Willis Towers Watson High Performance Insights in Health Care

2018 Health Care Financial Benchmarks

Washington State Health Care Authority — PEB program

August 29, 2018

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Survey Overview — Major Areas Included

Cost Efficiency	Health plans are evaluated on how efficiently they perform by adjusting cost data for plan design, demographics and geographic cost differentials. This helps employers understand how well their plans are performing on an apples-to-apples basis.
Employee Cost-Sharing	How health plans are priced to employees is analyzed to determine the impact on net company costs. This is important because prior studies have shown that many employers create unintended incentives for employees — and increase company costs — by pricing options without a clear understanding of true costs.
Employee Incentives	An increasing number of employers are using arrangements such as HSAs, HRAs and wellness incentives to encourage responsible behavior among plan participants.
Dental	Dental plan costs are compared, as well as enrollment, administration and employee contributions.

- This year's database includes:
  - 2,248 companies in 18 industry groups
  - An annual medical premium-equivalent cost of $133.7B from more than 10.8M enrollees
  - An annual dental premium-equivalent cost of $8.5B from more than 10.1M enrollees

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Survey Overview — Specific Questions Addressed

Medical Benchmarks

- How do your plan costs compare to others in your industry, as well as to best performers?
- How does enrollment by plan type compare to the database?
- What is the cost impact of key factors in your population, including: age/gender, family size, geography, plan value?
- After adjustments, how efficient is your total plan overall? What is the financial impact of moving to benchmark or best practice performance?
- After adjustments, how efficient are each of your individual plans relative to benchmarks?
- How does the employer's contributions as a percentage of plan cost compare to employee contributions?
- How does your account funding for HRAs and/or HSAs compare to other employers?
- How do your incentives/wellness credits compare with the database?
- Where do your administrative fees fall within the range of other employers' fees?

Dental Benchmarks

- How do your plan costs compare to others in your industry, as well as to best performers?
- How does enrollment by plan type compare to the database?
- How do employee contributions compare to the database?
- Where do your administrative fees fall within the range of other employers' fees?

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Medical Cost Benchmarks

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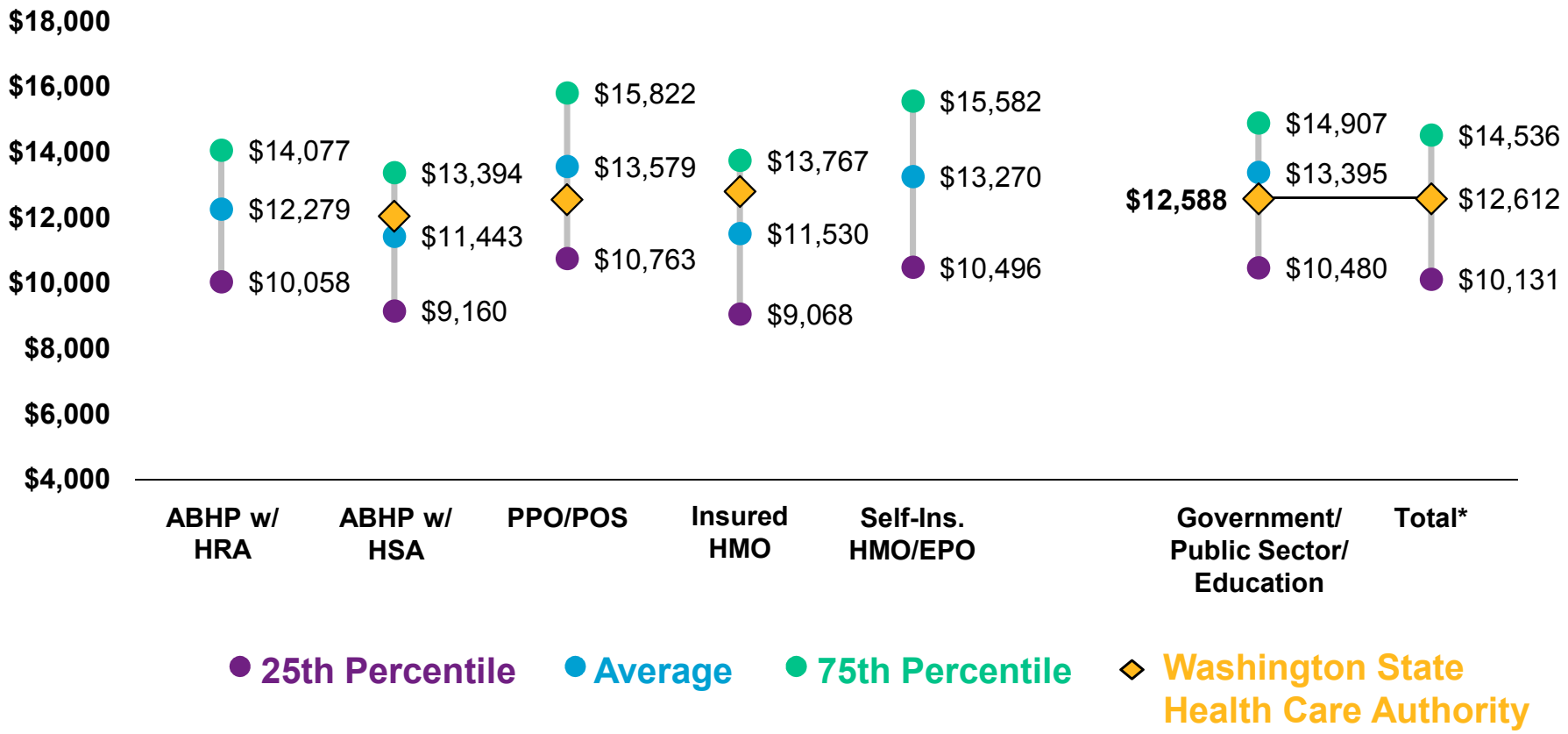
Medical Cost Benchmarks

Total Cost per Covered Employee per Year (Unadjusted)

How do your plan costs compare? How does enrollment across plan type impact the average cost? Even if total plan costs are favorable, are some plans more exposed to the excise tax?



- PEB costs PEPY are about the same as the benchmark average, 6% below average vs. PEB industry
- PEB cost PEPY has increased 4.6% vs. 2017 whereas market average has increased 3.4%

*Total costs represent an enrollment weighted average of all plan types.

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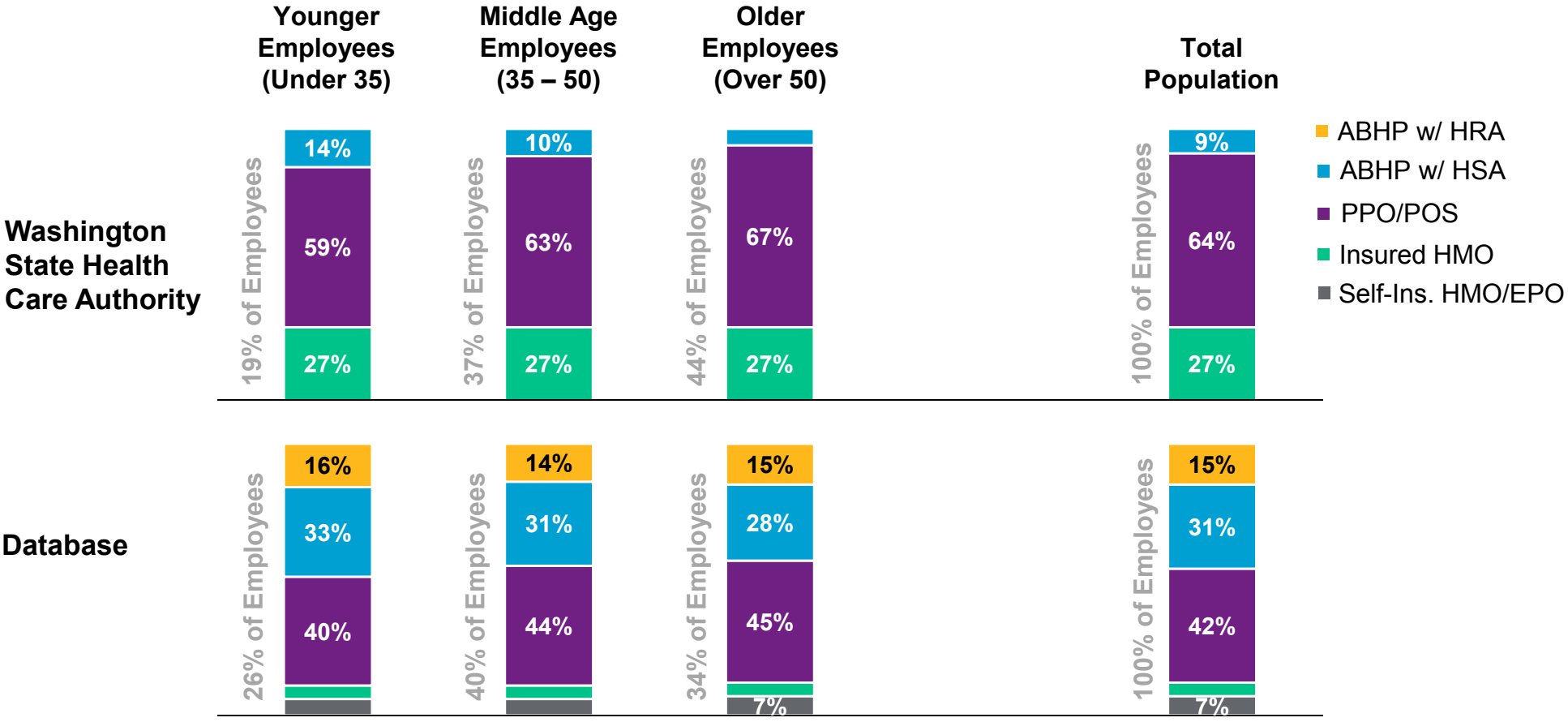
Medical Cost Benchmarks

Enrollment by Plan Type and Age Breakdown

- How does enrollment by plan type compare to the database?
- Does the enrollment by age have implications for plan pricing?
- Is the plan enrollment by age influenced by employer funding of employees/dependents?



- As in 2017, older employees on PEB plans show somewhat stronger preference for the PPO plan
- Like the market, PEB enrollment by type of plan has changed little from 2017
- What are the implications of enrollment on pricing and funding?

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Developing a Population Adjusted Benchmark

The first step in understanding the cost benchmarks is to understand your population. The average cost for employers in the database is the benchmark.

- The benchmark is adjusted to reflect differences between your organization and the database for each of four key criteria, noted below
- The result of these adjustments is a benchmark that is customized to your population (custom benchmark)
- The custom benchmark is the database cost if the database looked like your population with your plan designs

Age/Gender	The age/gender profile of the population — cost is directly correlated with age. The impact of gender on expected cost varies with age.
Family Size	The estimated number of members covered per employee, expressed in terms of adult cost equivalents — larger-than-average family size is expected to increase costs per employee.
Geography	The underlying cost for basic health care services in an area — provider competition and more prevalent managed care plans may reduce costs in some areas. More enrollment in higher costs areas is expected to increase costs.
Plan Value	The level of benefits covered under your medical plan — plans reimbursing a higher percentage of medical expenses than the database average are expected to increase costs.

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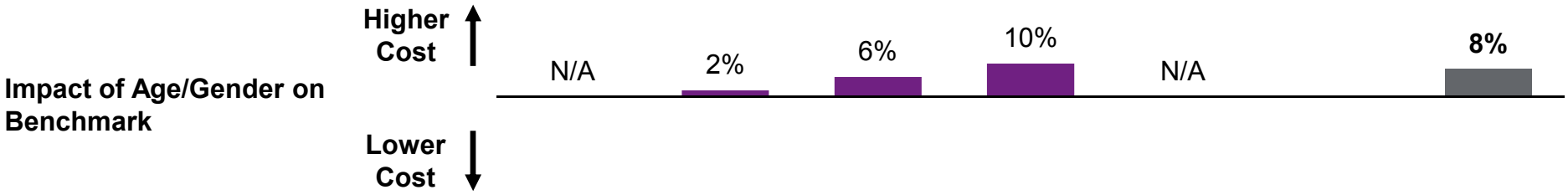
Medical Cost Benchmarks — Adjusting for Age/Gender

- What is the cost impact of age/gender in your population?
- How different is the impact of demographics by plan?
- If it is significant, why do company averages have a different pattern across plans than the database?



	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO	Total
Average Age — Database	45.3	42.9	46.2	43.9	44.9	44.8
Average Age — Your Population	N/A	43.0	48.4	47.6	N/A	47.7
% Female — Database	42%	39%	42%	43%	47%	42%
% Female — Your Population	N/A	53%	58%	53%	N/A	57%

To reflect the characteristics of the WSHCA — PEB covered population, the custom benchmark will be increased by 8% due to age and gender demographics: that is, the PEB population has a higher-than-average *expected* cost.

