



# ESTABLISHING A HIGH QUALITY, VALUE-DRIVEN HEALTH CARE SYSTEM IN WASHINGTON STATE

## Executive Summary

Washington state health care spending increased from \$2.7 billion (or 21.7 percent of state spending in FY 2000) to \$4.8 billion (28.5 percent of state spending in FY 2007).<sup>1</sup> Such dramatic increases put significant pressure on the state budget and, consequently, are eroding funding for priorities such as education and infrastructure. At the same time, there is no clear evidence the state is achieving health care quality and outcomes commensurate with its investment.

Washington state is making progress on the cost side. For example, state spending on public employee benefits rose 11 percent in 2005. The state successfully reduced that growth rate to a projected three percent in 2008.<sup>2</sup> The reduction resulted from decisions to limit the number of health plans offered to state employees and improved negotiations with insurance providers. The Roundtable applauds these efforts. However, the long-term growth trend in state health care spending remains daunting and much more work is needed to contain costs and reduce the growth rate.

Important efforts to improve health care quality are taking place in our state as well. Two examples are re-engineering efforts at Virginia Mason Medical Center in Seattle and the Puget Sound Health Alliance's efforts to promote transparency related to health care quality and cost. Innovative work like this is needed at the state level to improve health outcomes by rewarding quality and increasing efficiency in what today is an underperforming health care sector.

This white paper sets forth four principles that will serve as the foundation of the Roundtable's work to assist policymakers in efforts to improve health care quality, reduce cost growth and stabilize state funding for key priorities like education and infrastructure.

## Principles for high quality, value-driven health care:

- **Create best-in-class care management programs.**

Currently, the state does not have a mix of care intervention programs that effectively addresses the needs of the 15 percent of the population that account for 85 percent of claim costs. Most of this population suffers from chronic conditions, yet they must navigate a system designed for essentially healthy individuals. Targeting this population with a continuum of integrated care management programs – including services, appropriate incentives, measurements and evaluation – will focus treatment and improve prevention by modifying behavior.

- **Re-engineer health care delivery.**

A wide body of research indicates that health care delivery in the United States is sub-optimal, with anywhere from 30 to 50 percent of health care dollars being wasted on inappropriate or unnecessary medical care. Washington state should take a proactive role in re-engineering the delivery of health care to promote efficiency and quality. The state can learn from successful efforts already under way in the private sector.

- **Promote value-driven health care.**

In 2006, U.S. Health & Human Services Secretary Michael Leavitt challenged private and public health care purchasers across the country to implement “four cornerstones of value-driven health care.” Through this voluntary effort, employers in more than 25 states and regions, including a number of state health care plans, have committed to (1) support development and use of health information technology standards, (2) promote public reporting on health care quality, (3) promote public reporting on price, and (4) implement incentives to use high-performing providers.<sup>3</sup> The Roundtable has endorsed this approach. It brings valuable information to the consumer and mitigates the negative effects of misaligned reimbursement incentives.

- **Align state spending on employee health care with that of comparable purchasers and pursue opportunities to improve return on investment for K-12 health dollars.**

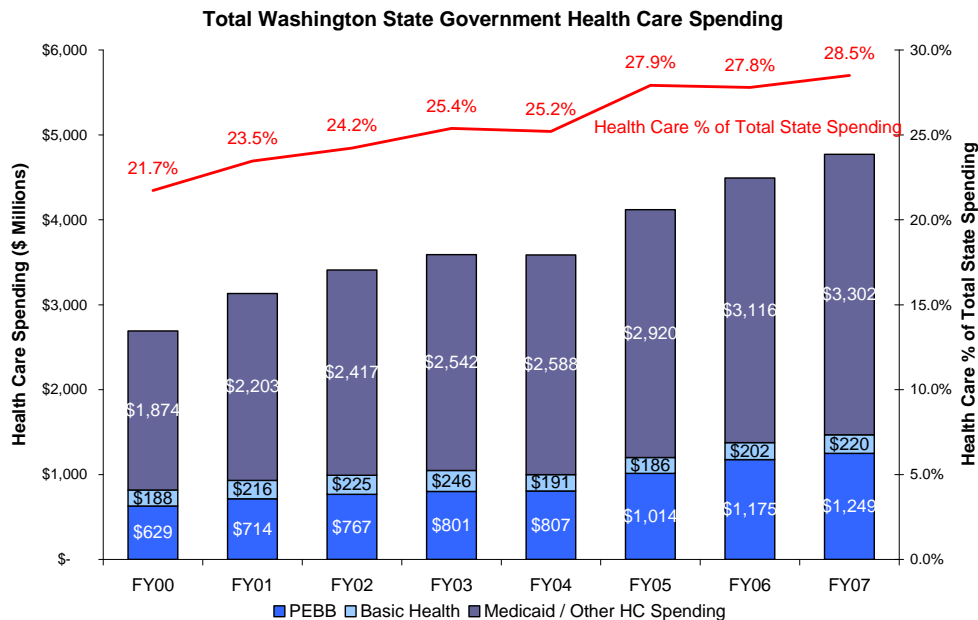
Washington state's contribution to employee health care is more generous than that of peer states and large private sector purchasers. As the state works to improve health care quality, it should simultaneously strive to better share the cost burden through increased employee contributions. Aligning Washington state's contribution to employee health care with the national comparable median of state contributions could save the state \$210 million per biennium.<sup>4</sup>

The state can realize potential efficiencies and savings through better management of K-12 health dollars as well. One option is to require K-12 employees to enroll in health care coverage through the state's Public Employees Benefits Board (PEBB). All other state employees are enrolled under PEBB and consolidation would reduce administrative burden. More significantly, it would provide policy advantages by allowing for a unified vision and purchasing strategy for public employee health care. A comprehensive audit of K-12 health dollars would provide data upon which to better analyze the potential impacts of policy changes and drive future efforts.

