

# Public Employees Benefits Board Meeting

June 21, 2017

## Public Employees Benefits Board

June 21, 2017

1:30 – 3:00

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

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**TAB 1**

## AGENDA

**Public Employees Benefits Board**  
**June 21, 2017**  
**1:30 p.m. – 3:00 p.m.**

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

**Call-in Number: 1-888-407-5039**

**Participant PIN Code: 95587891**

1:30 p.m.*	<b>Welcome and Introductions</b>		Dorothy Teeter, Chair	
1:40 p.m.	<b>Meeting Overview</b>		Lou McDermott	Information
1:45 p.m.	<b>Approval of July 13, 2016 Minutes</b> <b>Approval of July 27, 2016 Minutes</b> <b>Approval of August 10, 2016 Minutes</b>	TAB 3	Dorothy Teeter, Chair	Action
1:55 p.m.	<b>Legislative Update</b>		Dave Iseminger, PEB	Information
2:10 p.m.	<b>PEB Policy Proposals</b>	TAB 4	Barbara Scott, PEB	Information
2:40 p.m.	<b>Public Comment</b>			
3:00 p.m.	<b>Adjourn</b>			

### \*All Times Approximate

The Public Employees Benefits Board will meet Thursday, June 21, 2017, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8<sup>th</sup> AVE SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

Prior to the meeting, pursuant to RCW 42.30.110(I), the Board will meet in Executive Session to "consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026," and for the purpose of discussing current litigation against the governing body with legal counsel when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency. The Executive Session will begin at noon on June 21, 2017, and be concluded no later 1:30 p.m.

No "action," as defined in RCW 42.30.020(3), will be taken at the Executive Session.

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](mailto:board@hca.wa.gov).

Materials posted at: <http://www.pebb.hca.wa.gov/board/> no later than close of business on June 19, 2017.

## PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8 <sup>th</sup> Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 <a href="mailto:dorothy.teeter@hca.wa.gov">dorothy.teeter@hca.wa.gov</a>	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 <a href="mailto:greg@wfse.org">greg@wfse.org</a>	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma WA 98408 V 253-583-5353 <a href="mailto:mljohnso@cloverpark.k12.wa.us">mljohnso@cloverpark.k12.wa.us</a>	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 <a href="mailto:gwenrench@covad.net">gwenrench@covad.net</a>	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 <a href="mailto:maryklindquist@comcast.net">maryklindquist@comcast.net</a>	K-12 Retirees

## PEB Board Members

### Name

### Representing

Tim Barclay  
7634 NE 170<sup>th</sup> ST  
Kenmore WA 98028  
V 206-819-5588  
[timbarclay51@gmail.com](mailto:timbarclay51@gmail.com)

Benefits Management/Cost Containment

Yvonne Tate  
1407 169<sup>th</sup> PL NE  
Bellevue WA 98008  
V 425-417-4416  
[ytate@comcast.net](mailto:ytate@comcast.net)

Benefits Management/Cost Containment

Marilyn Guthrie  
1640 W Beaver Lake DR SE  
Sammamish WA 98075  
V 206-715-2760  
[maguthrie52@gmail.com](mailto:maguthrie52@gmail.com)

Benefits Management/Cost Containment

Harry Bossi\*  
19619 23<sup>rd</sup> DR SE  
Bothell WA 98012  
V 360-689-9275  
[udubfan93@yahoo.com](mailto:udubfan93@yahoo.com)

Benefits Management/Cost Containment

### Legal Counsel

Katy Hatfield, Assistant Attorney General  
7141 Cleanwater Dr SW  
PO Box 40124  
Olympia WA 98504-0124  
V 360-586-6561  
[KatyK1@atg.wa.gov](mailto:KatyK1@atg.wa.gov)

\*non-voting members

1/17/17



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](http://www.pebb.hca.wa.gov)

**2017 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 8<sup>th</sup> Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 17, 2017 (Board Retreat) 10:00 a.m. – 4:00 p.m.

March 16, 2017

April 12, 2017

May 18, 2017

June 21, 2017

July 12, 2017

July 19, 2017

July 27, 2017

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 11, 2016**

**TIME: 11:06 AM**

**WSR 16-17-045**

**TAB 2**

## 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**

**Public Employees Benefits Board**  
**Meeting Minutes**

**D R A F T**

July 13, 2016  
Health Care Authority, Sue Crystal Rooms A & B  
Olympia, Washington  
2:00 p.m. – 3:30 p.m.