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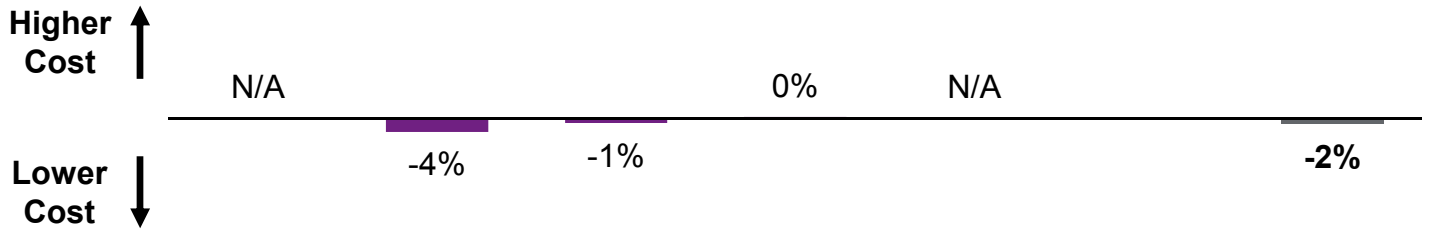
Medical Cost Benchmarks — Adjusting for Family Size

How different is the impact of family size by plan?
If it is significant, why do your organization's averages have a different pattern across plans than the database? How has this been impacted by contribution strategies your organization has adopted?

Impact of Family Size on Benchmark



	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO	Total
Dependents (%) — Database	51%	49%	51%	48%	53%	50%
Dependents (%) — Your Population	N/A	47%	53%	52%	N/A	52%

To reflect the characteristic of the WSHCA — PEB covered population, the custom benchmark will be decreased by 2% due to family size.

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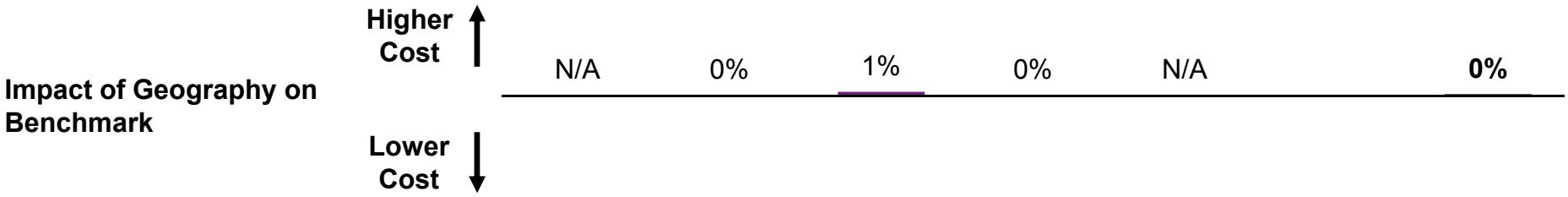
Medical Cost Benchmarks — Adjusting for Geography

- How does the geographic footprint of your covered population impact your costs?
- Does the geographic impact vary by plan?



	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO	Total
Geographic Factors — Database	1.00	1.00	1.00	0.99	1.01	1.00
Geographic Factors — Your Population	N/A	1.00	1.01	0.99	N/A	1.00

Your population's geography will have no impact on the custom benchmark. That is, the expected cost of health care in PEB's Washington locations is about the same as the U.S. average.

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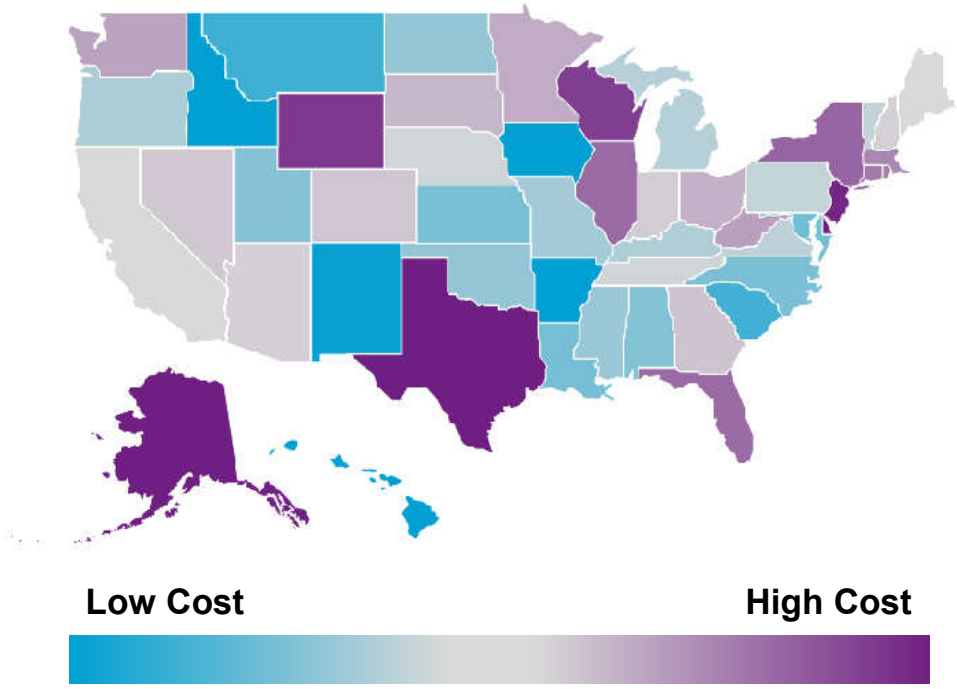
Adjusting for Geography — Additional Details

How do overall health care costs vary by state?

Health Care Costs by State



Your Top States for Enrollment

Rank	State	Your Enrollees	% of Total
1	WA	135,311	100%
2			
3			
4			
5			
Total — Top 5 States		135,311	100%

PEB program enrollment is up about 3% from a year ago, or about 3,800 enrollees.

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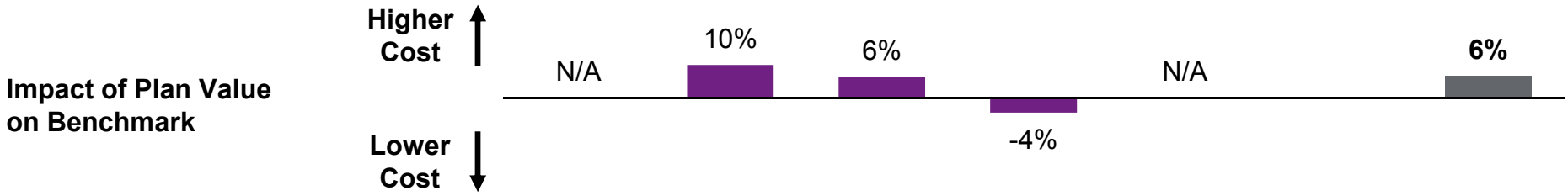
Medical Cost Benchmarks — Adjusting for Plan Value

How do your plan values compare to benchmark?



	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO	Total

To reflect the higher value of the WSHCA — PEB offered plan designs, the custom benchmark will be increased by 6% due to plan value.

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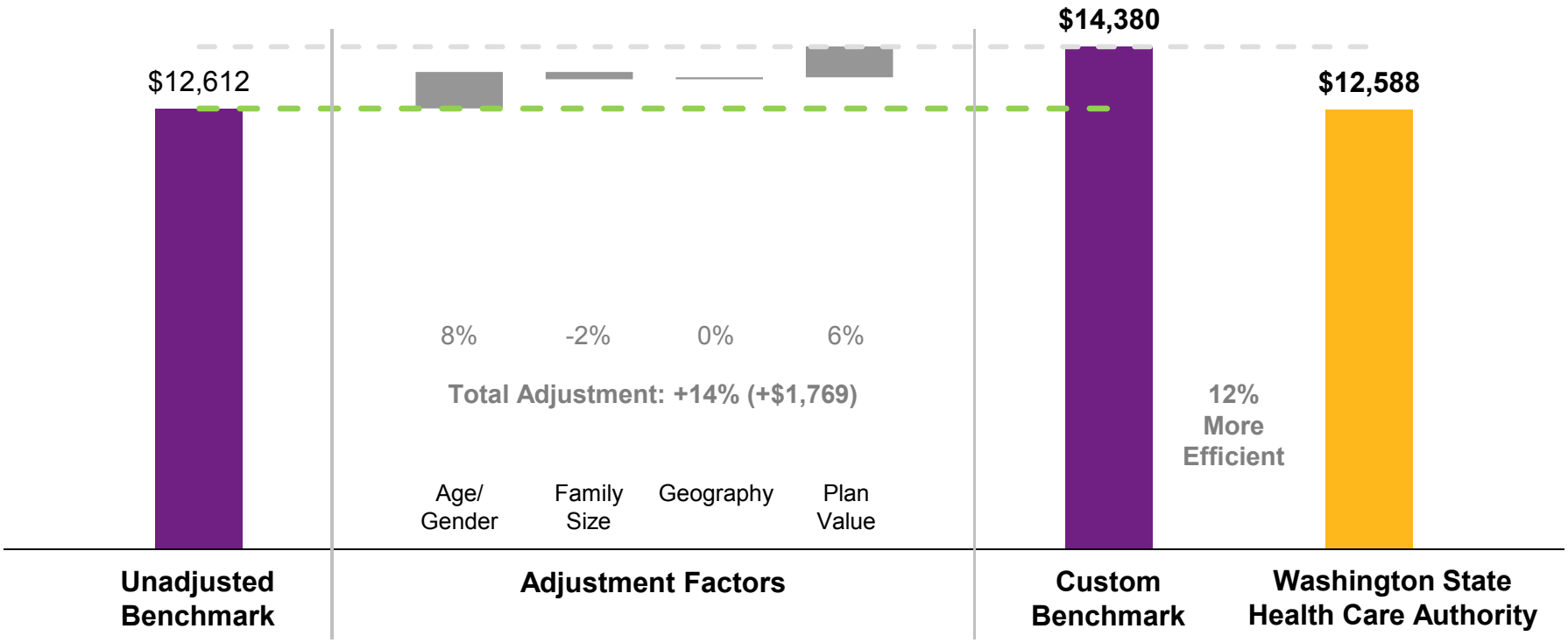
Medical Cost Benchmarks

Overall Program Efficiency

- After adjustments, how efficient is your total plan overall?
- What is the financial impact of moving to benchmark performance?



Your total program, for the plan designs provided, is 12% more efficient than the average database performance. This translates into a current annual savings of $243 million. Relative to top-quartile performers, your total program is 2% more efficient, translating into a current savings of $31 million.

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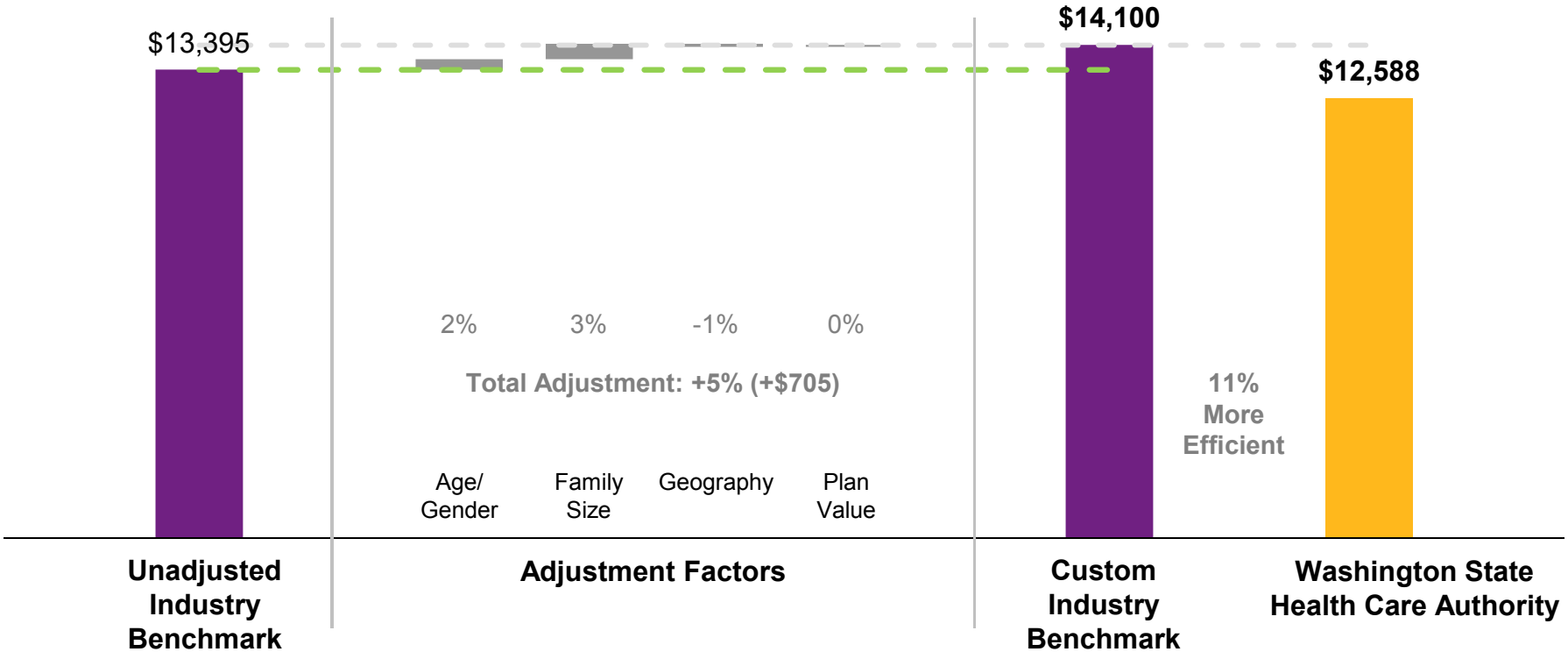
Medical Cost Benchmarks

Industry Efficiency

After adjustments, how efficient is your total plan compared to the government/public sector/education industry?



Your total program, for the plan designs provided, is 11% more efficient than your industry (government/public sector/education). This translates into a current annual savings of $205 million.

