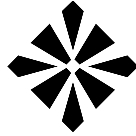
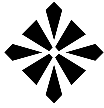


Washington State
Health Care Authority

Public Employees Benefits Board

April 20, 2011 Meeting



Washington State
Health Care Authority

Public Employees Benefits Board Meeting

April 20, 2011
1:00 p.m. – 3:00 p.m.

Health Care Authority
Sue Crystal Center
Lacey, Washington

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P.O. Box 42700 • Olympia, Washington 98504-2700 • www.hca.wa.gov • 360-923-2828 • FAX 360-923-2606 • TTY 360-923-2701

Washington State
Health Care Authority

AGENDA

Public Employees Benefits Board

1:00 – 3:00 p.m.

Health Care Authority
Sue Crystal Center
676 Woodland Square Loop Southeast
Lacey, Washington

Conference call-dial in 1-877-597-2663, Conference ID 2896617

1:00 p.m.	**Welcome and Introductions**	Doug Porter	
1:05 p.m.	**Approval March 16, 2010 meeting minutes**	Doug Porter	Action
1:10 p.m.	**March Projection Update**	Annette Meyer	Information
1:20 p.m.	**PEBB Medicare Redesign**	Mary Fliss/Ben Diederich	Information
2:45 p.m.	**Public Comment**		
3:00 p.m.	**Adjourn**		

The Public Employees Benefits Board will meet April 20, 2011, at the Health Care Authority, Sue Crystal Center, 676 Woodland Square Loop Southeast, Lacey, Washington. The board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: board@hca.wa.gov

Materials posted at: http://www.pebb.hca.wa.gov/board/

Washington State
Health Care Authority

PEBB Board Members

Name	Representing
Doug Porter, Administrator Health Care Authority 676 Woodland Square Loop SE PO Box 42700 Olympia WA 98504-2700 V 360-923-2829 portejd@dshs.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Phil Karlberg* Arlington Public Schools 315 N French Ave Arlington WA 98223 V 360-593-6275	K-12
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Lee Ann Prielipp 29322 6th Avenue Southwest Federal Way WA 98023 V 253-839-9753 leeannwa@comcast.net	K-12 Retirees
Eva Santos, Director Department of Personnel PO Box 47500 Olympia WA 98504-7500 V 360-664-6350 evas@dop.wa.gov	Benefits Management/Cost Containment

Washington State
Health Care Authority

PEBB Board Members

Name	Representing
Margaret T. Stanley 19437 Edgecliff Dr SW Seattle WA 98166 V 206-484-9411 mtstanley@comcast.net	Benefits Management/Cost Containment
Yvonne Tate Human Resources City of Bellevue PO Box 90012 Bellevue WA 98009-9012 V 425-452-4066 ytate@ci.bellevue.wa.us	Benefits Management/Cost Containment
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*non voting members

Washington State
Health Care Authority

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2011 Public Employee Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, The Sue Crystal Center Conference Room, 676 Woodland Square Loop S.E., Lacey, WA, unless otherwise noted below. The meetings begin at 1:00 p.m.

January 12, 2011 (board retreat)

February 16, 2011

March 16, 2011

April 20, 2011

May 18, 2011

June 15, 2011

July 6, 2011

July 20, 2011

If you are a person with a disability and need a special accommodation, please contact Shelley Buresh 360-923-2829.

Jason B. Siems
Washington Health Care Authority
Rules Coordinator

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 02, 2010
TIME: 10:33 AM

WSR 11-01-005

PEBB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

D*R*A*F*T
Public Employees Benefits Board
Meeting Minutes

March 16, 2011
Health Care Authority, Sue Crystal Center
Lacey, WA
1:00 pm

Members Present:
Doug Porter
Greg Devereux
Phil Karlberg
Gwen Rench
Lee Ann Prielipp
Eva Santos
Yvonne Tate
Harry Bossi
Melissa Burke-Cain

Members Absent:
Margaret Stanley

Call to Order
Doug Porter, Chair, called the meeting to order at 1:00 pm. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Approval of October 20, 2010, PEBB Meeting Minutes
Greg Devereux asked that one change be made in the section titled "Hospital Unit Cost/High Cost Center Utilization & Variations in UMP." In the fifth paragraph, the first sentence should read, "Greg Devereux asked for examples of disincentives." It was moved, seconded, and carried to adopt the October 20 PEB Board meeting minutes.

February Projection Update
Annette Meyer, HCA, said she had some good news for the February projections. As you are probably aware the previous forecast had us at about $92 million below our optimal reserve level on the fund. The latest projections have us at about $56 million below the optimal reserve level. That's a $36 million improvement in where we are projecting to be through June 13. The most significant drivers of this change were better than expected claims experience for UMP for plan year 2010 as well as some shifting of employees to lower cost plans. Those were our drivers. Hoping to have good news next month as well, but we'll see what that claim experience looks like.

Eva Santos asked when we close the claims experience cycle for the year for purposes of procurement, etc. Annette Meyer said that for procurement modeling, this next projection cycle which takes us through March claims and enrollment through April is our starting point for our procurement and bid rate development.

John Williams, HCA, said we normally work to get it done by mid-May so the health plans have the information and can prepare their bids by the end of May. You can anticipate early May would be our target.

Greg Devereux asked about Tim Smolen. Doug Porter indicated Tim went to work for Labor & Industries. It was a great opportunity for Tim and we wish him well.

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Margaret Stanley Update
John Williams updated the Board regarding Margaret Stanley's husband's passing after a bout with Cancer. Margaret's husband did enter hospice and died peacefully at home. Margaret is doing well. John did get a notice of the details for the celebration of her husband's life and that information will be shared with the Board members.

PEBB Redesign
John Williams continued the discussion from an earlier meeting about a 2012 PEB Program portfolio redesign proposal that was initiated last summer at the request of the Governor. This process has moved along well. We had a good Board retreat with you and received a lot of input and a lot of good questions that we've been working on. I believe, at this point in time, we are to the point where we are presenting you a solid proposal. This has gone through a review with the Office of Financial Management. We've spent a fair amount of time with them going over the model; and at the end of the meeting with OFM, they did approve it to move forward for discussion by the Board. They felt we had answered their questions and they were comfortable with both the financial aspects of the proposal and the labor relations aspects of the proposal. That was good. I wanted to share that with you so you would understand that the proposal has gone outside the HCA and it has been reviewed with other authorizing agencies. There is a lot of interest on the part of legislators now. We feel like this has been a successful process. I believe it's a well designed proposal and I have to thank all the players that were involved. This was a concerted effort with Group Health Cooperative, Kaiser Permanente, Regence Blue Shield, and all the HCA staff to get to this point and try to address the issues we heard throughout the process.

One point of clarification I need to make is what we're proposing today is the redesign proposal for the portfolio for the non-Medicare risk pool. We will present to you our proposal for the redesign of the Medicare risk pool portfolio in April. We thought it would be better to split them so we're not combining or confusing the two risk pools.

