Washington State Health Care Authority

Headquarters location	676 Woodland Square Loop P.O. Box 42700, Lacey
Uniform Medical Plan **Prescription Drug Program**	Melbourne Tower 1511 Third Avenue, Suite 201 Seattle
HCA Warehouse	3919 Pacific Avenue Lacey
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2003-05 Budget Summary

	FTE	Administrative Expenditures	Benefits Expenditures	Funding Sources
Page 3				
Basic Health Administrative	114	$14,622,922		9% GF-F • 91% HSA
Basic Health Benefits			$448,301,516	18% BHTA • 82% HSA
Community Health Services	5	*See note below	$21,538,152	100% HSA
Page 4				
Public Employees Benefits Board Administrative	42	$15,776,817		42% HCAAA • 58% UDPAA
Public Employees Benefits Board Benefits			$2,203,830,485	100% PEBB BF
UMP Administrative	23	$33,943,021		16% HCAAA • 84% UMPAA
Page 5				
Prescription Drug Program	2	$2,585,504		27% GF-F • 9% HCAAA 8% AMAA • 56% HSA
Insurance Safety Net (WSHIP)	0	*See note below	$123,000	100 % HSA
Page 6				
Health Care Policy	10	$2,180,431		6% GF-F • 94% HSA
Program Support	78	$20,195,985		9% GF-F • 36% HCAAA • 55% HSA
*Administrative expenses are included in benefit expenditures				

Fund	Name	Revenue Sources
001	General Fund – Federal (GF-F)	Federal revenue earned in support of Medicaid eligibility coordination with DSHS Medical Assistance Administration.
172	Basic Health Plan Trust Account (BHTA)	Revenue is from the subscriber share of health premiums.
418	HCA Administrative Account (HCAAA)	Funds are transferred from the PEBB Benefit Fund (721) for PEBB administrative costs.
438	Uniform Dental Plan (UDP) Administrative Account (UDPAA)	Funds are transferred from the PEBB Benefit Fund (721) for UDP administrative costs.
439	Uniform Medical Plan (UMP) Benefits Administrative Account (UMPAA)	Funds are transferred from the PEBB Benefit Fund (721) for UMP administrative costs.
609	Accident & Medical Aid Account (AMAA)	Administered by Labor & Industries for Workers' Compensation medical and hospital expenses.
721	PEBB Benefit Fund (PEBB BF)	Revenue is from state agencies for employees, employee contributions, retirees contributions, K-12 and political groups, and self-pay enrollees. Other revenue, including non-participating K-12 remittance and investment income, contribute approximately 5% to the total revenue.
760	Health Services Account (HSA)	Revenue is received from state appropriated funds from tobacco and alcohol taxes, other licenses, fees and permits.

Basic Health Plan (BH)

	03-05 BIENNIUM
General Fund – Federal	1,335,885
Basic Health Plan Trust Account	79,792,848
Health Services Account	381,795,705
Total budget	**462,924,438**

BH Budgeted Enrollment: 100,000 Adults and Children

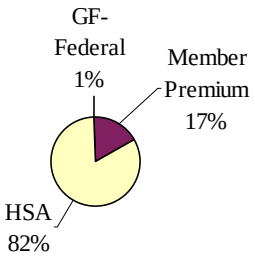
Revenue Sources: Health Services Account (HSA), member paid premiums, and Federal revenue earned in support of eligibility coordination with DSHS Medical Assistance Administration.

Expenditures are used to pay health insurance coverage for members as indicated in the chart to the right. Administrative costs include a call center to support members by determining and recertifying eligibility and income, managing member accounts, and responding to member inquiries by telephone and correspondence. This is approximately 3% of the total expenditures

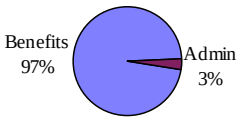
Note: The average 2004 monthly state cost for adult and children BH members:

	Between 100-200% FPL	Below 100% FPL
Adults	$140.75	$174.93
Children	$ 36.37	$ 46.75

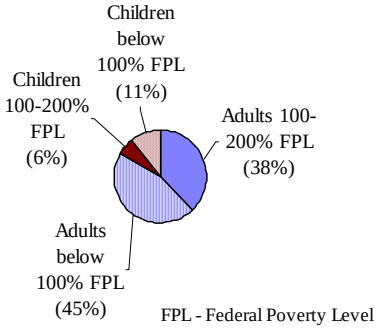
BH Fund Sources



BH Expenditures



BH Enrollment



Community Health Services (CHS)

	03-05 BIENNIUM
Health Services Account	21,538,152
Total budget	**21,538,152**

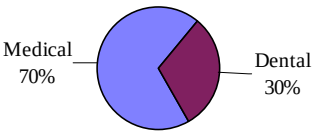
Clinic Sites: 31 clinics provide care at more than 121 delivery sites.

Revenue Sources: Health Services Account (HSA).

Expenditures are for medical and dental grant funding to community clinics and help pay for approximately 10-20% of the cost to deliver health services for sliding-fee patients who are at or below 200% of Federal Poverty Level (Federal Income Guidelines) with no insurance. Administrative costs are approximately 3% of the total expenditures**.**

Note: Number of Clients Served:
Medical – 143,770
Dental – 62,255

Clients Served in Clinics



Public Employees Benefits Board (PEBB)

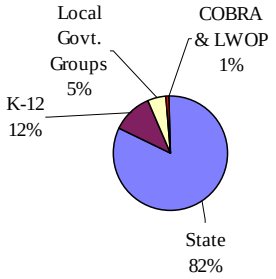
	03-05 BIENNIUM
HCA Administrative Account	6,319,817
Uniform Dental Plan Administrative Account	9,457,000
PEBB Benefit Fund	2,203,830,485
Total budget	**2,219,607,302**

September PEBB enrollment: 312,666 employees, retirees and family members

Revenue Sources: Generated from monthly contributions paid to plans from: state agencies for employees (62%), employees (8%), retirees (16%), K-12 and political groups (8%), and COBRA and other self-pay (1%). Other revenue, including non-participating K-12 remittance and investment income, contribute approximately 5% to the total revenue. The state agency monthly contribution for FY2005 is $584.48 for each PEBB-eligible employee.