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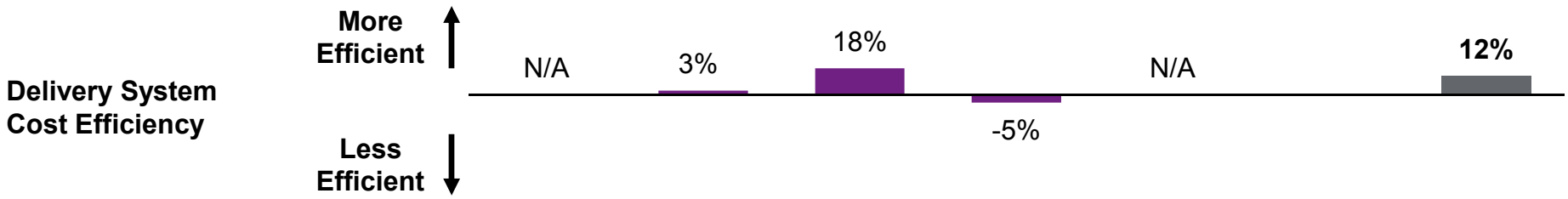
Medical Cost Benchmarks

Delivery System Cost Efficiency

How efficient are your plans relative to the benchmark?



	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO	Total
Enrollment	0%	9%	64%	27%	0%	100%
Actual cost per employee	N/A	$12,059	$12,564	$12,815	N/A	$12,588
Custom benchmark cost per EE	N/A	$12,379	$15,254	$12,156	N/A	$14,380
Efficiency	N/A	3%	18%	-5%	N/A	12%
Summary		Low Enrollment	High Enrollment	Average Enrollment		
		Average Efficiency	High Efficiency	Low Efficiency		High Efficiency

- WSHCA — PEB plans have nearly the same annual costs per employee
- PPO plans have the highest benchmark costs
- Plan efficiency is most important for plans with higher enrollment, as this drives overall efficiency

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Employee Cost Sharing Overview

An important driver of overall cost results is how employers price different medical plan options to employees. This section shows how your organization's employee contributions compare with the database averages and how contributions are structured for different delivery systems.

Included are:

- Comparisons of employee vs. dependent subsidy levels
- Net cost analysis by plan type

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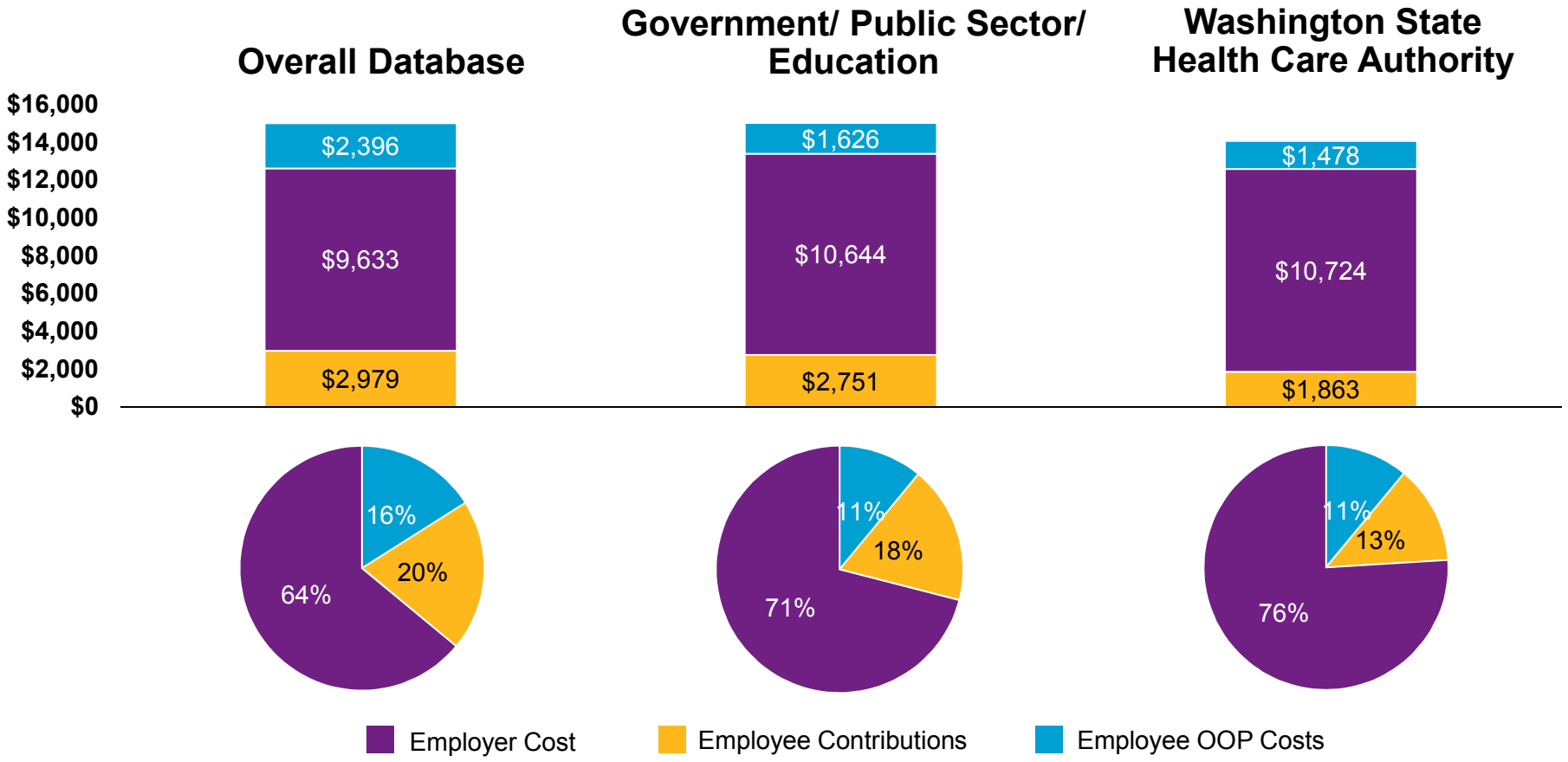
Medical Cost Benchmarks

Total Cost and Contributions

How does your employees' share of total cost, including contributions and out-of-pocket expenses, compare to benchmarks?



- Compared to the overall database, your employees' share of total costs is lower
- Compared to others in your industry, your employees' share of total costs is lower

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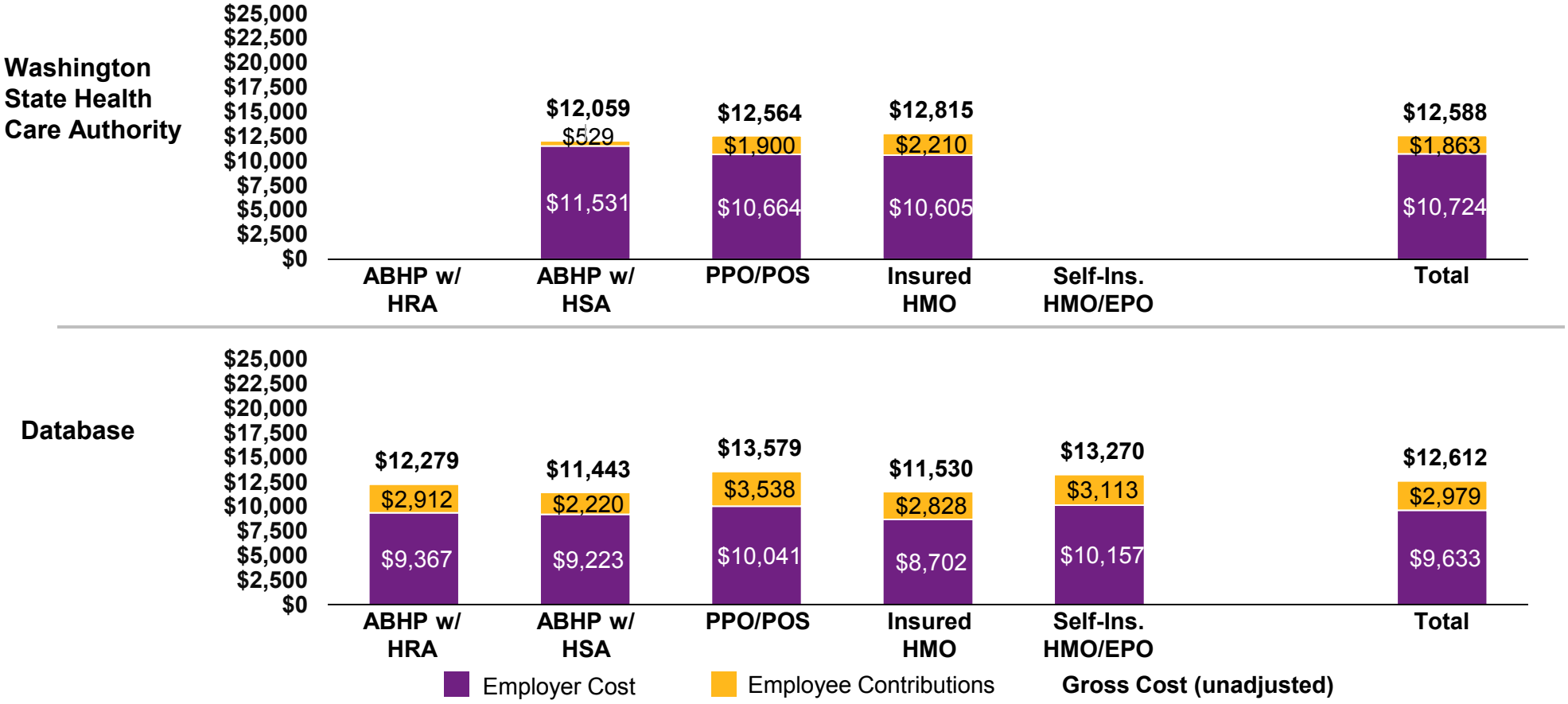
Medical Cost Benchmarks

Employee Cost-Sharing (Unadjusted)

How do your employee payroll contributions vary across plans?



On average, your employees pay $1,116 less per year for health benefits than the market benchmark.

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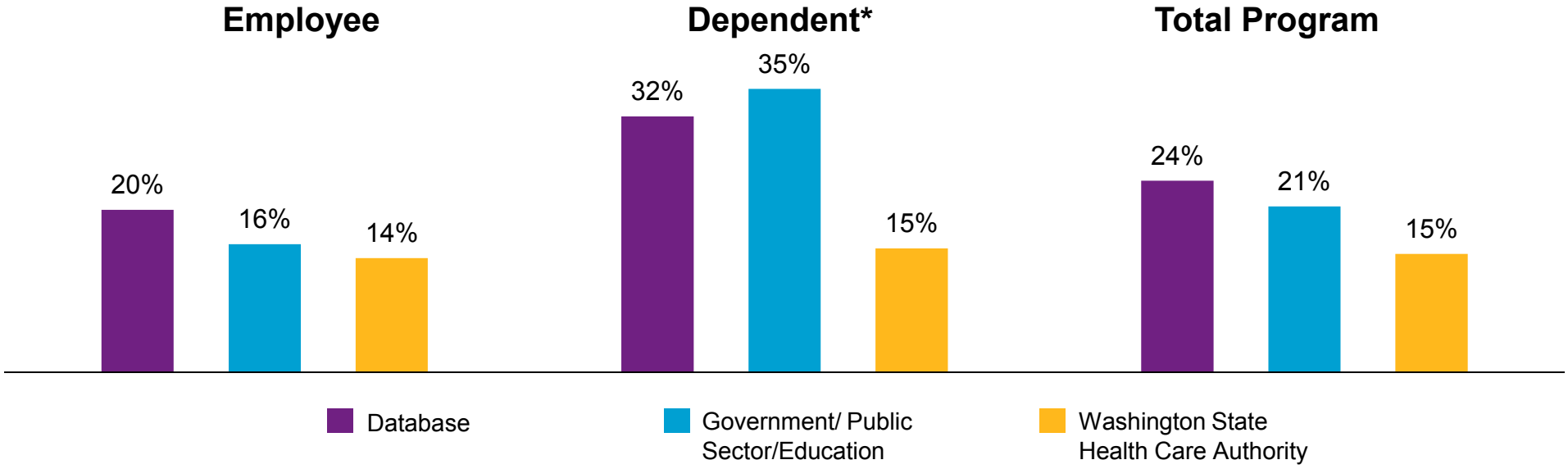
Medical Cost Benchmarks

Employee Contributions as a % of Plan Cost

How does your cost-sharing, for employees and dependents, compare to benchmarks?



Employee Contributions as a % of Total Cost	ABHP w/ HRA	ABHP w/ HSA	PPO/POS	Insured HMO	Self-Ins. HMO/EPO
Washington State Health Care Authority	N/A	4%	15%	17%	N/A
Database	25%	20%	27%	25%	24%

- Employees contribute a lower premium percentage than the overall market and industry averages
- Employee contributions for dependents are well below the overall market and industry averages

*Dependent includes spouse, children, family, etc.