This is the non-Medicare risk pool. In your packet, you do have the proposal in Section 4. The first page is really important. As Annette briefed you, we only have our update for a portion of 2010's experience so this is still a design that's in motion and evolution. We really won't be able to finalize a lot of the detail until we actually get the funding rate for the PEB Program out of the legislative session. We'll see what changes there will be to the PEB Program as a result of legislation that passes, and we'll get, as we discussed, the final experience modeling for 2010 so we can then actually develop the information we need to give to the various carriers to be able to develop their bid rates.

This is a point in time proposal based on the knowledge we had as of the February financial update. It will evolve a little as we move forward. What we're presenting to you is a very solid set of umbrella health plans and products that we do not expect to change at that level. What will change is essentially the actual level of premium sharing, the actual levels of the member cost sharing, and some of the features we will actually require as the member engagement portion of this design. The high level design itself is solid at this point in time.

Moving into the background information, I've provided for you the redesign strategy that we've moved through in the redesign process. I want to point out to you that 2012 is the introductory year for the new culture of accountability and engagement in the PEB Program. It is not the final. We are creating a culture and as health care reform moves forward, and as we work with the market, we expect that the PEB Program portfolio will continue to evolve and update from year to year. Just know this is the introductory year, but it is a work in motion.

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The other thing I want to emphasize about the strategy is we worked hard to find a way to balance engagement; people becoming engaged in how they purchase health care and how providers prescribe health care to our PEB Program members. The actual financial accountability will then tie to the level of engagement. We've gone back and forth throughout the design to find a balance among the things the members will want to do in terms of managing their own health and the affordability of their health plan, what the providers will be willing to do and will be expected to do as part of the larger health reform of our market and reasonable financial accountability features. Recognizing that for members to change their behavior, they need to have reasonable incentives to do so. We've tried to find those balances.

Moving to the next slide, you've seen this slide before. It's an overview of the medical portfolio for 2012. It has not changed since you saw it at the January retreat. I want to spend a little time on this one to give you a sense of what we've achieved in the redesign. There are some key points I want to make for you. The first is that throughout this process, HCA has made a concerted effort to position the umbrella Uniform Medical Plan to be the benchmark plan for PEB Program in the future. It is now our largest plan in terms of member enrollment. We believe, as a self-insured plan, we have a lot of control over it. We have a very good partner as our third party administrator. We believe we should use this plan as the benchmark for the rest of the portfolio.

This design, I believe, achieves a couple of key things that our statute lays out as the primary purpose of HCA as it relates to the PEB Program. The first is that we will continue to use the UMP to meet our statutory responsibility to provide access to at least one comprehensive benefit plan to employees and retirees. That's our first goal, to always retain in UMP a comprehensive benefit plan as required by the statute.

The second thing that I believe the benchmark UMP will achieve is that we will meet our statutory responsibility to develop a flexible benefit plan design that provides economic incentives for persons who the state is purchasing health care for in order to get them to appropriately utilize and purchase health care services to offset increases and individual financial responsibility. That's been in our statute all along. I believe this redesign is moving us forward in meeting that responsibility.

The third thing that's in the statute, that I think this design very much moves us forward on, is to utilize provider arrangements that encourage cost containment and ensure access to quality care in all areas of the state.

I wanted to share with you that the basis for this design is in the statute and in the obligations of the Health Care Authority as the state's single state purchasing agency. I believe this portfolio redesign stays true to those responsibilities.

I also want to share with you that we have been very transparent throughout the redesign process with all the players about what the new design of UMP would look like as we've developed it. We did this in order to lay the foundation for UMP to be the benchmark and we wanted Group Health Cooperative and Kaiser Permanente to know what we were doing with UMP so they knew what the benchmark would be that they would be measured against in the future.

The Governor recently issued an executive order around performance-based contracting. We fully intend to work through our contracts with all of our vendors, using UMP as the benchmark, to set some standards of how we'll measure against the value of their plans, against the affordability of their plans, and other performance standards using UMP as the benchmark. I'm really hoping, and I actually believe at this point in the design, that Kaiser Permanente and Group Health Cooperative, by having that transparency, may actually have exceeded in their redesigns what we've been able to do with UMP

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as the bench mark, which makes me very happy. It just challenges us to keep looking at UMP and to keep raising the bar. I believe that's another positive feature of this proposal.

I'm going to move into the design, and I'd like everybody to understand this design accomplishes two things as a result of the transparency we've had and the open dialogue during the design among Regence, Group Health, Kaiser, and HCA. The first thing is that as you look across the proposals, the three umbrella plans themselves as seen on this sheet - UMP, Group Health, and Kaiser - actually have a set of products that look very similar to each other in terms of there being a consumer directed health plan with an HSA in each of the umbrella plans and there is at least one accountability plan that looks very much like UMP 2 in the Group Health and in the Kaiser plans. So the products themselves have a level of similarity that we believe will keep us out of the slippery slope of having members start switching between the umbrella plans chasing premiums or chasing plan designs depending on the level of engagement required. All three umbrella plans have a consumer directed health plan so we don't believe we're going to have members switching between plans to get into those products. We don't believe that we're actually going to see a lot of switching during open enrollment.

What I believe we've achieved is a stability across the plans so that we don't have unintended switching for the wrong reasons. And that's very important. What that does is to allow each of the carriers to design their specific plan with the liberty to adjust their internal products within their umbrella to best use their own business model to move into the engagement arena in a way that remains attractive for the members who have traditionally preferred their model.

The second thing I believe we've achieved is internal to each umbrella plan. Members will have choice, they'll have different balances of accountability with engagement, and they'll be able to find products within their own umbrella plan so that they're not looking to switch to the other plans.

So we have stability across the portfolio on one hand and we have flexibility within each of the umbrella plans on the other hand. Overall what we have is that we've reduced the possibility of people going into open enrollment thinking they have to choose between eight different options. They'll really be looking at choosing between two or three products within the plan that they've always chosen to be in. I think that's been one of the biggest successes of this design.

So with that, I want to jump in to the actual overview of Uniform Medical. The concept has not changed since the retreat. What we've added is a lot of detail given the point in time snapshot that we had of the budget. For all of the carriers we modeled an index rate based on the February projection so everyone was using the same funding rate and the same index rate. Then we shared what UMP 1 member cost sharing arrangements will be under the Collective Bargaining Agreement that's been negotiated because those did not change for UMP 1. Once everybody had that information, the three design teams were able to develop this level of detail for you. The important thing at this point in time is you now can see the relativity within each health plan of the products themselves; how the premiums differ from each other, how the cost sharing arrangements differ from each other; and in the case of UMP, at the bottom of the table, you can actually see our projections at point in time of what we believe the migration will be from UMP 1 into UMP 2, and to the UMP HSA. You'll note there are two options still on the table because we wanted you to see one version that is more aggressive than the other. One has a greater range variation in the premium and the greater the range variation, the more switching or migration out of UMP 1 into the other two. Our recommendation is to go with the more aggressive scenario where the range in premiums across products varies from $89 to $26, the migration out of UMP 1 into UMP 2 is 24%, and into the consumer directed health plan is 9%. The less aggressive scenario that we still have on the table is a range of premiums from $85 to $30 which change migration so that more people will stay in UMP 1, less will move to UMP 2, and less will move to the consumer directed health plan.