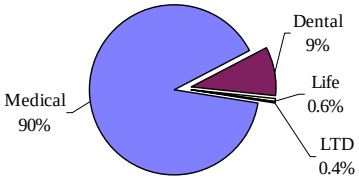
Expenditures are used to pay for health, dental, life and long term disability products as indicated by the pie chart to the right. Funds are transferred from the PEBB Benefit fund to cover PEBB administration, to UDP benefit administration, and to UMP for benefits administration (funds 418 & 439) as detailed below. Additionally, UDP dental claims and UMP medical claims are directly paid from fund 721.

PEBB Health Coverage Membership Type



Each type includes active and retired employees

Total PEBB Premium Expenditures by Benefit Type



Uniform Medical Plan (UMP)

	03-05 BIENNIUM
HCA Administrative Account	5,301,021
UMP Benefits Administrative Account	28,642,000
Total budget	**33,943,021**

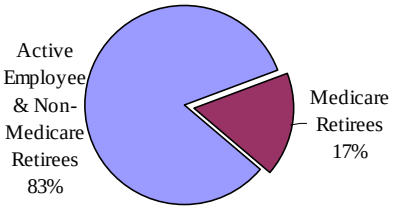
UMP Enrollment: 134,863

Revenue Sources: Generated by contributions paid for those who select UMP for their health coverage, which are deposited into the PEBB Benefit fund.

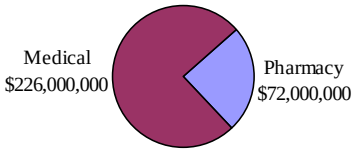
Expenditures include internal operations for UMP (fund 418), and UMP benefits administrative costs (fund 439) such as claims administration, utilization management, enrollee printing & mailings and customer support, most of which is contracted with a third-party administrator. The HCA Administrative account and the UMP Benefits Administrative account are funded from the PEBB Benefit fund as are all payments for services for PEBB members.

Health Plan Expenditures by Group

UMP Member Enrollment Types

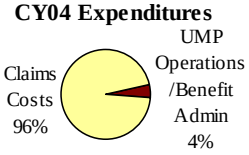


UMP Claims Paid for CY2003



Medical: 1,360,702 claims (average of $166/claim)
Pharmacy: 1,242,474 claims (average of $58/claim)

CY04 Expenditures

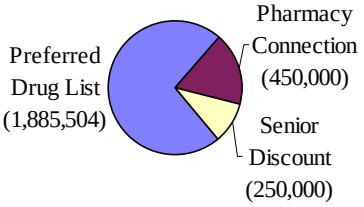


Benefits Admin includes payments to a contracted third-party administrator.

Chart Definitions:
Life – Life Insurance
LTD – Long Term Disability Insurance
MCO – Managed Care Organization
PPO – Preferred Provider Organization

Prescription Drug Program (PDP)	03-05 BIENNIUM
General Fund – Federal	698,783
HCA Administrative Account	226,946
Accident & Medical Aid Account	213,000
Health Services Account	1,446,775
Total Budget	2,585,504

PDP Expenditures by Program



Revenue Sources: Health Services Account (HSA), employer and member contributions for UMP coverage, and Accident & Medical Aid Account funds administered by Labor & Industries.

Expenditures are for development and administration of the evidence-based Preferred Drug List; the Rx Washington mail order senior discount prescription drug program; and the Pharmacy Connections program.

Note: PDP program information is available on the internet at http://www.rx.wa.gov. Currently on the website information is available regarding the Evidence Based Review Process and the Preferred Drug List. Consumers may also access information on prescription drug programs and Canadian drugs. Beginning December 2004, the website will include a drug cost comparison service to compare the prices of the most commonly prescribed drugs.

Insurance Safety Net (WSHIP)	03-05 BIENNIUM
Health Services Account	123,000
Total budget	**123,000**

Current enrollment: 27 people

Revenue Sources: Health Services Account (HSA).

Expenditures subsidize the cost of health premiums for individuals who are between 50 and 64 years old, whose income is less than 300 % of Federal Poverty Level, and have been denied individual health insurance.

Note: In January 2005, the Health Care Tax Credit (HCTC) program will be added to this activity. It will provide approximately $120,000 in Basic Health Program health care coverage for eligible workers and their dependents that lost their jobs due to the effects of international trade. The HCTC program is funded 65% by Federal contributions and 35% by subscriber payments.

Health Care Policy (HCP)

	03-05 BIENNIUM
General Fund – Federal	126,976
Health Services Account	2,053,455
Total budget	**2,180,431**

Revenue Sources: Health Services Account (HSA).

Expenditures are used to coordinate medical and dental procurement for Basic Health and the Public Employees Benefits Board and to analyze policy and purchasing initiatives for the agency and state. Staff support for PEBB and BH policy analysis and for collaborative purchasing initiatives.

Administration and Support Operations

	03-05 BIENNIUM
General Fund – Federal	1,757,556
HCA Administrative Account	7,235,916
Health Services Account	11,202,513
Total budget	**20,195,985**

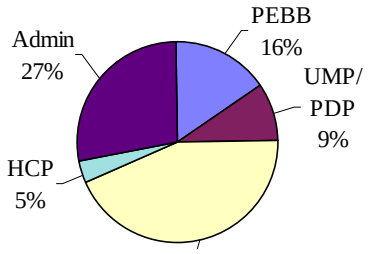
Chart Definitions:
Admin - Administration
BH – Basic Health
CHS – Community Health Services
HCP – Health Care Planning
Med Dir – Office of the Medical Director
PEBB – Public Employees Benefits Board
PDP – Prescription Drug Program
UMP – Uniform Medical Plan

This program includes: Executive Office, Human Resources, Information Services, Legal and Contracts, Communications, Finance, Office of the Medical Director, and Administrative Services/Facilities.