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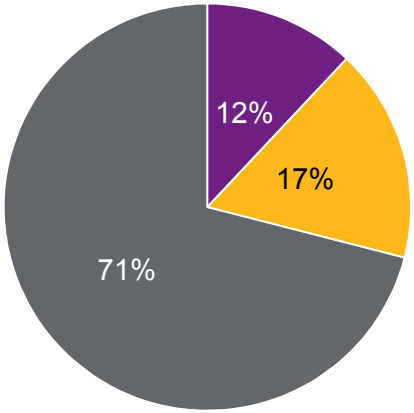
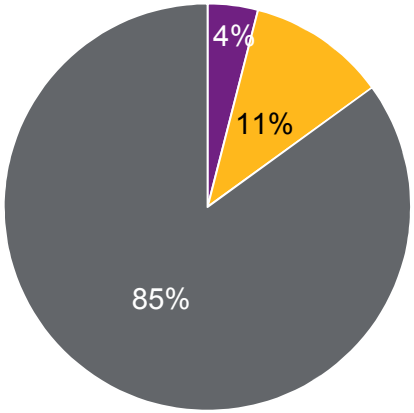
Wellness Credits for Accounts and Contributions

How does your organization's approach compare to the market practice?

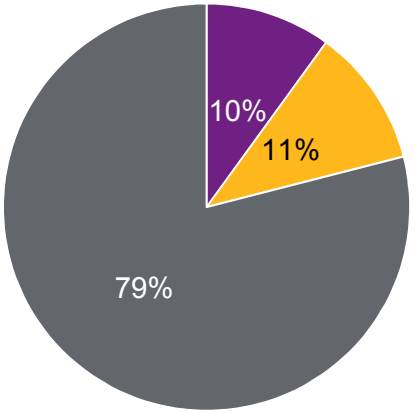
% of database with wellness credits



% of database with wellness credits deposited in HRA or HSA accounts



% of database with wellness credits applied to payroll contributions



Employee Only | Employee and Spouse | None

Your plan provides wellness credits: credits to an HSA account for enrollees in a CDHP; for PPO enrollees, wellness credits offset the deductible.*

* Wellness credits impacting plan design are not captured in this study.

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Medical Cost Benchmarks

Impact of Account Seeding on HSA Plan Design*

- How does your funding of the HSA compare with the database?
- How does your net deductible (deductible minus guaranteed and earned incentives) compare with the database?

HSAs	Client	Database		
		25th	Average	75th
Base Deductible	$1,400	$1,500	$2,297	$2,700
– Guaranteed Contribution	$700	$0	$433	$600
– Average Earned Incentive	$22	$0	$39	$0
Net Deductible Paid by Employees	$678	$1,050	$1,825	$2,300

Your net deductible is $1,147 less than the database average.

*Employee coverage only

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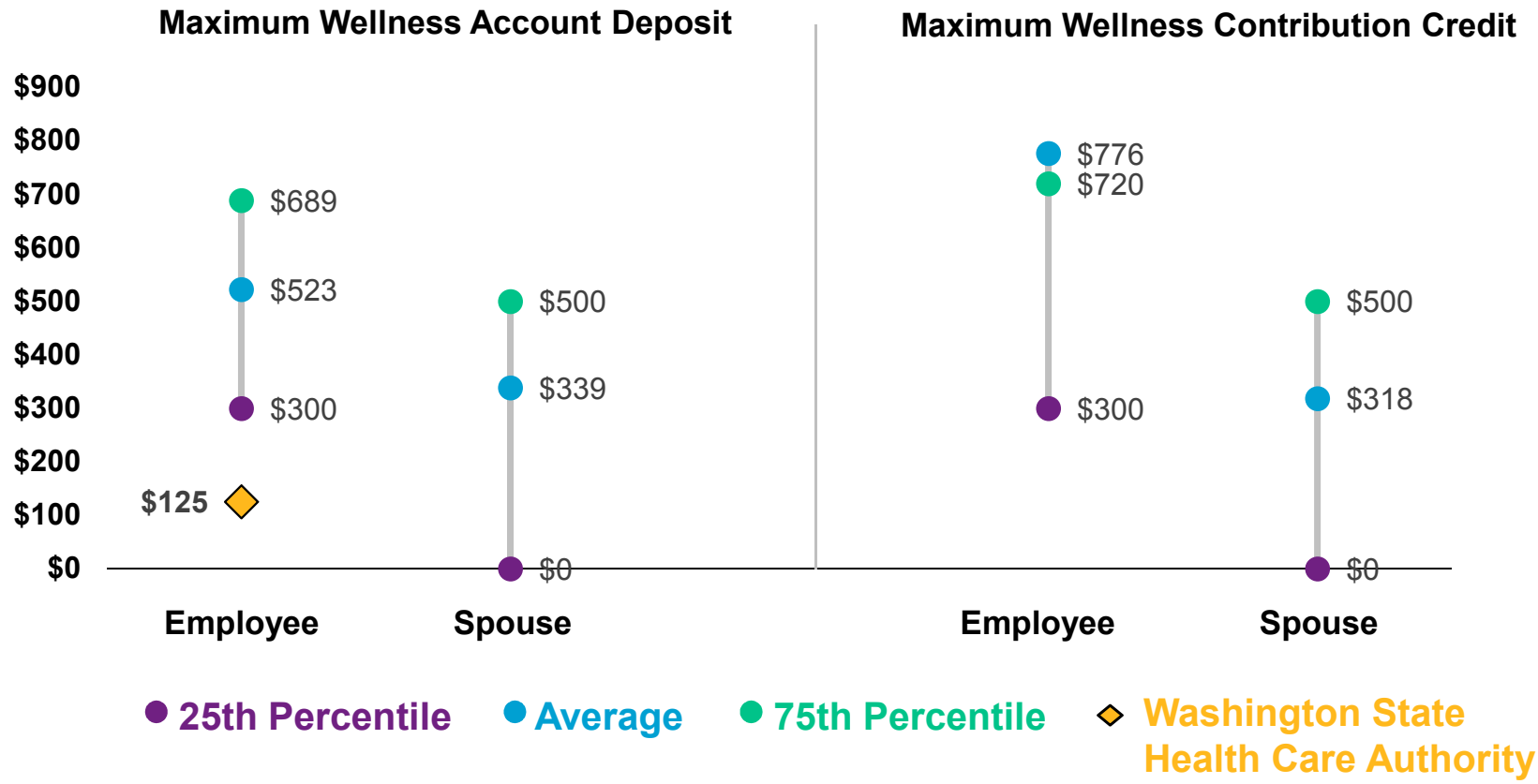
Medical Cost Benchmarks | Wellness Incentives

- How does your organization's maximum potential wellness credit compare with the database?
- How does the allocation between employee and spouse compare to the database?
- How does the approach for employees and spouses compare between contributions and wellness credits?



Maximum wellness account deposits and contribution credits average $523 and $776 for employees and $339 and $318 for spouses, compared to the $125 available to enrollees in the WSHCA plans.

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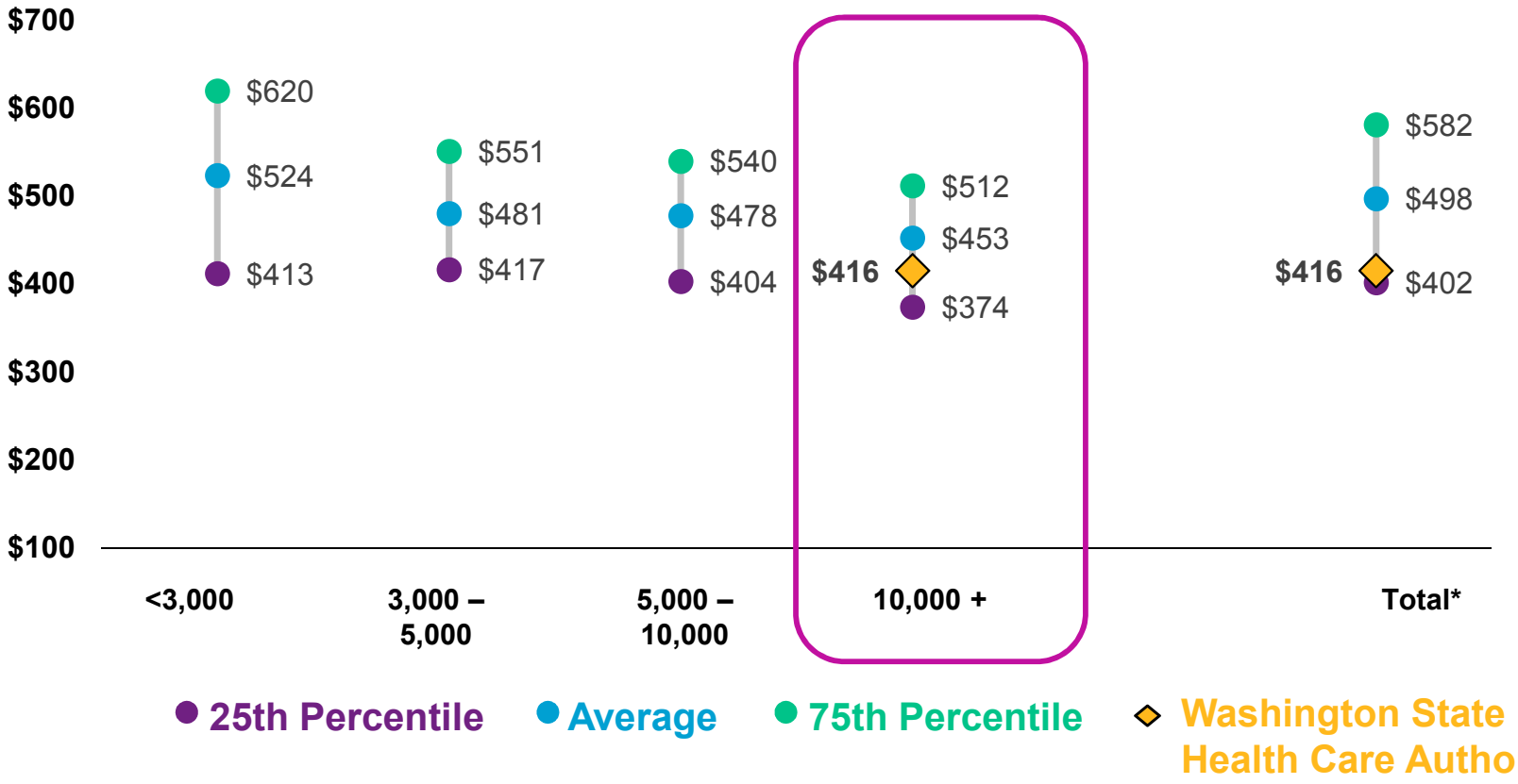
Medical Cost Benchmarks

Annual Self-Insured Administration Fees by Covered Employee by Employer Size*

How do your administration fees compare to the database? What is contributing to the company's variance from average? Number enrolled? Number of vendors?



Your TPA administration fees are about 8% below the benchmark average for plan sponsors of at least 10,000 enrolled employees.

*Results by employer size for companies with self-insured arrangements.

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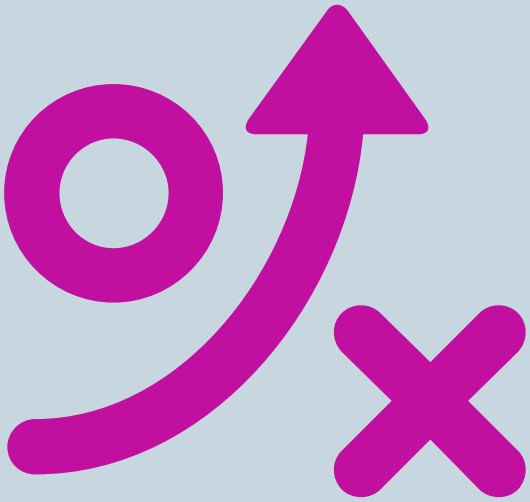
Plan Design Benchmarks



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Medical Plan Design Benchmarks

ABHP w/ HSA Plan Design

How do your plan designs compare to the database?

Medical* (Single/Family)	Washington State Health Care Authority			Database	
	UMP CDHP	Kaiser WA CDHP	Kaiser PNW CDHP	All Companies	Government / Public Sector / Education
Account Funding	$700 / $1,400	$700 / $1,400	$700 / $1,400	$500 / $1,000	$600 / $1,100
Deductible	$1,400 / $2,800	$1,400 / $2,800	$1,400 / $2,800	$2,000 / $4,000	$2,000 / $4,000
Plan Coinsurance	85%	90%	85%	80%	90%
Office Visit (OV) Copays**	N/A	N/A	$20 / $30	$25 / $40	$28 / $45
Inpatient (IP) Copay	N/A	N/A	N/A	$250	$375
Outpatient (OP) Copay	N/A	N/A	N/A	$150	$150
Emergency Room (ER) Copay	N/A	N/A	N/A	$150	$200
Out-of-Pocket Maximum***	$2,800 / $5,600	$3,700 / $7,400	$3,700 / $7,400	$2,000 / $4,000	$2,000 / $3,775

*In-network benefits
**Primary Care Physician / Specialty Care Physician copays (if applicable)
*** Excludes deductible

- The WSHCA CDHP plans are more generous (i.e., higher actuarial value) than the market benchmark
- All companies — copays are applicable in 4% (OV), 1% (IP), 1% (OP) and 6% (ER) of employers
- Industry — copays are applicable in 6% (OV), 4% (IP), 4% (OP) and 6% (ER) of employers

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Medical Plan Design Benchmarks

PPO/POS Plan Design

How do your plan designs compare to the database?