## Background

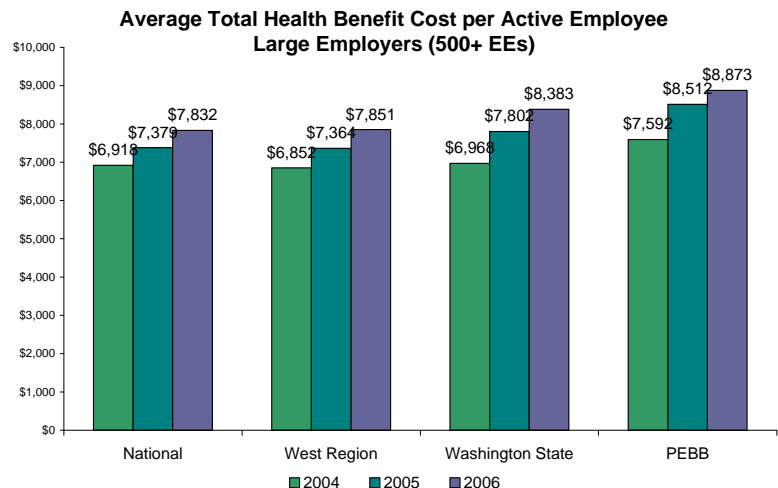
In March 2005, the Washington Roundtable released a policy brief, "A Review of Washington State Health Care Costs," highlighting the rate of increase in health care spending as the greatest budgetary challenge facing Washington state. With rates of increase exceeding 10 percent per year, state health care spending growth was fast outpacing state revenue growth and, consequently, consuming a larger portion of the state budget.

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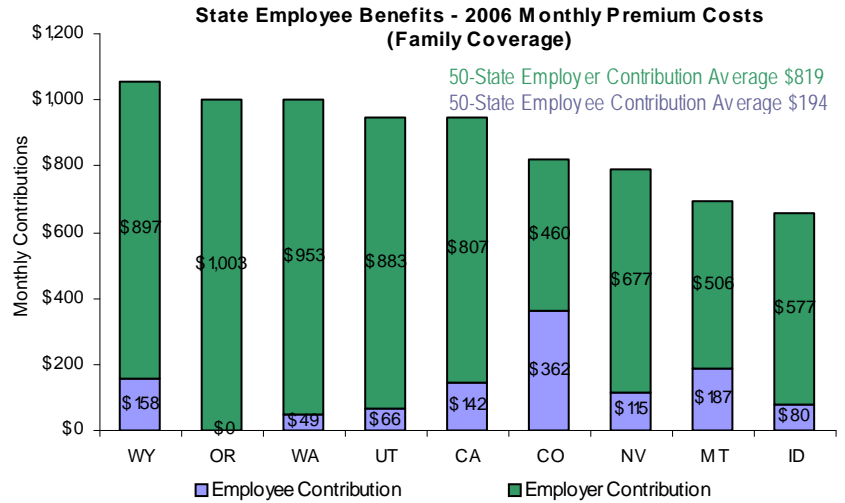


Washington's growth in health care spending relative to other expenditures has moderated since publication of the Roundtable brief in March 2005. However, as compared to the 50 states, Washington continues to be an outlier in spending on state employee health benefits and Medicaid, which comprise the lion's share of state health care expenditures.

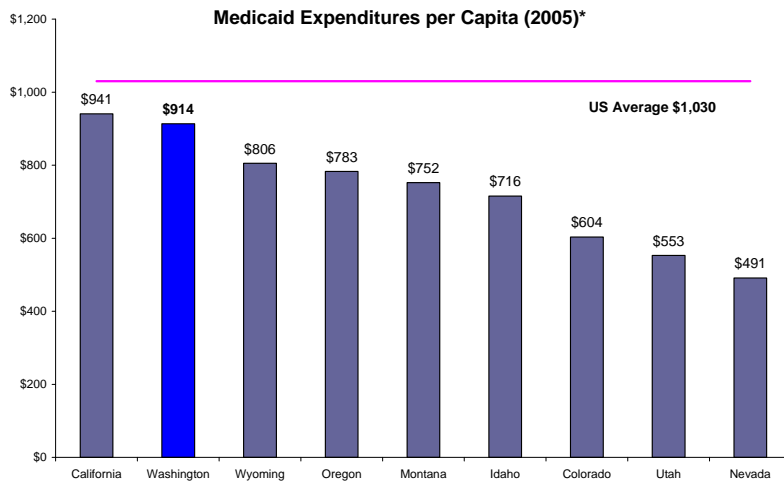
- Washington state employee health benefit costs are higher than those of employees in large, private firms.** Washington state employees covered by the Public Employees Benefits Board (PEBB) had average total health benefit costs in 2006 that were 5.8 percent greater than per employee costs of other large employers in Washington state.



- Washington state employees contribute considerably less to their health care coverage than the average of state employees across the country.** Nationwide, the average monthly contribution of state employees for family health care coverage was nearly four times that of the \$49 monthly contribution made by Washington state employees in 2006.
- Washington state per capita costs for Medicaid ranked second among the nine western states in 2005.** Higher per capita expenditures results in Medicaid comprising a larger percentage of the state's general fund. In 2004, Washington devoted 21.2 percent of its general fund to Medicaid spending.