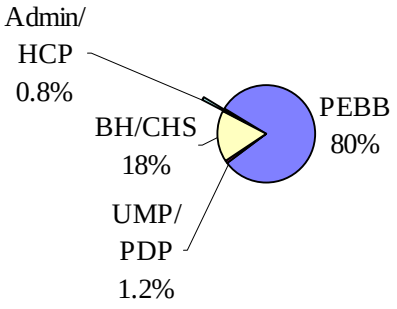
Revenues are provided through the various funds as listed above.

Expenditures are used in support of the operations of the HCA as indicated above and are 0.8% of the total expenditures as show in the chart below. Costs are allocated to the appropriate funds based on the agency's cost allocation plan.

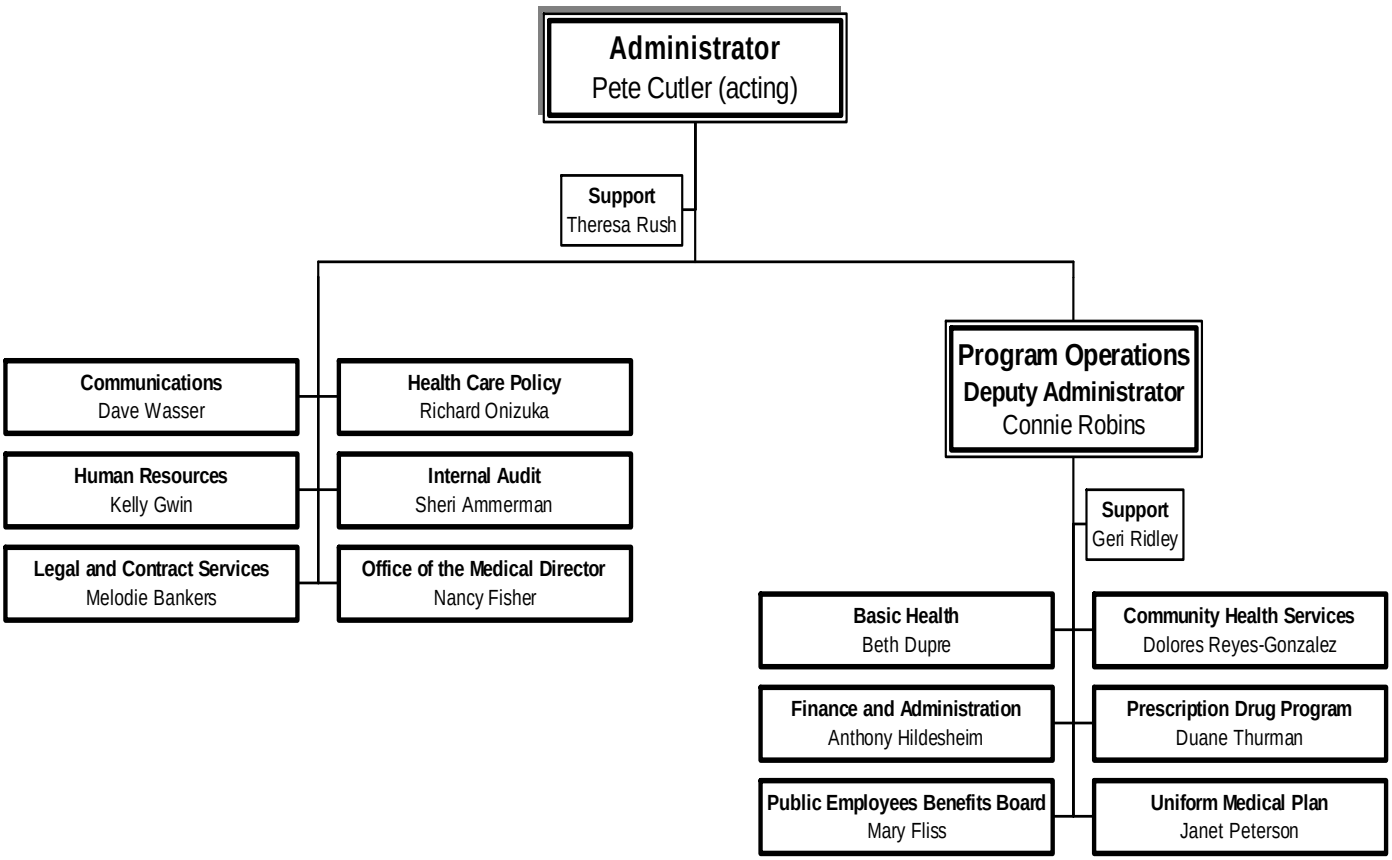
FTEs by Program



HCA Total Expenditures



Organization Chart



Executive Biographies

Pete Cutler - Acting Administrator (exempt) since March 2004. Assistant Administrator of Finance, Legal and Policy (2002).
Previous employment: Senate Ways and Means Committee – staff (1999-2001); Department of Retirement Systems – Legal/Legislative Affairs Manager (1992-1998); Office of Financial Management – Compensation/Benefits staff (1989-1991); Office of State Actuary – counsel (1987-1989).
University of Washington Law School - JD (1982)

Theresa Rush – Executive Assistant (exempt) since March 2004. Administrative Assistant (1994-2004).
Previous employment: Office of the Insurance Commissioner (1992-1994); Department of Natural Resources (1982-1992); Department of Revenue (1981-1982)

Connie L. Robins – Deputy Administrator (exempt) since January 2004.
Previous employment: Lewis County - Chief Administrative Officer (1999-2004); Budget Officer (1998-1999); State Auditor's Office (1990-1998).
City University - BA Business Administration (1988)

Beth Dupre - Assistant Administrator for Basic Health (exempt) effective November 2004.
Previous employment: Polyclinic System Implementation Manager (2004); Premera Blue Cross – Operations Manager (2002-2004); Print Fulfillment Manager (2000 – 2002); Team Leader (1999-2000); HealthSouth Corporation (1998-1999); Johnston & Culberson (1993-1998).
University of Washington and University of Texas at El Paso.