Medical* (Single/Family)	Washington State Health Care Authority		Database	
	UMP Classic	UMP Plus	All Companies	Government / Public Sector / Education
Deductible	$250 / $750	$125 / $375	$750 / $1,500	$500 / $1,200
Plan Coinsurance	85%	85%	80%	90%
Office Visit (OV) Copays**	N/A	N/A	$25 / $40	$25 / $35
Inpatient (IP) Copay	$600	$600	$250	$250
Outpatient (OP) Copay	N/A	N/A	$125	$100
Emergency Room (ER) Copay	$75	$75	$150	$125
Out-of-Pocket Maximum***	$1,750 / $3,250	$1,875 / $3,625	$2,500 / $5,000	$2,300 / $4,550

*In-network benefits
**Primary Care Physician / Specialty Care Physician copays (if applicable)
*** Excludes deductible

- The WSHCA PPO plans are more generous (higher actuarial value) than the market benchmark average
- All companies — copays are applicable in 88% (OV), 15% (IP), 13% (OP) and 70% (ER) of employers
- Industry — copays are applicable in 89% (OV), 24% (IP), 21% (OP) and 75% (ER) of employers

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Medical Plan Design Benchmarks

HMO/EPO Plan Design

How do your plan designs compare to the database?

Medical* (Single/Family)	Washington State Health Care Authority			Database	
	Kaiser WA Value Plan	Kaiser WA Classic Plan	Kaiser WA Sound Choice Plan	All Companies	Government / Public Sector / Education
Deductible	$250 / $750	$175 / $525	$250 / $750	$500 / $1,075	$500 / $1,000
Office Visit (OV) Copays**	$30 / $50	$15 / $30	N/A	$20 / $30	$20 / $30
Inpatient (IP) Copay	$750	$450	$600	$250	$250
Outpatient (OP) Copay	$200	$150	N/A	$100	$100
Emergency Room (ER) Copay	$300	$250	$75	$100	$100
Out-of-Pocket Maximum***	$2,750 / $5,250	$1,825 / $3,475	$1,750 / $3,250	$2,000 / $4,500	$2,000 / $5,000

*In-network benefits
**Primary Care Physician / Specialty Care Physician copays (if applicable)
***Excludes deductible

- The WSHCA HMO plans are on par with the market benchmark designs
- All companies — copays are applicable in 97% (OV), 58% (IP), 57% (OP) and 87% (ER) of employers
- Industry — copays are applicable in 98% (OV), 61% (IP), 64% (OP) and 94% (ER) of employers

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Pharmacy Plan Design Benchmarks ABHP w/ HSA Plan Design

How do your plan designs compare to the database?

Pharmacy (Retail)	Washington State Health Care Authority			Database			
	UMP CDHP	Kaiser WA CDHP	Kaiser PNW CDHP	All Companies		Government / Public Sector / Education	
Deductible (Single/Family)	Combined w/ medical	Combined w/ medical	Combined w/ medical	$2,500 / $5,000		Combined w/ medical	
Out-of-Pocket Maximum (Single/Family)	Combined w/ medical	Combined w/ medical	Combined w/ medical	$2,000 / $3,700		$2,648 / $5,295	
Generic (Min/Max)	85% ($0 / $0)	$13	$15	$10	80% ($0 / $0)	$10	90% ($0 / $0)
Formulary (Min/Max)	85% ($0 / $0)	$40	$40	$30	80% ($0 / $0)	$30	82% ($0 / $0)
Non-Formulary (Min/Max)	85% ($0 / $0)	50% ($0 / $250)	$75	$60	80% ($0 / $0)	$50	80% ($0 / $0)

*Out-of-pocket maximums shown are for database participants with separate medical and pharmacy out-of-pocket maximums.

- All companies — copays are applicable in 39% of employers
- Industry — copays are applicable in 40% of employers

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Pharmacy Plan Design Benchmarks

PPO/POS Plan Design

How do your plan designs compare to the database?

Pharmacy (Retail)	Washington State Health Care Authority		Database			
	UMP Classic	UMP Plus	All Companies		Government / Public Sector / Education	
Deductible (Single/Family)	$100 / $300	N/A	$100 / $200		$100 / $300	
Out-of-Pocket Maximum (Single/Family)	$1,900 / $5,700	$2,000 / $6,000	$2,500 / $4,300		$2,000 / $4,200	
Generic (Min/Max)	90% ($0 / $25)	90% ($0 / $25)	$10	80% ($0 / $7)	$10	80% ($0 / $0)
Formulary (Min/Max)	70% ($0 / $75)	70% ($0 / $75)	$30	75% ($20 / $60)	$30	75% ($0 / $50)
Non-Formulary (Min/Max)	50% ($0 / $0)	50% ($0 / $0)	$55	60% ($30 / $100)	$50	60% ($0 / $78)

*Out-of-pocket maximums shown are for database participants with separate medical and pharmacy out-of-pocket maximums.

- All companies — copays are applicable in 89% of employers
- Industry — copays are applicable in 92% of employers

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Pharmacy Plan Design Benchmarks

HMO/EPO Plan Design

How do your plan designs compare to the database?

Pharmacy (Retail)	Washington State Health Care Authority			Database			
	Kaiser WA Value Plan	Kaiser WA Classic Plan	Kaiser WA Sound Choice Plan	All Companies		Government / Public Sector / Education	
Deductible (Single/Family)	$100 / $300	$100 / $300	$100 / $300	$100 / $250		$100 / $175	
Out-of-Pocket Maximum (Single/Family)	$1,900 / $5,700	$1,900 / $5,700	$1,900 / $5,700	$3,075 / $4,200		$2,100 / $4,200	
Generic (Min/Max)	$15	$13	$10	$10	80% ($0 / $20)	$10	85% ($8 / $35)
Formulary (Min/Max)	$50	$40	$60	$30	75% ($19 / $68)	$30	75% ($18 / $65)
Non-Formulary (Min/Max)	50% ($0 / $0)	50% ($0 / $250)	50% ($0 / $0)	$45	60% ($0 / $70)	$50	70% ($0 / $0)

*Out-of-pocket maximums shown are for database participants with separate medical and pharmacy out-of-pocket maximums.

- All companies — copays are applicable in 96% of employers
- Industry — copays are applicable in 98% of employers

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Dental Plan Design Benchmarks

PPO/POS Plan Design

How do your plan designs compare to the database?

In-network Dental Plan Design	Washington State Health Care Authority	Database	
	Uniform Dental Plan	All Companies	Government / Public Sector / Education
Deductible (Single/Family)	$50 / $150	$50 / $150	$50 / $150
Annual Limit (per person)	$1,750	$1,500	$1,500
Preventive Coinsurance	100%	100%	100%
Basic Coinsurance	80%	80%	80%
Major Restorative Coinsurance	50%	50%	50%
Orthodontic Services			
▪ **None**	N/A	33%	34%
▪ **Children Only**	N/A	53%	48%
▪ **Adult and Child**	Yes	45%	44%
Orthodontia Coinsurance	50%	50%	50%
Orthodontia Lifetime Limit	$1,750	$1,500	$1,500

Dental PPOs are the most prevalent plan type. Dental plan designs tend to have similar design characteristics and to have less variation in plan value than medical plans. Sponsors tend to increase the annual limits periodically over time to maintain plan value as the cost of dental services increases.

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Dental Cost Benchmarks

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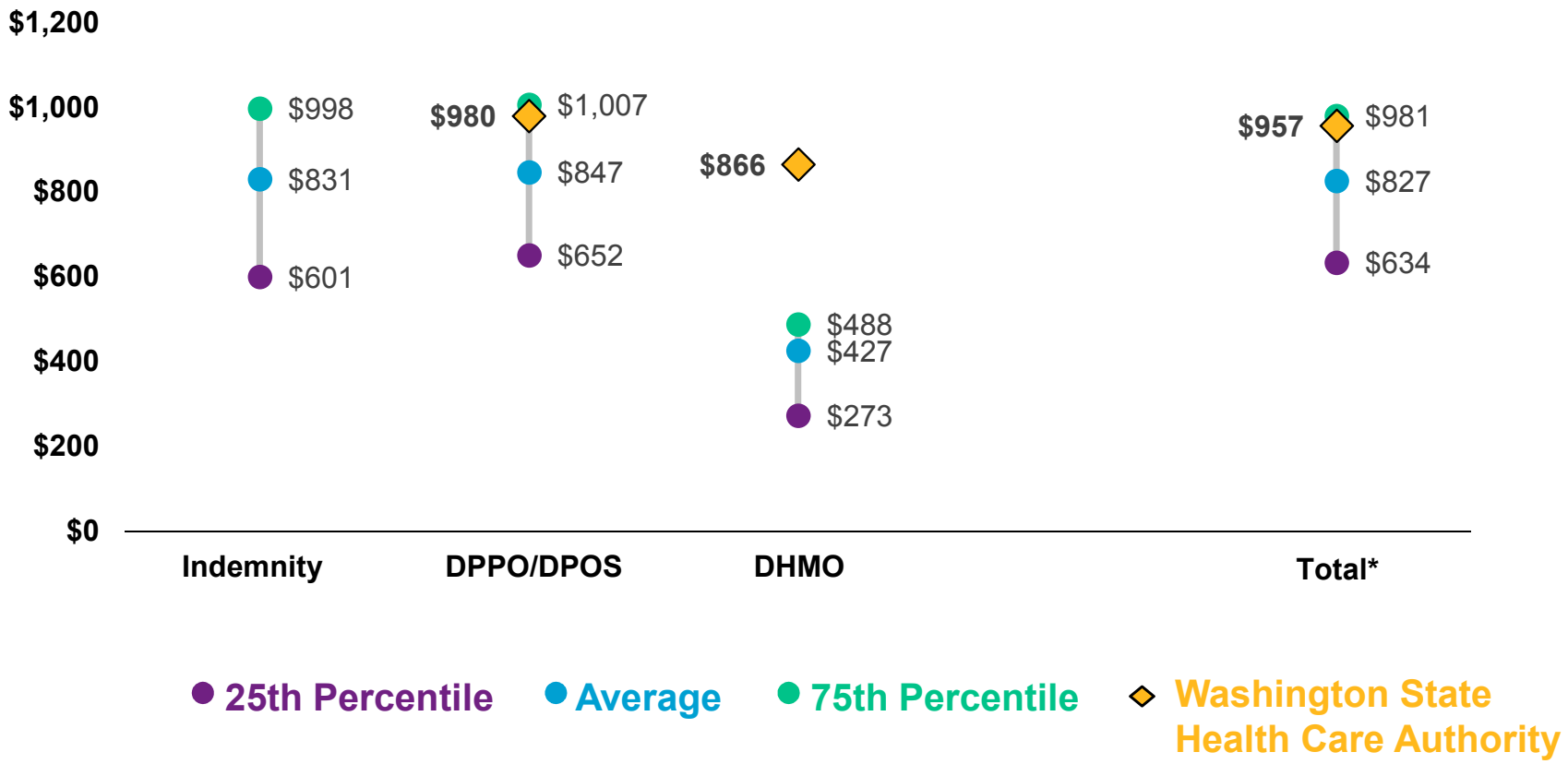
Dental Cost Benchmarks

Total Cost per Covered Employee per Year (Unadjusted)

- How do your plan costs compare to the database?
- How do costs vary by plan type?



Your dental costs are 16% higher than database average. The cost of the WSHCA plans increased by 4.4% over 2017, whereas the benchmark average decreased slightly versus 2017. Though DHMOs are a much lower cost delivery system in our benchmarking database, this is not the case for the WSHCA — PEB plan.

*Total costs represent an enrollment weighted average of plan types.

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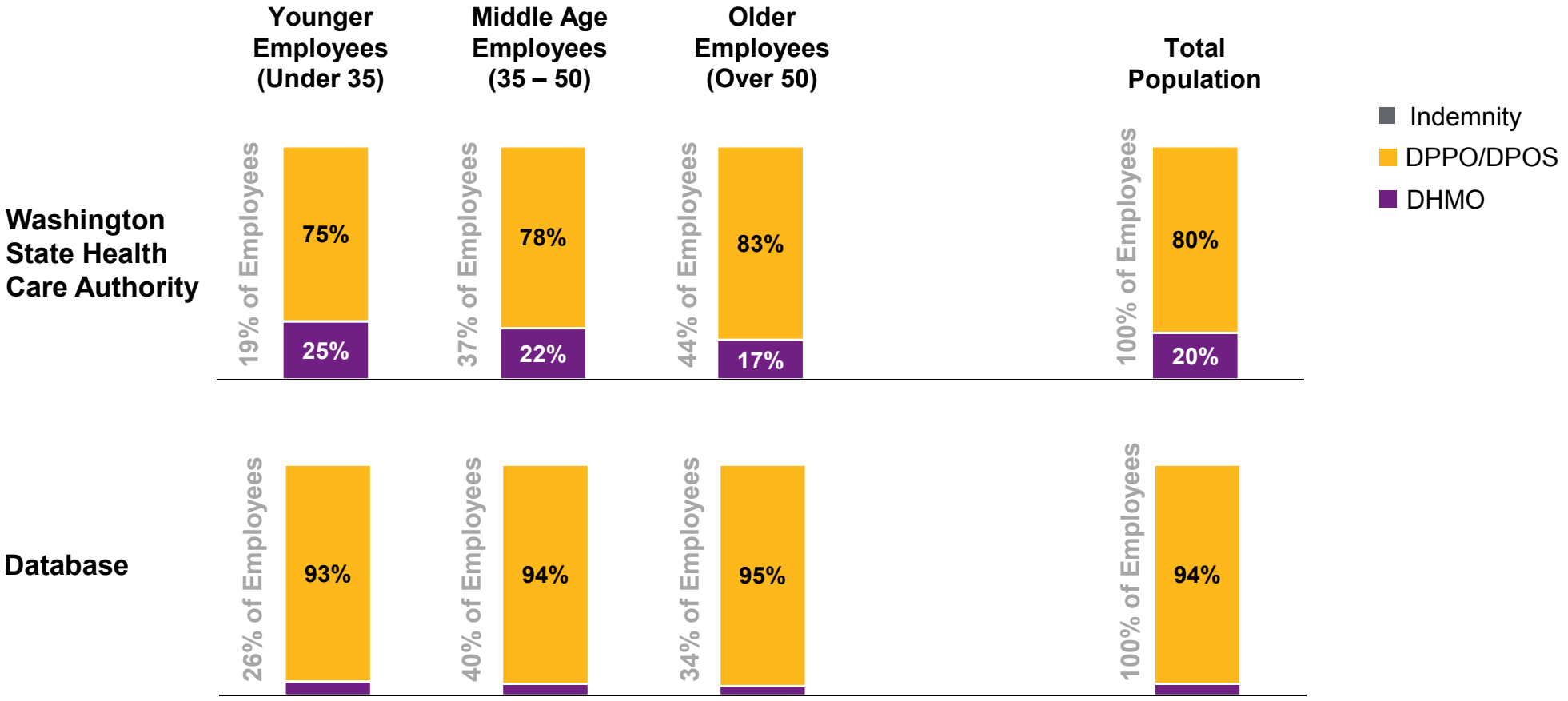
Dental Cost Benchmarks

Enrollment by Plan Type and Age Breakdown

How is enrollment distributed by age and plan?