Source: National Conference of State Legislators Health Program



Source: Kaiser Family Foundation, US Bureau of the Census

*Long-term solutions must be implemented to contain costs.*

In 2006, the Washington State Legislature created the Blue Ribbon Commission on Health Care Costs and Access to develop consensus around measures to address cost issues and improve health care quality. The broad consensus approach resulted in a lack of defined expectations, cost and implementation strategies.

Traditionally, when confronted with the need to reduce health care spending, states cut back programs, shift costs to participants or limit eligibility. These tactics provide cost relief in the short-term; however, program reductions and eligibility caps also tend to increase the number of uninsured individuals. This results in more uncompensated care, which drives up insurance premiums and shifts the cost burden to private employers. Clearly, longer-term solutions must be implemented to contain costs.

This paper describes four principles that the Roundtable has adopted to guide its state health policy efforts. The first three examine the underlying drivers of rising state health care costs and provide recommendations for addressing those drivers and improving health care quality and outputs over the long-term. The fourth principle examines the impact of rich state employee health benefits in Washington, curtailment of which could yield immediate savings and enable the state to better protect core funding for other priorities.

**Principle 1: Create best-in-class care management programs.**

Private employers consistently find that approximately five percent of their employees are responsible for half of their health care costs and 15 percent of employees account for 85 percent of costs. This is also true for enrollees in Washington state’s PEBB and Medicaid programs.

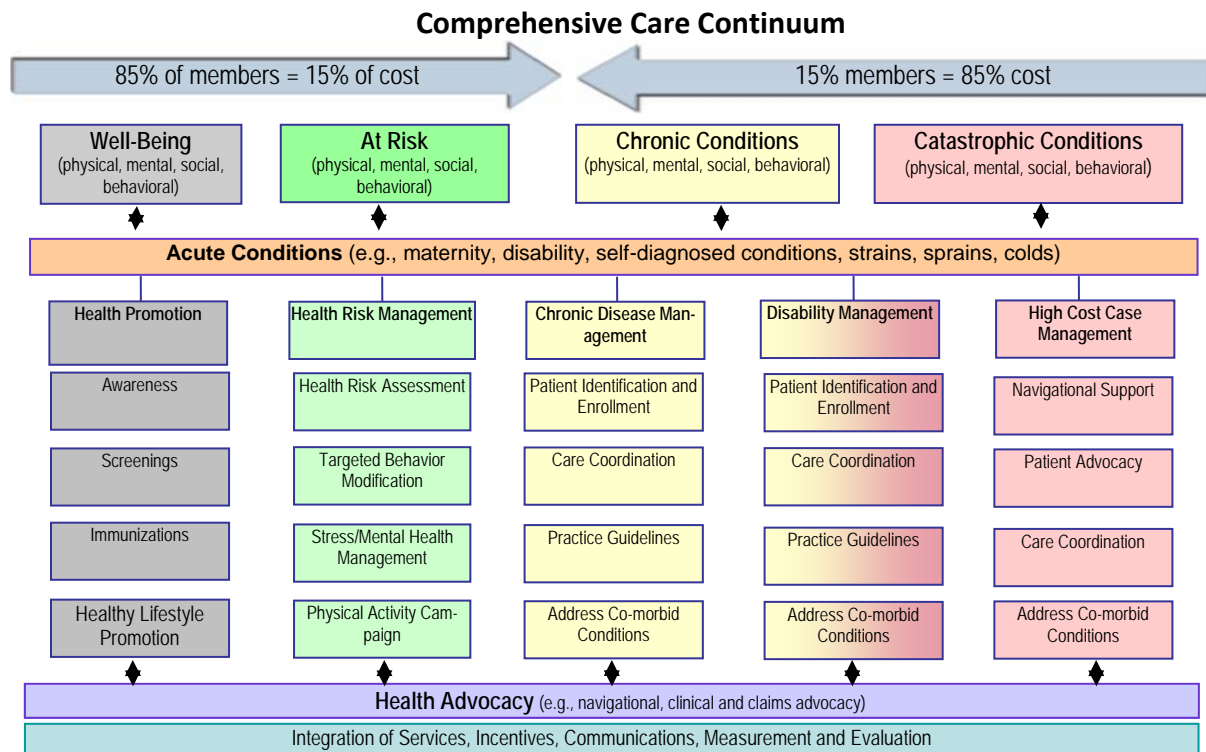
Most of the demand for health services is concentrated in care for chronic conditions such as heart disease, cancer, stress, depression and obesity. In recent years, private employers have targeted their high-cost, chronically-ill populations with disease management programs. (Disease management can be defined as reducing health care costs and improving quality of life for individuals with chronic disease conditions by preventing or minimizing the effects of a disease through integrative care.) Mercer Health & Benefits’ 2006 *National Survey of Employer-Sponsored Health Plans* found that 65 percent of large employers (500+ employees) offer such programs.

Disease management programs have been available long enough to permit compilation of a significant body of evidence confirming their effectiveness. Current studies indicate that well-run programs can produce returns on investment ranging from 1.2:1 to 1.8:1.<sup>5</sup>

Despite demonstrated return on investment, Washington state has been slow to adopt disease management.

- The state’s Medicaid program offers programs targeting congestive heart failure, diabetes, chronic obstructive pulmonary disease, asthma and chronic kidney disease (CKD) through two vendors. Participation ranges from 14 to 25 percent of eligible enrollees depending on the program. (All Medicaid enrollees identified with chronic kidney disease participate in the CKD program.)
- The state Health Care Authority (HCA) intends to implement its first disease management programs for PEBB enrollees this year.
- No centralized disease management programs are offered to Basic Health Plan members.

