Washington State Health Care Authority

Public Employees Benefits Board Meeting

April 13, 2016

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Public Employees Benefits Board Meeting

April 13, 2016
1:30 p.m. – 3:30 p.m.

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board
April 13, 2016
1:30 p.m. – 3:30 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

Conference Call Dial-in Number: 1-888-450-5996 **Participant Passcode: 546026**

1:30 p.m.*	**Welcome and Introductions**		Dorothy Teeter, Chair	
1:40 p.m.	**Approval of June 24, 2015 Minutes** **Approval of July 22, 2015 Minutes** **Approval of August 6, 2015 Minutes**	TAB 3	Dorothy Teeter, Chair	Action
1:50 p.m.	**Updates:** • **Legislative** • **ACP Expansion** • **TJR Centers of Excellence** • **SmartHealth**	TAB 4	Lou McDermott Cade Walker Marcia Peterson Scott Pritchard	Information
2:20	**Life Insurance Procurement Results**	TAB 5	Beth Heston	Information
2:40	**Pharmacy Trends**	TAB 6	Donna Sullivan, Chief Pharmacy Officer	Information
3:10	**Public Comment**			
3:30 p.m.	**Adjourn**			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, April 13, 2016, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626th 8th AVE SE, Olympia, WA. 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/ no later than COB 4/11/16.

Washington State Health Care Authority

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.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
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-583-5353 mljohnso@cloverpark.k12.wa.us	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 maryklindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170th ST Kenmore WA 98028 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
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*non-voting members

1/26/16

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2016 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 7, 2016 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 16, 2016

April 13, 2016

May 24, 2016

June 22, 2016

July 13, 2016

July 20, 2016

July 27, 2016

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 07, 2015
TIME: 7:10 AM

WSR 15-17-011

TAB 2

Washington State Health Care Authority

PEB 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.

TAB 3

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

U P D A T E D D R A F T

June 24, 2015
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:00 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Gwen Rench
Yvonne Tate
Marilyn Guthrie
Myra Johnson

Members Absent:
Mary Lindquist
Harry Bossi

PEB Board Counsel:
Katy Hatfield

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Dorothy stated: Pursuant to RCW 42-30-110, the Board met this afternoon in Executive Session to consider proprietary or confidential non-published information related to development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session began at 12:00 p.m. and concluded at 1:00 p.m. No action, as defined by RCW 42.30.020(3), was taken during Executive Session."

Dorothy told the Board that Marc Provence resigned from the PEB Board and is now working for the Health Care Authority in the Healthier Washington Program. A search for Marc's replacement is underway.

Board and audience self-introductions followed.

Approval of April 15, 2015 PEBB Meeting Minutes

It was moved and seconded to approve the April 15, 2015 PEB Board meeting minutes with one correction. On page 2 of the minutes, in Gwen Rench's comments, change Medicare subsidy to Medicaid premium. Minutes approved by unanimous vote with noted correction.

Legislative Update and Accountable Care Program Update

Lou McDermott, PEB Division Director, indicated that the legislature was still in session. The Public Employees Benefits (PEB) Division has done an analysis of the House budget and we're still waiting on the Senate budget. The retiree subsidy in the House budget is $150. County Bill 1740 is still in the budget which would require the PEBB Program to accept all counties regardless of their claim history.

The smoking surcharge remains at $25 and the spousal surcharge remains at $50 with a 95% actuarial value of the Uniform Medical Plan, as in previous years. The funding rate is less than our model projections, so it appears they may have adjusted the funding rate by projecting a lower trend.

We will do an analysis on both budget bills when they come out.

All non-essential state employees were given layoff notices, effective July 1, 2015. If the budget isn't signed, HCA will close June 30, 2015. Without a budget resolution, there may be an impact on how soon we can gather information and prepare for our 2015 Open Enrollment season.

The Accountable Care Program (ACP) will take effect January 1, 2016. ACP is a subset of the Uniform Medical Plan (UMP) Program. The Health Care Authority signed with two delivery systems: 1) Providence UW and 2) Puget Sound High Value Network centered around Virginia Mason and their partners Multi-Care and Evergreen. We are still working with attorneys to determine what elements of the contracts are proprietary and what elements are not. There are care components and member experience components.

Numerous delivery systems applied and three were considered. HCA was unable to come to an agreement with Providence.

HCA is now going through the process of clarifying the contract. It is a four-year contract for calendar year 2016 through calendar year 2019. These two options will be offered in King, Kitsap, Snohomish, Pierce, and Thurston Counties. We are still waiting for the network to be finalized so we can communicate that information to our third party administrator, Regence. They need to program their system so they know who is inside the ACP.

Some aspects of the ACP:

- Members who sign up for this product must reside in the county where the product is offered.
- There will be a lower premium share for the member.
- The benefits are the same as in UMP Classic, but certain aspects of the benefit design are different, such as the deductible, cost share for primary care visits, and out-of-network patient responsibility.
- Enhanced member experience.
- A Toll-Free number for members to call with issues, make appointments, care coordination, and any other questions they may have.
- Web portal to provide information on provider services, link to other HCA activities, medical charts where they can get test results, see appointments, refill requests, and ultimately have conversations with their doctors. (This currently is available in Group Health.)

The financial component provides a trend guarantee over that four-year period. This allows us to offer a richer benefit. Quality metrics are important to the trend guarantee. The quality of service provided will have a positive or negative impact on finances for the providers depending on their level of quality.

We are still in the process of finalizing the benefit design. Our goal is a 30% premium differential, which will bring the cost down for the member. If you compared this to today's UMP premium of $84 for 2015, the ACP product would have been $59. We are also looking at a reduction in the deductible – from $250 to $125. If the member was in an ACP, participated in the SmartHealth Program, and earned the wellness incentive for the following year, potentially their deductible could be zero.

There will be deductibles for drugs. Today, the deductible is $100 for a single member and $300 for a family. In the ACP, the deductible would be zero for both. The maximum out-of-pocket (MOOP) will remain the same.

There will be a slight increase in the coinsurance on the out-of-network. It will go from 40% to 50%. We are looking at no coinsurance for office visits with your Preferred Care Provider (PCP). You may go to your PCP as many times as you like with no coinsurance.

This is the basic framework of the benefit design we are looking at now. We continue to make tweaks as we go through procurement. It's all tied to rates, trend, and now they tie together.

Dan Lessler, HCA Chief Medical Officer, discussed the care transformation component of the Accountable Care Program (ACP). There are three core elements to the care transformation:

- Patient Centered Medical Home
- Care Coordination for Patients with Complex Chronic Illness
- Implementation of Bree Recommendations – Bree best practices

Patient Centered Medical Home – The Accountable Care Program offers an opportunity to emphasize primary care and have a system that is primary-care driven and able to report out on population-based metrics of outcomes. The concept of Patient Centered Medical Home involves core elements related to delivery of primary care that ensures optimal care and drives good population health. The ACPs are required to meet a very high standard of accomplishment with respect to Patient Centered Medical Home. The NCQA, the accrediting body for health plans and clinics, has a set of criteria around Patient Centered Medical Home. Over the course of the contract, the ACPs will be required to meet an equivalent, if not the actual Level 3 NCQA accreditation criteria.

Care Coordination for Patients with Complex Chronic Illness – From a cost utilization and quality standpoint, it is important to address the needs of those with complex chronic illness. Intensive care management is an evidence-based option for addressing this need and is a requirement in the ACP contract for high risk PEBB Program beneficiaries who are participating or enrolled in the ACP.

Implementation of Bree Recommendations – Bree best practices – The Bree Collaborative is a legislatively charted stakeholder group in the state of Washington that brings together experts, clinicians, plans, and purchasers to identify best practices in terms of high cost, high utilization, or practice variation. This is an opportunity to drive those best practices into the delivery systems. There are expectations that the ACPs will adopt, disseminate, and implement the

Bree recommendations. The existing Bree recommendations include recommendations on joint replacements, obstetrical care, end-of-life care, care for patients with substance use disorders, care related to spine, and cardiac care; and especially in the outpatient setting, optimal care for those with low back pain; and then transitions of care – to coordination of care from inpatient to outpatient. These elements are incorporated into the contract with very clear expectations.

Marilyn Guthrie: Care management, care coordination is a concept that is easy to talk about but hard to do. How will you ensure that the delivery systems are actually meeting the expectations?

Dan Lessler: It will be possible to do. There is good literature around what components are needed to provide complex care management. Essentially, the contract contains the well vetted and researched elements and is clearly spelled out in terms of what needs to be included. There are measures in terms of regular reporting of the numbers of people who are being identified as in need of complex care management. They would need to meet the identified quality metrics that tie back to the work that's being done in terms of complex care management.

Dorothy Teeter: This is our introduction to the concept of an Accountable Care Program. You will be hearing more as the programs are developing, what those performance measures are, and how they're being achieved.

UMP Bundled Payments for Total Joint Replacement

Marcia Peterson, PEB Division Benefit Strategy & Design Manager, shared information on the Uniform Medical Plan (UMP) bundled payments for the total joint replacement project. As background, Governor Inslee encouraged us to be a leader in improving our health care system, emphasizing quality and coordinated care. The new Accountable Care Program and the bundles are designed to offer choices and high quality care to our members. HCA has taken a leadership role in accelerating the adoption of value-based reimbursement methods, the focus on the whole person, that provide quality and coordinated care and that reward providers for high quality outcomes. Our goal is to achieve the Triple Aim of better health, better care, and lower costs.

In developing our models, we are using resources like the Washington Health Alliance and the Bree Collaborative. The Washington Health Alliance helps us define value in health care. The Bree Collaborative was established in 2011 by the Washington State legislature to allow public and private entities and stakeholders the ability to identify areas for improvement in health care and provide information on best practices. The Bree Collaborative is focusing on areas around high variation in the way care is delivered; areas where care or treatment is frequently used but doesn't necessarily lead to better care or patient health; and in areas of patient safety.

The use of the Bree criteria is largely voluntary among providers throughout the state; but as a purchaser, we will offer incentives to those using the criteria. HCA has identified an opportunity to ensure that our members receive high quality care following the Bree criteria for quality around the area of total knee and hip replacement. For this area, Bree has recommended a bundled approach along with a warranty on both the materials and the hospital stay.

One of the challenges of improving health care quality is the fragmented way it's currently organized, particularly in surgery. You have the surgeon, the pre-surgical work, an operating team, nursing care, post-operative care, physical therapy, and all of the other elements, who are often not on the same team. This lack of coordination that can take place between the players can result in poor quality outcomes, as well as a confusing and frustrating experience for the patient and the family. By bundling the components of these procedures together, identifying the evidence-based quality components of care and tying payment to the whole bundle of care rather than to the pieces of it, providers are incentivized to work together to provide high quality care.

The bundle, as defined by Bree, identifies expected components of pre-operative, intraoperative, and post-operative care that are needed for successful knee and hip replacement. It includes both clinical components and quality standards. In 2013, there were 544 UMP members that had at least one of these procedures, some having more than one. The overall cost in claims paid was approximately $18M. That averages about $30,000 in claims per procedure, with some of those costs borne by the members.

A surgery like this is a significant life event; and as Bree and others within the health care industry have identified, it has great potential for variation in quality. It's an area we feel should be considered for payment reform, linking quality with finances. While total joint replacement can result in vastly improved quality of life for the individual, there are other less aggressive treatments that are available; and in some cases, those can be tried first to see whether or not surgery is necessary.

There's an upward trend in the volume of these procedures being done nationwide. We expect to see that going forward, partly driven by demographics, but partly driven by technology and what we are now able to do. An example of Bree standards for the surgical team performing total knee and hip surgery includes things from how many procedures a surgeon must have performed in a year to the types of credentials, training, and experience that members of the team must have. It even speaks to the latest time a procedure should be scheduled. Most lay people wouldn't think to ask these types of questions before scheduling a procedure. These are evidence-based details the Bree Collaborative is recommending.

The bundled payment program for hips and knees, following the Bree criteria, is scheduled to be fully implemented by benefit year 2017. A phased approach is planned to implement this program, with the first phase being a letter and survey to providers requesting they tell us if they have adopted the Bree criteria, or if they plan to. This request will draw attention in the industry to the Bree criteria and will signal to the market that we are serious about quality within the PEBB Program. An RFP will be issued in the fall for a bundled product for knees and hips, to be effective January 2017. Member involvement, member education, shared decision-making tools, and benefit design are important components of the bundle.

As mentioned, the first phase of this project has started, with an RFP to providers scheduled to go out in the fall for the second phase. Throughout 2016 we will embark on a campaign to educate members on purchasing health care and quality within health care, not just around hips and knees. Tentatively around first quarter of 2016, contracts will be signed with the apparent successful bidders, with implementation to begin in 2017.

Yvonne Tate: Would you go to your primary care doctor first and they would know the physicians in this group to refer you to?

Dr. Lessler: Yes, you would go to your primary care doctor who would make an initial diagnosis as to whether or not you might be a candidate. A surgical recommendation would be made by an orthopedist. Primary care doctors would know who those orthopedists and facilities were that contracted with UMP to provide joint replacement surgery. The member should know the advantages of having their joint replacement with a contracted orthopedist and facility. The benefit design would be such that it would be less expensive for you to have it done in this context as a part of the bundle than if you were to choose an orthopedist or facility not contracted with UMP for the bundle.

Yvonne Tate: Does that mean if I participate in this program, I would still have the choice of not using one of your recommended orthopods?

Marcia Peterson: The benefit design is being developed. That phase hasn't started, but that's certainly something we've talked about. You could be paying more if you selected a physician that wasn't contracted with UMP. The Bree criteria involves appropriateness, and if the physician didn't meet the criteria and you selected them anyway, the cost could be greater. That is yet to be determined.

Myra Johnson: On the phased approach, when will the letters and surveys go out and how many providers will receive them? Regarding the RFP for proposals, how many do you anticipate hearing back from? Will it be limited to Eastern Washington, Western Washington, or the entire state? How will member education be disseminated to the members? What will that look like?