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You've had these in advance so I don't want to lecture to you. I would rather you ask your questions. We have representatives from Regence here who can help answer the questions.

Gwen Rench: It seems like there is little incentive to stay in UMP 1 because if you're 50 years old and looking at premium levels, I know there is supposed to be more accountability in UMP 2, but that's not defined in this material. It would seem like you would go with the lowest premium which would be the natural thing to do.

John Williams: We do believe that the premium will be the driver because of the arrangements of not significantly changing out-of-pocket sharing. The modeling actually showed the experience of other large employers that had instituted consumer directed health plans. There is inertia, at least initially, where people are not going to move because they don't understand it; they haven't had time to work through what it really means to them individually. So the numbers are somewhat low in the migration just because there will be a lot of inertia in the first year. But we're also not done, and we'll do a lot more work and give you more detail in April. We are now mining UMP data to really understand what target subgroups of UMP should not move because of their health status and the financial implications of making the wrong choice. We do know there are people that we really need to get in front of so they clearly understand even though the HSA premium is going to be a lot less, there could be negative financial impacts to their out-of-pocket cost if they move. We are researching people who have chronic illnesses or persistent illnesses. We're initially looking for those where year after year they would exceed the out-of-pocket maximum of the high deductible health plan, and especially those where their incurred out-of-pocket costs happen very early in the year. They wouldn't be able to fall back on the HSA or their premium reduction, had they chosen to bank that, when they go to fill their prescriptions in January; the bill is $1,800 and they have no back up. We're going to spend a lot of time over the summer identifying those groups that we need to get in front of and help protect them from making a bad choice.

Lee Ann Prielipp: My constant mantra for a couple of years has been how do we help the pre-Medicare retirees and do you feel that this HSA piece would probably meet the needs of people like that who consider themselves still in relatively good health at their age? I'm hoping that's what this is about.

John Williams: I do. Again, we want them to understand and they need to make the right choice. Given the UMP population and the statistics, because this is both working employees and the pre-Medicare retirees, we do have a high number that don't incur a lot of expenses, and this will be beneficial for them. The other advantage of this for the pre-Medicare retirees is, if they are able to bank money in their HSA, it's their money; it rolls over from year to year and they can actually use those funds when they are Medicare eligible to pay for their Medicare premiums.

Harry Bossi: Through a VEBA?

Cary Badger, Regence: Medicare premiums are eligible expenses under the Treasurer rules that govern tax treatment of HSA funds. It would be tax exempt and then they could use it for Medicare premiums.

Question (Greg Devereux): Just a follow up on Gwen's question. What are some of the incentives under the consumer driven UMP 2?

John Williams: The incentives or the engagement requirements? The incentive is they do have a lower premium than UMP 1. They actually have a lower deductible ($200 instead of $250). Those are the financial incentives for them. What we are going to ask them to engage in is to complete a Health Risk Assessment (HRA) and the health screening so we really identify their risk. Then if they do have risk,

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they'll need to be willing to engage with Regence's case managers to manage those risks. We haven't designed them specifically, but we're really looking for those opportunities where once we know there is an intervention to either improve their health status or to keep their health status from declining, we want them to engage in activities and we will expect them to engage in those activities. We're going to look at drug adherence, so if they have a prescription to control their high blood pressure or their cholesterol, they actually fill those prescriptions on a regular basis which is a proxy indicator that they are taking their medications. It's things like that.

The other side of it, which is non-voluntary behavior on their part, is the Centers of Excellence. We already do Centers of Excellence where all members can only get bariatric surgery through a structured program they have to complete. Then they must use specific providers. We hope to expand that into other elective surgeries, such as elective knee surgeries, to do the same thing.

You can see in UMP 2 we're also tiering the emergency rooms by number of visits. We didn't do it in UMP 1, but those that move to UMP 2 will be subject to a higher co-pay the more times they go to the ER during the year for non-emergent care.

Greg Devereux: With the HSA under the annual deductible, it says "family deductible must be met in full before any benefits are paid by health plan for any family member except preventive services." Two pages later when you talk more about the HSA, the first bullet, second sentence says "The anticipated monthly premium savings ($756), in combination with the $700," that's the overall anticipated monthly premium savings of employee-employer combined?

John Williams: The $756 is to show you that if the member themselves, because they are paying a lower monthly premium, chose through a payroll deduction to voluntarily deposit that into their HSA on top of the contribution that's already there, the $700, they would actually be able to cover their total deductible in the HSA.

Greg Devereux: But that's not the way we're going to do it, is it?

John Williams: Yes. We're going to put $700 in over the course of the year, and we will make arrangements for them to be able to do direct deposit that's pre-tax into the HSA in any amount they want to add to the amount they have available to them.

Greg Devereux: So it's not based on premium savings.

John Williams: No, it's if they take what they didn't pay in a premium and use it to build their bank account to cover their deductible. It's not premium savings that we're then going to put in on top of the $700.

Greg Devereux: So this is the modeling right now, the employer would put in $700 and the anticipated savings would be $756 and they can choose or not to put it in.

John Williams: Yes.

Greg Devereux: What if, in the second year, the anticipated savings is $200 and the deductible is still $1,400?

John Williams: Once the money is in their HSA account, it is their money. If they don't have expenses that draw down their HSA, it just rolls over to the next year. And then the next year they get $700 more from the State.

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Greg Devereux: So let's say they use their entire deductible the first year, the second year they get $700, premium savings the second year are $200, and the deductible is still $1,400. If they have to meet a $1,400 deductible the second year, they can only meet $900 of it.

Nicole Oishi, HCA: But the member can choose how much they want to put in. That premium savings was just an indication of the difference between UMP 1 and the consumer driven health plan. So if you take that difference, the employees are not required to put that in. They could put zero in or they could put more.

John Williams: Your calculation is correct. That's why we're looking for that population where year after year, because of their medical condition, we pretty much know they're not going to have anything left the end of the year in their HSA. When they roll into the next year, it's just going to be the same thing over again. Those are the ones we really want to educate. Don't pick the HSA. This is not the right model. I think you are right on. There is a group there where this doesn't work well for them. It's those that are going to exceed what they have in their HSA every year.

Phil Karlberg: Does state statue allow for the K-12 group to be able to contribute to an HSA with regard to the fact they're funded on an FTE basis instead of a per capita funding?

John Williams: For the K-12 that voluntarily participate in the PEB Program, this will be set up so the HSA is being built through a premium pass through. They'll play the game the same way as the state employees. They actually will still be assessed the complete premium which goes into the PEB Program fund; and then when we pay the carrier for those that enrolled in the HSA plan, the premium will have the HSA contribution in it.

Phil Karlberg: So there will be no difference in the way the plan works regardless of the funding source.

Mary Fliss, HCA: Correct, in regard to the employer-employee contribution it will be the same as it is now. We accept the premium. HCA sets the premium and we'll distribute it in accordance to the model. In addition, we'll be working with all of our political subdivisions to make sure there is the data tie to those discretionary HSA contributions that can then tie into that account and that the W2 reporting gets fed back in under it as well.

Phil Karlberg: My second question with regard to the HSA, with regard to the tax implications for the employee, is there a limit on how much they can contribute to the HSA?