The majority of employees in the database are enrolled in DPPO/DPOS dental plans.

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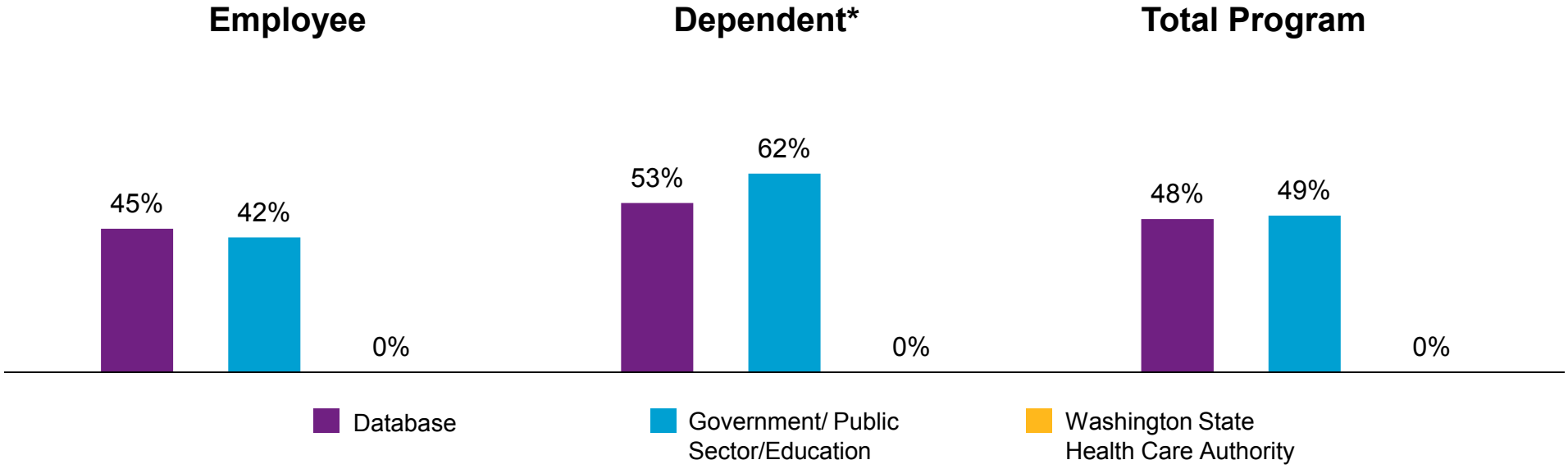
Dental Cost Benchmarks

Employee Contributions as a % of Plan Cost

How do employee contributions as a percent of plan cost compare to the database benchmarks?



Employee Contributions as a % of Total Cost	Indemnity	DPPO	DHMO
Washington State Health Care Authority	N/A	0%	0%
Database	44%	48%	49%

Unlike the plans at most organizations, WSHCA does not charge employee contributions to enroll in the Dental plans.

*Dependent includes spouse, children, family, etc.

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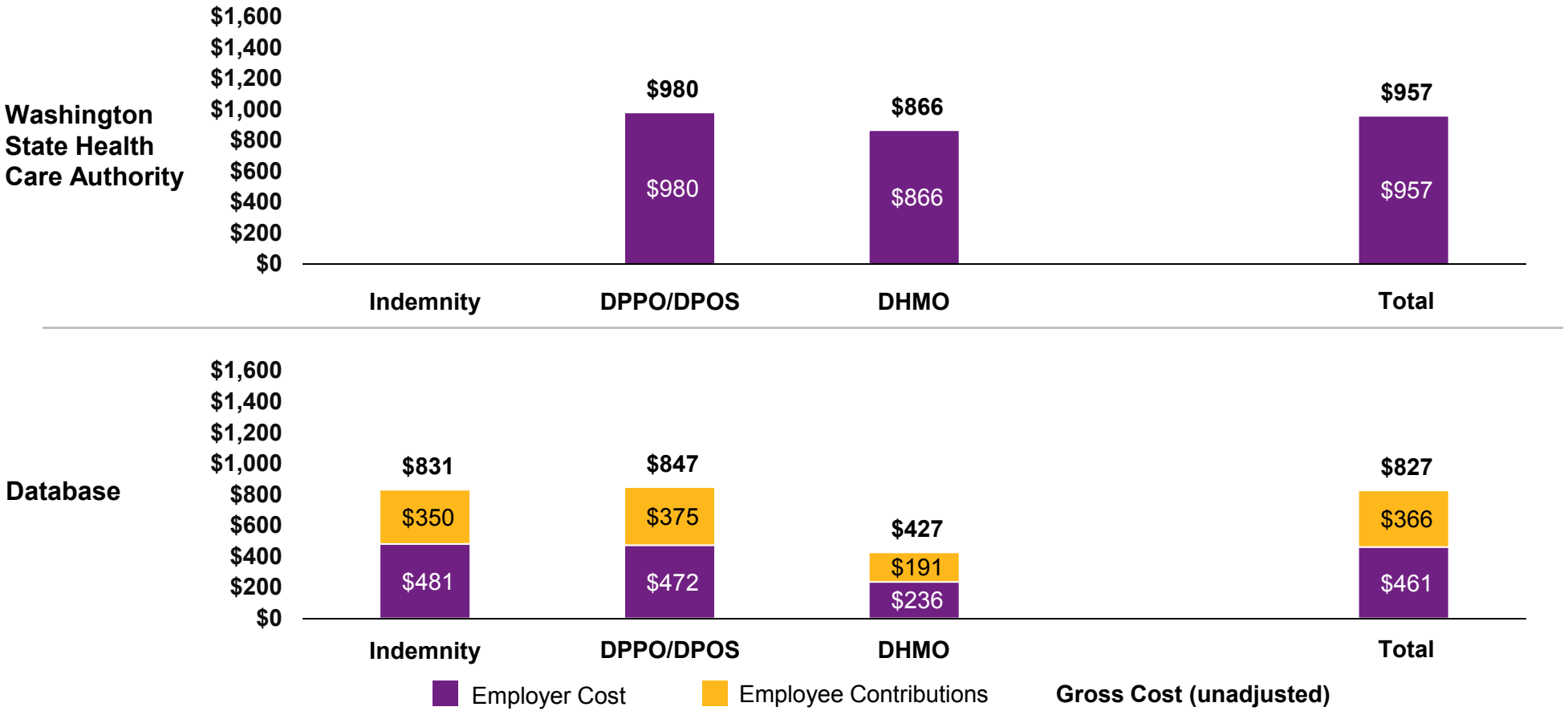
Dental Cost Benchmarks

Employee Cost-Sharing — Net Cost Analysis

How do your employees' payroll contributions vary across plans?



On average, your employees pay $366 less per year than the database.

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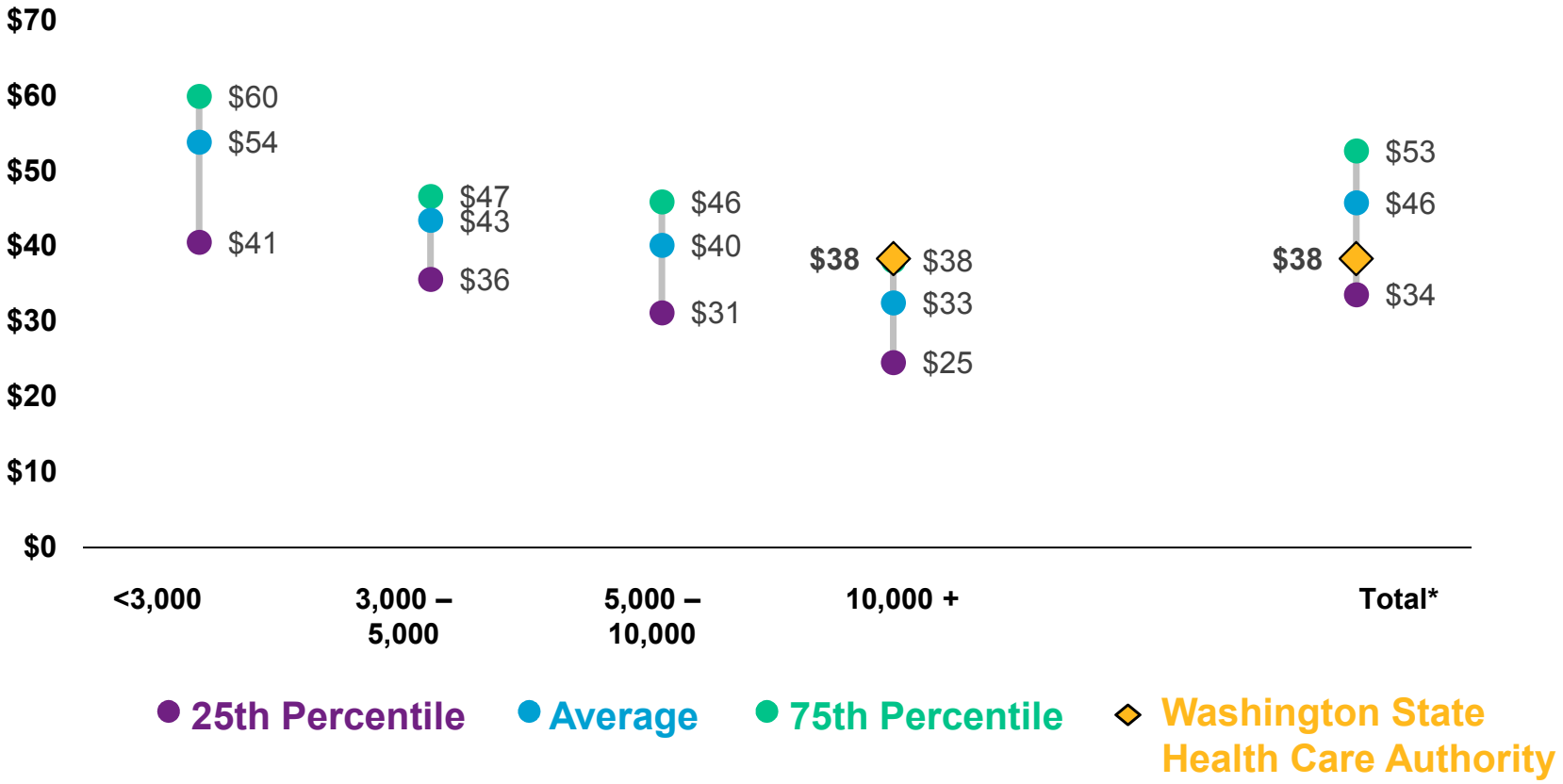
Dental Cost Benchmarks

Annual Self-Insured Administration Fees per Covered Employee by Employer Size*

How do administration costs compare to the database benchmarks?



Your dental administration fees are about 15% above the database average for plan sponsors with at least 10,000 enrolled employees.

*Results by employer size for companies with self-insured arrangements.

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Appendix

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2018 Rates and Contributions

Medical

- The following rates and employee contributions were used in the analysis

Rates* (Monthly)	Uniform Medical Plan			Kaiser WA				Kaiser PNW	
	Classic	CDHP	Plus	Classic	CDHP	SoundChoice	Value	Classic	CDHP
Employee Only	$644.96	$635.70	$588.78	$704.30	$635.97	$595.20	$621.10	$679.08	$637.62
Employee + Spouse	$1,285.00	$1,260.62	$1,172.65	$1,403.68	$1,261.15	$1,185.49	$1,237.27	$1,353.23	$1,263.97
Employee + Child(ren)	$1,124.99	$1,133.27	$1,026.68	$1,228.84	$1,133.74	$1,037.92	$1,083.23	$1,184.69	$1,136.27
Employee + Family	$1,765.03	$1,642.67	$1,610.55	$1,928.22	$1,643.40	$1,628.20	$1,699.41	$1,858.85	$1,647.10

Contributions (Monthly)	Uniform Medical Plan			Kaiser WA				Kaiser PNW	
	Classic	CDHP	Plus	Classic	CDHP	SoundChoice	Value	Classic	CDHP
Employee Only	$102.00	$25.00	$45.00	$162.00	$25.00	$51.00	$78.00	$137.00	$27.00
Employee + Spouse	$214.00	$60.00	$100.00	$334.00	$60.00	$112.00	$166.00	$284.00	$64.00
Employee + Child(ren)	$179.00	$44.00	$79.00	$284.00	$44.00	$89.00	$137.00	$240.00	$47.00
Employee + Family	$291.00	$79.00	$45.00	$456.00	$79.00	$150.00	$225.00	$387.00	$84.00

*2018 Cobra rates. Cobra rates are reduced by 2% in the Financial Benchmarks Survey to estimate plan costs.

