was not fully operational at that time. State employees had the opportunity to participate in a special FSA open enrollment the following May when the new payroll system was able to accommodate the plan

Fringe Benefit Management Company, of Tallahassee, Florida, currently administers the FSA benefit under a contract with the HCA, but we have issued an RFP and will be considering applications for a new third party FSA administrator beginning in 2007.

Administration Insurance Accounting System (BALAS) project.

PEBB eligibility and accounting is currently done through the State's agency payroll system (HRISD). In the first half of 2006 non-benefit functions migrated to a new system, HRMS. HCA is the only remaining user of the old system. We are responsible for sole support of the software code and HCA bears the risks associated with the antiquated mainframe systems. Enrollment and insurance accounting for both PEBB and Basic Health premium collection and carrier payment accounting functions are supported by the old system. In order to adequately support current and anticipated PEBB business needs, HCA is pursuing development of a benefits administration system; for implementation in FY 2008. HCA also anticipates reduced operating costs in FY2008 related to implementation of the new system. This initiative requires review and updating of the systems requirements and functionality originally designed for the project that was terminated in March 2004; and review of contracting and business processes to ensure vendor performance. We plan to issue an RFP in August 2006.

Customer Communications

PEBB's objective is to meet industry standards for customer response times and comply with the Governor's directive to ensure that all communications are written and designed to be easily understood by the general public. A charter/work plan for reviewing and revising PEBB materials to meet Plain Talk standards will be completed by June 2006, and a percentage goal for correspondence response time will be in place by December 2006. An action plan to meet these goals will be completed in the first quarter of 2007.