Cary Badger, Regence: Yes. On a taxed deferred basis, the money an employer and employee can contribute to the fund without taxes is $3,050 total for an individual and $6,150 for a family. That would be a combination of the $700 plus whatever they chose to contribute. And that would all be pre-tax.

Phil Karlberg: Is it also true that the money that goes in tax deferred will be spent tax free?

Cary Badger, Regence: It's never taxed as long as they spend it on eligible expenses or after retirement for Part C or D premiums or long-term care.

Phil Karlberg: Is it true the generalization of HSAs is for the healthy and the wealthy? And something we should be considering?

Cary Badger, Regence: It's been modeled both ways. We worked with HCA staff to model the maximum exposure for any enrollee. And actually the way it's designed for the PEB Program, it actually has sufficient, strong protections at the out-of-pocket levels which you typically don't see in

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HSAs. The maximum out-of-pocket costs are reasonable. In addition, the deductible does include prescription drugs, which means there are no additional co-pays that the members have to make once they meet their deductibles. It's a better deal.

Harry Bossi: Back on the health risk assessment, what are the other tools that are being used as the financial accountability to get the incentives? Without more specificity as to what they are, it's hard to know/judge/evaluate what that would be like. I would ask that they be reasonably stringent. I think in the UMP now, if someone designates a physician or enrolls online, and they take an HRA online, you get a $50 gift card. That's about ten minutes of work. It's pretty easy. If the incentives are going to be so good and the accountability is not real stringent, then I think your movement will be significant in that middle plan. If that's what we want to accomplish, then that's great. I think I heard somebody say they thought there would be greater movement into the 2 because it looks like if someone doesn't want to take a lot of risk, it's a really good place to be. That would be my observation. I understand the need to do it and the whys to do it, and I hope the projections are correct; but my sense is that they'll be much lower or maybe much higher because $24 a month is pretty enticing. I did want to ask a question. John, have you thought through the funding on the HSA in terms of the timing of it? The $700, because there needs to be some upfront seed money if you will, as opposed to just monthly deposits? You don't want to put the whole $700 in January and February and have a member walk out the door.

John Williams: I'm going to try to remember all the questions you asked me. The first one about the actual engagement activities, the reason we do not have a hard list yet is because of what you've said. We've really got to find that balance where the member actually starts moving into the culture of responsibility toward their lifestyle behaviors that contribute to their health status and their purchasing behaviors. The balance is the first year we don't want to make them so onerous that nobody will move, but we don't want them to do what you suggested. What would be the opposite is to not make them stringent enough that everybody will move in there because they don't have to do anything and they get a lower premium.

There's a note in here indicating we are having discussions with the National Business Coalition on Health and the CDC to have them work with us to identify things that clearly have a desired outcome that's short term that really has something to do with the member while they're an employee. It's pretty well known that if people with depression aren't managing their depression or smokers aren't trying to quit smoking, it does have an impact on their attendance at work. We're looking for outcomes that have to do with their productivity as an employee, and then identifying what interventions we need to do to impact them in a way that we see a short-term gain. CDC wants to help us work through that using some instruments and data logic that they have to identify interventions where they can then come in independently and measure the impact on productivity for a couple of years. We're trying hard to find those things where it makes a difference but it's not too much to start with. But I have to say, and this is my personal opinion, the real savings to the PEB Program, in terms of bending the cost curve, are not going to come through lifestyle behavior changes of the members for the short term by stopping smoking, controlling high blood pressure, and other things. We believe we'll see some savings by avoiding some acute episodes, but the real savings are going to accumulate in the long term in their health status change.

To bend our cost curve, and bend it the way we need to bend it, is going to come through the other side of the engagement; that is engaging the providers and the members in their interactions with providers to use the system more effectively when they are actively receiving services. And that's why we have two sides to the engagement. There are the voluntary activities, which are the incentives and premium targets to get them to manage their lifestyle behaviors better, to manage their health. But the true short-term cost savings is in the Centers of Excellence and in a future year being able to tier the network so we don't have members going to high cost facilities where they are getting services that

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don't provide better outcomes. It's the provider side we have to take on to get the cost savings. The members have to be in the engagement plan and under the culture of having to have some responsibility in also helping us manage how they use the provider system.

Greg Devereux: With the HSA, is the employer contribution, is it contributed over the course of the year? What happens if you have a medical occurrence early in the year?

John Williams: That is a problem. If it's an unanticipated medical occurrence, then yes, they will not have a lot of money in their HSA under the way it's modeled now to help cover their deductible and their out-of-pocket maximum for early occurrences. We went round and round, especially with the financial people, about frontloading the HSA, putting some portion of the $700 in from day one like the Flexible Savings Account does. The problem is that we would have to find that money in the budget someplace to frontload it because the money is actually going to come from the monthly contributions we collect from the members and the employers. So we're collecting money on a monthly basis and passing the premium through. To have the two or three million dollars that we anticipate would be needed at these migration levels to deposit half of their HSA up front, we would have to take it out of the reserves. In this current environment, I don't think anybody is really comfortable about taking any more money out of the reserves at the start of the year, especially when you're giving that money to the employees whether they stay throughout the benefit year or not. If the employee gets it on January 1 and leaves employment on February 1, that's their money. We would have frontloaded money.

Greg Devereux: So if you leave, let's say you left state service after three months, it still goes with you?

John Williams: Yes.

Greg Devereux: What happens if you never had another employer that has an HSA?

Nicole Oishi: You can take the money out just like you can with a 401K or you can save it, and when you retire, you can use it to apply to your Medicare premium. You can also use it for those health related expenses that you currently can fund from your FSA. Those are all of the health related expenses that are on for the HSA.

John Williams: But if you use it for non-approved purposes, it's taxable.

Greg Devereux: So regardless of the plan in the future, if they're approved, you can use it.

Nicole Oishi: The minute the dollar hits that account, it belongs to you personally, so it's yours.

Greg Devereux: And it does not have to be spent in an HSA per se, it can be spent for approved health care.

Nicole Oishi: Correct. Anything authorized for an FSA. You can spend it on eyeglasses, hearing aids, or prescription drugs. Anything you can spend the FSA on you can use HSA funds.

Question: If someone becomes a new employee in March, we don't know at this point whether it's going to be sequential or some could be frontloaded or quarterly deposits or whatever.

John Williams: So the way it's set up now under this design, they're going to get approximately $59 per month into their HSA. It'll come with the premium, so when they enroll, the premium that we pay for that enrollee will start from the month they enroll. They may not be in for the whole year.

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Question: So that's a potential $700. So is there is a way to have some reasonable, affordable way to do some prefunding?

John Williams: As I said earlier, this is a design in motion. So we will continue to look at all of these issues from year to year to determine what are the best modifications we can make to keep enhancing this program to achieve the goals that we've set out to achieve.

In the interest of time, I want Nicole to move into the Group Health Plan because as I said, each one has a little different design to it so you need to understand the whole portfolio. Group Health representatives are here also to help answer questions.