**Members Present:**

Dorothy Teeter  
Harry Bossi  
Gwen Rench  
Tim Barclay  
Marilyn Guthrie

**Members on the Phone:**

Greg Devereux  
Yvonne Tate  
Mary Lindquist  
Myra Johnson

**PEB Board Counsel:**

Katy Hatfield

**Call to Order**

**Dorothy Teeter, Chair**, called the meeting to order at 2:00 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

**Agenda Overview**

**Lou McDermott**, PEB Division Director, provided an overview of the agenda.

**Approval of April 13, 2016 PEBB Meeting Minutes**

It was moved and seconded to approve the April 13, 2016 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

**SmartHealth Legislative Report**

**Marcia Peterson**, PEB Benefit Strategy and Design Section Manager, shared the first legislative report on the effectiveness of the SmartHealth Program. The Health Care Authority (HCA) will submit reports on a quarterly basis evaluating the effectiveness of the program. The first report is due on June 30, 2016. We worked collaboratively with the Office of Financial Management, the Washington State Institute for Public Policy

(WSIPP), and with Limeade who provides our SmartHealth portal, to conduct the evaluations. The report is to include the overall effectiveness of the Wellness Plan - including the costs of the plan, what were the communication strategies, what were the rates of employee engagement and participation, and things such as health outcomes, sick leave use, and improvements in chronic medical conditions.

October 2013, Governor Inslee issued Executive Order 1306 directing the creation of a State Employee Health and Wellness Steering Committee, which developed a comprehensive wellness program for state employees.

In 2014, the Legislature took a little different approach, requiring PEBB Program members who use tobacco products to pay a \$25 surcharge. In addition, the PEBB Board and Legislature authorized the use of a financial incentive to encourage healthy behavior. So under that, members who attested to participating could receive a discount of \$125 on their medical deductible in the next plan year, or a contribution to their HSA.

Also in 2014, funding was approved to procure an online tool so members could track their wellness activities and earn points towards the wellness incentive. In January of 2015, the SmartHealth online portal was launched. Members who earned at least 2,000 points by June 30, 2015 were eligible to receive the \$125 incentive. For plan year 2016, the Board extended the deadline. Instead of June 30, subscribers have until September 30 to earn 2,000 points. We hope to encourage greater participation. Members could use the summer months to participate in wellness activities. The incentive will be distributed in January of 2017.

Our communication strategies in the first year of the program were a base line year and we tried to focus on creating member awareness of this new program and on member engagement. We had some known barriers to participation and even awareness. One barrier has to do with access and being able to email people. Once they register for the program, we have their emails. We did a lot of home mailers and other promotions, engaged leadership, and so on. We had a Seahawk ticket giveaway which was extremely successful. Another barrier had to do with the complex structure of state government. We have higher education and many different sized agencies. Once size did not fit all. We tried to address those barriers with communication strategies and will continue to do so. We continue to learn from our members. The Committee is also very helpful in directing us towards how to make changes to the program.

Defining worksite wellness programs is quite a challenge. We talk quite a bit about that in the report. They fall into three basic areas. One area is around prevention where they have activity challenges like anti-smoking campaigns. These are focused around keeping well people well. Then there are programs focused around high risk folks. They involved things like weight loss classes and smoking cessation. And then there are wellness programs focused on disease management, and really focused on a

particular disease, like depression or diabetes. So it's challenging defining what a worksite wellness program is. Measurement is difficult.

In the report we have a literature review; and in that review, we talk about some of the limitations of the research on wellness programs. There are two main areas that are challenges when we try to evaluate the effectiveness of these types of programs. The first one refers to the potential selection bias. People who choose to participate in a program like SmartHealth, or any sort of wellness program, may already have some sort of bias to want to change their behavior. When we try to compare that group with a cohort that didn't get involved, there can be some skewing in terms of really doing an apples to apples comparison. The vast majority of studies are not able to have a randomized control group so that you can really say with any certainty that this wellness program was the cause of certain things happening. That's one challenge. The other challenge has to do with the long lag time that is inherent in trying to measure an effect of any type of public health intervention. It can take decades for some of these things to manifest themselves in better health or avoidance of disease. Those are two of the challenges identified in the report in the literature review.

We also found a lot of information in the literature about what makes for strong programs; what encourages the engagement of people in these worksite wellness programs. One of them is the existence of some explicit goals around health engagement, like completing a well-being assessment that identifies things you should work on and setting goals. Those tend to encourage engagement. The use of financial incentives is often strongly tied to engagement. Then finally, a work culture and environment that supports health and wellness tends to be cited very often in the literature as necessary to have a strong program.