Marcia Peterson: We're hoping the letter and survey will be sent next week. We're still editing. They are being sent to physicians, orthopedists, and facilities in the Regence network that provide this service.

As to how many will participate, we'll have to wait and see since this is so new. There are providers in the community who are working on bundles, but we're the first purchaser in this market to go forward with the idea. There are health plans trying to do the same thing. It's unclear how many will meet our criteria for the RFP.

Myra Johnson: Worst case scenario, if no one responds, what is the next step? What is option B or C?

Marcia Peterson: It would definitely cause a discussion. We would have some quality information from those surveys. I would be surprised if there was no response. The market is very interested in this concept. Providers have been working on putting these together but haven't had a purchaser.

Dr. Lessler: We do know of a number of places that are working on developing bundles. Some already contract with other entities through a bundle-like methodology.

Myra Johnson: You're thinking you'll get the responses you're looking for and it won't be an issue, and they'll meet your qualifications?

Dr. Lessler: Yes.

Myra Johnson: How will the members' education be given? Will it come from their primary care provider? How will it be disseminated to the members?

Marcia Peterson: That is part of our implementation plan yet to be determined. We are looking at patient/member education in general and how to choose wisely. There is a national Choose Wisely campaign that we are reviewing; and we anticipate communicating through our website, through direct mail, and through the providers themselves. There are shared decision-making tools, too, that Dr. Lessler is providing leadership on. It's a whole package to help consumers become more aware of their choices in health care; how to make wise choices around quality.

Dr. Lessler: In terms of the mechanics, there are details to be worked out. The member needs to be made aware of the need for prior authorization before a procedure is covered by Regence, our TPA. Preauthorization provides the opportunity to make sure the patient is connected to the information they need when making that medical decision. It allows that shared decision making. There will be opportunities along the way to ensure the member is engaged.

Dorothy Teeter: We will be following this with great interest. Hopefully others will join us in this way of doing value-based purchasing.

SmartHealth Update

Scott Pritchard, PEB Division Health Management Unit, provided a SmartHealth update. We are almost half way through the first year and nearing the end of the qualification period for the financial incentive. Our vendor, Limeade, provides weekly reports allowing us to track how we're doing. We will measure our progress against the goals we set for ourselves.

Data is updated every Monday, and today's numbers are through June 15. It appears that members who register with SmartHealth complete their well-being assessment. As expected, there was a sharp upturn in participation as we neared the deadline for completion. The registrations increased to 50,500 (49,086), well-being assessments went to 47,300 (45,898), and the incentive completion is now 25,600 (22,449).

Our population works at different places and we have segmented the different work types. There are state employees in state agencies, 54,000; higher education, about the same number; political subdivisions, which are public employers not employed by the state but get insurance through the PEBB Program; retirees; and then all those agencies that have under 50 employees, about 1,800 people. We track them separately. The agencies have the highest participation; higher ed, political subdivisions, not as many. This tracks with our outreach work.

The top twenty participating agencies, ranked by completion of the well-being assessment, were identified. The Health Care Authority is the leader among the large agencies. Three agencies reached our goal of a seventy percent completion rate, with ten agencies near that rate. Cabinet agencies were tracked as well. Three achieved the goal seventy percent well-being assessment completion rate and six other cabinet agencies are near that goal.

We're working with the Department of Social & Health Services (DSHS) and the University of Washington, the two largest state employers. DSHS has over 15,905 employees that are insured through the PEBB Program and the University of Washington has well over 29,000 employees. Both of these programs have made significant progress since they started this year. They've been good partners and we'll continue to work closely with them because they represent about 34% of all state employees.

As we monitored state employee participation, we identified three groups. One group wasn't registered. They either weren't getting the message or chose not to participate. The second group registered, completed their well-being assessment, but didn't complete enough activities to earn the incentive qualification level of 2,000 points. The third group completed their well-being assessment, earned the required 2,000 points for the incentive, and continued to earn additional points. Some of our promotions were based on this breakdown. Our goal was to get employees to register who hadn't, to get those employees to 2,000 points who weren't, and to create enough interest for those who earned the incentive to continue earning points. Our registrations went from 42,700 to 51,700; those earning the incentive went from 12,723 to 26,075.

Our two most successful promotions were from Governor Inslee's email to state employees and the Seahawks ticket giveaway! We also gave away three Mariner's ticket packages. Each Mariner's package included four tickets at the diamond level, free food and drink, and two parking passes. The first drawing was for those who completed their well-being assessment. The other two drawings will take place June 30 – one for those who completed their well-being assessment and earned 2,000 points, and the other drawing for those who earned 3,000 points.

Hoping to get employees to earn 2,000 points, we brought back some of the most popular activities. Some point levels were increased and the number of activities increased. The initial goal of the program is to get employees to register and take their well-being assessment; to get them to participate. Going forward, we'll start emphasizing behavior change and the importance of choosing activities that can improve their health.

A special activity was the Governor's Walk on June 17. He called it the Walk for SmartHealth. Employees met on the Capitol steps, listened to the Governor give a speech, and then took a thirty-minute walk. You could participate in the Governor's Walk by walking thirty minutes wherever you were. 3,941 people indicated they completed this activity.

We have worked to engage senior leaders, which helps create an authorizing environment and a culture within their organization that says wellness is important. It helps engage from top management to mid management, and down to all agency employees. Chair Dorothy Teeter and DOH Secretary John Wiesman shared the Executive Cabinet Completion Ranking Table with Cabinet leaders. The response was good and some leaders wanted to improve their numbers. This table is updated weekly and has been a great tool for awareness. There is value in senior leader engagement. Competition is great, but we really want senior leadership to understand that employees with well-being can help accomplish their agency's mission. Again, we focused on UW and DSHS because they are tasked with engaging 29,000 plus, or 15,000 plus, employees across different parts of an organization.

As the data from the well-being assessments is collected - it's in aggregate, privacy-protected, no individual data - the aggregate begins to show us the health risk status. Healthy weight is one of the highest risks within the population, back health is high, and sleep is high. Exercise and fitness is always important. As this information is gathered, we are looking at available resources. We will add to the PEBB Program portfolio resources that will help improve the health of our members.

We are approaching the fifty percent level of people that have registered and done their well-being assessment, which is excellent. That's about 50,000 people and larger than any other employer in the state if everybody completed it. Data indicates that this group is the healthier part of our population. This would be unusual if this continued as we get to the 75% completion rate. As we continue to collect data on health risks, the information will identify some of the challenges moving forward of whom we need to reach.

Well over 50 activities have been offered to employees to assist them in achieving better health. Some of those activities are: Track Your Activity, More Veggies, Visit a State Park, Connect Your Device, 7-Minute Workout, to name a few. External program options were also offered, such as Health Coaching with Group Health, Diabetes Prevention Program, Quit Tobacco, and a Diabetes Control Program. These help to reduce risk and to manage health conditions through health plans.

Myra Johnson: Could you talk about Healthy Start?

Scott Pritchard: Healthy Start is eating a good breakfast.

Scott Pritchard: Our goal is to reach 132,000 PEBB Program-insured people and we've currently reached 50,000. Customer research will be important in helping us shape a product they want to use. We're listening to our customers and gathering their feedback. We just finished a survey and we're analyzing the data now. It went to two agencies, two higher eds, and two political sub groups. We are doing a non-participant and participant survey and our vendor Limeade will send a survey that they use.

We are planning focus groups for September; we'll work with the UW Health Promotion Research Center to do research around the impact of mid-manager engagement; and we have an intern working with us this summer to help develop the value proposition for senior leaders. The intern will address the value of healthy employees to the mission of the agency. That is an essential part of moving forward.

Marilyn Guthrie: Scott, this is really remarkable. I have to commend you and your team for doing what I think is really great work. And to be at this point in the year, is especially commendable.

Dorothy Teeter: I don't think there is anyone more enthusiastic than Scott about the data. We are a data driven program in PEB. It's been really interesting to see the curve of people's adoption rates for this, and how we want to make our next challenge will be how to keep it going throughout the rest of the year.

Policy Recommendations

Barb Scott, PEB Division Policy & Rules Section Manager, shared information on two policy recommendations requiring Board action at the next Board meeting.

The first proposal is related to the SmartHealth Program deadline for completing program requirements. In 2014, eligible subscribers were required to complete wellness incentive program requirements by the later of June 30, or within 60 days of their medical effective date, in order to be eligible to receive a wellness incentive in January 2015. Last month the Board

adopted a change to the policy so newly eligible subscribers now have 120 days instead of 60 days from their medical effective date to complete wellness incentive program requirements. The policy change was adopted for the 2015 plan year and will be used to determine eligibility to receive a wellness incentive in January of 2016.

The proposed policy would change the current June 30 deadline to September 30. The policy change would be effective for the 2017 plan year and forward. It would not impact the upcoming 2016 plan year.

The proposed policy states:

> Effective January 1, 2016, to receive a Public Employees Benefits Board (PEBB) wellness incentive in the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements by the following deadline:
>
> - For subscribers continuing enrollment in PEBB medical and subscribers enrolled in PEBB medical with an effective date in January, February, March, April, May, or June, the deadline is September 30
> - For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is 120 days from the subscriber's PEBB medical effective date
> - For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31

Originally we needed data by June 30 for rate development. Going forward, we will rely on historical data to set rates. The September 30 deadline will provide health plans with a sufficient amount of time to have accurate accounts displayed for Open Enrollment so members will know whether or not they're receiving an incentive in the upcoming plan year.

The second policy proposal is related to Tricare. We received a request to review our administration of the PEBB rule that allows an employee to waive enrollment in PEBB medical if they're enrolled in medical through another employer; for example their spouse's employer-based medical insurance.

Currently, our rule allows an employee to waive PEBB medical if enrolled in Tricare coverage related to current employment. This policy proposal will allow an employee to waive PEBB medical when enrolled in Tricare coverage related to retirement.

The Proposed Policy States:

> An employee may waive enrollment in Public Employees Benefits Board (PEBB) medical if he or she is enrolled in Tricare.

Based on a review of the federal regulation, we recommend making this adjustment in order to fully comply with federal Department of Defense regulation governing Tricare coverage.

Our next step is to bring this back to the Board for a vote at the next Board meeting.

Affordable Care Act Update – Cadillac Tax and Play or Pay

Mary Fliss, PEB Division Deputy Director, gave a brief highlight on the actions taken to date related to the Cadillac Tax, as well as our efforts to comply with Play or Pay reporting. The last time these topics were shared with the Board was at the Board Retreat in 2013. This is in addition to that presentation and I anticipate continued periodic updates related to these efforts.

By way of background, the Cadillac Tax requirement is a 40% excise tax on health plans with an annual premium of more than $10,200 for an individual and $27,500 for families. These amounts do include any payroll deductions related to Flexible Medical Spending Accounts (FSA) or Health Savings Accounts (HSA), both of which we offer to our employees. It does not include, however, any carved out programs we have related to dental or vision, or accidental disability, or long-term care insurance coverage. It is structured as a per-individual assessment to the employer and will begin with 2018 health plans.

The current status is that we have provided comments to the IRS on their most current rule making. In addition, we've started conducting the analysis required for the tax amounts. Our next steps will be to evaluate the available options if we need to take action to reduce any tax liability, and then to be considering those options for the 2017 or 2018 plan years.

Dorothy Teeter: Will we know during this Board session what the analysis looks like regarding the Cadillac Tax? Or is this something that will be ongoing into next year?

Mary Fliss: This will be ongoing into next year. We could, however, bring information forward as it becomes available.

Greg Devereux: Is the Health Care Authority looking at any options to reduce the tax?

Mary Fliss: Some of the options before us include limiting the amount of the election for Flexible Medical Spending Accounts. It's currently set at $2,500 as a maximum. This is a per-employee assessment so we could look at reducing both the FSA, as well as the Health Savings Account payroll deductions that our employees take. Another option would be to look at our vision coverage to see if there would be any feasibility of creating that instead of having it imbedded in the medical plan, to carve it out of the medical plan leaving the benefit levels the same. We continuously look at the trend for the health expenditure. Hopefully, some of the efforts shared earlier today related to ACPs, bundled care, and the SmartHealth Program will be bending that cost curve as we look at reducing the overall trend as part of the Triple Aim.

Greg Devereux: Who is the tax on?

Mary Fliss: The tax is assessed against the employer on a per-individual basis for those employees receiving a benefit over that amount because individuals have their election amount in terms of how much FSA or HSA elections they can take.

Yvonne Tate: I am guessing that this will probably have a bigger impact on government employers than most private employers because the government plans tend to be a bit richer.

Mary Fliss: It is based upon the cost of those plans. It does correlate to those costs. Sometimes there's that factor of richness in addition to other factors.

Yvonne Tate: The other thing I worry about is public safety employees that typically get free health care, what is that impact? Do you have the State Patrol in your plan?

Mary Fliss: We do have the Washington State Patrol and other safety officers as part of our plan and they are part of our pool. In the case of PEBB, all of those expenditures are pooled together as one reporting for that cost component.

The second requirement we're working on for the Affordable Care Act is our Play or Pay reporting. The requirement is for all large employers to either provide benefits to full-time employees or pay a penalty if that employee receives subsidized coverage through an Exchange. Full-time is defined by the IRS and there are several rules and requirements related to how a full-time employee is defined. The requirement of the employer is to report to the IRS for all of those covered on our self-insured plan the months they've been enrolled in coverage, by person; and if they are an FTE according to that definition, the month's affordable minimum value coverage has been offered. Employers are also required to report to subscribers for FTEs, a copy of the return that we sent to the IRS with that report; and for non-FTEs (retirees or self-pay members), as well as those employees who don't meet the full-time criteria, proof by month that they received coverage. This is to help them report for the IRS, if needed, that they have complied with the individual mandate. This is a dual purpose for that reporting.

Currently we have completed the analysis in terms of how to determine an FTE and set up the operating environment. We are working with the state HR database, the eight state payroll systems, as well as others, to operationalize the bulk of the data collection. In terms of next steps, we're working on building a new reporting database; then we'll test and validate the data and reports. We will continue to train agencies, inform our members, implement the reporting for our members in January of 2016, and complete IRS reporting by March 2016. We'll also work on supporting other operations for analysis and reporting now that we will have this information.