Nicole Oishi: I have the honor of sharing the Group Health proposal with the Board, and much like John, would like to thank the Group Health folks. They did the bulk of the work and did a phenomenal job. There are two of their representatives here so if I say the wrong thing I told them to hit me with a rubber band or something from behind. I would like to start out by saying, again, these are place holders. We don't have actual dollar amounts. None of this is absolute final by any stretch. It's a snapshot in time, our best guess, and what we could bring to you today as an example of where we think the plan will be.

Similar to UMP there will be three products under the Group Health Cooperative umbrella. The Classic, the Value, and then a Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA). On the Classic Group Health Plan, it is relatively similar to how it is now in 2011. It is a co-pay plan. The deductible, providing you select a primary care doctor and take a health risk assessment, will be the same as it is in 2011. Preventive care is the same. There is one small change to the retail pharmacy and that is adding this value tier of a $5 amount for generic chronic disease prescriptions. Group Health's approach was to look at the more value-based design. The value plan is very similar to what they offer to their employees. It is the tiered structure placing the emphasis on making sure people get the care that the evidence shows makes a difference, and making that very affordable to the point of making it free. You get four free visits with your primary care doctor, you get your preventive care for free, and then you move into the co-pay structure which is very similar to what it is today, $30 to see a primary care doctor, $50 to see a specialty care doctor. Again, if you take the health risk assessment and you select a primary care doctor, you get the benefit of that reduced deductible which matches the 2011 Group Health Classic or Group Health Value deductible.

John did all of the legwork for me on the HSA and the consumer driven health plan because it's very similar. The laws are pretty clear about how those two plans are administered. The difference for Group Health is that both the Classic and Value plan will still be the Group Health Network; and in the HSA, it will have an expanded network. For the Classic and Value plan, it's the same network that it is currently today. You'll have those same providers and it's a limited network. The difference with the HSA is that it broadens its network and you'll be using the Group Health Alliance Network which is an expanded version of the Group Health Network. So with an HSA, it makes more sense to provide people more choice, if you will, and allowing them to select additional providers.

Fred Armstrong (GH): What Nicole has described is what Group Health would like to do starting in 2012, but there are still some capabilities that need to be worked out in terms of what we're actually going to be able to execute. These next few months will be key to understanding that. Our final submission for procurement might be a little bit different than this. The only difference will be based on if capabilities will soon be in place.

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Harry Bossi: Back to the incentive. I think it's too rich for the request we're asking people to do. I think by design that HMO people are expected to have a primary care physician, so incenting them to get one, I don't see as that's a big hurdle. Again, the Health Risk Assessment I really think is pretty easy to do. I'd like to see it become more robust. Perhaps they somehow connect it to well woman exam, or annual physical for a man, or something else that causes a little more engagement.

Nicole Oishi: Maybe I went through the value design a little too quickly. There are things, certain services that will fall into the tier 3 that require additional costs and additional engagement. If you choose to select certain procedures, if you choose to have elected procedures, you will pay additional fees. I'll use the scenario of low back pain. If you have your first episode of lower back pain and you walk into the doctor, what happens now frequently is people say, "my next door neighbor had an MRI and they were all better" and they want an MRI – the evidence says that isn't actually the right way. That's very expensive and it doesn't yield any results. So if you want that, you can get it, you're just going to pay for it. Whereas if you get the standard course of treatment, which is rest, ice, and all of those things, you'll pay less. Imbedded in the value design is actually a lot of those things, Harry, that I think answer that question for you,because if you don't do the right thing, you pay more at the time of service.

Harry Bossi: So the premium is the same at all tiers.

Nicole Oishi: Yes, in the Value Plan. The differences are the point of service costs. You get your free four visits and that's in addition to your preventive care. So that's incenting you. If you've got diabetes, you need to be visiting your doctor on a regular basis to make sure you're getting your meds, your blood tested, etc. We want you to do that so we're not going to charge you any co-pay for that. On the reverse, if you decide you don't want to see your primary care doctor for that, and want to be seen by an endocrinologist, because that's what you want, then you're going to pay more. You can do that. Evidence doesn't show that as the right thing to do, so you'll pay more.

Harry Bossi: I understood the concept about the tiering, but I think the HRA is tied directly to the deductible. Is that right?

Nicole Oishi: It is. As well as selecting a primary care physician.

Harry Bossi: All I'm suggesting is maybe there could be some additional because $150 is pretty good value for that amount of engagement. Maybe we could somehow take it a little bit further, get a little bit more engagement. I don't want to be parental for enrollees, but I just think that it's a great incentive that people would be willing to do a little bit more.

Nicole Oishi: Got it! We'll take that back.

Eva Santos: What's the percent of our participation today in the HRA. I understand it's low.

Nicole Oishi: 30% is what the HRA uptake is currently for UMP.

Question: Is that the one that's done on the computer?

Nicole Oishi: Correct.

Question: So a person has to have computer access in order to do that.

Nicole Oishi: For the UMP Health Risk Assessment? Yes.

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Harry Bossi: I told our staff about it and they jumped all over it. That's the easiest $50 anyone ever got. So anybody out there who's enrolled and hasn't done it, you better go do it.

Nicole Oishi: I think the point of that is we hope the feedback you get is helpful in the sense that you're not getting preventive care, or if you have a chronic disease or some issue that you can identify, that we're able to give you feedback that helps you get on track, more than just the $50.

John Williams: Harry, you're also making a good point. A lot of the experience has been that just getting them to take the HRA for $50 is going to lose its appeal very rapidly. It can't be the only incentive because from year to year they ask why keep doing this? The $50 isn't worth it; give me $100 to do it next year. We've got to build onto where we start to enhance the engagement as we move forward year to year. But we certainly will go back and see if we're starting too light.

The last design is the Kaiser Permanente. Hilary is here and I may very well have to draw on Hilary for the details of it. Essentially Kaiser has approximately 7,000 enrollees. Because of the limited volume of their membership today, we're not able to develop a design for three products. So what they chose to do, and we discussed this at the Board, the engagement piece and the accountability piece, primarily the engagement piece, is already inherent in the fact that they're an integrated health system. Our challenge to them is to make sure that the members are engaged in what their system is already designed for them to be engaged in, and that they're getting the outcomes from it. So rather than focusing on what is their engagement, I believe that their design strategy is to make sure that they move into a comparable accountability arena; and because of their size, they do that by primarily modifying their current classic plan so that it mirrors or is aligned with UMP 2, not with UMP 1. And then they also add the HSA option to their portfolio to have two choices and the benefit of the consumer directed health plan HSA for members that are currently enrolled with them and want to stay in Kaiser Permanente.

Hilary Getz, Kaiser Permanente: We really tried to be mindful of listening to conversations of the last few months as you grappled with these different things. We wanted to be mindful of not creating perceived barriers and that's why, if you compare the classic benefits, even though you'll see a deductible that isn't there presently, the rest of the benefits were really designed to mirror as closely as possible what exists now. There are some deviations, obviously, when you create a deductible and co-insurance for some services. That's really where that additional financial accountability or engagement of the member around some of those higher cost items and bringing that thought process to the forefront to engage in these conversations. We are an integrated health plan so you have the spectrum of the primary care, the specialty care, the hospitals and all of the ancillary systems that go around that are already connected providing some of that member engagement. The goal was really to stay in line with the direction that the PEB Program is headed, not create additional financial barriers where we were able to avoid doing so. You'll see there is still an out-of-pocket maximum so the well person is going to pay more for hospitalization or perhaps emergency care; and in these cases, the deductible applies. There's still going to be that limit they'll hit where they'll still have coverage for catastrophic types of events.

