HOUSE BILL REPORT
HB 2565

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to a mutual accountability model for clinical practices and healthy behaviors.

Brief Description: Concerning a mutual accountability model for clinical practices and healthy behaviors.

Sponsors: Representative Rodne.

Brief History:
Committee Activity:
Health Care & Wellness: 1/29/14, 2/3/14, 2/5/14 [DP].

Brief Summary of Bill

- Creates a pilot project for enrollees in the Uniform Medical Plan to test the Mutual Accountability Model in which financial incentives are offered to providers and patients for adherence to best clinical practices and healthy behaviors.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 17 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Clibborn, DeBolt, Green, G. Hunt, Jinkins, Manweller, Moeller, Morrell, Rodne, Ross, Short, Tharinger and Van De Wege.

Staff: Jim Morishima (786-7191).

Background:

The Public Employees Benefits Board (PEBB), an entity within the Health Care Authority, develops benefit plans, forms benefit contracts, develops participation rules, and approves rate and premium schedules for state employees and their covered dependents. One of the benefit plans designed by the PEBB is the Uniform Medical Plan (UMP). The UMP is a self-

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insured preferred provider organization and is administered by a third party administrator, Regence Blue Shield. Enrollees in the UMP are eligible for financial incentives for wellness activities, but there are no encounter-based financial incentive programs for providers.

The Uniform Medical Plan Benefits Administrative Account is a non-appropriated account containing receipts from amounts due from, or on behalf of, UMP enrollees for expenditures related to benefits administration. Moneys in the account may only be used for contracted expenditures for UMP claims administration, data analysis, utilization management, preferred provider administration, activities related to benefits administration where the level of services provided pursuant to a contract fluctuate as a direct result of changes in UMP enrollment, and administrative activities required to respond to new and unforeseen conditions that impact the UMP.

Summary of Bill:

The PEBB must conduct a pilot project for UMP enrollees to test the mutual accountability model (MAM), in which financial incentives are offered to both providers and patients for declaring or demonstrating to one another adherence to best clinical practices and healthy behaviors. At a minimum, the MAM must:

- incorporate evidence-based medicine treatment guidelines and information therapy (defined as providing a patient the right information at the right time to make an informed decision);
- be voluntary for health care providers and patients on an encounter-by-encounter basis;
- compensate providers for declaring to their patients their adherence or reasons for non-adherence to evidence-based medicine treatment guidelines and for providing their patients with relevant educational material as information therapy;
- offer a financial reward to patients for responding to the delivery of information therapy by:
    - demonstrating the patient's understanding of his or her health condition and recommended care;
    - declaring or demonstrating adherence or providing a reason for non-adherence to recommended care;
    - agreeing to allow the patient's provider to view the patient's response and acknowledge the patient's health accomplishments; and
    - rating the quality of care provided to the patient against the treatment guidelines and recommend care; and
- allow the health care provider and the patient to earn additional financial incentives by applying the MAM to wellness, prevention, and care management regimens such as health risk assessments and screenings, smoking cessation, weight loss and fitness programs, and disease management.

To conduct the pilot project, the PEBB must contract with a vendor that offers a web-based health care cost containment program incorporating the MAM for plan years 2015, 2016, and 2017. The PEBB must determine the number of beneficiaries necessary to participate in the

pilot project to achieve a statistical significance. The number of beneficiaries must be at least 10 percent of the enrollees in the UMP.

The PEBB must contract with an independent entity to collect and analyze pilot project data. The entity must provide an analysis of the progress of the pilot project at least once a year. By September 1, 2018, the entity must submit a final report to the PEBB regarding the financial sustainability of the pilot project, its effectiveness at controlling health care costs, and other relevant objectives identified by the PEBB. The report must also include recommendations for improving the program and expanding its use. The PEBB must submit the report to the Governor and the Legislature by October 1, 2018.

The PEBB must use funds from the Uniform Medical Plan Benefits Administration Account for the cost of the pilot project and may not pass the costs on to the participating state agencies, other entities participating in the PEBB, or providers.

Appropriation: None.

Fiscal Note: Requested on January 23, 2014.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The MAM has produced dramatic impacts and cost savings and has led to decreased utilization and healthier outcomes. It achieves the triple aim of better health, better health care, and lower outcomes. The model has been implemented statewide in Oklahoma with bi-partisan support. The MAM answers the question of how a civilized society provides coverage without bankrupting the economy. Other states that have employed this model have used a web-based tool that aligns the interests of consumers, providers, and insurers. The model has been used for more than 10 years and evaluated by experts. Patient incentives alone do not work. Provider incentives alone do not work. The MAM introduces a fourth party that acts as an intermediary, which produces cost savings. Financial incentives do not last long, interpersonal relationships are powerful and long-lasting motivators, and knowledge lasts a lifetime. The MAM combines these three incentives in a unique way and also incorporates information therapy. When a doctor is paying attention to a patient's behavior, the patient is on his or her best behavior. This authority-obedience response is why the MAM is so effective. Health literacy is important; people with low health literacy are four times more expensive than literate patients. The MAM is about empowerment and motivation. Other jurisdictions and organizations that have employed the MAM have realized significant cost savings.

(Neutral) The MAM's focus on evidence-based treatment, value-based purchasing, and consumer engagement is appreciated. The state is already moving in this direction. It is unclear how the MAM will fit into existing efforts.

(Opposed) None.

Persons Testifying: (In support) Representative Rodne, prime sponsor; and Jeff Greene and Jim Dempster, MedEncentive.

(Neutral) Dennis Martin, Health Care Authority.

Persons Signed In To Testify But Not Testifying: None.