A few highlights from the report are:

- Of the 132,000 eligible for SmartHealth, 39% registered. That's 51,407 people; and most of those, 37%, completed their well-being assessment, and 24% earned the incentive. Of the 51,407 who registered, 94% of those completed their well-being assessment. That is an amazing statistic in comparison with some other programs that our vendor uses. 61% of those earned the incentive.
- Women tended to participate more than men across SmartHealth.
- State agencies tended to participate at greater levels than those institutions of higher education. This will be an area of focus this year.
- Our levels of engagement were very good the first two quarters, which took us to the end of the incentive period. Engagement starts to drop off in quarter three. Getting the incentive clearly was a focus for a lot of people in terms of participation.
- In reviewing risk factors, nearly three quarters of the respondents had either zero or one self-assessed risk factor, and only four percent had four or more. In the future, we hope to be able to determine whether or not this is normal or did we get a lot of people who have a lot of risk factors compared with the underlining population.

- Limeade sent a randomized survey to 27,000 employees asking about their satisfaction with SmartHealth. About two thirds of those surveyed agreed, or strongly agreed, that SmartHealth was easy to use and they would recommend it to a co-worker.

As we look at future evaluations, we are trying to put a plan together at the end of 2017-2018 to look at risk, and whether or not we are starting to impact any sort of health outcomes. Some of the questions we will be asking are:

- What percent of subscribers who qualify for the incentive on January 1 use none, or only part, of the incentive because the total dollar value of their annual deductible may be too low.
- What behavior changes in health and well-being status can be measured by comparing year-to-year on a population basis of those well-being assessment results.
- What advantages and disadvantages does the current method of incentive delivery contain? For instance, we use a discount basically off of your deductible for the next year. What is the effect of that? Are there other approaches that we might be able to take to be more effective?
- What are the impacts of other strategies on participation performance, including other communication channels, different types and values of activities?

**Marilyn Guthrie:** In terms of the demographics, both age and gender, did you get a sense of how closely that mirrored the overall population?

**Marcia Peterson:** In terms of age, I believe we did. We did see that women were more highly represented in terms of SmartHealth; but the age was definitely reflected in the population overall.

**Greg Devereux:** The key to this is what results we see in 2018 with changes in behavior and risk in trends. It seems that this will be hard to evaluate long term, but that's really the essence of this; to see what the incentives have done over time to really change people's behavior.

**Marcia Peterson:** The literature definitely shows that it can take most of these programs three to four years before they can look at this question. We hope to have a plan around this for the future.

**Dorothy Teeter:** We'll look forward to your next quarterly report. I know this is a huge amount of work and it's a very important program so it's worth the evaluation.

### **Annual Rule Making Briefing**

**Rob Parkman,** PEB Division Policy and Rules Section: This presentation is to provide a high-level information briefing on the more significant changes being considered for 2016 annual rule making. No action is needed from the Board for this briefing.

The scope of this rule making will be to address benefit administration issues; provide clarity in areas identified by members, business partners, and staff; make some technical corrections; implement legislation; and implement policies adopted by the Board. The administrative changes being considered will include the following:

- Amending rules to more clearly state the methods retirees must use to request termination of their enrollment in PEBB Program retiree coverage, and to describe how the request will affect the subscriber's account.
- Amending a number of rules related to the administrative hearings process for appeals to the Office of Administrative Hearings. Some examples include creating a rule that describes service of documents/pleadings requirements, creating a rule on subpoenas, clarifying that appeal request must be in writing, establishing that HCA employees cannot represent an appellant in a hearing against the agency, requiring that a hearing notice must be served on parties at least twenty-one days prior to a hearing. The current requirement is fourteen days, which is often too short a timeline and prompts continuances.
- Changes to respond to requests for greater clarity in some rules and improved readability in others. These changes include the following: we will propose adding a definition of the word employer (as defined in chapter 41.05 RCW) and a number of definitions for phrases that include the word employer in order to provide clarity and context within the rules.
- Amending the premium payment language in a number of rules to include greater detail around the time frames subscribers have to pay unpaid account balances.

Technical corrections being considered are:

- Amending the employee eligibility rules to create better alignment between the rules and RCW 41.05.065. Proposed amendments focus on language that describes eligibility determined by considering both the number of hours and the number of consecutive months the employer anticipates the employee will work.

**Greg Devereux:** I think I understand the problem we are trying to solve by adding the word consecutive, but I would love to hear what it is.

**Dave Iseminger:** This is related to one of the policy proposals that comes up in the next presentation defining the word "season." Over the past couple of years we've had some agencies that have presented unique employment situations where an individual has seven months where they are employed, two months where they are not employed, one month where they are employed, and two months where they are not employed. And this is related to the policy resolution in the next presentation.