Dorothy Teeter: We are canceling our next meeting which is July 8. We will meet again on July 15 and then again on July 22.

Meeting adjourned at 2:55 p.m.

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

D R A F T

July 22, 2015
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:00 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Gwen Rench
Yvonne Tate
Marilyn Guthrie
Mary Lindquist
Harry Bossi
Tim Barclay

Members Absent:
Myra Johnson

PEB Board Counsel:
Katy Hatfield

Call to Order
Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum.

Dorothy introduced Tim Barclay, our new Board member. Tim replaces Marc Provence who is now an employee of the Health Care Authority. Tim is a Fellow in the Society of Actuaries and a member of the American Academy of Actuaries with nearly thirty years of health actuarial experience. He recently retired from Milliman where he was a principal and consulting actuary serving numerous government entities and private sector clients. Tim has a long history of supporting the state of Washington with Medicaid, Basic Health, and PEBB Programs, and has worked on numerous health care reform initiatives, not only here but in other states as well. He's been actively involved with the health exchanges, working closely with managed care organizations in Massachusetts during their implementation, and also has worked with our Washington health exchange. Tim knows a lot about what's going on in health and insurance not only here, but nationally. His familiarity with health care delivery in Washington and his familiarity with the PEBB Program should allow him to quickly contribute to the Board's activities.

The remaining Board members introduced themselves and then audience self-introductions followed.

Legislative Update

Lou McDermott, PEB Division Director, provided a legislative update. This year's session was challenging. We had two significant issues that did not pass. The first bill was bringing K12 into a new entity called SEBB, under the Health Care Authority. It would have consolidated all K12 purchasing. That would have been a huge undertaking for HCA.

The second bill would have changed how we review county entities that want to participate in the PEBB Program. If it had passed, it would have eliminated the Litmus test we use to determine the risk impact to HCA. We would have had an influx of additional members creating a significant workload issue.

What we did get out of session was continued surcharges - a $25 tobacco surcharge and a $50 surcharge for members whose spouses have other credible insurance. The language originally enacted was carried forward in this budget.

We have the explicit subsidy for Medicare retirees set at $150.

Our Technical Corrections Bill passed, which clarifies eligibility criteria in statute. This bill has no impact on benefits.

The funding rate was set for 2016 and 2017 at $840 and $894 respectively. That funding rate was not the amount our model was projecting we needed. There was a trend assumption that was changed by the legislature to come up with this number. It was a small change off of our anticipated trend, so we don't think it's going to have a significant impact. We will deal with it as the experience comes in and we determine at what amount we need it to be funded.

We're already starting to put forward bills and ideas for our supplemental budget for next year.

Greg Devereux: I just want to say that we continue to object to the surcharges. We think it is an end-run around our contract. We have dually noted that in the grievance process. We'll continue that objection.

Annual Rule Making

Rob Parkman, PEB Division, Rules and Policy Section discussed the annual rule making.

Rob provided a high-level overview information briefing on the more significant changes being considered during the 2015 annual rule making. No action is needed from the Board for this part of the briefing. The Board will be asked to take action on the two policy resolutions presented at the June 24 Board meeting.

The scope of the rule making addresses benefit administration issues; provides clarity in areas identified by members, business partners, and staff; makes some technical corrections; and implements policies adopted by the Board.

The administrative changes being considered include the following:

- Amending the rule that prohibits a member from being enrolled in PEBB coverage under more than one subscribers account to add clarity that an employee must waive enrollment in PEBB medical under their eligibility as an employee if he or she wants to remain enrolled in a spouse's, registered domestic partner's, or parent's PEBB health plan as a dependent.

The rest of the bullets add clarity to the rules governing enrollment in PEBB retiree insurance:

- The retiree eligibility rule specifically allows an employee to enroll in PEBB retiree insurance when their employer paid or COBRA coverage ends. The rule does not currently clearly include PEBB coverage continued during an approved leave of absence. We will propose amending the rule so it is clear that an employee is eligible to enroll in retiree insurance when their PEBB coverage continued during a leave of absence ends.

- Based on legal advice, we will integrate Policy 21-1 into rule. This will add two exceptions to the deferral form submission requirement.

    1. Exception: When a PEBB retiree enrolls as a dependent in PEBB, K-12, or ESD employer-sponsored medical plan, they would not need to turn in the form.

    2. Exception: When the 60-day deadline for retirees to join or defer PEBB coverage occurred between January 1, 2001 and December 31, 2001. At that time, we were accepting a letter.

We are considering changes to respond to requests for greater clarity in some rules and improved readability in others. These changes include:

- Adding several new definitions, like "pay-status" which we will propose means "all hours for which an employee receives pay" and "full-time appointed officials" which we will propose means "officials who are appointed by the governor, confirmed by the legislature, and work full-time for the state of Washington."

- Resolving questions regarding data used for the evaluation, the period of time the evaluation is good for before a group has to reapply, and to make it clear that if the size of the group is such that we require an actuarial evaluation, the actuary who conducts the evaluation will be designated by the PEBB Program.

- Having the first level of appeals for a Medical Flexible Spending Arrangement (FSA) or Dependent Care Assistance Program (DCAP) enrollment appeal at the employing agency level. This should improve the current process since the employing agency is the point where the employee's eligibility is determined.

We will make a technical correction to update an Internal Revenue Code (IRC) reference for “qualifying relative” of an employee as it relates to a special open enrollment event for the Dependent Care Assistance Program (DCAP). We will also make a couple of changes based on the passage of the PEB Technical correction bill, otherwise known as Senate Bill 5466.

The Board was provided with information on two proposed policy changes during the June Board meeting. One will change the deadline for completing requirements to receive a wellness incentive under the SmartHealth Program and the other will allow an employee to waive PEBB medical when they are enrolled in Tricare retiree coverage. We will vote on those now:

Proposed Policy Resolution #1:

> Resolved, effective January 1, 2016, to receive a Public Employees Benefits Board (PEBB) Wellness Incentive in the following plan year, eligible subscribers must complete PEBB Wellness Incentive Program requirements by the following deadline:
>
> - For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June, the deadline is September 30.
>
> - For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is 120 days from the subscriber's PEBB medical effective date.
>
> - For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Proposed Policy Resolution #2:

> Resolved, that an employee may waive enrollment in Public Employees Benefits Board (PEBB) medical if he or she is enrolled in TRICARE.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

The next step are to file draft rules so they are available for public comment, conduct a public hearing in August, and adopt the final rules in September. Any new or amended rules will become effective January 1, 2016.

UMP Purchasing for Value

Lou McDermott, PEB Division Director and **Charissa Fotinos**, Deputy Chief Medical Officer provided information on UMP purchasing for value. Lou explained why HCA procured the new products we did for 2016. Our goal is the Triple Aim – better experience of care, population health, and cost. A way to achieve the Triple Aim is through value-based purchasing. We've defined value as appropriateness, quality, price, outcomes, utilization, patient experience; all the things that most people would consider when they are making a purchase or receiving a service. Is there value? The current fee for service system does not lend itself to providing value. We think there are better ways to incentivize our providers, our delivery systems, the facilities, the hospitals, all the different components of health care. We feel the products we've purchased for 2016 will do that. We have two new Accountable Care Program products through the Uniform Medical Plan and a new plan through Group Health. We are continuing to offer the Group Health and Kaiser plans. These are all falling into a more coordinated care theme.

The new UMP ACP will be available in King, Pierce, Snohomish, Kitsap, and Thurston counties. They'll be available to members who live in those counties. We are still evaluating those counties to ensure that there is an appropriate network for our members. If we were to determine that one of the counties did not have sufficient participation in the network, then we would eliminate that county by the time we got to open enrollment. Currently, the ACPs are continuing to make arrangements with providers.

Greg Devereux: Do both ACPs cover the same geographic area?

Lou McDermott: That's our intention. We are going to see if both ACPs can provide adequate network coverage. There may be some discrepancy by the time we get to open enrollment.

With the ACPs we are aiming for more coordinated care - smaller, integrated networks. We are encouraging the use of primary care. We are doing that through benefit design. The focus is on improving health, on quality. The providers are going to be held accountable for patient experience, for clinical quality. One of the items that we're going to do is no co-pays, or co-insurance, for primary care visits. We want people to go see their PCP. We don't want to have any benefit design issues with that access. There will be dedicated websites, call centers, enhanced customer service - all the things you would expect from a more tightly knit coordinated network. There will be one phone number you call to get appointments to make it easier for the member.

There may be changes in the provider network between now and the fall. In our communication to our members we will give them an express list of who's in the network. We're also hoping to provide an express list of providers. We understand that most members are going to make their determination on whether or not they want to belong in the ACP based on whether or not their provider is in the network.

In the plan design, we are reducing the deductible from $250 in UMP down to $125 in the ACP. We like that number because not only is it less than what it is in UMP, but it also coincides with the $125 deductible reduction you can get by fulfilling your wellness requirements, bringing it down to zero.

There will be no deductible for drugs. The maximum out-of-pocket will be identical to UMP, $2,000 and $4,000. The maximum out-of-pocket for Rx is $2,000. I did misstate this in a previous Board meeting where I indicated that all aspects of the ACP were more generous than Uniform Medical. I'm incorrect in two ways. First, it is a more limited network, so it's not more generous in the fact that you can't go wherever you want in the state for this specific plan design. Second, is regarding the out-of-network coinsurance. In Uniform Medical Plans, it is 40% member responsibility and in the ACP it will be 50%, so it's 10% higher. They are trying to encourage members to go inside the network so PCP visits will be at no cost. The prescription drug will be the same; four tiers as in the Uniform Medical Plan. Plan details are outlined in the meeting documents.

Greg Devereux: Could you expand on provider accountability, the clinical quality, and the patient experience? Will those be financial incentives? How actually will it be done?

Lou McDermott: It is financial.

Charissa Fotinos, Deputy Chief Medical Officer, provided information on the clinical aspect of purchasing for value. In the development of this contract, the HCA has directed the Accountable Care Programs to implement and report on progress in a couple different ways focusing on care transformation. The first is to invest in an infrastructure that advances primary care medical home standards across all the ACP partners, and that means all of the clinics where primary care providers are throughout each of the networks. The ACPs will adopt the coverage decisions of the Health Technology Clinical Committee, deploy electronic health records, and participate in the WA State Health Information Exchange once it's up and ready. The other piece is that for members who, either through risk modeling or analytics, are found to be at higher risk of admissions or emergency room utilization, the ACPs will be asked to provide care coordination for those members out of the patient-centered medical home rather than having a telephone contact them and say we want you to go to the doctor. This is a more active care coordination strategy approach through the clinic from which the member gets their care.

In terms of quality, the ACPs will be required to develop quality improvement efforts specifically related to each of the Bree recommendations to date, which include: potentially avoidable readmissions, obstetric C-section reduction, joint replacements, spine surgery, cardiology, low back pain, end of life care, and addiction and dependence treatment. The idea is for the ACPs to develop specific quality improvement plans related to each of those recommendations with milestones. Those discussions will include Dr. Lessler to determine if those milestones and the timeline are appropriate; if assistance is needed to help them maintain that, with the expectation that at the end of the four year contract, each of these, across each of the clinics providing care, will have met the quality improvement initiatives of the Bree Collaborative recommendations. If there are additional recommendations identified that are deemed appropriate to be implemented and/or have a quality improvement plan, those too will be added over time.

In terms of the accountability for outcomes, nineteen quality measures will be used. These measures are in the Washington State Core Measure Set and cover the following domains: Chronic conditions – diabetes and hypertension; behavioral health management (depression); patient experience; medical screenings and immunizations; and C-section rates.

This is a great opportunity for both the purchaser and the plan to align their quality measure sets. Providers have hundreds of measures they are responsible for, so by selecting these nineteen measures and coordinating with both the purchaser and plan, it makes it easier for the practices to focus and provide metrics and respond to those measures.

There are two components of how the quality will be measured and rewarded. The first piece is looking at improvement from whatever the practices baseline is and the second piece will be gauging that performance rate against national benchmarks. A practice could have either great improvement in their baseline scores, but not quite meet national benchmarks, or they could do both well, or neither well. And whether or not, and in what combination they have, will either lead to them owing money or they will get some savings based upon their performance in those two domains. We'll be driven by value and outcomes that are clinically based.

I was part of this process early on. I did all the site visits and spent a number of days with the team. It was an excellent process. It gave me a great opportunity to see where health care is and where it's moving. It's really a pleasure for me to see how this has developed and the product that it has with the focus on quality and value. As a provider, it is very exciting. This has been developed with providers and patients in mind. It is quite pleasing to see.

Greg Devereux: Who determines the baseline and how is it determined?

Charissa Fotinos: The baseline is wherever that practice is at its current metrics. For instance, the measure is we want to make sure that every adult over eighteen has been screened for depression, where are you starting? If 20% of your practice has been screened, that's your baseline. If that is a measure that you've never implemented, then you just start with whatever the first metric is. It's really where they are at that point. Does that make sense?

Tim Barclay: On that same topic, do you have a mechanism to adjust for the particular population that chooses to enroll in a given ACP, or is it more of a broader baseline of whoever's using that network today. How are you dealing with the sort of selection that might take place there?

Lou McDermott: Are you asking if we are risk adjusting for quality metrics?

Tim Barclay: That would be one way, kind of. Yes.

Lou McDermott: No. We're saying these are the measures, these are the benchmarks, and you need to achieve the benchmarks. It rewards providers from a fiscal perspective for two things. One reward is for achieving benchmark and the other is moving along the continuum of wherever they're at to the benchmark. There is a reward built into the model to handle that. There is no risk adjustment process that takes place between different networks that because of the population that went into yours, they have higher quality metrics for whatever reason than this population. Two sets of rewards, one around getting there and one around the journey to there.

Tim Barclay: That will avoid a lot of conflict in the end as well.

Greg Devereux: I assume regarding either the gross savings or deficit, if you don't meet the benchmarks, you don't get the reward. What does that mean? Does that just mean the Health Care Authority keeps whatever that was?