Disease management and case management tackle chronic and catastrophic conditions at one end of the comprehensive care continuum. At the other end, health screenings, immunizations, health risk assessments and other activities promote well-being and reduce health risks. To be successful, the continuum needs an overarching integration of services, incentives, employee communications, measurement and evaluation. This includes adequate funding based on a reliable ROI and accurate participation numbers.



Source: Mercer Health & Benefits

During the fall of 2005, the state convened a task force to recommend a comprehensive health promotion program for state employees, their families and retirees. The task force identified the attributes that would characterize a best practice health promotion program, including:

- Evidence-based design and evaluation metrics, including return on investment.
- Emphasis on long-term behavior change among participants.
- Provision of incentives to motivate behavior change.
- Continuum of wellness-to-chronic disease prevention activities.
- Inter-agency coordination of services and communications.

Although the task force initially recommended three short-term and relatively modest programs – smoking cessation, on-site flu shots, and stair reminders – it is not clear if the programs were funded or implemented.

State agencies offer a hodge-podge of care intervention programs designed to control costs and improve quality of care for select populations. These programs range from the aforementioned Medicaid disease management programs, to a narcotic review program targeted at Medicaid enrollees who utilize multiple prescription narcotic drugs, to a pilot program for people with diabetes and depression co-morbidity. When reviewed as a whole, these programs demonstrate several shortcomings:

- **No program addresses the full-care continuum.** No agency offers an integrated program that encompasses health promotion, risk reduction, chronic condition management and case management. In 2008, the state Health Care Authority (HCA) will provide some PEBB members with smoking cessation, health risk appraisal, disease management, and case management for the first time.
- **The programs are not well aligned with the disease burden of the state's insured populations.** Analysis of Medicaid and HCA populations has identified oncology, cardiovascular, musculoskeletal and mental health/substance abuse as the most costly conditions for state-funded programs. Of these four conditions, only cardiovascular is addressed by an existing disease management program (Medicaid's Congestive Heart Failure disease management program).
- **Efforts to address patients with co-morbid diagnoses are limited.** Best-in-class programs tailor interventions to address the most problematic co-morbid conditions. However, a pilot program for diabetics with depression is the only state program that addresses a specific co-morbid condition. The PEBB is attempting to address this shortcoming through development of its disease management request for proposal.
- **Predictive modeling is not used.** Best-in-class interventions not only focus on identifying those individuals in the five percent of the population that accounts for 50 percent of state health care costs, but focus on those who are most likely to become the future five percent as well. However, current state intervention programs make virtually no effort to prevent at-risk clients from becoming high-cost users. Targeting at-risk clients would offer a significant opportunity for cost savings by

providing members with tools that facilitate health improvements and minimize downstream expenses. A focused strategy to implement a single collection point for health care data and a sophisticated decision support system would support more informed program initiatives.

- **Programs often exist in silos.** There are few examples of genuine efforts to coordinate programs across different Washington state agencies. For example, the state's Medicaid population is notoriously volatile, as individuals go on and off enrollment from month to month. Consequently, they drop in and out of intervention programs. Programs that fail to bridge these gaps have limited ability to produce long-term behavior changes or health improvements in the variable portions of their populations. Best-in-class interventions coordinate between agencies where population exchange is frequent.
- **Education and communications efforts are not sufficient to achieve desired behavior among state populations.** The state needs to continually reinforce the link between behavior, lifestyle and personal health status through a program of personalized education and communication. It should use a variety of media – including personalized health portals – to drive targeted, concise, creative and engaging messaging.
- **Programs must use risk adjusted data to drive decision making and improve performance.** Both Medicaid and the HCA use performance guarantees and outcomes measures in vendor contracting; however, both fail to require return-on-investment guarantees. Best-in-class interventions use standardized measurement and evaluation based on research-tested methodology and process, outcomes and financial performance guarantees to drive vendor improvement.

The Blue Ribbon Commission on Health Care Costs and Access recommended that the state “become a leader in the prevention and management of chronic illness” (Recommendation #2) and “integrate prevention and health promotion into state health programs” (Recommendation #16).<sup>5</sup> To accomplish these recommendations, the Commission urged the appropriate state agencies to:

- Integrate proven chronic care management into all state programs.
- Require enrollees with chronic conditions to participate in such programs.
- Structure benefits and reimbursement in all state insurance programs to promote health choices and disease and accident prevention.
- Require enrollees in the Basic Health Plan to complete a health assessment, and provide appropriate follow-up.
- Reimburse cost-effective prevention activities.
- Develop prevention and health promotion contracting standards.
- Strengthen the state’s employee wellness program.<sup>5</sup>

Prior to funding and implementing these initiatives, the legislature should require a detailed review of the implications and return on investment. It is important these approaches be thought through and clear expectations put in place.

In the near-term, the state has a unique opportunity to leverage efforts that are beginning to take shape at the University of Washington’s Institute for Health Metrics and Evaluation. The Institute is pursuing a pilot project to benchmark health care performance statewide by assessing improvements that result from new health care interventions in the state’s 39 counties. This effort will enable the state to chart trends across the counties and drive subsequent health care quality improvements. The state committed to a start-up funding for this effort in the 2007-09 biennial budget. Further public support, which augments significant levels of private funding, would be in the state’s best interest.