Greg Devereux: John, do you think the redesign will yield short-term gains in the governor's desire to bend the cost curve, or are we looking more towards longer-term gains?

John Williams: Our primary goal was to get a redesign that would not impact the budget negatively. It is not designed to, in the first two years, generate a lot of cost savings, or avoid a cost in the design itself. It was to start changing the culture. It's more putting a system in place that will bend the cost curve in the future on an ongoing basis. That being said, I believe that by moving to the Centers of Excellence, we do have the possibility of incurring savings. We just didn't build them into it as a

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guarantee we're going to save that money. We were very focused on our current budget situation, and the last thing we could do is get too aggressive or too radical to where it could fail and we'd lose money. It's very conservative for the first two years.

Phil Karlberg: In terms of design, do you have models that you have looked at that have successfully applied these concepts other places in the nation? And if so, what have their results been?

John Williams: I will have to let Regence speak to that specifically. Throughout this process, we relied heavily on Regence's experience with their larger book of business and with the Regence Group that's multi-state, and also on Milliman that was drawing from their resources across the nation as consultants; but I don't have specific plans that they told me this is something we're modeling after. We did look very seriously at Indiana and their experience with it because it is highly visible, but I have to tell you we decided early on we were not going to go down the same road as Indiana. We've learned what worked for them but they were essentially an all-in approach. Their intent over the course of five years was to move all state employees to a high deductible health plan and that's all they would have available. That is not where we want to go. So early on we reviewed Indiana. We found they frontload, and this is what gave them a lot of movement. They got more movement by driving up premiums in non-preferred plans. There were good features, but we did not follow the model itself.

Jan West, Regence: Perspective on experience with this design. We've taken a look at the information we used on our current medical designs, as well as other organizations. We do feel very strongly, as John has indicated, that while we're not going to quantify exactly what those Centers of Excellence are going to save, what it will do is put in that certain level of do we really need to have that particular service, and then directing members to where they can have those services at a quality location and at an efficient price. We do believe that we're going to be saving those savings, but we're not here to quote those. Cary, why don't you talk a little bit about some of the analysis that we did regarding the HSA, not only with our own employee group, but with others across the country and using Health Equities, which is our financial banking for the HSA, and their broad range of experience with HSAs.

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Cary Badger, Regence: We benchmark for the HSA experience provided by Milliman actuaries. We did heavily benchmark our own employees, about 43% of our 6,000 employees in four states in HSAs right now. We frontload the premiums. There is a cost to that which we know about, and we benchmark the experience, the claims experience, the utilization and enrollment percentages over time. We did have a lower enrollment the first few years and increased that from about four percent to 43 percent in time. You do see an uptake after people understand the plan designs better. We also benchmarked other companies. We benchmarked the state of Utah which had very low enrollment, so we wanted to find out why that happened. We benchmarked the study done by Mercer from the state of Indiana. Those are the things we tried to triangulate to get to the conclusions we did.

Greg Devereux: I guess I would just comment to Phil's comment that I don't know of another progressive state in the country that has implemented HSAs for state employees.

Harry Bossi: I did that five years ago in Kansas and that's why I have some concerns. Not so much concerns, lessons learned. Because everything Cary said is absolutely right on. The education is really important and getting rid of the fears of doing this. The comment that was made that this is for the healthy and the wealthy, our experience was that university professors who were maybe sophisticated with the financial or whatever, or fairly healthy, chose to join; but folks who had more labor intensive jobs tended to not have access to computers where they could become more knowledgeable and use the tools and all those kinds of things. Or if they weren't previously invested in the 401K or the 457, they didn't quite understand how investments worked. It can be very overwhelming. Kansas, my last year there, they weren't very successful so I called them a month ago

and said I've been gone five years now, did you do anything? They said still not very successful but we're still trying.

John Williams: Before we leave this topic there is one more thing I do want to share with you and I will email this chart out to you so you have it. We have been able to actually look at our 2010 costs so far, with the experience we have of how the costs distributed across the population. For 17% of the UMP members, they had no claims at all in 2010. An additional 8% had claims that totaled for the year less than $250 deductible in UMP 1. So 25% of the UMP members did not have health care claims that even got them to the deductible maximum. An additional 22% (so now we're up to 47% of the population) did not have claims that exceeded the $1,400 HSA deductible. So 47% of UMP members, even if they were in the HSA, would not have hit the deductible amount. We then had 47% more of the population (so we're now talking about 94% of UMP) who did not get to the UMP out-of-pocket maximum of $2,000. 94% of all UMP members had total allowed costs that fell below $2,000. We go up to 95%, that one percent addition is those who had claims that fell between $2,000 and $2,800. And then you hit the magical 5% of UMP who exceed the total liability that any member would pay in UMP regardless of what product they were in. This is where the state is paying the whole bill and those are our large claimants. Essentially 95% of UMP members will not hit the out-of-pocket maximum of the HSA plan given our experience to date.

It's that group in the 5% that are going to be those people who absolutely should not be in the high deductible plan because they spend everything. Whatever limit we set, they're going to most likely hit it and we're going to pay 100% of the rest of the cost. It's not good for them to be in plans where the option is pay more out of pocket before the state starts paying. Those are the ones that should, for their own financial benefit, pick the plan where their out-of-pocket liability is the least. That's not good for the state; but for them personally, those are the ones who shouldn't be selecting the high deductible health plan, the HSA plan. That's why we believe we can find those people in the data, not market to them directly, but know there is a small subgroup that we have to develop very effective communications to. When we go out to the UMP and the PEB Program population saying something new is coming, we have to highlight that if you're in this subgroup, be really cautious about the high deductible health plan. We intend to do that now that we know what to look for. We're actually trying to identify what's causing them to do that. Is it chronic illness, is it medication costs, what is it?

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Yvonne Tate: I've looked at two things, the fees of the third party administrators who administer these HSAs and the rate of return on the money that's invested in those HSAs. It bothers me that the fees are higher than the 457 or 401K and the rate of return is always lower than what you would get in a 457 and a 401K. I've never understood why that is true. I guess they figure since you're getting a tax benefit, they can charge higher fees and give you a lower rate of return. I've always been concerned of why that is and if there is anything we can do to try to make sure that the rate of return you're getting on your accounts is similar to what you might get in a normal mutual fund account. Everyone I've looked at, it's always bothered me that the administrative fees were higher and the rates of return were lower than what you'd find in normal investment products.

John Williams: I don't have an answer. I don't remember us talking about that, but that's a great question. Do we have anyone from Health Equity here or somebody that can speak to this?

Cary Badger: I can probably address that. The administrative fees are comparable. It just depends on the type of administrator you hire. The rates of return are depressed right now. That's a function of the market place.