Lou McDermott: In the model, there is upside and downside risk. For example, if a provider were to come in under the amount that they needed to come in under, they're going to be entitled to a reward, a check. That check will be impacted by whether or not their quality was where it needed to be. If their quality was where it needed to be, where they made substantial improvement along the continuum or achieved target, then they will be getting the full benefit of the reward. If their quality lags or they go in the wrong direction, it will have a negative impact. And that same philosophy applies the other way. If they have to write us a check because they didn't come in where they needed to be, and they have good quality, then the check they have to write us would go down. If they have poor quality, then they would have to write us the full check. Quality has an impact on both sides of the fence.

Greg Devereux: What happens if they don't meet either one? What happens to the check they have to write to you? Does it just go into the General Fund surplus?

Lou McDermott: It goes into our account. The way this program was built is that there's a certain amount under our trend that they are saying "we can accomplish." We took that money and rolled it into benefit design. That's why you see a deductible from $250 to $125 and no coinsurance for PCPs. If we didn't get that money back from them, then we would be overspent on the plan. We do need that money back in the coffers because we've said this is how much money we need to pay it - whether it's this is how much we spent, this is how much we needed, or if we spent this much and they have to give back a certain amount of that, it all goes back in 721.

2016 PEBB Program Procurement Summary: Kim Wallace, PEB Procurement Manager, shared details about the 2016 Procurement. There are four handouts in Kim's documents that will assist in understanding Kim's presentation – Overview of 2016 PEBB Medical Plan Benefit Design, 2016 PEBB Medical CDHP Plans, Overview of 2016 PEBB Medicare Plan Benefit Design, and 2016 AV Summary By Plan. The first two handouts are tables that give you an at-a-glance context of our PEBB Program medical plans, the non-Medicare, non-CDHP medical plans and how the new plans and some of the benefit design changes for 2016 affect our whole portfolio.

Dorothy Teeter: The reason those tables are included is because as we go through all the pieces, it's a reference so you can see the whole big picture.

Greg Devereux: I think it's incredibly helpful. I was going through the piece and I kept thinking it would be great to have a side-by-side of all of these.

Kim Wallace: I will be covering medical benefit changes and touching briefly on dental benefits and life and long-term disability benefits.

There are benefit changes that will be implemented across all of our PEBB Program medical plans: UMP, Group Health, and Kaiser. The Bree Collaborative recently published reports including recommendations with respect to end-of-life counseling and alcohol and substance

abuse intervention. All of our PEBB Program plans will, as of January 1, 2016, be implementing and be compliant with coverage for end-of-life counseling and Short-term Brief Intervention Referral and Treatment for alcohol and substance abuse in various settings by various provider types. That's the difference, various settings and various provider types. In emergency departments and emergency rooms, sometimes there's an opportunity for providers to take the time to provide an alcohol or substance abuse screening interaction, an intervention. The Bree recommendation included advocating for that coverage.

The second type of change that will be implemented across all our plans has to do with the United States Preventive Services Task Force (USPSTF). This is a group of experts that convenes on a regular basis to discuss and develop recommendations to promote various types of preventive services. They give them different levels of ratings. Our PEBB Program medical plans implement regularly all of the A and B level recommendations that are issued. The ACA actually refers directly to the USPSTF recommendations; and in order to be in compliance with the ACA, we have to do this. Our plans do this on a regular basis.

Two of the recommendations we are implementing for 2016 have to do with tobacco cessation medications and aids. The difference is that all medications and all NRT over-the-counter prescriptions will be covered. The other change is that there are eight new preventive services that the USPSTF Task Force says should be provided to members with no member cost sharing. That list includes: sexually transmitted infections, Chlamydia and gonorrhea, Hepatitis B, cardiovascular disease, dental caries, abdominal aortic aneurysm, gestational diabetes mellitus, and preeclampsia. All of our PEBB Program medical plans will be providing these preventive services with no member cost sharing. Many of them currently have no cost-sharing, but what we know is as of January 1, we will be complete.

The UMP Classic Plan will not have any benefit changes for 2016 other than the Bree Collaborative recommendations and the USPSTF mentioned above.

For the UMP CDHP, Consumer Directed Health Plan, the Department of Health and Human Services (DHHS) issued a final rule this past February stating that individual out-of-pocket limits for people who are in a family cannot exceed $6,850/year. That caused us to make a change in our UMP CDHP, our Group Health CDHP, and our Kaiser CDHP plans.

The UMP CDHP will embed a per-person maximum out-of-pocket limit of $6,850/year in family CDHP plans. To clarify, if you and another family member are on a family CDHP plan together on PEBB UMP CDHP, each of you will now be subject to a $6,850/year limit on your out-of-pocket costs. Currently, you would be subject up to $8,400. It's a bit of a benefit, an improvement for individuals who are on a family CDHP plan together. The deductible and the maximum out-of-pocket levels will remain the same. Specifically, our deductible level on CDHP is still $1,400 for an individual, still $2,800 for a family, and the maximum out-of-pocket levels are the same except we're embedding the per-person limit of $6,850.

Group Health is offering a new plan for 2016 called SoundChoice. The Group Health SoundChoice plan is something that you will be asked to vote on at our August 6 meeting. SoundChoice will be offered in four counties. There are currently about 45,000 PEBB Program Group Health enrollees in these four counties. This offering is relevant and significant. This plan will have the same covered services and exclusions as the Classic and Value plans and will use the same provider network in those four counties.

The table titled Overview of 2016 PEBB Medical Plan Benefit Design highlights the new plans for 2016, their key features, and how they compare.

Group Health will also be making a change to their Cardiac Rehab benefit. It will now be included under the rehab benefit with combined limits of 60 inpatient days and 60 outpatient visits per year. This is a change because currently there is a separate stand-alone Cardiac Rehab benefit. The change for 2016 is that it will be incorporated into the regular rehab benefit - OT, PT, Speech, etc.

Group Health CDHP will also be complying with the federal rule and embedding a per-person maximum out-of-pocket limit in their family CDHPs. The dollar level that they have chosen is $5,100/year, which is different from the $6,850 for UMP. The table titled 2016 PEBB Medical CDHPs – Comparison of Deductibles and Maximum Out-of-Pocket (MOOP) Limits compares the deductibles and maximum out-of-pocket limits for all three of the CDHPs. The Group Health CDHP change for 2016 is that there will be an embedded per-person maximum of $5,100 that matches the single subscriber level. Group Health will be embedding a per-person MOOP of $5,100 in family plans. If you are an individual person on your own plan, or if you are an individual person together with other people on a family plan, you have the same maximum out-of-pocket. Kaiser CDHP also has a change for 2016 that's very similar.

Kaiser Permanente Classic Plan also has some changes for 2016. There will be an increase in the annual medical deductible from $250 to $300. There is no Rx deductible. There is a $5 increase in copays for office visits. The emergency room cost sharing copay changes from $75 copay to 15% coinsurance. There is also cost sharing for administered medications. These are medications that are infused or injected in a provider setting. The 15% coinsurance applies to the medication only.

Kaiser Classic will also be changing their prescription drug tiers. There is a Tier 1 Generic $15 copay and a Tier 2 Preferred Brand $30 copay. There currently is no Tier 3 or Tier 4. The Kaiser Classic Plan currently only has two tiers and so members pay $30 just like Tier 2 for non-preferred brands and for specialty drugs. For 2016 Kaiser Classic will change to four tiers and a copay or coinsurance associated with each tier. The 2016 design is more aligned with UMP and Group Health.

Yvonne Tate: On the generic, if it's less than $15, do you just pay the actual cost?

Kim Wallace: Yes.

Another Kaiser CDHP change actually changes the dollar values of the maximum out-of-pocket from $4,200 for a single, which is like UMP, to $5,100 for a single, which is like Group Health. They will also embed the per-person maximum. The CDHP plan will also go from two prescription drug tiers to four tiers in 2016.

There are no benefit changes for our Medicare plans for 2016.

There are no changes to dental benefits or long-term disability benefits for 2016.

Gwen Rench: Is there any concern that by 2018 when the Cadillac provision of the Affordable Care Act comes into play that our plans under PEBB will get hit by that with a penalty? Some of our members are concerned.

Kim Wallace: Yes, we're very aware of that and we're actively working on ensuring that the impact to us is as positive as possible.

The fourth table identifies the 2016 actuarial value by plan according to the federal calculator. All of the actuarial values are in the 80s – it's the percentage of coverage the typical covered person would get from each plan.

Lou McDermott: There are federal regulations coming out all the time about the Cadillac Tax, how it's going to be applied, and what the components are. We do have staff who review that on a consistent basis. Milliman does actuarial reviews of our plans to make sure. The last thing we want to do is use some of our benefit money to be paying a tax. We're monitoring that and making sure this isn't an issue and we don't add undo cost to the plan. There are some fixes we can do with benefit design. We can minimize impacts on the Cadillac Tax.

Dorothy Teeter: I was just listening to story about this; and to your point Lou, there is constant pressure on the whole topic of the Cadillac Tax and whether it's even a wise idea at the national level. So, we're on it all the time.

Rates Overview

Lou McDermott introduced Gwen Grams who is new to the agency. Gwen worked in Oregon as the Administrator of Forecasting and Performance Management, which is part of their Oregon Health Authority. Gwen has joined HCA as the manager of our Forecasting and Fiscal Analytics Section.

Gwen Grams: Gwen presented a rates overview and some background on our rates setting process. Gwen indicated the SmartHealth Wellness incentive qualification had higher participation rates among our Consumer Directed Health Plans. We speculate that this may be because they get an actual $125 deposited into the accounts as opposed to a reduced deductible.

Gwen shared the employee contribution calculation rates. They are grouped by plan type to provide some comparability. Adding the proposed employee contribution to the employer contribution gives you the composite rate. Compared to last year, we have two new plans, SoundChoice and UMP ACP.

Gwen shared information for employee contribution by tier. The first tier is subscribers, the second tier is subscriber and spouse, third tier is subscriber and children, and the fourth tier is full family. Kaiser Classic has gone up and the UMP CDHP has gone down. The Kaiser increase is due to changes in the administrative fees. We have not been charged administrative fee increases for a couple of years in this plan, and so they were added in this time. The UMP CDHP has gone down because of some switching assumptions, such as risk scores/health of the clients that will enroll in each of the plans and what changes these assumptions can make in some of the rates.

Gwen shared the non-Medicare retiree rates by tiers.

She also shared the estimated Medicare retiree premiums. UMP Classic did go up due to changes in the pharmacy costs resulting from the Affordable Care Act. Some of these rates are going down because of changes in the state explicit subsidy.

Gwen Rench: I'm very concerned about the huge increase in the UMP where the other plans don't have such a large increase. I would think the prescription costs wouldn't be that different between the different plans.

Gwen Grams: There actually was one difference in a very expensive prescription for Hepatitis C. There were some different assumptions made by the plans. I don't have all the details right now; but if you are interested, I'm sure we could provide you more of the details.

Gwen Rench: Yes, because we are very concerned about that large of an increase for our members who aren't getting any cost of living increases. That's a $33 per month hit and that hurts.

Gwen Grams: We will prepare some additional information for you about what led to those increases.

Harry Bossi: On the retiree non-Medicare rates, are they subject to the same process that you went through initially about the rates?

Gwen Grams: I would say no and then I would ask Lou to explain.

Harry Bossi: If that's the case, is the proposed premium for non-Medicare retirees in essence the bid rate?

Lou McDermott: No, that's not the bid rate. If you are talking about how we calculate, it's all related. When you have subscriber and spouse, subscriber and children, it's a formulaic approach to how you calculate those. There is a certain multiplier that kicks in to get to each rate.

Harry Bossi: Let's stick with the subscriber component. The proposed 2016 in Group Health Value is $574. Is that in essence the bid rate?

Lou McDermott: We are going to have to look because I don't want to answer off the cuff.

Gwen Grams: The dental premiums for DeltaCare and Willamette are holding steady. They have been in a rate guarantee that will continue through calendar year 2016. The UDP Dental Plan premium is going down because of the claims experience. The state does pay 100% of the dental.

Basic Life insurance premiums are going down. There are two types of life insurance premiums - basic which is funded by the state and supplemental which is paid by the employee. The rates are lower due to buying down some of the reserves.

Long-term disability insurance is the same thing. The rates are not changing for the basic LTD. However, in the optional coverage, we had been subsidizing this rate. With changes in the reserves, we've made changes in the subsidization so there is a slight increase in the optional employee coverage.

Lou McDermott: Harry, when I look back, it looks like it's matching up to the bid rate less the administrative fee per account, but we'll take a look at that. I'm looking at the math and that's what it looks like, but I just want to make sure.

Dorothy Teeter: And Mary Fliss behind you is nodding her head in agreement.

Lou McDermott: We have two people from the program side saying yes, so we'll circle back with fiscal and make sure we are giving you the right answer.

Dorothy Teeter: Lou, let's send out a note to everyone when the answer is confirmed.

Lou McDermott: We can bring it up at the next Board meeting.

SmartHealth Participation Update

Scott Pritchard, PEB Health Management Unit, provided a SmartHealth update on our participation numbers at the halfway point for 2015. June 20 was the end of our financial incentive qualifying period. We challenged ourselves for high participation.

As of July 5, 2015, 51,528 people registered for SmartHealth, 48,451 people completed the well-being assessment, and 29,096 people have qualified for the financial incentive. That's quite an achievement. More may qualify for the incentive as new hires come in. There is a process for them to be able to earn the financial incentive if they are hired and begin in the second half of the year. We have a ways to go to reach our goals.

There are distinct groups of people participating based on where they work; or with retirees, where they are. There are significant differences in participation and they all receive the same mailings. The most significant difference between them is that we've had outreach staff working with state agency wellness programs for quite some time. We've now added a person to work with higher education and one to work with political subdivisions. That onsite presence for SmartHealth makes a difference.