Mary Fliss - Assistant Administrator for PEBB (exempt) effective November 2004.
Previous employment: Good Samaritan Community HealthCare - Vice President (1999-2004); Puyallup Valley Healthcare (1993-1997); University of California San Francisco Mount Zion Hospital (1988-1991); Albany Medical Center 1985-1987).
University of Minnesota - Masters Degree in Healthcare Administration (1993)

Anthony Hildesheim - Assistant Administrator for Finance and Administration (exempt) since August 2004.
Previous employment: Lewis County - Information Service Manager (2001-2004); Fuze Technologies – Vice President, Operations (2000-2001); Federal Home Loan Bank – Assistant Vice President (1996-2000); Technology Unlimited – Director, Network Services ((1993-1996).
University of Phoenix and Maryland University

Janet Peterson - Assistant Administrator for Uniform Medical Plan (exempt) since January 2002. Deputy UMP Program Manager (1999-2001); Basic Health Deputy Program Manager (1996-1999); Finance and Budget Manager (1994-1996).
Previous employment: Seattle School District (1990-1994); Washington House of Representatives – Fiscal Analyst (1985-1990); Office of Fiscal Management – Program Analyst (1983-1985).
University of Washington - Masters Degree in Public Administration (1983)

Duane Thurman –Prescription Drug Program Manager (WMS) since August 2003. Assistant Administrator/Special Assistant to the Administrator (2001-2004).
Previous employment: Governor's Office – Policy Advisor (1996-2001); Health Care Policy Board – Policy Analyst (1995-1996); Assistant Attorney General (1990-1995).
University of Puget Sound School of Law – JD (1986)

Dolores (Loly) Reyes-Gonzalez, MSN, RN – Executive Director for Community Health Services (exempt) since September 2004.
Previous employment: WSU College of Nursing – Clinic and Outreach Service Manager (1999-2004); US Air Force – Director, Occupational Medicine (1995-1999); Director Health Promotion (1994-1995); Clinic Director/Manager (1988-1992).
University of Puerto Rico – MSN (1987)

Dr. Nancy Fisher - Medical Director (exempt) since September 2003.
Previous employment: Options for Knowledge – Consultant (2002-2003); Regence BlueShield – Medical Director (1999-2002); DSHS Medical Assistance Administration – Medical Director (1997-1999); Manager/Supervisor (1996-1997); Private Practice (1994-1996); Swedish Hospital – Director of Genetic Services ((1989-1994).
University of Washington – MPH (1982); Baylor College of Medicine - MD (1976)

Dr. Richard K. Onizuka - Manager, Health Care Policy (exempt) since January 2003.
Previous employment: DSHS – Chief, Mental Health Division (1998-2003); Kaiser Permanente Colorado – Medical Office Administrator (1995-1998); Supervising Psychologist (1989-1995).
University of Kentucky – PhD. Clinical Psychology (1986)

Kelly Gwin - Human Resource Manager (WMS) since August 2000.
Previous employment: Department of Agriculture – Personnel Manager (1989-2000); Department of Fisheries (1987-1989); Department of Corrections(1983-1987).
Western Washington University - BA Industrial Psychology (1983)

Dave Wasser - Communications Director (WMS) since August 1997. Public Information Officer (1993-1997).
Previous employment: Department of Information Services – PIO, Policy Advisor (1989-1993); State Library – PIO (1985-1989); KBAM Radio - News Director (1977-1985).
Central Washington University – BA Journalism (1976)

Melodie Bankers - Director, Legal and Contract Services (WMS) since June 1999.
Previous employment: Office of the Insurance Commissioner – Deputy Commissioner (1996-1999); Policy Analyst (1994-1996); Legislative Liaison (1993-1994); Rules Coordinator (1986-1993).
Golden Gate University – JD (1985)

Sheri Ammerman - Internal Auditor (WMS) since June 2002.
Previous employment: State Auditor's Office – Assistant Audit Manager (1996-2002); Audit Examiner (1991-1996).
Saint Martin's College – BA Accounting (1991)

Authorizing Environment and Environmental Scan

Public Employees Benefits Board

Statutory Authority

Chapter 41.05 RCW
- Establishes program and defines roles and responsibilities for PEBB and HCA administration
- Eligibility criteria for PEBB participation

RCW 41.04.205
- Inclusion of political subdivisions

RCW 41.80.020
- Establishes collective bargaining with state employees

Public Employees Benefits Board Members

Pete Cutler	Acting Chair	
Helen Carlstrom	K-12 Retiree Representative	Term expires 10/01/03
Greg Devereux	State Employee Representative	Term expires 10/01/04
Eugene Lux	State Retiree Representative	Term expires 10/01/05
Penny Palmer, M.D.	Benefits Management/Cost Containment	Term expires 10/01/05
Gary Robinson	Benefits Management/Cost Containment	Term expires 10/01/05
Yvonne Tate	Benefits Management/Cost Containment	Term expires 10/01/05
Richard D. Rubin*	Benefits Management/Cost Containment	Term expires 10/01/04
Vacant*	K-12 Employee Representative	

* Non-voting member

Partners, suppliers and customer groups:
- Partners: Personnel and payroll offices that conduct PEBB administration at the agency and higher education institutional level. The Office of the Insurance Commissioner (OIC) regulates the health plans that contract with HCA. HCA communicates with the Department of Personnel and Department of Retirement Services on state employee benefit issues. HCA partners with five state payroll systems and the state pension system to collect health care premiums and to pilot a medical flexible spending account (FSA) for higher education employees. The HCA partners with the Department of Health (DOH), and the Department of Social and Health Services, Medical Assistance Administration (MAA) to conduct TEAMonitor quality audits of contracted health plans.
- Suppliers: Contracted medical (Community Health Plan of Washington; Group Health; Kaiser; PacifiCare; Regence BlueShield) and dental plans (Washington Dental Service; Columbia Dental Plan) and other insurance contractors providing PEBB enrollees with insurance for life, long-term disability, long-term care, and flexible spending accounts (FSA).
- Customer groups: Public employee unions and other public employee groups; public retiree organizations; health care providers; hospital and medical associations.