*The state has a unique opportunity to leverage efforts that are beginning to take shape at the University of Washington’s Institute for Health Metrics and Evaluation.*

## Principle 2: Re-engineer the delivery of health care services.

Numerous studies have concluded that health care delivery in the United States is sub-optimal. Researchers at the Dartmouth Medical School estimated that one of every three dollars spent on health care in the United States is wasted on unnecessary or inappropriate medical care.<sup>6</sup> Studies at the Boston University School of Public Health found even greater inefficiency, determining that as much as one-half of health care spending can be attributed to waste, excessive pricing and fraud.<sup>7</sup> Further, the Rand Corporation study “How Good is the Quality of Care in America” concluded that only 55 percent of patients receive recommended care.<sup>8</sup>

### Sub-optimal health care delivery has enormous costs, both financial and personal.

In 1999, with the publication of *To Err is Human*, the Institute of Medicine grabbed the country’s attention with its finding that medical errors in hospitals kill as many as 98,000 Americans and cost more than \$17 billion dollars annually.<sup>9</sup> Later studies have indicated the number of deaths could be twice as high. Research conducted in recent years concluded that more than 50 percent of patients with diabetes, hypertension, congestive heart failure, asthma, depression and other chronic conditions are managed inadequately. Many of these patients suffer avoidable complications or die prematurely.

### Failure in Care Leads to Complication & Premature Death

Condition	Shortfall in Care	Avoidable Toll
<i>Diabetes</i>	Average blood sugar not measured for 24%	2,600 blind; 29,000 kidney failure
<i>Hypertension</i>	<65% received indicated care	68,000 deaths
<i>Heart Attack</i>	39% to 55% didn’t receive needed medications	37,000 deaths
<i>Pneumonia</i>	36% of elderly didn’t receive vaccine	10,000 deaths
<i>Colorectal Cancer</i>	62% not screened	9,600 deaths

Source: Elizabeth McGlynn et al, RAND, 2004

Underperformance in health care can be attributed to many causes:

- Employer-based health insurance insulates consumers from price and results in a consumer perception of value divorced from the cost of care. The result is a dysfunctional market that, in most instances, is immune to functional market attributes.
- Purchasers focus on discounted health care and unit costs without recognizing the cost impact of overuse, under-use and misuse of health care services.
- The “mom and pop” organization of physician practices results in under-capitalization and prevents ongoing investment in health information technology and other necessary improvements.
- The current reimbursement system tends to pay all providers equally regardless of quality or efficiency.

### Sustained cost containment depends on more efficient care delivery.

In a 2002 report to the National Business Roundtable, Mercer Health & Benefits presented the case that more efficient care processes, treatment options and providers would address health care’s under-performance and cost inflation. Health care economists and researchers engaged by Mercer concluded that traditional approaches to cost containment, such as more efficient plan administration or leaner coverage options, could yield at best four to six percent static savings. Implementing more systemic solutions could yield as much as 15 to 17 percent savings year over year.

The current health care delivery system is more suited to serve the basically healthy individual, who has an acute problem, rather than the chronically ill person who requires customized attention. The sickest, most frequent users — the five percent of patients who account for at least 50 percent of costs — are perhaps the least well served by this system.

Patients with complex or multiple health concerns face a delivery system characterized by:

- Primary care physicians with untenably large caseloads.
- Office visits limited to 12 to 15 minutes.
- Provider access largely limited to office hours.
- Inconsistently applied evidence-based “best practice” medicine.
- Complex navigation to specialists.
- Care focused on responding to immediate needs rather than preventing downstream hospitalization.
- No advocate for comprehensive, high quality, efficient care.
- A significant number of provider organizations and individual providers wedded to the status quo.
- Medical school training that is out of step with the reality of the contemporary practice of medicine.

Redesigned care for patients with complex or multiple health concerns — care that relies on robust IT systems, consistent use of evidence-based medicine, dedicated high performing physicians and integrated services across disciplines — would be a key advance in correcting under-performance in health care delivery.

A number of projects throughout the country are testing re-engineering concepts to drive more efficient care delivery.

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**Success Headlines by US Medical Systems**

<b>Headline</b>	<b>Location</b>
Percent of patients with all medications reconciled on admission rose from 47% in 2005 to 99% in 2006.	Contra Costa Regional Medical Center, Martinez, CA
95% of patients’ hospital medical records are free of medication reconciliation errors.	University of Massachusetts Memorial Medical Center, Worcester, MA
Average ambulance diversion time in the ED decreased from 82 hours per month in 2005 to 6 hours per month in 2006.	Shawnee Mission Medical Center, Shawnee Mission, KS
Wasted capacity in the ED decreased from 23% to 10%.	Hackensack University Medical Center, Hackensack, NJ
Mortality from heart attacks decreased from 7.9% in 2004 to 4.5% in 2006.	East Alabama Medical Center, Opelika, AL
Dispensing errors in the pharmacy reduced by 40%.	Metropolitan Hospital, Grand Rapids, MI
Time to first medication dose reduced from 92 minutes to 7 minutes.	McLeod Regional Health System, Florence, SC
\Wait for CT scans reduced from 3 weeks to same day.	ThedaCare, Appleton, WI

Source: Self-reported to the Institute for Healthcare Improvement through March 2007

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Seattle’s Virginia Mason Medical Center has received nationwide attention for a new management method designed to improve quality, eliminate waste and reduce costs. The Virginia Mason model rejects the idea that defects and poor quality are acceptable at any point in the value stream. Success at Virginia Mason indicates that efforts to re-engineer care delivery can significantly reduce costs while improving quality and throughput.