Scott shared the top twenty agencies based on their well-being assessment completion rate. The top five are Student Achievement Council, Department of Financial Institutions, Health Care Authority, Department of Retirement Systems, and Department of Health. Part of the success of these agencies is due to their strong leadership. They have an authorizing environment and they participate heavily in their own wellness programs. That is represented in their online participation of SmartHealth.

Next year there is a longer incentive qualification period. Instead of June, employees can continue through September.

The purpose of SmartHealth is not to complete well-being assessments, but to do activities. We want to improve the health of the population. It's a state-of-the-art approach using current

behavioral change techniques and the latest research. We are starting to identify the risks in the population which helps us identify opportunities for reducing that risk.

The top risks identified are healthy weight, back health, and sleep. We will examine these, and more, as we move forward to help us determine where to put our resources.

For less than half of the people participating, 132,000 potential and just over 50,000 participating in the first six month, zero risk and one risk are heavily skewed that direction. It is unusual to see a population that is age 49 have this high concentration in zero and one risk. We may begin to see that we've attracted a lower risk group to start. We'll see how it changes as more people participate.

Some of the activities we've selected are:

- Tracking Your Activity. This is a physical activity. A high proportion visited a state park.
- Connecting Your Device. This includes devices like FitBits or smart phone tracking devices. These are strong tools for behavior change. 12,000 plus have connect their devices. We're looking at options to help people do that.
- Healthy Start, which was breakfast.
- The 7-Minute Workout.
- WA Employee Assistance Plan.
- Governor's Walk. The Governor led 3,900 people on a 30-minute walk, either in person or sometime during that day.

There are external programs, too. Some of these are:

- Delta Dental. There was an increase of 12,000 annual preventive care visits.
- Quit Tobacco (UMP and Group Health).
- Diabetes Prevention Program.
- Living Well – Group Health.
- Diabetes Control Program.

We're shifting our thoughts to health improvement. We're looking back asking ourselves how can we improve? What went well? We have anecdotal information, a survey, focus groups starting in late September, UW research, and an intern who is working with our vendor Limeade and OFM. Our goal is to get senior leaders involved. When they're involved, higher participation usually results. We want to provide those leaders with a value proposition letting them know what's in it for them as they try to accomplish the mission of their agency.

Yvonne Tate: Down the road, how do you evaluate the program in terms of determining that there has actually been an improvement in the health status of the participants; and likewise, how do you evaluate whether or not that resulted in a cost savings for the agency.

Scott Pritchard: That hasn't all been worked out. We are starting with a new set of data, the well-being assessment. Instead of an assessment for each plan, we now have one. We can compare year-to-year to see if there's change. Then we can begin to look at the well-being assessment and claims utilization and begin to see how that works. That's well down the road.

2016 PEBB Program Procurement Resolutions 1-7

Lou McDermott shared the seven resolutions that will be voted on at the August 6 PEB Board meeting.

Procurement Resolution 1

Resolved, that the Uniform Medical Plan Consumer Directed Health Plan (CDHP) will administer an embedded per person maximum out-of-pocket (MOOP) limit of $6,850 per year in family CDHP plans.

Procurement Resolution 2

Resolved, that Group Health will offer a new PEBB health plan called SoundChoice starting in Plan Year 2016.

Procurement Resolution 3

Resolved, that PEBB Program will offer a new Uniform Medical Plan Accountable Care Program (ACP) health plan starting in Plan Year 2016.

Procurement Resolution 4

Resolved, that the PEB Board endorses the Group Health Employee Premiums.

Procurement Resolution 5

Resolved, that the PEB Board endorses the Kaiser Employee Premiums.

Procurement Resolution 6

Resolved, that the PEB Board endorses the Uniform Medical Plan Employee Premiums.

Procurement Resolution 7

Resolved, that the PEB Board endorses the maximum $150 employer Medicare Contribution, not to exceed 50% of the plan premium, set forth in the legislative budget appropriation.

2016 PEB Board Meeting Schedule

Lou McDermott shared the 2016 PEB Board meeting schedule. The projected meeting dates are from January 7 through June 27. If there is a need for additional Board meetings, we'll schedule as appropriate. If we need to cancel a Board meeting or don't require one at the time, we'll notified PEB Board members through email and the Listserv.

Dorothy Teeter: The next meeting is August 6.

Meeting adjourned at 3:03 p.m.

Public Employees Benefits Board
Meeting Minutes

D R A F T

August 6, 2015
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 2:15 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Yvonne Tate
Harry Bossi
Myra Johnson

Members On the Phone:
Gwen Rench
Marilyn Guthrie
Tim Barclay

Members Absent:
Mary Lindquist

PEB Board Counsel
Katy Hatfield

Call to Order
Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum.

Board and audience self-introductions followed.

Approval of June 24, 2015 PEBB Meeting Minutes
Dorothy Teeter: Are there comments or corrections from the Board?

Greg Devereux would like clarification on page 2, bullet 3 which reads "All covered benefits will be the same as in UMP Classic. The benefit design is different, but the benefits are the same."

Lou McDermott: We will clarify, update the minutes, and bring to the Board for approval at our next PEB Board meeting.

Response to Rate Question

Dorothy Teeter: At our July 22, 2015 meeting, **Gwen Rench** had a question about rates. Gwen Grams is here to provide clarification.

Gwen Grams: Gwen Rench asked a question about why there was such a differential increase in the rates for Medicare retirees between what happened with UMP and Group Health and Kaiser. At that time, we answered that the experience in the UMP pharmacy was a major driver in the UMP rate increases. We also mentioned that we had different assumptions from UMP to Kaiser and Group Health about how many consumers would be using the new Hepatitis C drugs, which are very expensive.

Those reasons are still valid, but there is one more reason for that differential. It is just the nature of the plans. For UMP, Medicare is the primary coverage so all those claims are paid on fee for service. Group Health and Kaiser are called Advantage Plans. That means that consumers drop their Medicare coverage and they become the primary coverage for services. It also means that Medicare is providing those plans with some incentives to control the costs; and the plans are better, more enabled, to control the costs because they are in charge of the way the bills come in. Under UMP, it is primarily a fee for service when someone approaches their physician or their care giver and the services are provided under Medicare.

Greg Devereux: Did you say the first issue was in part drug, like the Hepatitis C drug?

Gwen Grams: Yes I did.

Greg Devereux: I can see where they would be expensive but I wouldn't think the incidence of usage would be that great among this population. Thus it would spread it across the population and not be that expensive.

Gwen Grams: I understand that the older population is actually more likely to be higher users of the Hepatitis C drugs.

Lou McDermott: A lot of the population who's been affected by Hepatitis C was before the blood supply was being screened. They received transfusions when they were younger. Hepatitis C is a very slow moving disease and it takes a long time for it to take effect, so this actually is the population that is affected. They are starting to have issues with Hepatitis C with liver fibrosis, etc. It is the older population who are mostly affected. The other population who is affected is the very young IV drug users.

Greg Devereux: I would be curious what the incidence is among the older population.

Lou McDermott: I believe that nationwide it is an average of three percent of the overall population that is infected with Hepatitis C. I don't know specifically for that age group, but we will research and provide that information to the Board.

2016 PEBB Procurement Resolutions 1-7

Dorothy Teeter: Today we will vote on the 2016 PEBB Procurement Resolutions 1–7. We shared all seven of these with the Board at our July 22 meeting. We will vote on each one individually.

Procurement Resolution 1

Resolved, that the Uniform Medical Plan Consumer Directed Health Plan (CDHP) will administer an embedded per person maximum out-of-pocket (MOOP) limit of $6,850 per year in family CDHP plans.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Procurement Resolution 2

Resolved, that Group Health will offer a new PEBB health plan called SoundChoice starting in Plan Year 2016.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Procurement Resolution 3

Resolved, that the PEBB Program will offer a new Uniform Medical Plan accountable care program (ACP) health plan starting in Plan Year 2016.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Procurement Resolution 4

Resolved, that the PEB Board endorses the Group Health Employee Premiums.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Procurement Resolution 5

Resolved, that the PEB Board endorses the Kaiser Employee Premiums.

Moved. Seconded. Approved.
Voting to Approve: 4
Yvonne Tate
Marilyn Guthrie
Tim Barclay
Dorothy Teeter
Voting No: 2
Greg Devereux
Gwen Rench

Procurement Resolution 6

Resolved, that the PEB Board endorses the Uniform Medical Plan Employee Premiums.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Procurement Resolution 7

Resolved, that the PEB Board endorses the maximum $150 employer Medicare Contribution, not to exceed 50% of plan premium, set forth in the legislative budget appropriation.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Dorothy Teeter: A technical question was asked as to why there was only one "B" when spelling PEB on procurement resolutions 4, 5, 6, and 7.

Lou McDermott: The word Board is the second "B." It is is spelled out - PEB Board = Public Employees Benefits Board.

Lou McDermott: The meeting dates for 2016 are: January 7, March 16, April 13, May 24, June 22, July 13, July 20, and July 27. There is the possibility of a meeting being canceled, if appropriate within the schedule, depending upon the legislature or how far along we are on certain issues, but that's the proposed schedule for 2016.

Dorothy Teeter: I'd like to say thank you to the Board Members for staying with us and really asking good questions throughout this whole set of meetings. We will offer a couple of new options for our PEBB members next year. I appreciate that due diligence on your part to help us get there. I'd also like to acknowledge the staff of our PEBB Program, and thanks to everyone who comes to these meetings and helps participate in making good policy.

Our next meeting is the Retreat on January 7.

Meeting adjourned at 1:54 p.m.

TAB 4

Washington State Health Care Authority

VALUE-BASED PURCHASING: ACCOUNTABLE CARE PROGRAM STATUS

Cade Walker, ACP Coordinator
PEBB Program
April 13, 2016

ACP Looking Ahead

- Expansion of ACP Plans into additional counties.
- HCA, PEBB Program, UMP Website redesign.
- Mid-year survey.
- Open Enrollment for 2017:
  - Webinars, benefit fairs, online & printed materials.

Questions?

Cade Walker, ACP Coordinator
PEBB Program
cade.walker@hca.wa.gov
Tel: 360-725-0855

Washington State Health Care Authority

Update: Total Joint Centers of Excellence

Marcia Peterson, Section Manager
Benefit Strategy & Design
Public Employees Benefits Division
April 13, 2016

Released RFP November 2015

- 1 to 5 Centers of Excellence
- Statewide
- Meet Bree Criteria
- Leaders in providing high-quality, evidence-based care
- Integrated program of care
- Best outcomes

Virginia Mason – UMP Center of Excellence

- Met/exceeded Bree Criteria
- Team-based approach with physician leadership
- Evidence-based care, best outcomes
- Shared decision making tools
- Experienced in bundled episodes of care

"We set a high bar for quality for our members" – Dan Lessler, MD

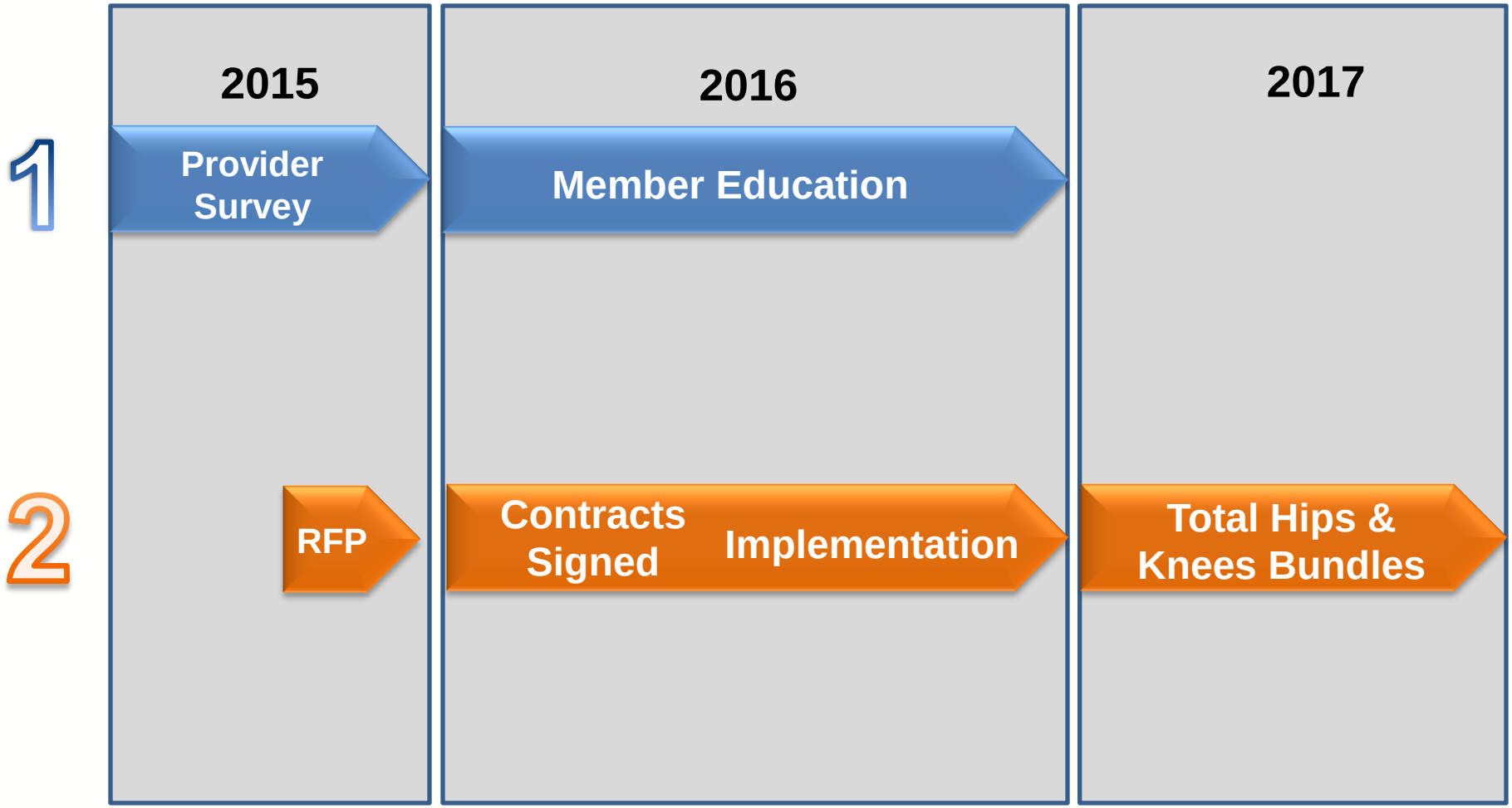
Premera Bundled Episodes TPA

- Case Management
- Member education
- Bundled Payments
- Coordinating with Regence and Virginia Mason

Next Phase

- Contract negotiations
- Implementation
  - Defining benefit and incentives
  - Defining what's included in the bundled episode

Total Joint Bundles
Two Phases



Washington State Health Care Authority

Questions?