External environmental scan:

- Health care inflation is significantly higher than general inflation. Major drivers include: an aging population; an accelerated rate of introduction of new technologies; medical errors impacting the quality of care and increasing costs; continued significant growth in prescription drug costs; and limited competition due to consolidation of health care systems.
- State Employee collective bargaining – -union interest in a joint decision making process for PEBB benefit design and related issues.
- The average retiree health care premiums have increased significantly from 2000 to 2005. In 2000 the non-Medicare and Medicare average premiums were $289 and $165 respectively; and the 2005 non-Medicare and Medicare average premiums are $529 and $265 respectively. (PEBB Medicare retiree premium increases have been partially offset by the increases in state Medicare Retiree subsidy, from $62 in 2000 to $116 in 2005). The share of a retirees' fixed pension income going to health care costs is growing rapidly.
- Employers are increasing employee cost sharing and accountability for health care decision making as a means to increase employee awareness of health care costs, and manage demand for services. HSAs (Health Savings Accounts) are being implemented by some employers as one of a variety of tools to accomplish this consumer driven approach.
- Fewer insurance companies are offering HMO plan designs, especially in rural areas. There is a move from HMOs to PPOs as part of the consumer driven approach.
- Market consolidation makes providing options to employees challenging. UMP's PPO design is the only option available in all counties; no managed care plan is offered in Asotin or Whitman Counties.
- Sweeping Medicare changes from the Medicare Modenization Act of 2003 require PEBB changes and create market changes for plans, pharmacy benefit managers, drug manufacturers, and Medicare retirees (see Tier 1 document).
- Many large employers, including Boeing and Weyerhaeuser, have implemented worksite health promotion programs designed to increase healthy behaviors and thereby reduce health care costs, and absenteeism while improving productivity.

Uniform Medical Plan

Statutory Authority

RCW 41.05.140 and 41.04.143

- Authorizes HCA to provide self-insured insurance coverage and defines roles and responsibilities
- UMP coverage is subject to the Patients' Bill of Rights, including quality program requirements

[C25, L2003, Sec. 213(6)]

- Working with other agencies on reducing administrative burden

RCW 70.14.050

- Participation in prescription drug project

Partners, suppliers and customer groups:

- Partners: UMP collaborates with MAA and L&I on provider reimbursement policies (through the interagency Reimbursement Steering Committee) and administrative simplification activities; UMP utilizes OIC standards as guidelines for its programs.
- Suppliers: Approximately 17,000 contracted network health care providers in Washington State; plus alternative care network through Alternare and out-of-state network through Beech Street. Interagency Technical Advisory Group (TAG) with representatives for all major provider organizations in Washington. Third party administrators for benefits administration including claims processing administration (Harrington for medical claims and Express Scripts for pharmacy claims). Actuarial services for UMP operations: Mercer Human Resource Consulting. PatientChoice for UMP Neighborhood.
- Customer groups: Employees and retirees, as well as the groups representing them (listed as PEBB customer groups).

External environmental scan:

- Growth in UMP membership has raised member expectations as well as concerns on the part of contracted PEBB health insurers.
- Growing difference in benefit design value between UMP (whose members pay percentage coinsurance) and the contracted PEBB plans (whose members pay flat dollar copayments). Several insurers would like to be able to offer their standard PPO plan designs to PEBB members.
- Challenges controlling health care utilization or directing members into disease management programs in a non-managed care setting.
- Pressure from health care providers to increase payment rates in response to rising costs such as malpractice premiums.

Basic Health

Authorizing Environment

Chapter 70.47 RCW

- Program authorization, creation, eligibility, subsequent expansion, setting of total enrollment, designation as state approved plan for the federal Health Care Tax Credit Program

[C 276, L 2004, Sec, 213(5)and(6)].

- Serves as health insurance option for DSHS foster care parents and low-income agency home care workers

Partners, suppliers and customer groups:

- Partners: Financial sponsor groups pay part of an enrollee's premium and include community groups, health care clinic organizations, and tribes. BH coordinates with Medical Assistance (DSHS) to offer coverage to children and pregnant women. The program also has a unique partnership with several WA State tribes as their primary source of health coverage. As part of the Centennial Accord process, HCA works with the tribes to continue a partnership that benefits the tribes and the state.
- Suppliers: Contracting managed care plans (Columbia United Providers; Community Health Plan of Washington; Group Health; Kaiser; Molina). Actuarial consulting: Milliman, USA.
- Customer groups: BH Advisory Council is a forum to discuss, explore, and shape BH health care policy. Numerous advocacy groups for low-income populations (also serve as partners helping to enroll new customers).

External environmental scan:

- Health care costs represent a large share of the state's budget and BH is state-funded (no federal funding). The high rate of health care inflation compared to general inflation increases the challenges of providing access to health care within the next biennium.
- Reduction in contracted health plans. Future contracting will include efforts to promote MHCS competition in order to provide a selection of BH options for many enrollees – currently only one option is available in many counties. A lack of bidders makes it very challenging to competitively select contractors based on quality and cost.
- BH recertifies that persons participating in BH are eligible for the assistance they receive [C 276, L 2004 Sec 213(7)]. This process has been the subject of intense scrutiny by the State Auditor's Office and the legislature.
- The increasing number of uninsured persons affects the ability of programs/services to provide for health care for low income populations. Community partners have become vital in helping locate health care coverage for these persons through BH or other programs.
- Advocacy groups are interested in restoring benefits to 2003 levels, increasing funding to cover more than 100,000 persons in BH and expanding coverage for low income persons through such options as pay or play insurance options for employers, subsidies for workers who enroll in employer-sponsored health insurance, and other proposals.
- Several local and regional health access projects are expected to introduce initiatives aimed at reducing the numbers of uninsured through various models. CHOICE Regional 100% Access Project, Health Access Spokane 100% Access, and Tri-County Community Health.