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2018 Rates and Contributions

Dental

- The following rates were used in the analysis

Rates* (Monthly)	Uniform Dental Plan	DeltaCare	Willamette
Employee Only	$45.82	$39.53	$42.37
Employee + Spouse	$91.64	$79.06	$84.74
Employee + Child(ren)	$91.64	$79.06	$84.74
Employee + Family	$137.46	$118.59	$127.11

- The Washington State Health Care Authority does not charge employees to enroll in the dental plans

*2018 Cobra rates. Cobra rates are reduced by 2% in the Financial Benchmarks Survey to estimate plan costs.

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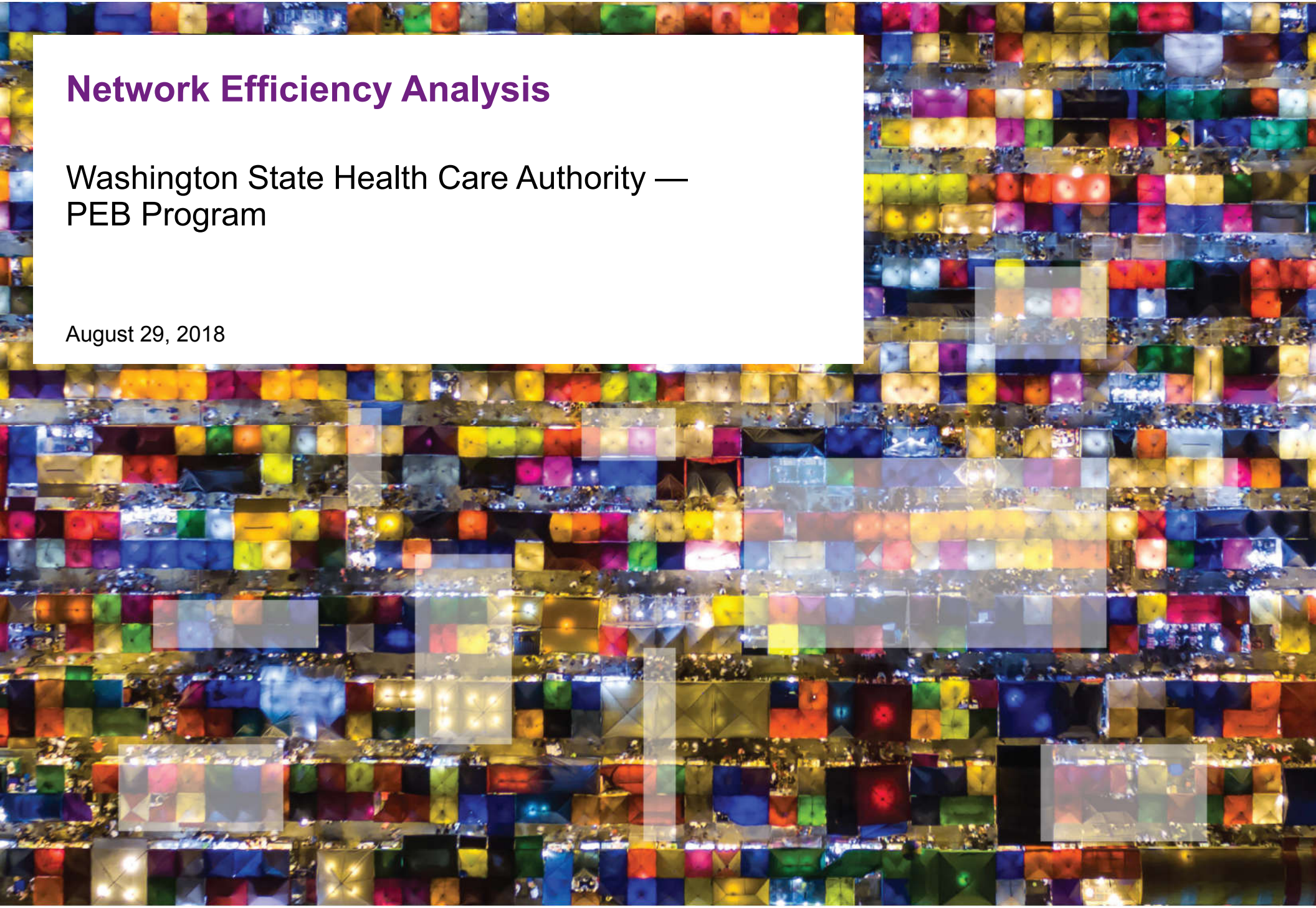
Network Efficiency Analysis

Washington State Health Care Authority —
PEB Program

August 29, 2018



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Key Questions

- What opportunities are there to optimize or manage plan costs, services and quality today
  - FBS network efficiency benchmarks
  - 2016 to 2017 trends (PMPM opportunity savings) on cost, utilization and high-cost claims
- Are benefit programs and provider/supply side strategies in synch?
- What can be learned from best practices in plan and cost management?
- What are the biggest opportunities to improve efficiency?

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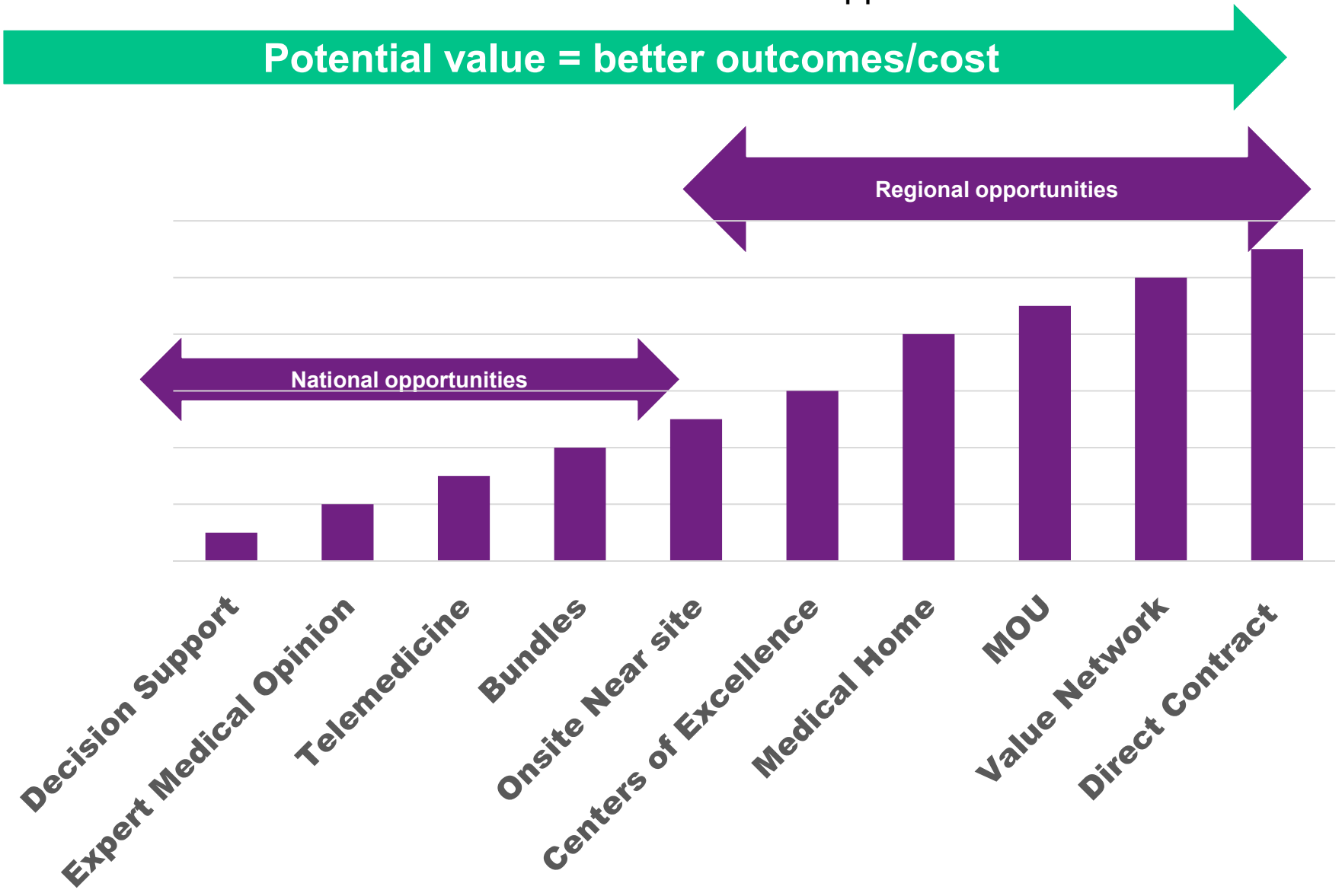
Strategic Value-Based Contracting

A Continuum of Potential Value Solutions to Maximize Opportunities and Tradeoffs



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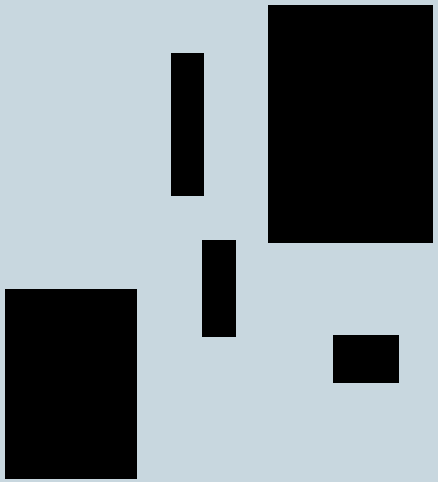
Findings

Best Practices for Medical and Pharmacy Network Management and Efficiencies



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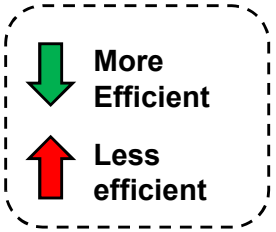
PEB Program Network Efficiency

Benchmarking Efficiency on Key Utilization Metrics



2017 Truven and Other National Benchmarks	Hospitalization rate per 1,000	GFR	ER Rate per 1,000	C-Sections as % of Deliveries	Percentage HCC GE $50K	30-day Readmission Rate per 1,000
Best in class (BIC)	40.0	92.0%	90.0	20.0%	1.00%	2.0
75% percentile	43.7	84.5%	180.4	27.3%	1.20%	7.6
50% percentile	51.9	83.1%	221.9	31.7%	1.60%	8.5
25% percentile	58.5	81.3%	260.2	36.4%	1.80%	9.0
HCA 2017	**53.7**	**87.9%**	**153.2**	**28.9%**	**1.42%**	**3.8**
HCA 2016	**52.9**	**81.0%**	**149.3**	**26.2%**	**1.24%**	**Not reported**

Poor Efficiency Average Efficiency Good Efficiency Best-in-Class Efficiency

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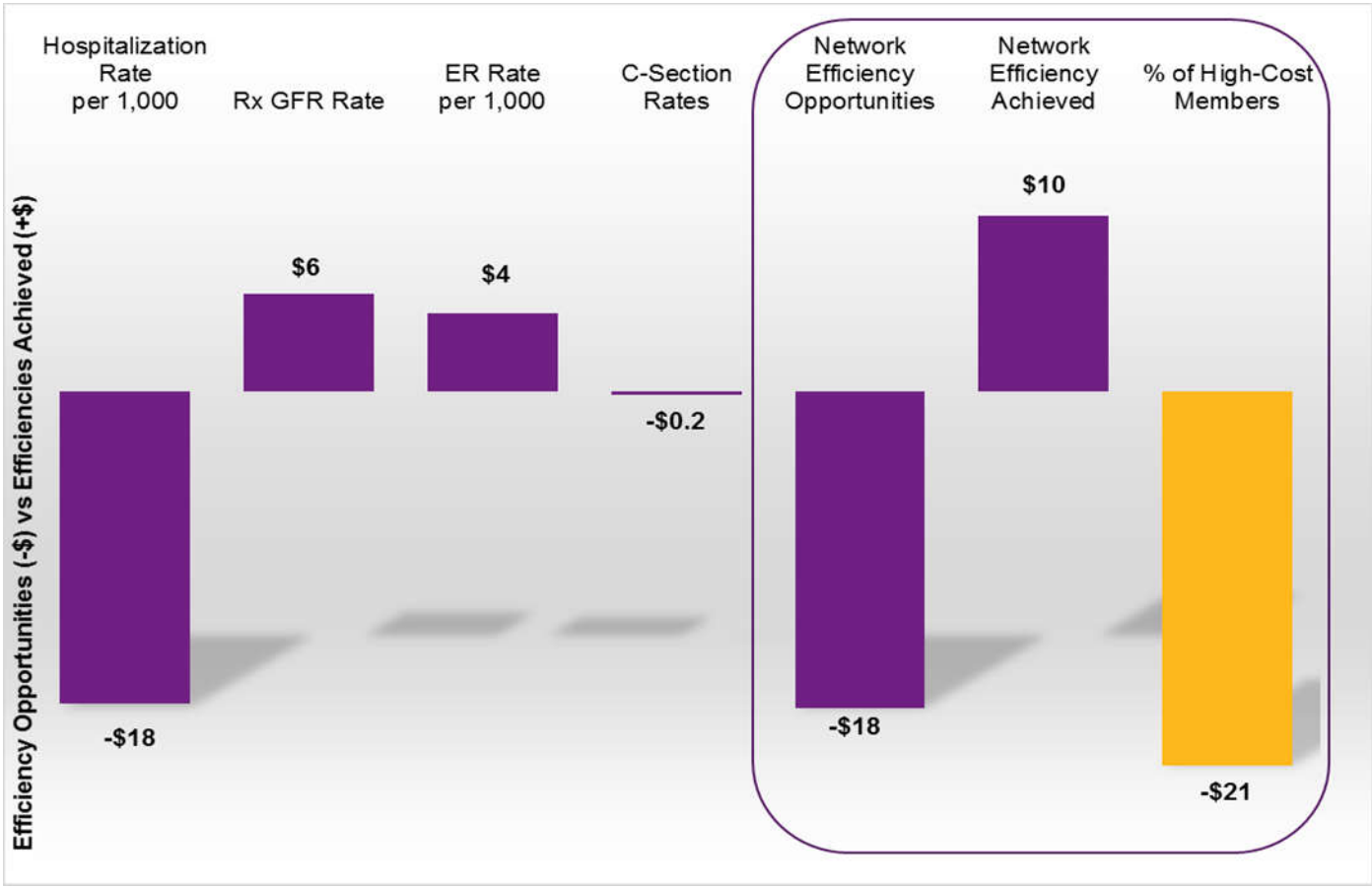
What are the Potential Cost Saving Opportunities of Improving PEB Program Provider Network Efficiency?