**Greg Devereux:** Okay. Thank you.

**Rob Parkman:**

Technical corrections being considered, cont.:

- Clearly describe how employers should be administering benefits for seasonal employees who are eligible for the employer contribution during the off-season following their season worked.

Implementing legislation considerations to amend rules relating to the employer group participation to implement two pieces of legislation that passed this year. The changes necessary for implementation do not require action by the Board. This information is provided for your information only. Considerations are:

- Senate Bill 6475 affects the application process HCA uses to approve or deny applications from counties and political subdivisions with fewer than 5,000 employees and allows HCA to apply a rate surcharge to participating counties, municipalities, other political subdivisions, and tribal governments that purchase PEBB Program benefits through a contract with the HCA.
- Engrossed Second Substitute Senate Bill 6194, or the Charter School Bill, has a minor impact on the way we referred to them within the definition of school district. We will amend the rules to list them separately but alongside school districts and educational service districts.

We may make further changes as we continue to analyze the effect of this legislation.

Our next step is to file draft rules so they are available for public comment, conduct a public hearing in September, and adopt the final rules in October. Any new or amended rules will be effective January 1, 2017.

**Dorothy Teeter:** There were three policy resolutions introduced at our June 22 meeting that are before the Board today for a vote. Dave Iseminger will review the three resolutions before we open it up for discussion.

**Policy Resolutions**

**Dave Iseminger,** PEB Division Deputy Director: The three policies we are presenting to you for a vote are: defining “season,” defining “tobacco products,” and related to domestic partner eligibility.

**Policy Resolution 1 - Season**

Resolved, that “Season” means any recurring, annual period of work at a specific time of year that lasts three to eleven consecutive months.

**Greg Devereux:** Dave, if a seasonal worker works six months every year for ten years but it’s not at the specific same time each year, would they not be captured by the “seasonal” definition?

**Dave Iseminger:** If I understand your question, you're saying in year one the person has six consecutive months from January to July; but in year two, that six months is, March to September. Is that correct?

**Greg Devereux:** Correct.

**Dave Iseminger:** Then I believe they would not be captured by, or be affected by, this policy resolution.

**Greg Devereux:** They would not be affected? Because this says "annual period of work at a specific time of year."

**Dorothy Teeter:** Is the question then around the word "recurring?"

**Greg Devereux:** You could be recurring six months every year for ten years but it might not be at a specific time of the year.

**Dave Iseminger:** I'm thinking through a lot of conversations that staff had on this particular wording over the past year. Part of the review in developing this policy resolution was taking into consideration fire season, for example. We call that a season; but fire season, given changes in climate, might start two weeks earlier this year or two weeks later next year. In our discussions, we were also trying to account for the variance that might happen in things like fire season. Based on that example, does that clarify and answer your question? I'm not positive I fully answered it.

**Greg Devereux:** I don't think it does. I think the troublesome language to me is "at a specific time of year." What you just said about fire season, if you said season means any recurring annual period of work that lasts three to eleven consecutive months, I think that might cover it more accurately. I just don't want someone to say it has to be January to June. If it doesn't fit January to June then you don't get it. We represent thousands of seasonal workers.

**Dave Iseminger:** The other piece of this is that the only difference between this policy resolution and the statutory language in 41.05.065 is the word "consecutive." The specific time of year is actually mirroring and copying that which is already in statute; which wouldn't be able to be significantly altered.

**Dorothy Teeter:** I have a suggestion in terms of process. While Katy is looking that up, we'll move on and come back to this. Let's go on to the tobacco products resolution and give Katy enough time to do some thinking on this.

**Dave Iseminger:** Policy Resolution 2 is related to tobacco products. Before reading the resolution, there are two modifications from the version that was presented to the Board at the last meeting. One of those is including pipe tobacco within the illustrative non-exclusive list that is helpful and informative to members. This was in response to

Harry Bossi's suggestion about adding that clarity. The second is relocating where e-cigarettes falls within the last sentence. This was a syntax concern. Several people pointed out that the FDA could be considered an adjective of e-cigarettes; and so by moving e-cigarettes to the front, it avoids any concern about whether the FDA had a role in approving or not approving e-cigarettes. Those were the two modifications that came up as a result of some review and comments from the last meeting.

### **Policy Resolution 2 – Tobacco Products**

Resolved, that "tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids."

### **Policy Resolution 3 – Domestic Partner**

Resolved, that eligibility for domestic partners qualified under PEBB criteria in place prior to January 1, 2010 is removed effective January 1, 2017.

**Dorothy Teeter:** Let's check in with Katy Hatfield and see what she's found on Policy Resolution 1 – Season. If I understand correctly, we're not completely sure about how to properly answer Greg's question about clarifying the language relative to the legal implications of that. Since we're not completely sure let's hold Policy Resolution 1 and not vote on it today. Given the timing of WACs, we need to take this up again next cycle. We'll provide more information at a later date.