Community Health Services

Authorizing Environment

RCW 41.05.220 and 41.05.223
- Establishment of program, eligibility, purpose.

Partners, suppliers and customer groups:
- Partners: Contracted community clinics
- Suppliers: Many of the clinics are members of the Washington Association of Community and Migrant Health Centers which publishes data collected by CHS from the clinics during the grant procurement process.
- Customer groups: Community clinic customers

External environmental scan
- High rate of health care inflation compared to general inflation increases the challenges of providing access to health care when state funds will be stretched tighter next biennium.
- As limitations on access to other public programs increase, reliance on community clinics as safety nets and expectations for grant programs are increased.
- Uncompensated care costs, especially hospital emergency costs, are increasing due to an increase in uninsured and underinsured persons as evidenced by DOH trend data.

Prescription Drug Program

Statutory Authority

RCW 70.14.050 and RCW 69.41.190
- Directs HCA to coordinate interagency purchase of prescription drugs.
- Describes the Prescription Drug Project (PDP) to coordinate the development of an evidence-based Preferred Drug List and provides for therapeutic substitution.

RCW 41.05.500 through 41.05.520
- Directs PDP to develop the Rx Washington discount card program, a mail order discount for low income residents age 50-64 and the Pharmacy Connections program, a toll-free clearinghouse to assist WA residents apply for discount programs

Partners, suppliers and customer groups:
- Partners: Department of Labor and Industries and DSHS - Medical Assistance Administration
- Suppliers: The Pharmaceutical Researchers and Manufacturers of America and individual manufacturers actively monitor interagency developments.
- Customers: Health care provider groups such as the state pharmacy and medical associations; advocacy groups for consumers, seniors, and mental health.

External environmental scan
- Unanticipated effects of a common preferred drug list on agency programs.
- Many of the prescribers who write the most prescriptions don't yet participate in the PDL.
- Implementation and maintenance of current programs, while exploring additional interagency efforts and managing the various consumer expectations.

Health Care Policy

Authorizing Environment

Chapter 41.05 RCW
- Directs HCA to study all state-purchased health care, alternative health care delivery systems, and strategies for the procurement of health care and development of quality initiatives.

Partners, suppliers and customer groups:

- Partners: State agencies: HCP works directly with the Governor's Policy Office, the Office of Financial Management, MAA, L&I, and OIC on legislative and health policy issues. OMD works with the Agency Medical Directors Group, representatives from the agency medical directors and other related agencies such as OIC. OMD meets regularly with the Health Plan Medical Directors and Health Plan Pharmacy Directors.
- Suppliers: Actuarial consulting: Mercer Human Resource Consulting (PEBB) and Milliman, USA (BH).
- Customers: All customer groups previously listed in other programs. Also policy staff from various state and federal offices, university health policy programs (e.g. UW Health Policy Analysis Program), other health and policy research groups (RAND; Kaiser Health Foundation), health care purchasing organizations (e.g. LeapFrog; Pacific Business Group on Health); and other state purchasers (CALPERS).

External environmental scan

- Advocacy groups that support HCA programs wish to expand access to current health care programs or develop new programs or approaches.
- Investment in quality initiatives, including evidence-based and improved health outcome approaches can require significant staff and consulting resources, and does not always meet policymaker expectations of immediate savings.
- Maintaining enrollee choice in health plans and statewide coverage is a challenge in today's consolidated marketplace.
- Collective bargaining creates new considerations in PEBB health care procurement.
- There are an increasing number of purchasers participating in collaborative purchasing strategies that leverage quality improvements in plan and provider performance. The Puget Sound Health Partnership, initiated by King County, is one such collaboration. Another emerging collaborative effort is "Care Focused Purchasing" which Boeing, Weyerhauser and many other large companies have joined.

Strategic Plan Highlights

As a health-focused agency within the Executive Branch of state government, the HCA Strategic Plan reflects the Priorities of Government (POG) process' statewide goal to "Maximize the Health of Washingtonians." The HCA's core functions and operations are critical to this end. We provide health insurance coverage to over 400,000 Washington residents through Basic Health (BH) and the Public Employees Benefits Board (PEBB) programs and help fund community clinic medical care to another 143,000 residents and dental care to 62,000 through our CHS program. Both BH and CHS provide access to health care services to low-income residents who might not have any other health care alternatives. In addition, our prescription drug program coordinates with other state agencies to implement strategies to make prescription drugs more affordable to seniors.

The HCA relied significantly on the POG process to help develop our agency goals and initiatives for 2005-2007. We also sought direction from our internal self assessment, and our assessment of the changing health care environment.

The POG process identified four categories of agency interventions that contribute to the goal of "Maximizing the Health of Washingtonians." These include programs and activities that:

1. Increase healthy behaviors;
2. Provide access to appropriate health care;
3. Mitigate environmental hazards;
4. Identify and mitigate risk factors.

The HCA's long-time mission: "To provide access to quality affordable health care," is primarily focused on the second category of government interventions.

The agency vision, to "deliver the best value in health care," has traditionally focused on our role as a purchaser. However, it has become clear that lifestyle choices are a major source of the steep increases in health care cost trends, and it is in everyone's interest to address these root causes and thus reduce the need for expensive medical interventions. Encouraging healthy behavior among our enrollees will improve their overall health, and will also help reduce health care costs by creating a healthier risk pool that will need fewer services.