### Re-engineering at Virginia Mason Medical Center:

With more than 400 physicians and 5,000 employees overall, Virginia Mason (VM) is one of the largest health care providers in the Central Puget Sound region, garnering net patient services revenues of \$590 million in 2006.

During a research trip to Japan in 2001, VM leaders realized that the processes employed throughout the hospital and clinic were not always conceived or implemented with the patient in mind. They set out to re-engineer the delivery of health care by employing a new management method modeled after the Toyota Production System. The effort has resulted in dramatic gains. Some examples:

- Reduced lead-time between diagnosis and treatment of breast cancer by 50 percent.
- Reduced the average time patients wait from arrival to the medical center until the start of chemotherapy infusion by 2.5 hours (63 percent reduction).
- Reduced the number of ventilator acquired pneumonia cases from 40 in 2000 to three in 2006.
- Increased the net margin per room for GI/endoscopy by 48 percent from 2001 to 2005. Improved efficiency also eliminated the need for additional procedure rooms, netting an estimated savings of \$2 million in capital costs.
- Reduced the time it takes to report lab test results to the patient by more than 85 percent.
- Freed an estimated 25,000 square feet of space by using a different approach to facility design.
- Saved \$11 million in planned capital investment.
- Reduced inventory costs by more than \$1 million.
- Reduced staff walking by 60 miles per day.
- Reduced labor expense in overtime and temporary labor by \$500,000 in one year.

The results at VM are remarkable. It has not come without challenges as systemic change is always difficult. However, the net result is a workforce more engaged and empowered, an improved patient experience and higher quality health care that delivers on value.

Like other health care purchasers, Washington state cannot hope for a sustained reduction in health care costs without reducing inefficiencies and waste. The state should learn from successes across the nation and take an active and preeminent role in promoting re-engineered health care delivery. The state has several opportunities:

- As the largest purchaser of health care in Washington, state government has leverage to recognize and reward re-engineered health care delivery.
- Leveraging its role as a funder of community clinics, the state HCA could develop pilot projects to re-engineer primary care delivered at those clinics.
- There is potential to leverage research and engineering programs at state universities to increase understanding of health care re-engineering and train the next generation of physicians, engineers and health care administrators in re-engineering principles.

*Re-engineering yields a more engaged and empowered workforce, an improved patient experience and higher quality care that delivers on value.*

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### Principle 3: Promote value-driven health care as a means for improving quality and value in the delivery of patient care.

Consumers are insulated from information about the quality of health care services and, consequently, have little information on which to base health care decisions. For the most part, they cannot compare the price they (or their insurance company) will be charged for a hospital stay or a physician office visit. Consequently, they often underestimate the costs of health care services or do not take cost into account when seeking service.

Further, consumers have little information upon which to rate quality of care. It is difficult, if not impossible, to determine if one surgeon has better outcomes than another or if a primary care physician adheres to best practices for the treatment of common illnesses. Further, patients cannot determine if the hospital recommended by their physician has fewer hospital-based infections. This type of information is rarely compiled or made readily available to the public.

Without quality and price information to inform consumer decisions, the health care system will not be stimulated to improve quality or value.

At the national level, the Department of Health & Human Services is championing reforms that will fill the information void by creating a value-driven health care system that “provides consumers with the information necessary, and the incentive, to choose health care providers based on value.” The agency has challenged health care purchasers in the public and private sectors to implement what it calls the “four cornerstones of value-driven health care.”<sup>10</sup> Washington state accepted that challenge, both with a pledge from Governor Gregoire and by incorporating the following cornerstones into the work of the Blue Ribbon Commission:

**1. Support health information technology standards that make it possible to share medical records securely.**

Health care cannot be improved until good health information is portable, well-structured, standardized and secure. David Brailor, national coordinator for health information technology, has noted that health care has not shared in the productivity gains other industries have generated through extensive use of information technology. Manufacturing, retail, food production, insurance and financial services have all added value to their goods and services during the last two decades because of advances in information technology. Health care has not. Interoperable health information technology promises to enable the exchange of clinical data and to create greater efficiency in health care delivery by eliminating significant redundancy of services and by providing data to measure and improve the quality of care.

**2. Support transparent, public reporting regarding the performance of doctors, hospitals and other providers.**

Consumers need information regarding health care quality to make informed decisions. This information is important to providers interested in improving the quality of care they deliver. It also is necessary for health care purchasers to drive quality improvements.

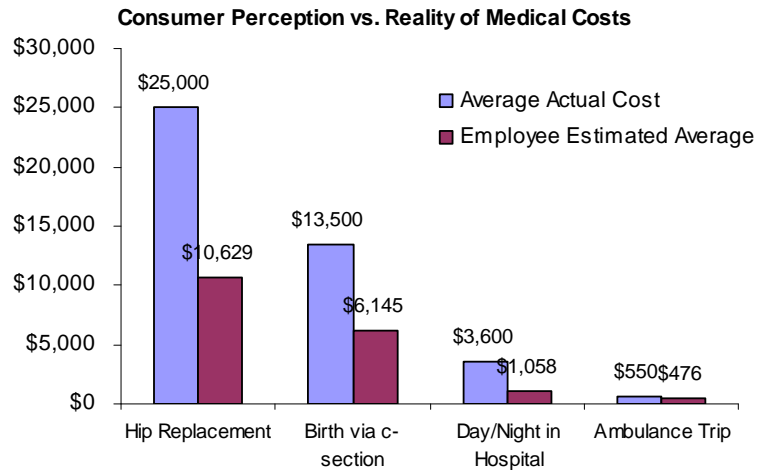
In recent years, national consensus-based organizations have begun developing the standardized quality measurements necessary for consistent reporting and benchmarking of provider performance. For example the AQA (formerly the Ambulatory Care Quality Alliance) published a starter set of 26 measures of physician quality while the Hospital Quality Alliance issued measures for five areas of hospital quality—acute myocardial infarction, health failure, pneumonia, surgical infection prevention and patient experience. Establishing consensus-based standards across the range of physician specialties and conditions treated in a hospital will require years of effort.