Key Network PMPM Efficiency Compared to 75th Percentile*



- PEB program greatest opportunity at the 75th percentile is related to its hospitalization rate. This represents a 4% savings on total medical/Rx spend.
- Rx GFR, and ER are at or above the 75th percentile

*Assumes average national cost or fair market cost from Health Care Blue Book and Truven

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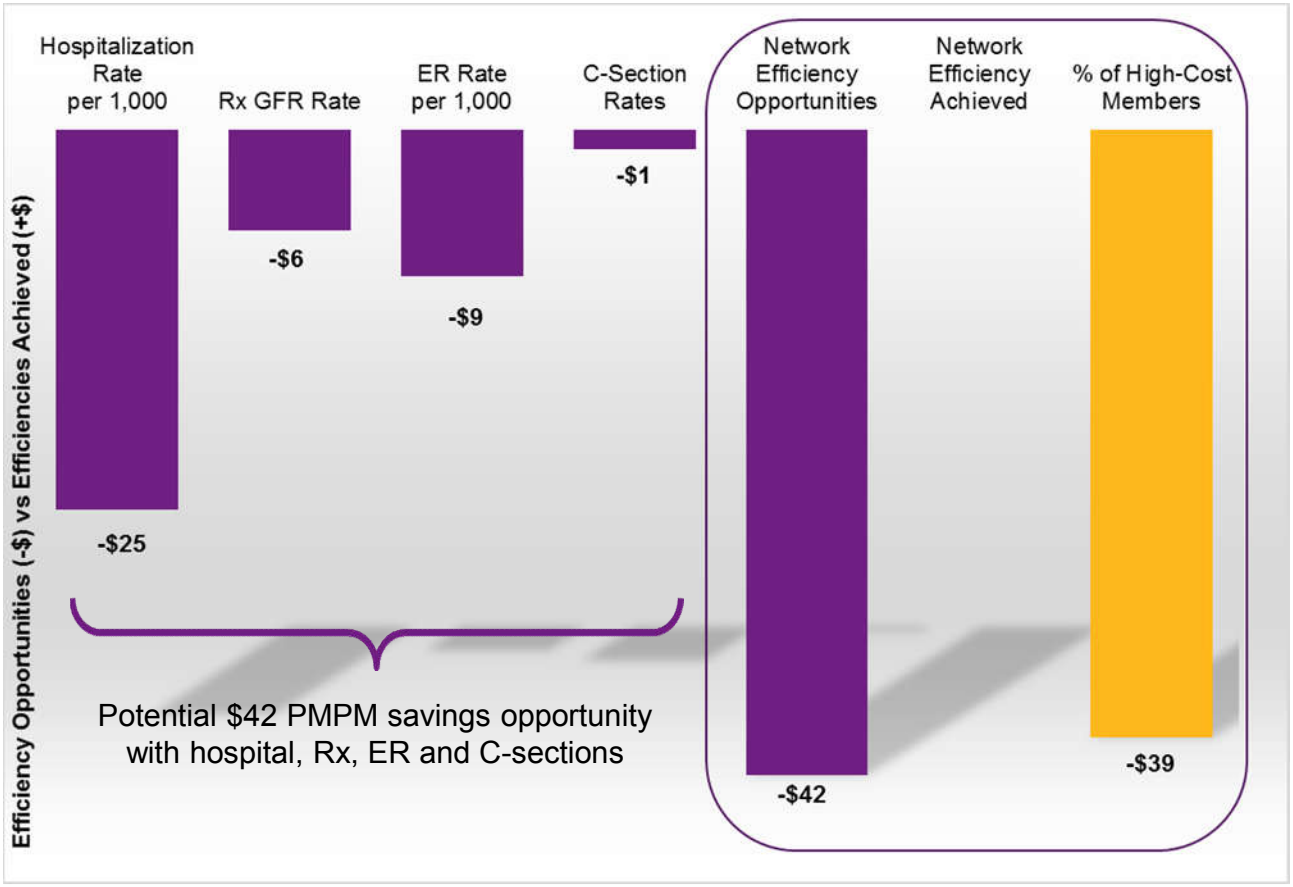
What are the Potential Cost Saving Opportunities of Improving PEB Program Provider Network Efficiency?

Key Network PMPM Efficiency Compared to Best-in-Class*



- -$42 PMPM in network efficiency compared to best-in-class (potential $141M savings)
- HCC members represent 36% of medical costs and 1.4% of members
  - Ideally, HCCs should be 30% of total costs and 1.0% of members

*Assumes average national cost or fair market cost from Health Care Blue Book and Truven

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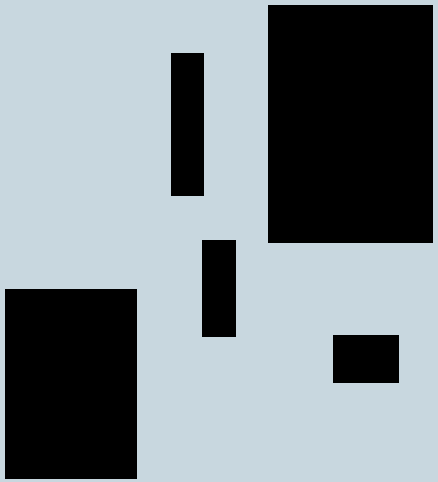
Recommendations and Next Steps



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Potential Next Steps

Medical/Pharmacy Programs Scorecard by Provider

Variable	Health Systems			Next Steps
Key utilization metrics (#, $ and diagnoses)	**UMP**	**GH**	**KP**	
1. Admits/1,000	**53.93**	**52.80**	**59.06**	▪ Compare and contrast rates between carriers ▪ What process and or policy creates better numbers ▪ Get carriers together to discuss best practices ▪ Create incentives for process improvement
3. Readmits and serial admissions	**3.79**	**3.63**	**6.55**	
4. Generic fill rates	**87.91%**	**88.26%**	**83.99%**	
5. Specialty drug	**ND**	**ND**	**ND**	
6. Radiology	**ND**	**ND**	**ND**	
7. ER/1,000	**161.06**	**136.09**	**122.43**	
8. Urgent care/1,000	**ND**	**ND**	**ND**	
9. C-section rates	**30.8%**	**25.0%**	**16.7%**	
10. High-cost claimants	**1.5%**	**1.3%**	**1.3%**	
11. Care management engagement	**ND**	**ND**	**ND**	

= Best Practice **= Market Average** **= Opportunity** **= Insufficient or No Data**

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Summary

Top Recommended Changes Based on the Network Efficiency Data (i.e., Cost Reduction Opportunities)

#1	**Reduce Hospital Admissions**
	▪ Find hospitals with high 30-day readmits and serial admits (>3 admits/member/year)
	  ▪ Determine if different venues of care offer more value (ASCs, birthing centers, non-facility Rx infusion)
	  ▪ Determine if care can be improved (high chemo dose and sepsis management)
	▪ Dependent on findings create incentives, MOUs and guarantees for improvements

#2	**Decrease High-Cost Claimants** ▪ Similar and related to hospital recommendations — determine venues of care, conditions and providers with opportunities to decrease HCC cost and numbers ▪ E.g., COE steerage, identification of poor practices, better network management and discussions with key health systems with gaps

#3	**Reduce Emergency Room Overuse**
	▪ Determine whether members and ERs have preventable ER visits (>5 ER visits/member/year and opiate seeking ER use)
	  ▪ Communicate with members on better use of ER services
	  ▪ Work with PCPs and health systems on same day/next day appointments and weekend access
	▪ Work with ERs and WSHCA on determining causes for high ER use

#4	**Improve Generic Fill Rates** ▪ Work with PBM to find prescribers with brand-only preferences when generic are options

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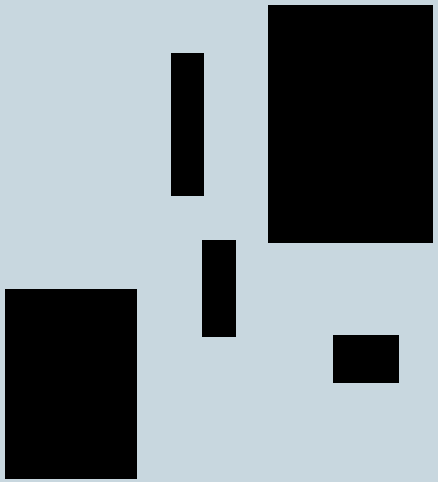
Appendix



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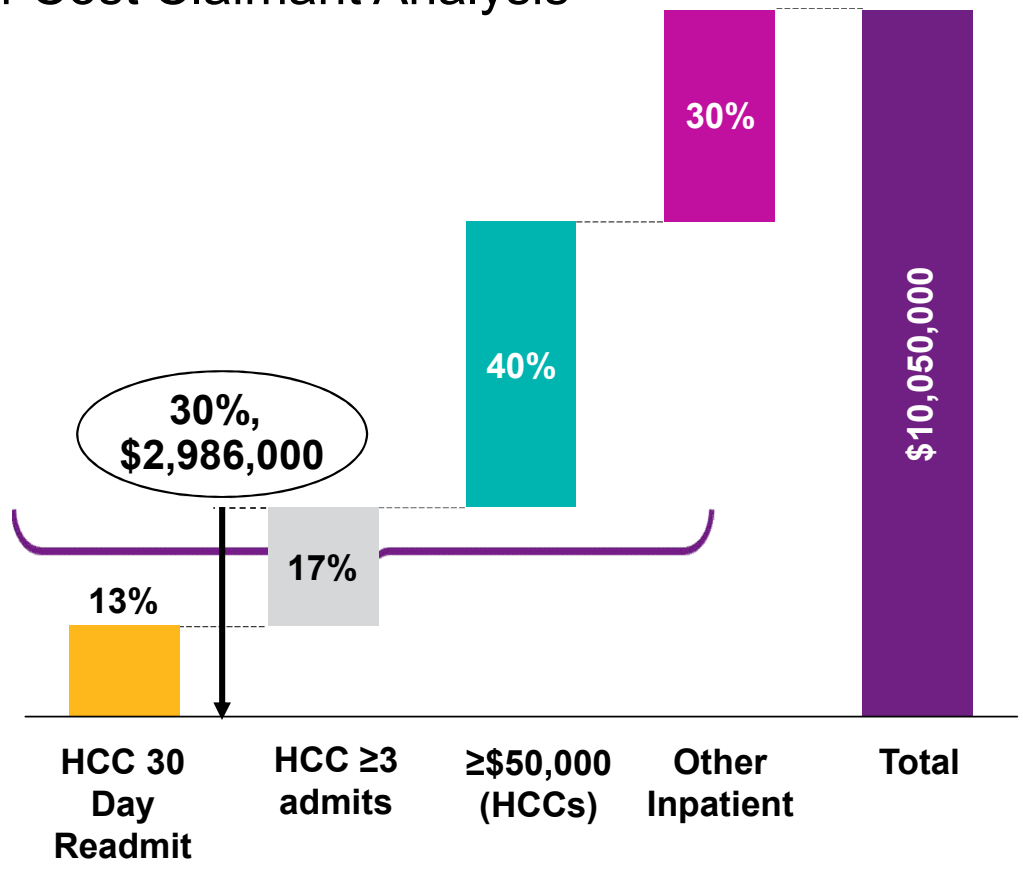
Example of HCC Review: Value-Based Purchasing Opportunity Analysis

High-Cost Claimant Analysis



- Analysis at population level
- Review of at-risk members
- Determine whether care management is targeting higher-risk members
- Review of top providers

- Willis Towers Watson has a tool to review high-cost claimants for prevention opportunities:
  - Preventable hospitalization and readmissions
  - Excessive ER use (>5 per year per member)
  - Excessive radiology use (>3 scans per year per member)

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