As an outgrowth of the POG process review, our agency self assessment, and the review of the current delivery environment, the HCA identified five agency goals in its Strategic Plan:

1. HCA, employers and health plans will provide incentives to promote healthy behaviors.
2. Members and policy makers will have data on health care services quality, costs, utilization and access for decisions.
3. HCA divisions and leadership will promote and recognize efforts to improve communication and business processes.
4. HCA will identify health care initiatives that promote evidence-based quality, affordable care.
5. HCA will promote efforts to provide access to health care.

SWOT (Strengths, Weaknesses, Opportunities, Threats)

Strengths

- Basic Health sponsoring organizations help make the program efficient and effective
- Culture of continuous improvement, as demonstrated by more than 50 governor performance awards since 1998. This includes awards for the recertification and recoupment processes, online customer service improvements, and customer service responsiveness.
- Experience with purchasing strategies that promote quality and affordability
- Commitment and passion for health care throughout the agency
- Strong support for Basic Health (BH) from advocacy groups and community leaders
- Well established relationships with health plans that includes monitoring for quality
- Ability to pilot innovative health care initiatives through the state's self insured medical plan
- Collaboration with private healthcare organizations, other state agencies, local governments, health quality forums, and stakeholder groups
- Good relationships and communication with state employee and retiree organizations, and state health policy leaders
- Emphasis on member use of internet services to reduce postage and printing costs
- Strong provider network in our self insured plan
- Access in almost every county to both managed care and preferred provider plans
- Strong actuarial support for BH program

Weaknesses

- Difficult to get consistent, standardized data
- Processes for application and recertification for Basic Health are onerous
- Communication between programs is not well established
- Lack of continuity of leadership
- Periods of high volume result in slow response times
- Members are often not knowledgeable about their health care and health plans
- Roles and responsibilities of the Health Care Authority and the agency payroll offices are not well defined for certain issues
- The PEBB eligibility and accounting system will be very expensive to operate after DOP stops using the current payroll system (Pay 1) in 2005.
- State level net impact to implementing the preferred drug list is not yet known.

Opportunities

- New technology makes interacting with members more effective. For example, internet application processes, online health assessments, and better information about health services.
- The priorities of government health team provides an opportunity to coordinate and streamline efforts between state agencies that have common missions related to health.
- New initiatives in evidence based assessments of prescription drugs and medical technologies can result in more efficiency while retaining quality of care.
- Capitalize on the increased social awareness of the importance of healthy behaviors.
- Quality standards and measures for health care are being developed by national quality organizations and can be incorporated into contracts with managed care plans and into our self insured plan.

Threats

- Trends in increased health care costs are much steeper than increases in revenue.
- Further reductions to the benefits in Basic Health could result in adverse selection and increased costs as only those with the highest need continue with the program.
- Impacts from the changes in Medicare, such as the prescription benefit, are unknown.
- An aging population will likely result in higher overall costs.
- If fewer plans participate in Basic Health, it may not be possible to ensure access in all counties.

Critical Issue

Basic Health: A growing need versus a limited funding source

The issue: The number of Washington residents without health care is growing. Currently 14.8% in state are uninsured, compared to 13.9% two years ago, and 12.9% ten years ago. The Basic Health program has been proposed as a coverage option for several uninsured groups (e.g., 2004 enacted legislation for Health Coverage Tax Credit program). The current BH funding source is already over committed. Also, adding new groups can affect the program demographics, costs, and the willingness of health plans to participate in the program.

Urgency: In the 2005-07 biennium, Health Services Account (HSA) revenue will not be sufficient to fund the cost of continuing all programs currently funded through this account. Early estimates indicate an $85 million shortfall in the 2005-07 biennium.

Significance: Funding for Basic Health is being reduced in several ways. Health care cost trends are well beyond general inflation, so maintaining current funding would buy less health care. In addition, the primary funding source for Basic Health, the HSA, is seeing a decrease in revenue due to reduced use of tobacco, one of the major revenue sources. If the HSA revenue shortfall is addressed by reducing the Basic Health enrollment level, greater impact will be felt at emergency rooms and community clinics which are becoming the final safety net for many low-income people in need of health care. The clinics also receive part of their state funding through the HSA.

Stakeholders: Low-income advocacy groups; hospitals; community clinics; health plans; legislators; OFM.

Resolution: The revenue sources for the HSA will have to be increased, programs currently funded from the account will have to be reduced in scope or eliminated, or more health programs will need to be funded from already thinly-stretched GF-state resources. Reduction of BH enrollment levels to address the HSA shortfall would reduce the attractiveness of the BH program for health plans and may affect the viability of the program.

More info.: http://www.basichealth.hca.wa.gov/bhhistory.shtml

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Critical Issue

Basic Health and PEBB: Strategies to reduce high cost trends

The issue: HCA is adopting new and potentially controversial strategies to mitigate double digit medical inflation trends. Medical costs are projected to continue to escalate at double digit rates (average 11% increase for 2005 for PEBB). Causes for this include:

- Costs of advances in medical technology, including prescription drugs
- Inappropriate delivery of care (as demonstrated by recent reports on medical error and quality deficiencies by the Institute of Medicine), and overuse of medical services (defensive medicine).
- Continued aging of the population
- Increased medical utilization
- Increased costs of services, led by increased hospital costs

HCA is pursuing several initiatives to improve the quality and effectiveness of care as a means to address increasing health care cost trends. Some of these initiatives include:

Initiative 1 Collaborative efforts with other state agencies and health providers to implement evidence based medicine. Examples include: the Agency Medical Director's Group (AMDG) work plan for implementing HB1299 (2004); the federal Agency for Healthcare Research and Quality Evidence Based Medicine (EBM) conference in December, 2004; and the Clinical Outcomes Assessment Project (COAP) to improve hospital cardiac surgery procedures and outcomes. **Controversial aspects:** Evidence based medicine (EBM) sometimes results in denial of payments requested for medical technologies, devices, or procedures which have not been proven to result in improved health outcomes.