We will not vote on Policy Resolution 1, but we will vote on the other two.

### **Policy Resolution 2 - Tobacco Products**

Resolved, that "Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

### **Policy Resolution 3 – Domestic Partner**

Resolved, that eligibility for domestic partners qualified under PEBB criteria in place prior to January 1, 2010 is removed effective January 1, 2017.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

**Greg Devereux:** Thank you, Dorothy, for looking at the first resolution.

**Dorothy Teeter:** You're welcome. And thank you for checking. We want to make sure things are clear if we are going to vote on them.

### **Life Insurance Benefit Reprourement**

**Beth Heston,** PEB Procurement Manager: Beth reviewed the life insurance benefit reprourement information. She reviewed the benefit comparison chart which lined up the types of insurance available to PEBB Program members. Today we will vote on the resolutions that will change the benefit design going forward.

### **Plan Design Resolution 4 – Life Insurance**

Resolved, that the employer paid life insurance provided to eligible employees beginning January 1, 2017 will be a \$35,000 death by any cause benefit and a \$5,000 accidental death and dismemberment (AD&D) benefit.

### **Plan Design Resolution 5 – Life Insurance**

Resolved, that beginning January 1, 2017, employees will have 31 calendar days instead of the current 60 calendar days to elect employee paid voluntary life benefits up to the guaranteed issue amounts without medical underwriting.

**Gwen Rensch:** Is there any special reason why the time period had to be shortened?

**Dave Iseminger:** IRS rules really govern the use of tax preferred dollars to pay for employee premiums and FSA and DCAP elections, as an example. A significant goal of those IRS rules is to ensure that there is not hindsight with regards to tax preferred usage of dollars. We couldn't move, for example, the medical and dental in a more broad direction. Over the years, we've had concerns and questions raised from employees that are confused because some of their forms are due on 31 days and some of them are due in 60 days. With a lot of the benefit enhancement at the time of rebooting the benefit, we felt this would be a good opportunity to have a single, clear, consistent message for active employees that all deadlines are 31 days.

**Lou McDermott:** We did try and move everything to 60 days because we wanted the consistency. But because of the IRS regulations, it had to be 31 days.

**Greg Devereux:** I want the record to show that I understand the point and I do agree. I think some might view 60 calendar days and going back to 31 as a take away. I think that's outweighed by the confusion that might accrue between the two. Lining them up at 31 days I think does make more sense for the Health Care Authority.

**Dorothy Teeter:** Thanks for that perspective, Greg.

### **Plan Design Resolution 6 – Life Insurance**

Resolved, that beginning January 1, 2017, the employee paid voluntary life benefit will include:

- a) An employee supplemental death from any cause benefit of \$500,000 guaranteed issue with up to \$1,000,000 with medical underwriting;
- b) An employee supplemental AD&D benefit of \$30,000 guaranteed issue with up to \$250,000 with medical underwriting;
- c) A spouse or registered domestic partner death from any cause benefit of up to 50% of the employee supplemental elected amount with \$100,000 guaranteed issue;
- d) A spouse or registered domestic partner AD&D benefit of \$30,000 guaranteed issue with up to \$250,000 with medical underwriting;
- e) A child death from any cause benefit of up to \$10,000 guaranteed issue with up to \$20,000 with medical underwriting; and
- f) A child AD&D benefit of up to \$10,000 guaranteed issue with up to \$25,000 with medical underwriting.

### **Plan Design Resolution 7 – Life Insurance**

Resolved, that effective December 31, 2016, the current employee supplemental death from any cause benefit and spouse or registered domestic partner death from any cause benefit will be transferred to the new vendor for the full amount elected by the employee.

### **Plan Design Resolution 8 – Life Insurance**

Resolved, that effective December 31, 2016, the current employee supplemental AD&D benefit and the dependent AD&D benefit will no longer be available. Existing employee supplemental AD&D will be transferred to the new vendor for the full amount elected for the employee, but any existing AD&D for dependents (spouse/child) will not transfer and will terminate. Employees who do not elect replacement coverage during the November 2016 open enrollment for dependents (spouse/child) will have to apply for and, if required, go through medical underwriting for new coverage.

**Tim Barclay:** I want to make sure I'm understanding the language correctly. So, if a PEBB employee who currently has dependent AD&D coverage elects to increase that amount in November, will they have to do medical underwriting or not?

**Beth Heston:** No.

**Tim Barclay:** They will not. So even if they increase the amount? What if somebody who doesn't have it currently elects to pursue it?