Marcia Peterson, Manager
Benefit Strategy and Design Section
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360-725-1327

Washington State Health Care Authority

SmartHealth Update

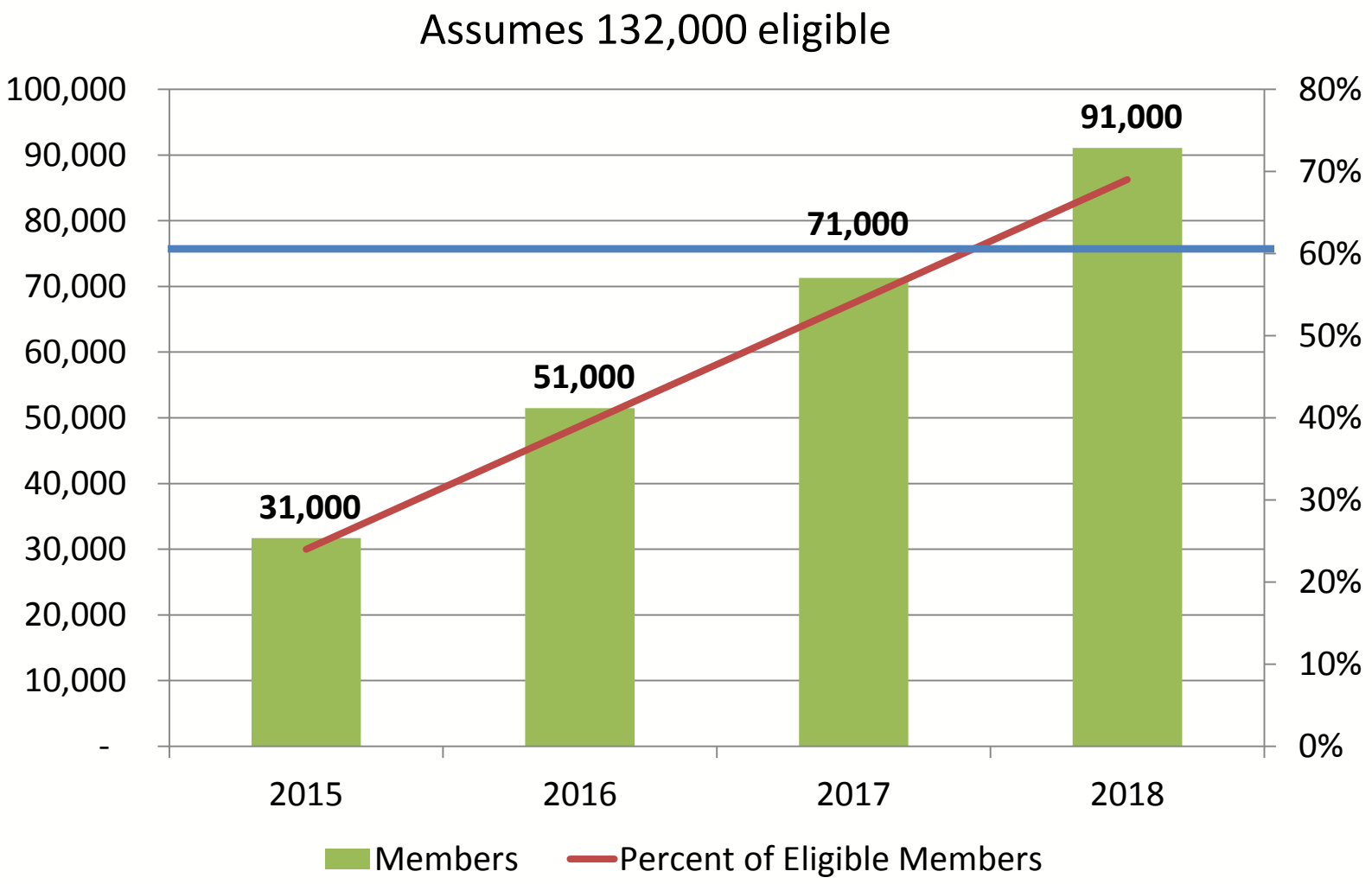
Scott Pritchard
Health Management
Benefit Strategy & Design Section
April 13, 2016

2016 Goals

Eligible Subscribers	2015 Baseline	2016 Target
Registrations Goal: 70%	52,000 39%	71,000 54%
Well-being Assessment Completion Goal: 65%	48,000 37%	69,000 52%
Incentive Qualification Goal: 60%	**31,000 24%**	**51,000 39%**

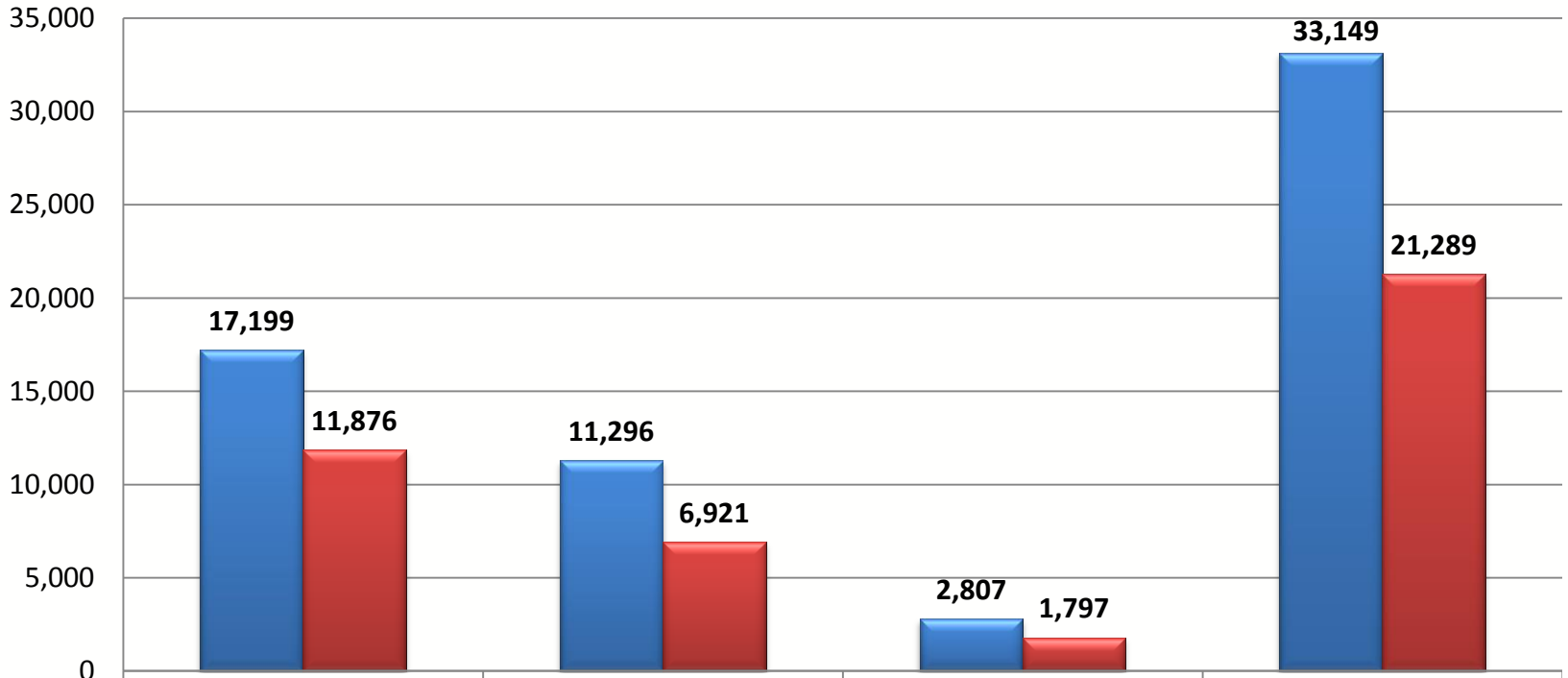
Baseline data as of 12/27/2015 | N = 132,000
Assumes 15 percentage point per year increase

Incentive Earned Goals



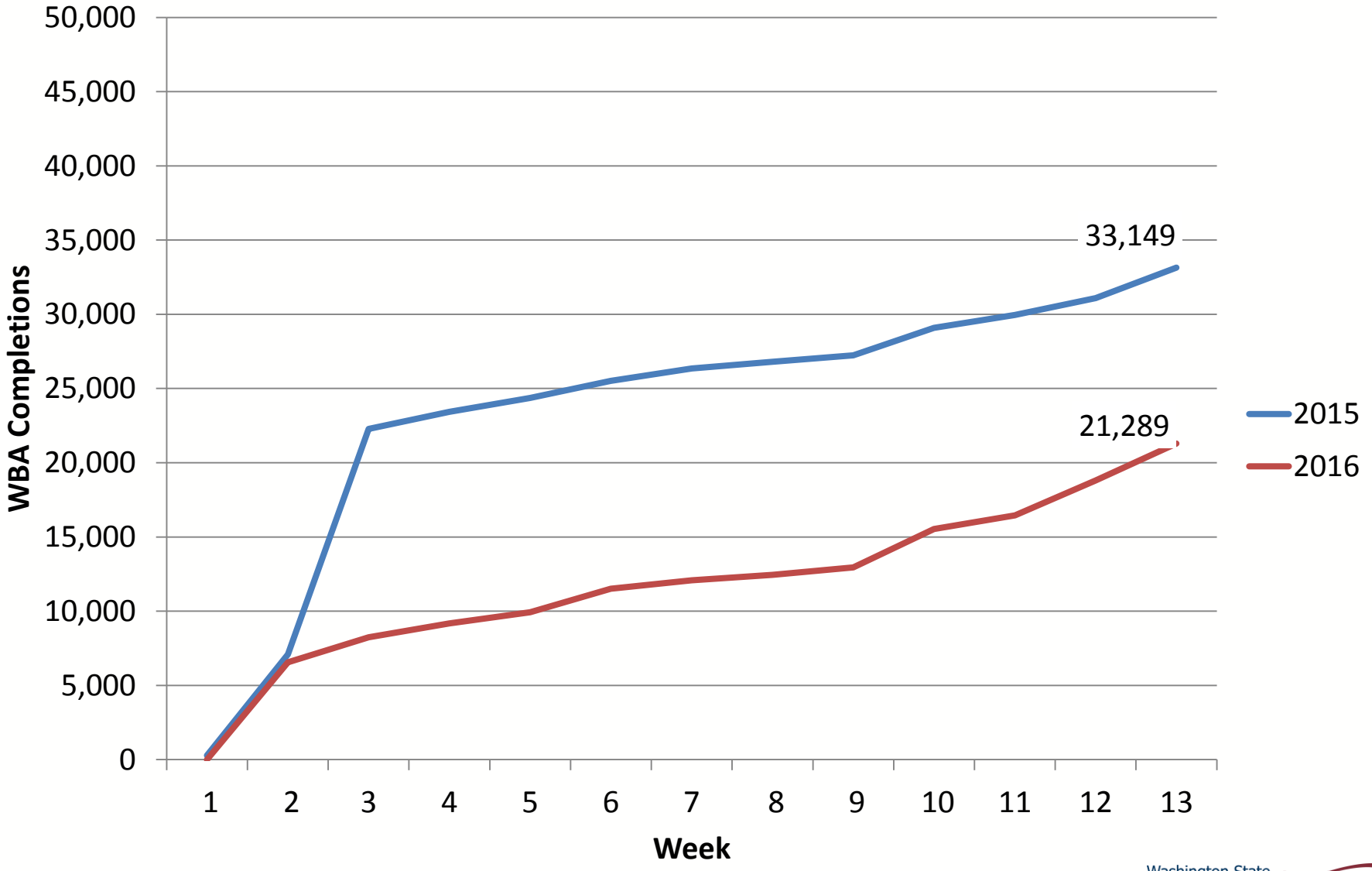
Washington State Health Care Authority

Well-being Assessment Completion 2015 vs 2016



	Agencies	Higher Education	Political Subgroups	All Eligible Subscribers
4/2/2015	17,199	11,296	2,807	33,149
4/3/2016	11,876	6,921	1,797	21,289