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**3. Support transparent, public reporting about the costs of health care services.**

Health care prices are opaque. Most consumers have no sense of the cost of health care. A study by Lehman Brothers demonstrated that consumers undervalued the cost of common procedures and services, such as a hip replacement or a day in a hospital bed, by as much as 300 percent. It is not surprising that with the lack of published health care cost information, consumers do not have a grasp of costs. However, with the rise of consumer directed health plans, consumers need to know and understand the cost of their health care to be able to wisely manage their health care accounts.

National health carriers such as Aetna, CIGNA and United Healthcare have implemented pieces of price transparency in select markets, but no one offers both hospital and physician pricing. For example, United Healthcare provides hospital cost information for 54 procedures on its web site. Aetna, on the other hand, targets physician cost information for 12 medical specialties. Eventually, carriers will need to compare providers on efficiency, not simply unit pricing. Total costs are a function of unit pricing and volume; involve multiple services delivered by hospital, physician, and ancillary providers; and are dependent on patient acuity of illness. Because of this, carriers will need to agree on standardized methodologies of price comparison for consumers to be able to benchmark their hospital or physician costs.



Source: Lehman Brothers, Health Insurance & Consumerism, May 2006

**4. Support incentives for quality and value in health care services.**

Two powerful disincentives for enhancing quality and reducing costs are embedded in the employer-based health insurance system.

First, the current reimbursement system, especially for physicians, does not reward quality, efficiency or innovation. Fee-for-service medicine pays the same regardless of outcome. Innovation is discouraged because payments are based on units of service, not value. In fact, the current payment approach rewards the less efficient.

Second, with traditional insurance policies covering almost all costs, consumers are indifferent to the cost of the care they demand or the efficiency or quality of the provider they choose. At worst, by insulating consumers from the costs of their health care consumption, employer-based health insurance indirectly encourages obesity, smoking and other risky behaviors.

Companies can provide incentives for quality and value in a variety of ways, such as:

- Encouraging beneficiaries to use providers with higher quality and lowest cost.
- Offering providers incentives and rewards for delivering high-value care.
- Providing beneficiaries with incentives for prevention, wellness and self-management of chronic illness.
- Offering consumer-directed health plan products.

Incentives alone will not drive value in health care. Interoperable health information technology, quality transparency and cost transparency, along with incentives, will be required before companies can use value to purchase health care.

Incorporating the four cornerstones of value-driven health care into its work, the state’s Blue Ribbon Commission on Health Care Costs and Access based its recommendations on four strategies; the first of which is to build a high-quality, high performing health care system that uses “information and incentives to assure a system in which every dollar spent goes only toward the most appropriate, higher quality treatment delivered in the most cost-effective way.”

Among its 16 recommendations, the Commission directed the state to:

- use its purchasing power to improve health care quality,
- provide cost and quality information for consumers and providers, and
- deliver on the promise of health information technology.

To accomplish these recommendations, the Commission highlighted such actions as rewarding health outcomes rather than paying for a particular procedure, directing enrollees to quality care systems, developing a sound set of measures allowing consumers to compare provider cost and quality, and encouraging the development of a system to provide electronic access to patient information from anywhere in the state.

The Commission has provided the roadmap for the state HCA and other agencies to enact the principles embodied in the four cornerstones. The HCA's membership in the Puget Sound Health Alliance – a collaborative of health providers, payers, business interests and local government working to improve health care quality and reduce the rate of cost growth in five counties in Western Washington – will provide one avenue to advance transparency and value-based health care in Washington.

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**Principle 4: Align state spending on employee health care with that of comparable purchasers and pursue opportunities to improve return on investment for K-12 health dollars.**

The Community Tracking Study – a large-scale investigation of health system change funded by the Robert Wood Johnson Foundation – documents multi-year trends in the public sector and compares them with developments in private employee health care. In 2005, the study found that “public employers have faced budget pressures threatening the health benefits for their employees. Public employers are responding with a range of noteworthy, yet relatively modest, changes in cost-sharing, product offerings, and benefit design. At the same time, a number of policy and market factors, including union influence and strategic budget maneuvering, have helped protect public employees’ benefits during the past few years. Despite their prominence in local markets, public employers’ influence on local health care purchasing and delivery has been muted.”

On the commercial side, escalating health care costs have caused private sector employers to shift more health care expenses to their employees. They have done this in two ways: (1) increasing the employee share of the health care premium (contribution) and (2) increasing employee out-of-pocket payments (deductibles, copays, and coinsurance).

According to Mercer Health & Benefits National Survey of Employer Sponsored Health Plans, large employers (defined as more than 500 employees) increased their employees’ average deductible by 49 percent and their employees’ average physician visit copay by 60 percent from 2000 to 2005. During that time, the large employer average in-network deductible increased from \$277 to \$366 and average office copay from \$10 to \$16.

For most employers, cost shifting may have run its course. In the 2006 Mercer survey, 37 percent of large employers (500+ employees) and 21 percent of jumbo employers (1,000+ employees) indicated that employee cost-shifting will be a significant cost management strategy in the next five years. In the 2008 survey, 40 percent of large employers said they will raise the employee contribution percentage in 2008.