**Beth Heston:** If someone who doesn't have it currently elects to pursue it, for this open enrollment only, they will have no medical underwriting.

**Tim Barclay:** Thank you.

**Greg Devereux:** For the subscriber, you can transfer your current coverage. Is the fact that you can't transfer your spouse or child, but you can then elect replacement coverage, is that simply a *pro forma* process?

**Beth Heston:** It will require them to go online and create an account with MetLife. The difficulty is that we don't have that data to send to the new vendor because Pay1 does not capture it.

**Greg Devereux:** Thank you.

**Plan Design Resolution 9 – Life Insurance**

Resolved, that effective December 31, 2016, the \$2,500 employee paid voluntary life benefit for dependents will no longer be available and that employees who do not elect replacement coverage during the November 2016 open enrollment will have to apply for and, if required, go through medical underwriting for new coverage.

**Plan Design Resolution 10 – Life Insurance**

Resolved, that for eligible individuals retiring on or after January 1, 2017, the retiree life insurance benefit will be a maximum \$20,000 benefit with no age reductions.

**Dorothy Teeter:** Hearing no questions, we are ready to vote on these resolutions.

**Plan Design Resolution 4 – Life Insurance**

Resolved, that the employer paid life insurance provided to eligible employees beginning January 1, 2017 will be a \$35,000 death by any cause benefit and a \$5,000 accidental death and dismemberment (AD&D) benefit.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

**Plan Design Resolution 5 – Life Insurance**

Resolved, that beginning January 1, 2017, employees will have 31 calendar days instead of the current 60 calendar days to elect employee paid voluntary life benefits up to the guaranteed issue amounts without medical underwriting.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

**Plan Design Resolution 6 – Life Insurance**

Resolved, that beginning January 1, 2017, the employee paid voluntary life benefit will include:

- a) An employee supplemental death from any cause benefit of \$500,000 guaranteed issue with up to \$1,000,000 with medical underwriting;
- b) An employee supplemental AD&D benefit of \$30,000 guaranteed issue with up to \$250,000 with medical underwriting;
- c) A spouse or registered domestic partner death from any cause benefit of up to 50% of the employee supplemental elected amount with \$100,000 guaranteed issue;
- d) A spouse or registered domestic partner AD&D benefit of \$30,000 guaranteed issue with up to \$250,000 with medical underwriting;
- e) A child death from any cause benefit of up to \$10,000 guaranteed issue with up to \$20,000 with medical underwriting; and
- f) A child AD&D benefit of up to \$10,000 guaranteed issue with up to \$25,000 with medical underwriting.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

#### **Plan Design Resolution 7 – Life Insurance**

Resolved, that effective December 31, 2016, the current employee supplemental death from any cause benefit and spouse or registered domestic partner death from any cause benefit will be transferred to the new vendor for the full amount elected by the employee.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

#### **Plan Design Resolution 8 – Life Insurance**

Resolved, that effective December 31, 2016, the current employee supplemental AD&D benefit and the dependent AD&D benefit will no longer be available. Existing employee supplemental AD&D will be transferred to the new vendor for the full amount elected for the employee, but any existing AD&D for dependents (spouse/child) will not transfer and will terminate. Employees who do not elect replacement coverage during the November 2016 open enrollment for dependents (spouse/child) will have to apply for and, if required, go through medical underwriting for new coverage.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

#### **Plan Design Resolution 9 – Life Insurance**

Resolved, that effective December 31, 2016, the \$2,500 employee paid voluntary life benefit for dependents will no longer be available and that employees who do not elect

replacement coverage during the November 2016 open enrollment will have to apply for and, if required, go through medical underwriting for new coverage.

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

### **Plan Design Resolution 10 – Life Insurance**

Resolved, that for eligible individuals retiring on or after January 1, 2017, the retiree life insurance benefit will be a maximum \$20,000 benefit with no age reductions.

**Gwen Rench:** What about retirees before January of 2017? My impression before was that there were options for them also.

**Beth Heston:** Yes. They will be grandfathered over and they'll have a chance to take their current \$3,000 benefit and stay at \$3,000. It won't be reduced. Or, they can go up to \$5,000 with no evidence of insurability. And they can go up to \$20,000 with evidence of insurability.

**Gwen Rench:** Thank you.

**Greg Devereux:** Does the retiree have to pay for this?

**Beth Heston:** Yes.

**Greg Devereux:** Thank you.

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

**Dorothy Teeter:** Thank you, Beth, for all your work on this. It's pretty awesome after forty years to get a remarkable new life insurance policy; and hopefully, this will be in place for another forty or fifty years. It will be our legacy! Thanks very much.