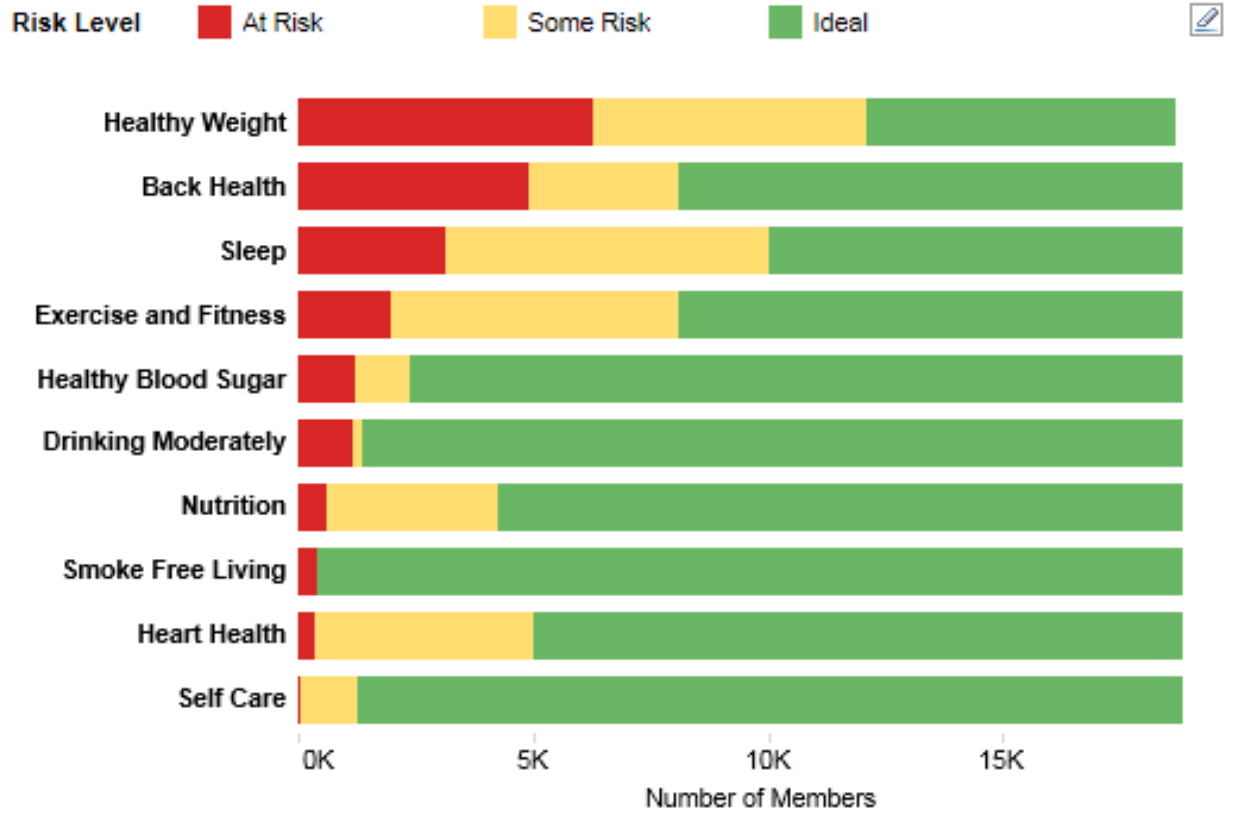
Well-being Assessment Completion
2015 - 2016



Washington State Health Care Authority

Activities - Focus on Risk Reduction

Most common risks in the population



2016 Activity Participation

ACTIVITY	PARTICIPANTS
Three Meals a Day	**11,502**
Track Your Zzzz's	**9,669**
Healthy Pantry	**10,370**
Dental Health	14,470
Sleep Well	**8,184**
Get Moving	**7,588**
Save For Retirement	7,907
Cardio for Beginners!	**6,900**
Nighttime is Device-Free Time	**6,673**
Just Track It	**5,817**
The Bright Side of Stress	5,644
Heal Your Back	**5,157**
Eat Real to Heal	**4,7 47**
SmartHealth Program Detective	4,715
Visit a State Park	**4,711**
Connect Your Device	**3,919**
Pay it Forward	4,032
Perfect Start - Beginner Flexibility	3,388
Subscribe to the EAP Newsletter	4,107
Advance Directive	3,075

Data as of 4/3/2016

Planned Promotions

- Communication Plan
- Engaged Marketing Firm
- Success Stories
- Wellness Coordinator Training
- Focus on Large Agencies
- Cabinet Participation Promotion
- WBA Completion Rate / Ranking
- WBA Results to Qualifying Work Organizations

Ethics Board

- Ethics Board clarification of rule regarding use of state time and resources for wellness participation

  Subsection (2)(b)(iv) reads as follows:

  An agency head or designee may authorize limited use of agency staff time and resources for the following uses as long as that use is specifically authorized in an agency policy and conforms to that policy:

  State or intermittent agency sponsored health activities, for example, vaccinations, diabetes screenings, cholesterol screenings; or recording participation in an agency or PEBB sponsored wellness program.

  Subsection (3)(b) states:

  A state officer or employee may use state resources for wellness or combined fund drive activities as long as use conforms with (a) of this subsection or as authorized in state law and rule.

Questions?

Scott Pritchard, Health Management
Benefit Strategy and Design Section
Scott.Pritchard@hca.wa.gov
360-725-1210

TAB 5

Washington State Health Care Authority

Life Insurance Benefit Reprocurement

Beth Heston
PEB Procurement Manager
Portfolio Management and Monitoring
Public Employees Benefits Division

History of Life Benefit

- Purchased in 1977 by State Employees Insurance Board (SEIB)
- Attempted reprocurement in 1993 for matching benefits and system requirements
- "Simplified" plan design and re-enrolled existing participating members in 2012

Goals of Reprocurement

- Align benefit with Results Washington and Procurement Reform law
- Explore more modern, efficient, and cost effective options for benefit administration
- Improve benefit design and cost
- Bring the benefit current with Life Insurance industry standards and practices

Current Benefits

Insurance Type	Current Employer Paid Plans
Employee Basic Life	$25,000
Employee Accidental Death & Dismemberment (AD&D)	$5,000
	Employee Supplemental Plans
Employee Supplemental Life (increments of $10,000)	Guaranteed Issue $250,000 up to $750,000 with EOI*
Spousal Life (Increments of $5,000)	up to 50% of Employee's Supplemental (with EOI when required)
Dependent (includes Spouses) Basic Life	$2,500
Retiree Life Pre-65 Age 65-69 Age 70 and over	 $3,000 $2,100 $1,800
Employee, Spouse, & Dependent Supplemental AD&D	up to $250,000 for Employee 40% for Spouse; 5% or 10% for Dependents

*Evidence of Insurability

Questions?

Beth Heston, PEB Procurement Manager
Portfolio Management and Monitoring
Beth.Heston@hca.wa.gov
Tel: 360-725-0865

TAB 6

Washington State Health Care Authority

PHARMACY TRENDS & CHALLENGES

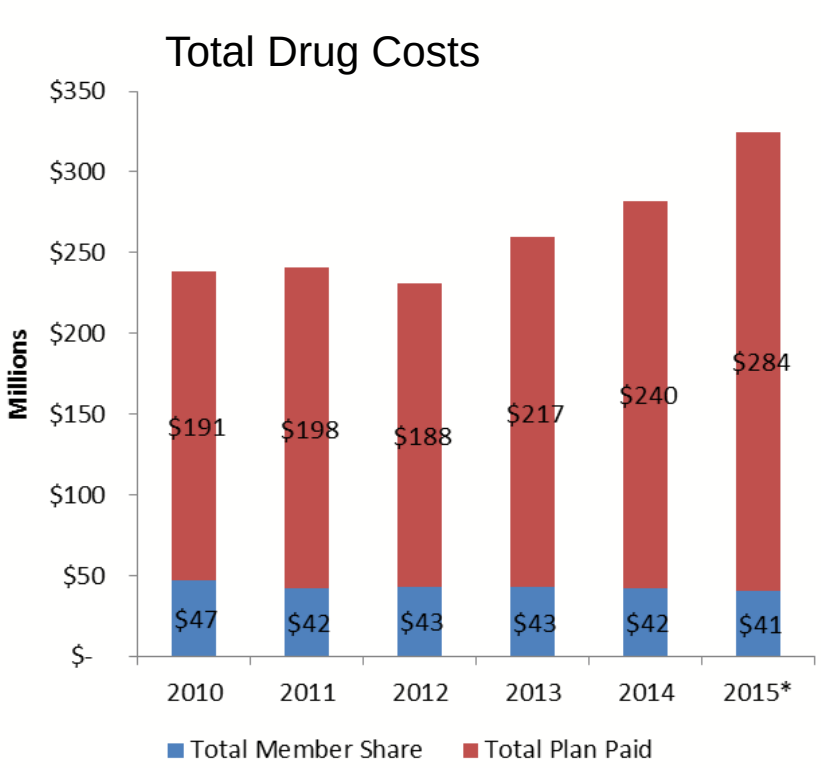
Donna Sullivan
Chief Pharmacy Officer
April 13, 2016

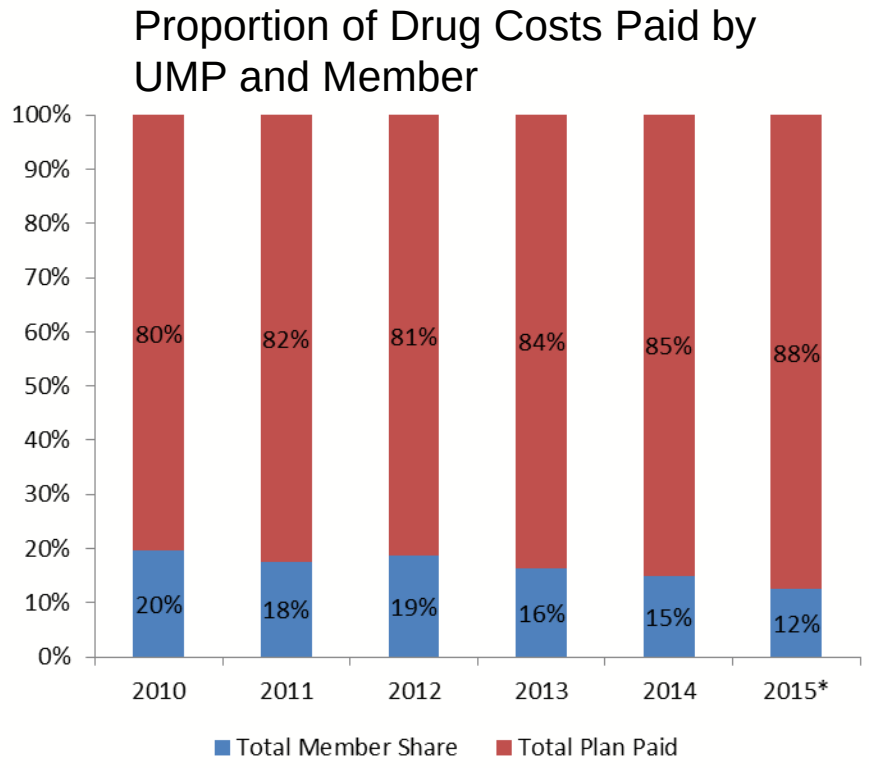
Pharmacy Trends & Challenges

- Specialty drugs are replacing traditional products
  - PSK9 Inhibitors (cholesterol)
- Consolidation of manufacturers and associated pricing strategies has diluted the value of generic medications and lower cost therapies[1]
  - Turing increased the price of Daraprim® used to treat toxoplasmosis from $13.50 to $900.00 per pill
  - Valeant increased the price of Glumetza® (a branded version of metformin to treat diabetes) 800% before it lost patent
- Biologics will be interchangeable – *may* be less expensive
- New break-through treatments (Hepatitis C Drugs) have a positive impact on patient care but a hefty price tag
- Cancer is now a chronic disease – drugs trending from injectable to oral
- Of the 50 new drugs approved in 2015, 19 were cancer drugs

[1]The Express Scripts 2015 Drug Trend Report

Uniform Medical Plan Prescription Drug Trend





- Total drug spend increased 15% in 2015; UMP paid amount increased 18% while member share decreased 1%
- Member share as a percentage of total drug spend decreased from 20% in 2010 to 12% in 2015

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Components of Drug Trend

Drug trend is driven by several components:

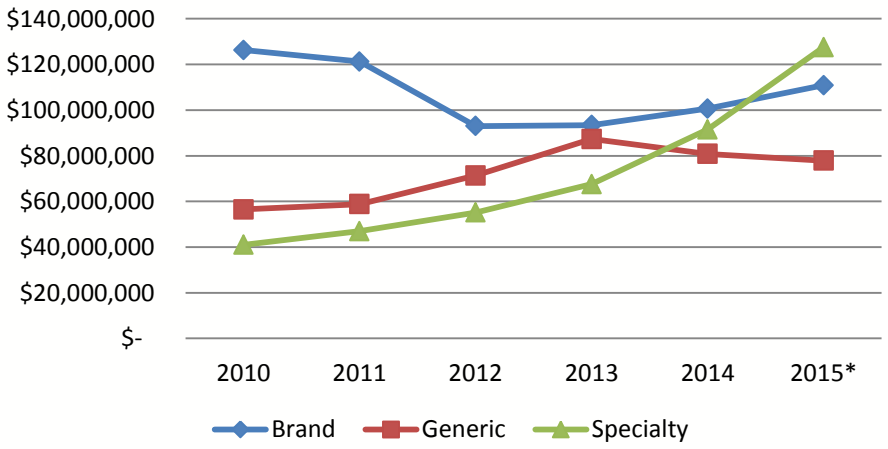
- Unit Cost: the cost of the medications
- Utilization: the number of people using prescription drugs and the number of medications they are taking
- Mix: the types of medications being used (e.g., brand, generic, specialty)

Drug Costs

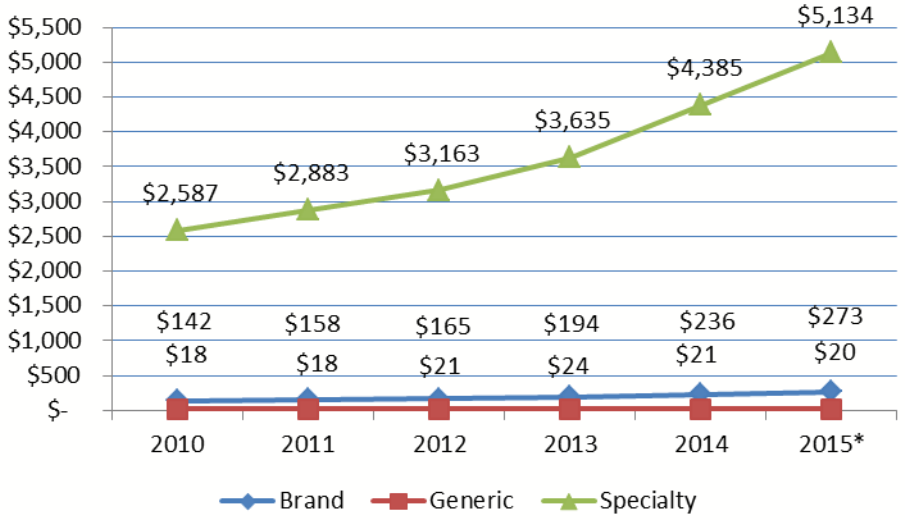
- Nationally, specialty spend increased 17.8% and unit cost increased 11%.
- Nearly one third of branded drugs experienced price increases of 20% or higher in 2015.
- The largest contributor to trend in 2015 was increased unit cost and utilization of specialty drugs.