Many private employers are moving onto other cost containment strategies. However, by comparison, the State of Washington has not similarly engaged in cost sharing strategies to reduce the rising burden of health care costs. Nor has the state benefited from the associated cost savings or the improvements that arise when employees are invested in and more aware of health care costs.

Washington state employees pay lower out-of-pocket expenses than employees in large private sector companies. State employees covered by the PEBB had a \$200 individual and \$600 family deductible in 2006; whereas employees of large private sector companies on average paid a \$300 individual and \$750 family deductible on average. Similarly, Washington state employees enrolled in the state’s largest plan pay 10 percent coinsurance for professional services, while employees of large private sector firms pay 20 percent coinsurance.

The argument can be made that public sector compensation and benefits should not be compared to those in the private sector; however, it is more than reasonable to compare and benchmark Washington state employee health benefits against benefits for state employees elsewhere.

*The State of Washington has not engaged in cost sharing strategies to reduce the rising burden of health care costs. Nor has the state benefited from the associated cost savings or improvements that arise when employees are invested in and more aware of health care costs.*

Comparison of PEBB Key PPO Plan Design to Private & Government Employers			
	Private sector	Government	PEBB
<b>Deductible</b>			
Individual amount (median)	\$300	\$300	\$200
Family amount (median)	\$750	\$600	\$600
<b>Doctor's Office Visit</b>			
Coinsurance amount (median)	20%	10%	10%
<b>Hospitalization</b>			
Copay amount (median)	\$250	\$250	\$200
<b>Out-Of-Pocket Maximum</b>			
Individual OOP max (median)	\$2,000	\$1,500	\$1,500

Source: Mercer Health & Benefits

In 2006, Washington state employees paid \$49 of their monthly premiums for family coverage, while the average premium paid by state government employees nationally was \$194. Washington state government employees contributed five percent of their health care premium as compared to an average 19 percent contribution for state employees in all states. By comparison, large private employers nationally required employees to contribute an average 23 percent toward their coverage in 2006.<sup>11</sup>

The HCA has not aggressively pursued employee cost-sharing strategies that are commonplace in other states and the private sector. Mercer Health & Benefits estimates that the state can reduce its share by \$15 million per biennium for each percentage point it increases employees' contributions. Lowering Washington's contribution to the 50-state median would save \$210 million per biennium. Leaner coverage options would achieve less savings per biennium and rely heavily on various benefit reductions. Detailed benefit design scenarios would be required to identify savings.

The HCA has initiated other cost management programs on behalf of its PEBB plans, including:

- Evaluating and re-aligning the PEBB portfolio of health plans.
- Replacing its legacy computer system with a new system designed to improve functionality for managing eligibility, benefits administration and insurance accounting.
- Transitioning to a new administration vendor for its self-insured plans to improve network management utilization, quality, oversight and other administrative features.
- Exploring the feasibility of implementing a high performing network to function on its largest plan's platform.
- Implementing a more aggressive approach to rate renewal negotiations.

The HCA has made progress toward containing spiraling growth with the activities listed above; however, there is opportunity to offer high quality health coverage while also realizing much needed savings through more competitive cost-sharing with employees covered under the PEBB.

In addition to continuing to improve management and coverage for the PEBB population, the state should undertake a thorough review of how K-12 health dollars are spent. Currently, the state spends approximately \$1 billion on K-12 health care per biennium, with purchasing decisions being made at the school district level. A thorough understanding of how those dollars are used will enable better purchasing decisions and improved outcomes. The data will also provide a foundation for analyzing the potential benefits of requiring K-12 employees to enroll in coverage under the PEBB. Consolidation of coverage for the K-12 and PEBB populations would reduce administrative burden and provide significant policy advantages by allowing for a unified vision and purchasing strategy.

*The HCA has not aggressively pursued employee cost-sharing strategies that are commonplace in other states and the private sector.*

*Lowering the state's contribution to employee health care benefits to the 50-state median would save \$210 million per biennium.*

## Conclusion

Washington state has made progress toward containing spiraling health care spending; however, the rate of health care spending growth remains daunting and it is compromising the state's ability to deliver on high priorities such as public education and infrastructure. Meanwhile the quality of the health care product is sub-optimal, with half or more of all health care dollars being wasted or unnecessary.

Clearly, further action must be taken to reduce the growth trend in health care spending, thereby protecting resources for other services, while also improving quality.

To assist in this effort, the Roundtable will:

- Support efforts to implement the Blue Ribbon Commission's recommendations regarding chronic care management, prevention and health promotion. The Roundtable will advocate for a culture among state agencies that demands best-in-class integrated services, incentives, communications, measurements and evaluation.
- Encourage policymakers to assume leadership in promoting health care re-engineering as a means to reduce waste and improve quality. At a minimum, no legislation should be passed that might interfere with the activities necessary to re-engineer health care delivery in Washington state.
- Support efforts to enact health care policy changes aligned with the four cornerstones of value-driven health care.
- Support efforts to promote prevention and wellness programs specifically among populations insured by the state and reduce Washington state's contributions to employee health benefits to the 50-state median contribution. This will encourage state employees to become more aware of how they use health care, ideally placing a greater emphasis on quality, wellness and prevention.
- Pursue a state audit of K-12 health care dollars and explore the benefits of mandating enrollment of the state's K-12 employees in health care coverage provided under the PEBB.

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## Research & Analysis

This report developed in consultation with the Seattle office of Mercer Health & Benefits.