Our next meeting is either July 20 from 1:30 p.m. to 3:00 p.m. or July 27 1:30 p.m. to 3:00 p.m.

**Lou McDermott:** We are working on the rates for 2017. The next meeting will most likely be July 27, but we will put a notification on the Listserv and website. There is an August 10 meeting scheduled for 9 a.m. in the event we don't meet on July 20.

Meeting adjourned 2:50 p.m.

**Public Employees Benefits Board**  
**Meeting Minutes**

**D R A F T**

July 27, 2016  
Health Care Authority  
Pear Room 107  
Olympia, Washington  
1:30 p.m. – 3:00 p.m.

**Members Present:**

Dorothy Teeter  
Harry Bossi  
Gwen Rench  
Yvonne Tate  
Greg Devereux  
Myra Johnson

**Members on the Phone:**

Tim Barclay

**Members Absent:**

Marilyn Guthrie  
Mary Lindquist

**PEB Board Counsel:**

Katy Hatfield

**Call to order**

**Dorothy Teeter, Chair**, called the meeting to order at 1:34 p.m. Sufficient members were present to allow a quorum. Board and audience introductions followed.

**Agenda Overview**

**Lou McDermott**, PEB Division Director, provided an overview of the agenda.

**2017 PEBB Program Procurement Summary**

**Beth Heston**, PEB Division Procurement Manager, Portfolio Management & Monitoring Section, covered the medical benefit changes for the Uniform Medical Plan (UMP) Classic, CDHP, and UMP Plus; Group Health Classic, Value, CDHP, and SoundChoice;

and Kaiser Permanente Classic and CDHP. Also discussed were the dental benefits, long-term disability benefits, and life insurance.

Slide 3 is about the new Centers of Excellence (COE) benefit for members needing total joint replacement administered by Premera Blue Cross. It will be available to Classic and CDHP members. Classic members will have zero deductible and zero co-insurance if they use the Center of Excellence for their total joint replacement. CDHP members will have zero co-insurance after they meet their deductible, if they use the Center of Excellence. Both Classic and CDHP members will have a travel benefit if they live outside of the 60-mile radius that serves Virginia Mason.

**Greg Devereux:** When you say Classic, do you mean all three? Uniform, Group Health, and Kaiser?

**Beth Heston:** No, I just mean UMP Classic.

**Greg Devereux:** Okay.

**Beth Heston:** Another benefit change this year for UMP Classic and CDHP is male sterilization. Plans will offer male sterilization at zero cost share to members for Classic and after the deductible for the CDHP.

Our Uniform Medical Plan Plus networks are going to be expanding this year. Additional counties for 2017 are: Skagit and Grays Harbor Counties for UW Medicine Accountable Care Network (ACN); and Spokane, Yakima, and Grays Harbor Counties for the Puget Sound High Value Network.

Group Health Classic, Value, CDHP, and SoundChoice will also offer male sterilization at zero cost share to members with the Classic and Value plans, and after the deductible for CDHP. There is a change to Group Health's coverage on acupuncture. The plans will change the number of covered visits from eight visits per medical diagnosis per year to a limit of twelve visits overall per year. Group Health is also offering telehealth to all members. This is a program where members can get a virtual visit for primary specialty and urgent care. It is delivered online using real-time video conferencing and audio, and can be done from smart phones, laptops, and tablets. Members will be able to schedule phone visits with, and send secure messages to, if they are working directly with their care team for chronic disease management.

This year, Group Health asked to offer a different design for the Value plan. The changes are reflected on Slide 8. The maximum amount of out-of-pocket will increase from \$2,000 per enrollee and \$4,000 per family, to \$3,000 per enrollee and \$6,000 per family. The annual deductible is reduced from \$350 to \$250. Primary office co-pays will increase slightly, from \$20 to \$30. Specialty office visit co-pays will increase from \$40 to \$50. In-patient hospital co-pays will increase by \$50 and the cap on those will increase by two days. The \$50 co-pay increase also applies for skilled nursing facilities.

The Value plan redesign adds two more tiers to the prescription drug benefit. Tier 0 – Value Copay stays at \$5. Tier 1 – Generic Copay will increase \$5, to \$25. Tier 2 – Preferred Brand Copay increases \$10 up to \$50. Tier 3 – Non-preferred Coinsurance will be 50% with no cap. Tier 4 – Preferred Specialty Copay is new and is \$150. And finally, the new Tier 5 – Non-preferred Specialty Coinsurance is 50%, up to \$400.

Kaiser Permanente Classic will be offering male sterilization at zero cost share to Classic members, and after the deductible for those in the CDHP.