Yvonne Tate: In any market, regardless of what the market is, the rate of return in these HSAs is always lower than what they would be in typical mutual fund accounts regardless of how the markets performed.

Cary Badger: The investment options we're using, Charles Schwab, are the same rate of returns you would get if you called Charles Schwab and used their portfolio. So they're not different, they have the same investment portfolio available for all of our HSA members. It's not limited to just money markets. They have funds they can choose from once they meet a minimum balance so they can start investing. The minimum balance is to protect a person so he or she doesn't put a bunch of money in an investment and then has to take it out to pay for health benefits.

Comment: I've typically seen, yours may be different, especially if you look at the leading VEBA companies that are administering VEBA accounts, you'll find there are higher fees and lower rates of return. So if yours is different, that's good to know.

Cary Badger: I'd be happy to compare them.

Comment: They're all similar. You've got to use a third party administrator and you have to use their investment options.

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John Williams: I'm going to switch gears on you unless there are more questions about the proposal itself. We included in your packet follow up to the Board retreat where we had briefed you again about things that we've been working, with our pharmacy benefit manager, to find aspects of our current pharmacy benefit plan that we could do improvements on to generate savings through the pharmacy benefit plan. At the Board meeting we were asked, after briefing you again, to roll it into a single comprehensive package and tell you what the projected cost savings would be. You have that in your packet now. It's a one page summary. By doing these changes, we're anticipating that we can save $16 million in 2012 on pharmacy costs. This is not part of the redesign plan proposal. I don't want to link the two together. This was just to follow up with you to get information in your hands and get your reaction to this because we really want to have a dialogue with you and your input before we make a final decision to implement these as part of 2012 improvements to UMP because this is a sizable cost savings. It's not a major change in the pharmacy benefit plan, it's tweaking what we're already doing to do it better and to realize savings. This is more dialogue with you than it has anything to do with the proposal. The savings aren't built into the redesign proposal financials.

Lee Ann Prielipp: So the savings is to the plan not to the participants. Will the participant pay more in the end? Be paying more than they have been before.

Nicole Oishi: The pharmacy design in terms of the cost sharing and that sort of thing is in the packet so there is some downgrading of the costs. For the members, for the value, generic prescriptions they'll be paying less. There is a $5 co-payment. If you take one of those generics for chronic drugs, then you will pay less. There is some variable there.

John Williams: Across the package as a whole, there are things that some members will pay more, there are things where everybody will benefit by paying less; but overall the savings to the plan could be $16 million.

Lee Ann Prielipp: Of course, that sounds good from the plan's side. But I'm just curious how much it would impact our members.

John Williams: The numbers really haven't changed from when we proposed it one piece at a time to you before, so we can get you those breakouts again. This was just an effort in response to the last Board meeting to put it in one package.

Lee Ann Prielipp: My question, as usual, is does that impact retirees more on Medicare than it might others because of the types of drugs that get moved around?

John Williams: You can see that we have broken it out by the savings, by risk pool, so $9.2 million of the $16 million is for the non- Medicare risk pool, $6.8 million is the Medicare risk pool. Both risk pools will be impacted. Some members will have higher costs and some will have less. It crosses both risk pools.

Nicole Oishi: I think this also goes to John's point about the consumer engagement piece, and making sure that we're educating people. In the consumer driven health plans with the HSA, your medication costs actually go towards the deductible and maximum out of pocket, where as in traditional UMP they don't. So if you're looking at medications and you have a very expensive drug that you take, you might sit down with one of these tools and say, "Oh this is how much my medication is. I want this HSA plan because all of those costs are going to that deductible." Again, this speaks to our task, our goal of making sure that we educate members about what plan really is the best plan for you.

Doug Porter, Chair: We will be moving forward with our procurement with this redesign proposal.

DRAFT

Public Comment

Jonathan Rosenblum, SEIU Health Care, 1199 NW: I'll be very brief. I just want to note a couple things, that we're pleased with the direction of the UMP and redesign. We hope that actually more can be built on it in the coming years and quickly soon around more aggressive disease management and more incentives around prevention and wellness. We think that health care has to be seen as a complete picture, not just pieces of the puzzle. A foundation for it is a strong relationship between the consumer and their primary health care provider. So we hope that you build on that. We, of course, continue to have grave concerns about the high deductible plan. I've mentioned them here before and I won't go into greater detail today except to say that we recognize there is some debate on your Board back and forth with John around the issue of the $700 being frontloaded versus not. In as much as any frontloading concept would require borrowing from savings, that savings for all the plans, we don't believe that other plans should subsidize any frontloading for this HSA. If you have any questions, I'll be happy to take them, otherwise, thank you for your time and your attention to the health care of Washington State employees.

Next Board Meeting: April 20, 2011

The meeting was adjourned.

Respectfully submitted,

Doug Porter, Chair

PEB MEDICARE PORTFOLIO REDESIGN PROPOSAL

April 20, 2011

This document presents an interim scenario for the PEB Medicare Portfolio Redesign project, and is a work in progress. The health plans' features described here are based on partial PEB 2010 financial experience as of December 2010.

Final plan features are contingent on:

- The PEB Board's approval of the PEB funding and explicit subsidy rate set by the Legislature and Governor.
- Analysis of 2011 legislation impacting the PEB Program.
- Federal approval of Medicare Advantage plans.
- The participating health plans' review of all current and 2010 patient claims, administrative costs, and membership forecasts.

PEB MEDICARE PORTFOLIO REDESIGN PROPOSAL

BACKGROUND INFORMATION

PEB MEDICARE REDESIGN STRATEGY

PEB's Guiding Principle: The PEB Program strives to provide health plan members the highest quality health care services that can be purchased within the funding level provided by participating employers and beneficiaries.

PEB Strategy Outcomes:

- Health status improvement
- Cost trend management
- Positive member experience and satisfaction
- Health care quality improvement