Stakeholders: Other state agencies (L&I, MAA, DOH, AMDG), PEBB Board, pharmacy industry, state medical association, advocacy groups

Urgency: No immediate action proposed. Issues and initiatives are likely to be the focus of legislative attention during the 2005 session.

Resolution: Request continued Governor's Office support for agency efforts.

Information: http://www.amdg.wa.gov/

Initiative 2 HCA has been a key participant in the King County Health Advisory Task Force and development of a proposed Puget Sound Health Partnership, a proposal for formal collaboration among public and private health care purchasers to develop shared quality initiatives, data requirements, performance measures, and consumer information. **Controversial aspects:** health plans and providers may seek their own role and involvement, as purchasers provide initial direction to move marketplace towards EBM and higher quality and efficiency; high start up costs for establishing a non-profit partnership; difficulty of coordinating strategic decision making among public private purchasers in coalition.

Stakeholders: Public purchasers (King County, Seattle, HCA), private purchasers (Microsoft, Costco, Starbucks, Washington Mutual, Weyerhaeuser, Boeing), health plans, providers.

Urgency: No immediate action proposed.

Resolution: Request support for partnership agenda and continued state involvement (financial and governance) in partnership during 2005

Information: http://www.metrokc.gov/exec/hatf/

Initiative 3 Investment in data management and data information tools to better understand our populations' health care utilization and health status and provide tools for consumers to both understand their health and health care choices, as well as inform their health plan and hospital choices (e.g., data warehouse and decision support tools). These tools may also enable HCA to incorporate purchasing alternatives that involve increased consumer involvement and decision making in choice of health care plans. **Controversial aspects:** requires increased data from health plans which may increase their administrative costs; agreement on data reporting elements may be difficult from different systems; providers and health plans may resist public reporting on quality and efficiency; high start up costs and limited return on investment in initial start up phase. Web based or on line tools regarding quality and care options have been supported by unions, tools to implement increased cost sharing have been opposed by unions.

Stakeholders: Health plans, Mercer consulting, other state agencies to expand data warehousing capability (DOH and MAA data), labor unions

Urgency: No immediate action proposed. Request continued support for feasibility study funding requested in budget.

Resolution: Data request for plans to be discussed beginning 2005, on line or web based decision support tools planned for 2006 open enrollment period (late 2005)

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Critical Issue

PEBB: Collective Bargaining and Establishing Benefit Design and Policy

The issue: The recent implementation of collective bargaining for state employee compensation and benefits has made it unclear which entities and individuals have the responsibility and authority to establish health care benefits, and health care benefit policy, for PEBB.

- The state spends about $1billion each year on medical and dental benefits for its employees, retirees, and their dependents.
- Current statute provides that PEBB's authority is to "design benefits and determine the terms and conditions of employee participation and coverage."
- Some state employee unions have proposed to have a more formal labor-management process for making benefit design and policy decisions, as well as to adopt joint cost-containment initiatives

Urgency: Ideally, clear authority and responsibility should be established in the 2005 legislative session. The PEBB will be voting on benefits and premium contributions for 2006 as early as June 2005. Discussions regarding health benefit funding, and benefits for 2007-09 will likely begin before the 2006 legislative session.

Significance: As the Legislature and public begin scrutiny of the collective bargaining agreement prior to legislative approval, clear messages and a sense of executive branch leadership will be needed. Health benefits are an important issue for labor, and for the state as an employer. They also continue to be a major source of budgetary concern. It is in the state's interest to have a clearly defined process and authority for shaping health benefit design and policy.

Stakeholders: New administration, OFM, state employee unions, Legislature, media, health plans.

Resolution: OFM's Labor Relations Office should work with the Governor's Chief of Staff, the OFM budget division, and the HCA to develop a proposed executive branch process to shape PEBB benefits. The process should include constructive collaboration with organizations that represent state employees.

More info.: Washington Works: http://washingtonworks.wa.gov/default.htm

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Critical Issue

Prescription Drug Program

The issue: The HCA, Medical Assistance Administration, and Labor and Industries need to continue to implement and expand the state preferred drug list and encourage provider acceptance in order to achieve expected cost savings.

Urgency: As drug costs continue to increase, the state must demonstrate real efforts to bring about cost containment.

Significance: This is a first of its kind attempt to achieve state prescription drug cost savings while maintaining the quality of care. This is being accomplished by creating an evidence-based preferred drug list to ensure that the state spends its resources on proven and cost effective medications.

Stakeholders: Public, media, medical profession, pharmaceutical interests, health and senior advocates, Legislature.

Resolution: Continue stakeholder involvement in the decision-making process and consistently apply program policies across all three agencies to maximize program credibility and provider acceptance of best practices and an evidence-based approach to state prescription drug purchasing.

More info.: Rx Washington: http://www.rx.wa.gov/

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Critical Issue

PEBB: Insurance System Replacement Project

The issue: The HCA must replace the portion of the old Department of Personnel (DOP) payroll system that supports PEBB benefits administration and insurance accounting for both PEBB and BH. Otherwise, the program faces a large increase in operating costs and continued constraints on enhancements, policy changes (such as those that may result from collective bargaining activities) and services including Web based transactions.

Urgency: By the end of the biennium (6-30-07), HCA will be the last entity using the current DOP system. At that point, we will be forced to pay the entire cost of running and maintaining that very expensive and outdated system.

Significance: The HCA's first attempt to replace its legacy system failed. We have completed a "lessons learned" process and will likely seek legislative funding for a new system. Because the PEBB benefits administration system covers all state employees, a new system will have ramifications within every state agency and higher education institution. Additionally, because the insurance accounting system covers both PEBB and BH, the new system will also have accounting implications to both programs.

Stakeholders: Legislature, state agencies, higher education, health plans.

Resolution: Secure funding for implementation of a new system.

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