Source: The Express Scripts 2015 Drug Trend Report

UMP Annual Spend for Brand, Generic, & Specialty Drugs



UMP Average Cost Per Month for Brand Generic, & Specialty Drugs



UMP Experience

- Average monthly cost of brand and specialty drugs increased 16% and 17% respectively
- Generic drug cost decreased 7% for a month supply

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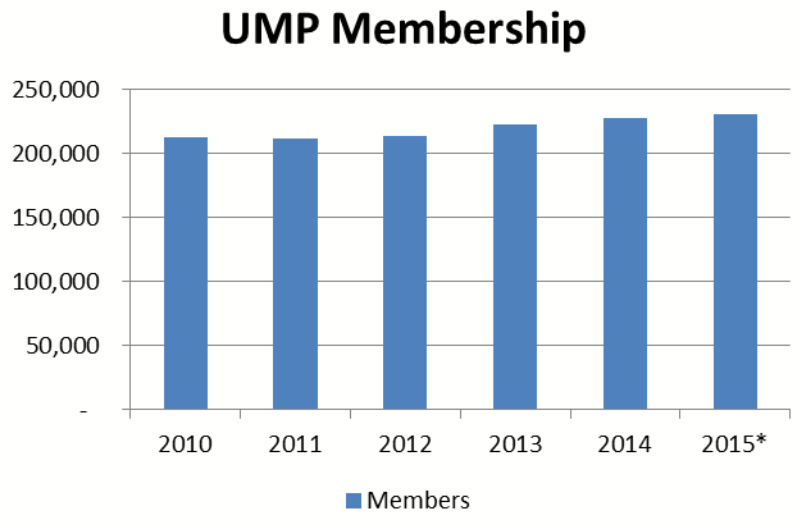
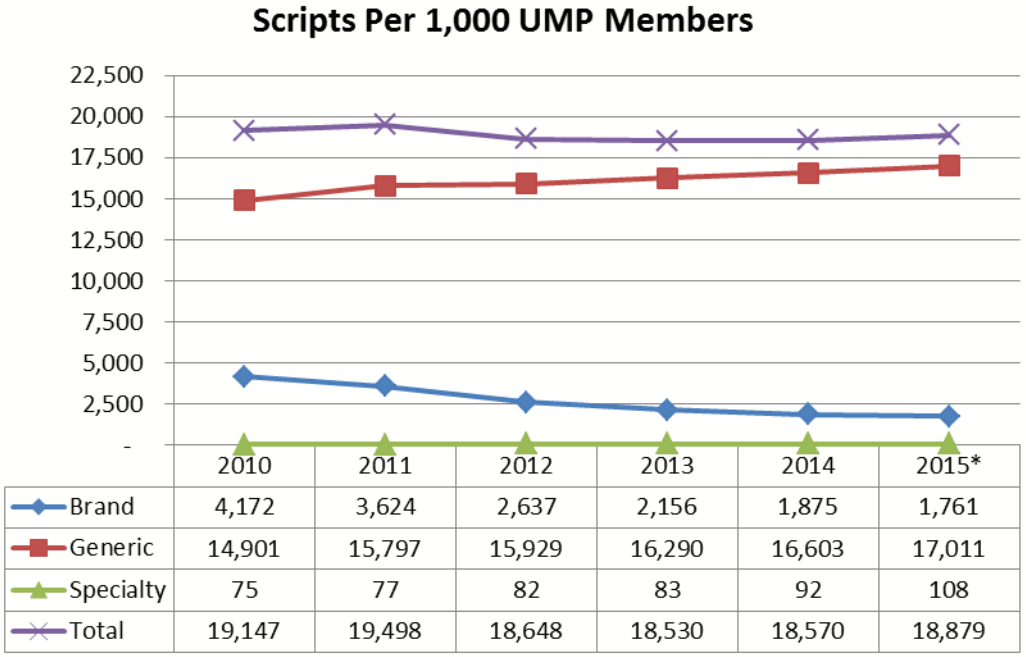
Utilization

- UMP 8.6% growth in enrollment since 2010.
- Overall utilization is unchanged, however the drug "mix" is changing.
- In 2015 UMP specialty increased 19% respectively while use of "traditional drugs," brands & generics combined, increased only 3%.





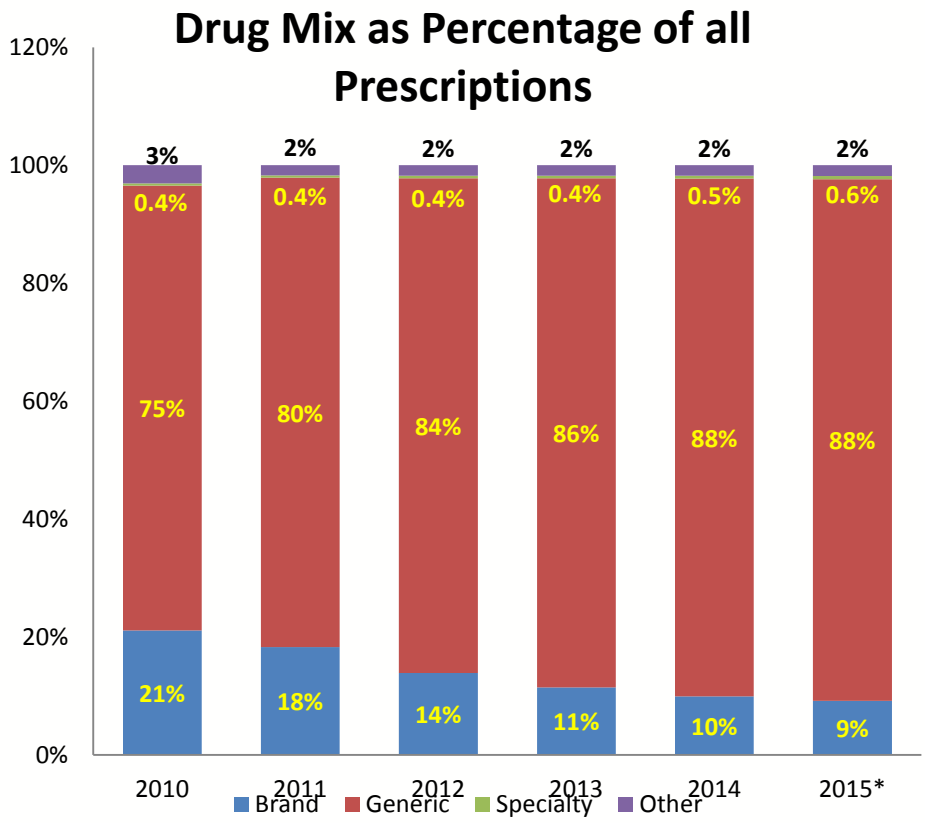
	2010	2011	2012	2013	2014	2015*
Brand	4,172	3,624	2,637	2,156	1,875	1,761
Generic	14,901	15,797	15,929	16,290	16,603	17,011
Specialty	75	77	82	83	92	108
Total	19,147	19,498	18,648	18,530	18,570	18,879

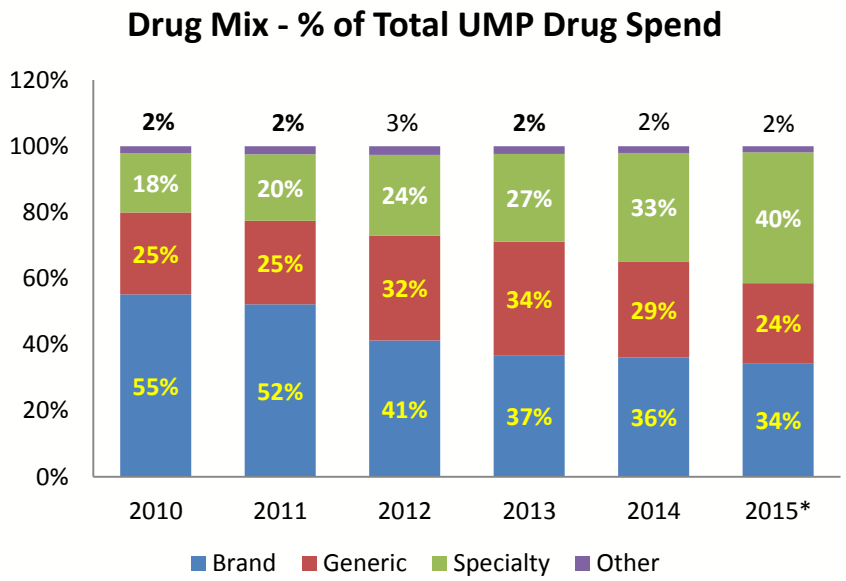
Nationally, utilization of specialty drugs rose 7% in 2015 where traditional medications only increased 1.9%.

Source: The Express Scripts 2015 Drug Trend Report

Drug Mix

Specialty drugs account for 0.6% of the total UMP utilization, but 40% of the total UMP drug spend.





Nationally, 37.7% of drug spend is for specialty medications with that number expected to increase to 50% in 2018.

Source: The Express Scripts 2015 Drug Trend Report

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Top 10 Traditional Drugs

Uniform Medical Plan experiences trends similar to national picture with 6 of the national top 10 drugs appearing in UMP's top 25 list.

TOP 10 TRADITIONAL THERAPY DRUGS

RANKED BY 2015 PMPY SPEND

RANK	DRUG NAME	THERAPY CLASS
1	Lantus® (insulin glargine)	Diabetes
2	esomeprazole	Heartburn/ulcer disease
3	Crestor® (rosuvastatin)	High blood cholesterol
4	Lialda® (mesalamine)	Inflammatory conditions
5	Humalog® (insulin lispro injection)	Diabetes
6	amphetamine/dextroamphetamine	Attention disorders
7	Januvia® (sitagliptin)	Diabetes
8	aripiprazole	Mental/neurological disorders
9	methylphenidate extended release	Attention disorders
10	Vyvanse® (lisdexamfetamine)	Attention disorders

Drug Name	Associated Therapeutic Class	Top 25
Lantus and Solostar	Antidiabetics	1
Humalog and Humalog KwikPen	Antidiabetics	2
Advair Diskus	Antiasthmatic and Bronchodilator Agents	3
Novolog Flexpen	Antidiabetics	4
Levemir FlexTouch	Antidiabetics	5
Levothyroxine Sodium	Thyroid Agents	6
Abilify	Antipsychotics/Antimanic Agents	7
Clobetasol Propionate	Dermatologicals	8
Novolog	Antidiabetics	9
Spiriva Handihaler	Antiasthmatic and Bronchodilator Agents	10
Truvada	Antivirals	11
Atripla	Antivirals	12
Asacol hd	Gastrointestinal Agents - Misc.	13
Amphetamine/Dextroamphetamine	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	14
Hydrocodone/Acetaminophen	Analgesics - Opioid	15
Methylphenidate HCl ER	ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants	16
Hydroxychloroquine sulfate	Antimalarials	17
Crestor	Cholesterol Medications	18
Metoprolol Succinate ER	Beta Blockers	19
Aripiprazole	Antipsychotics/Antimanic Agents	20
Xarelto	Anticoagulants	21
Restasis	Ophthalmic Agents	22
Androgel Pump	Androgens-Anabolic	23
Flovent HFA	Antiasthmatic and Bronchodilator Agents	24
Oxycodone HCl	Analgesics - Opioid	25

Source: The Express Scripts 2015 Drug Trend Report

Top 10 Specialty Drugs

"Specialty trend will increase 17% annually between 2016 and 2018. Existing specialty drugs will gain approval for other indications and will be prescribed more often. However, the major contributors to trend will be price inflation and high starting costs for new drugs.

TOP 10 SPECIALTY THERAPY DRUGS

RANKED BY 2015 PMPY SPEND

RANK	DRUG NAME	THERAPY CLASS
1	Humira® Pen (adalimumab)	Inflammatory conditions
2	Enbrel® (etanercept)	Inflammatory conditions
3	Harvoni® (ledipasvir/sofosbuvir)	Hepatitis C
4	Copaxone® (glatiramer)	Multiple sclerosis
5	Tecfidera® (dimethyl fumarate)	Multiple sclerosis
6	Viekira Pak® (dasabuvir/ombitasvir/ paritaprevir/ritonavir)	Hepatitis C
7	Gleevec® (imatinib)	Oncology
8	Revlimid® (lenalidomide)	Oncology
9	Gilenya® (fingolimod)	Multiple sclerosis
10	Atripla® (efavirenz/emtricitabine/tenofovir)	HIV

Drug Name	Associated Therapeutic Class	Top 15
Harvoni	Antivirals	1
Humira and Humira Pen	Analgesics - Anti-Inflammatory	2
Enbrel and Enbrel Sureclick	Analgesics - Anti-Inflammatory	3
Copaxone	Psychotherapeutic and Neurological Agents - Misc.	4
Tecfidera	Psychotherapeutic and Neurological Agents - Misc.	5
Revlimid	Assorted Classes	6
Gleevec	Antineoplastics and Adjunctive Therapies	7
Avonex and Avonex Pen	Psychotherapeutic and Neurological Agents - Misc.	8
Gilenya	Psychotherapeutic and Neurological Agents - Misc.	9
Zytiga	Antineoplastics and Adjunctive Therapies	10
Afinitor	Antineoplastics and Adjunctive Therapies	11
Stelara	Dermatologicals	12
Rebif	Psychotherapeutic and Neurological Agents - Misc.	13
Xtandi	Antineoplastics and Adjunctive Therapies	14
Pomalyst	Antineoplastics and Adjunctive Therapies	15

Source: The Express Scripts 2015 Drug Trend Report

Questions?

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