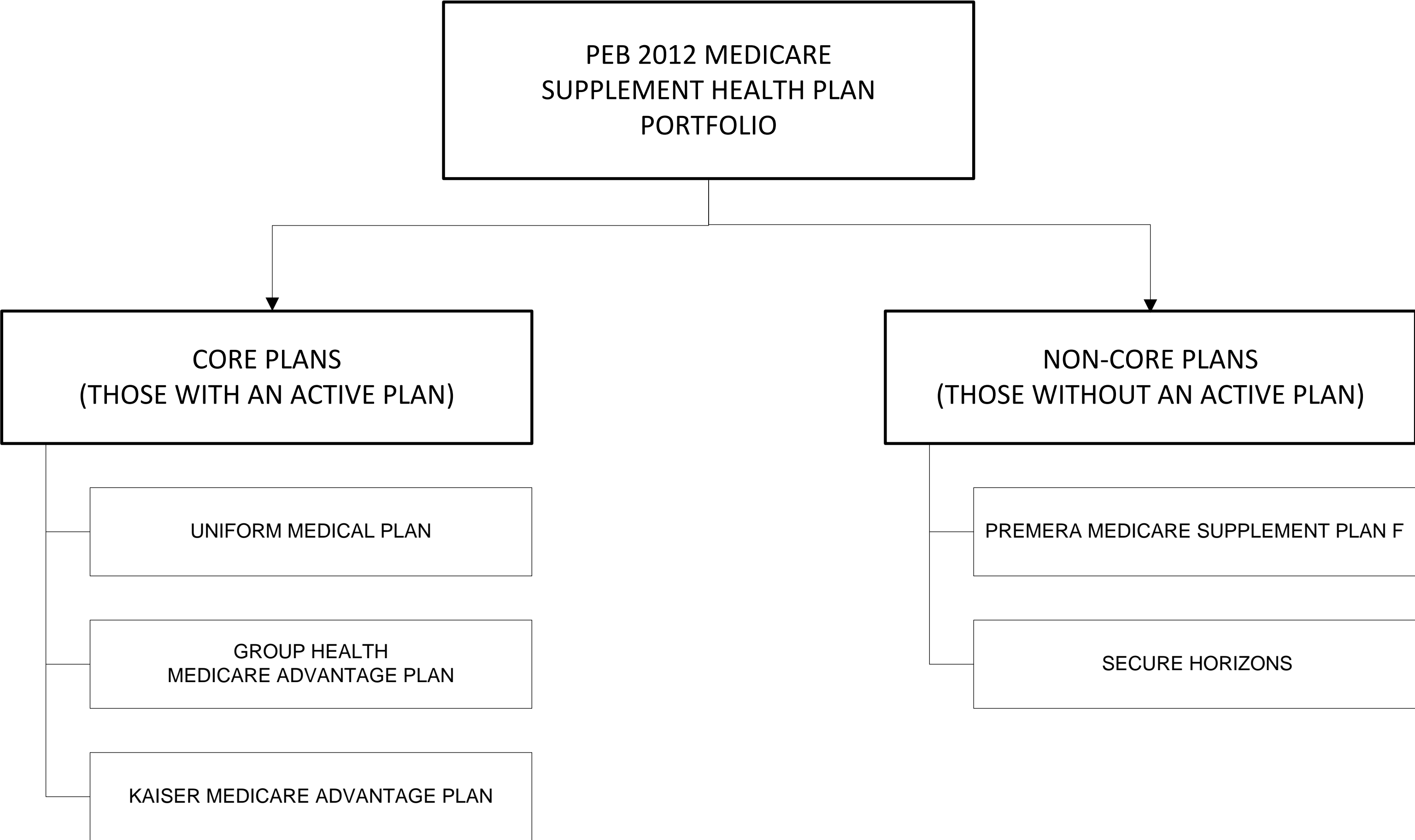
PEB Strategy Approach:

- High **engagement** by HCA, PEB members, PEB network providers, PEB contracted health plans, and PEB participating employers.
- Shared **financial accountability** for cost trend management by HCA, PEB members, PEB network providers, PEB contracted health plans, and PEB participating employers

2012 Medicare Redesign Expected Outcomes:

- Plan offerings that are designed to offer affordable Medicare supplemental coverage.
- Members understand their options and are able to choose an option that best suits their circumstances.

Tentative PEB
MEDICARE PORTFOLIO 2012



PEB MEDICARE PORTFOLIO REDESIGN PROPOSAL

HEALTH PLAN PRODUCTS

Group Health Medicare Advantage

Proposed Design Change	Premium Reduction	Retiree Increase
No change		7.2%
Baseline subtotal	n/a	7.2%
Change pharmacy copayment	4.0%	3.1%
Recommended Subtotal	4.0%	3.1%

	2011	2012
Retiree single premium	$137.51	$141.77
Prescription		
Retail pharmacy (30 day supply) Tier 1	$10	$20
Tier 2	$30	$40
Tier 3	n/a	$60
Mail order (90 day supply) Tier 1	$20	$40
Tier 2	$40	$80
Tier 3	n/a	$120

Additional details on the Group Health Cooperative Medicare product

- The Group Health Medicare redesign proposal aligns with the product Group Health Cooperative files with the Centers of Medicare and Medicaid Services (CMS). The filing requirements are changing for 2012 which may result in impacts to costs and benefits.
- Group Health Cooperative will offer one product given that:
  - The changes to Group Health's active member products no longer align to the historic Classic/Value offerings.
  - There are few differences between the 2011 Value and Classic benefits.
  - The Value plan has very low enrollment.
- The 2011 pharmacy benefit changes that apply to both the Group Health Classic and Value plans for active members will also apply to Medicare members. This is consistent with past practice.
- A Medicare Group Health product will continue to be available in those counties where Group Health offers active plan coverage and a Group Health Medicare Advantage plan is not available.

Kaiser Permanente Medicare Advantage

Proposed Design Change	Premium Reduction	Retiree Increase
No change		29.3%
Preliminary renewal estimate	0.5%	
Baseline subtotal	0.5%	28.4%
Change pharmacy copayment	10.0%	
Change Office Visit Copayment	3.0%	
Change Hospital Inpatients Copayments & OOP Max	3.0%	
Recommended Subtotal	16.0%	-4.7%

	2011	2012
Retiree single premium	$183.42	$174.80
Prescriptions		
Retail pharmacy (30 day supply) Tier 1	$10	$20
Tier 2	$30	$40
Tier 3	n/a	$60
Mail order (90 day supply) Tier 1	$20	$40
Tier 2	$40	$80
Tier 3	n/a	$120
Office Visit Copayment	$20	$30
Hospital Inpatient Copayment	$0	$500/admit
Out-of-Pocket Maximum	$600	$1,500

Additional detail regarding the Kaiser Medicare Advantage Plan:

- OOP Max stands for annual out-of-pocket maximum and includes hospital copayment.
- The Kaiser Medicare redesign proposal aligns with the product Kaiser files with the Centers of Medicare and Medicaid Services (CMS).
- The 2012 pharmacy benefits that apply to the Kaiser plan for active member will also apply to Medicare members. This is consistent with past practice.

Uniform Medical Plan

Proposed Design Change	Premium Reduction	Retiree Increase
No change		31.3%
Eliminate COB Savings Checks	5.7%	
Align Pharmacy with non-Medicare	4.9%	
Baseline subtotal	**10.5%**	**9.9%**
Change Hospital Inpatients Copayments & OOP Max	1.6%	
Recommended Subtotal	**12.1%**	**6.9%**

	2011	2012
Retiree single premium	$194.13	$207.52
Hospital Inpatient Copayment	$200/day ($600 max/year)	$200/day ($600 max/admit)
Out-of-Pocket Maximum	$2,000	$2,500

Additional details on the Uniform Medical Plan Medicare product

- OOP Max stands for annual out-of-pocket maximum and includes the hospital copayment.
- The UMP Medicare redesign proposal is limited to those changes under UMP's control as a secondary payer. Provider networks and reimbursements are set by Medicare.
- The member premium increase from 2010 to 2011 was 19%.
- The 2012 pharmacy benefit changes that will apply to both the current UMP plan and the UMP accountability plan for active members will also apply to Medicare members. This is consistent with PEB's practice. The proposed changes will standardize members' pharmacy cost-sharing, impose additional restrictions on select high-cost generics, and establish greater adherence to a previous PEB Board policy decision to not cover prescription drugs when effective over-the-counter medications are available.