**Tim Barclay:** Did Group Health do any analysis on the Tier 3 benefit change in removing the cap in terms of how many people are impacted by that and how severe that impact is? What that 50% coinsurance could mean to some people?

**Lou McDermott:** Tim, if there was an analysis done, I'm not aware of the detail that came to us regarding the impact of that.

**Tim Barclay:** Is that something that PEB could look into? I would like to know what exactly no cap means potentially to some of our clients.

**Lou McDermott:** Yes. We can look at what we would anticipate it would be, but we also have individual member behavior change that would occur because of the new tiering system. We can look at what today's world is anticipating, however, what tomorrow's world is under the new structure might be more complicated. We will get what we can out of the data we have.

**Dorothy Teeter:** Perhaps we can consult with Group Health to see if they have done that analysis.

**Lou McDermott:** Yes.

**Tim Barclay:** I have a second question. On the overall Value redesign, what is the composite impact of all of these changes together?

**Lou McDermott:** When you say the composite impact, are you talking about the actuarial value? How much that is going down?

**Tim Barclay:** Yes.

**Lou McDermott:** I believe it goes down from 86 to maybe 83?

**Ben Diederich, Milliman:** You're close, 87 to 84.

**Lou McDermott:** 87 to 84.

**Tim Barclay:** Okay, thank you.

**Greg Devereux:** Tell me what that is.

**Lou McDermott:** It is basically saying that the overall value of the plan is a little bit less; the benefits aren't as rich.

**Ben Diederich:** To that end, what the members expected to pay under the assumptions of the actuarial value cap. The actuarial value of the plan is a measurement that the Federal Government has created - that 87 percent is what the plan of benefits is expected to pay under their assumptions, and then 13 percent is what the member is expected to pay. So, the aggregate impact according to the actuarial value tool is that the member will pay three percent more under the redesign.

**Lou McDermott:** But of course, that is taken into consideration as well when premiums are reduced. You have premium reductions so it all depends on the particular member, their circumstances, and their care patterns as to how it will impact them.

**Greg Devereux:** Beth, can we go back to Page 7. Are virtual visits for urgent care services available on a smart phone now?

**Beth Heston:** Yes. It has been expanded. A lot of plans are moving towards it so people don't have to drive to the urgent care center if it's something they can take a picture of, like a cut, and let a licensed doctor look at it over the phone to determine whether or not it needs stitches, or just cleaned and bandaged. If your child has a rash and you don't want to take them to the doctor, it can be looked at over the phone.

**Greg Devereux:** Okay. But if it does need stitches, you still have to go in.

**Beth Heston:** Exactly, the doctor would determine the necessity of an on-site office visit.

**Greg Devereux:** Thank you.

**Lou McDermott:** There is a correction on Page 8. The annual deductible for 2016 says \$350 and \$125. It is actually \$225.

**Dorothy Teeter:** So in 2016, you are saying the annual deductible should say \$225/\$925?

**Lou McDermott:** Correct. 2017 is correct.

**Dorothy Teeter:** Okay, thank you.

**Beth Heston:** There are no benefit changes this year to either the dental benefits or the long-term disability benefit. You have already approved the life insurance resolution, but I have included it to give you a side-by-side comparison.

## **Rates Overview**

**Kim Wallace**, Financial Services Division Assistant Section Manager, Financial Analytics, provided an overview of the 2017 premiums that have resulted from the procurement process conducted over the past four to five months. I will present two sets or schedules of premiums and employee contribution levels. The reason for the two sets is that the PEBB Program may receive a court order to move from our current restricted drug treatment policy for Hepatitis C to an unrestricted treatment policy for UMP plans. Having the Board vote on August 10 to endorse premiums under either of these policies ensures that we are prepared to proceed without delay with our 2017 open enrollment activities under either policy. You will see a resolution directly addressing this later in the meeting. Please note that Group Health has already implemented an unrestricted Hepatitis C drug policy. Kaiser has not, and at this time plans to continue a restricted policy. The differences between Schedule A versus Schedule B affect the medical premiums for non-Medicare, not retiree Medicare, dental, life, or LTD.

Schedule A represents the employer and employee monthly premium contributions under a continued restricted drug treatment policy for Hepatitis C. Slide 3 shows the employee contribution, employee and employer premium contributions for the single subscriber tiers or levels. This is an at-a-glance feel of where the numbers fall for 2017. Column one shows employee contribution and column two shows the state, or employer, contribution. The employer contribution is \$522 for all plans and it does not vary by plan. If you add column one and column two, you get column three, the total composite rate. This shows the share that is being borne by employee versus employer.

Slide 4 expands this information to show the contribution levels by tier. The dollar figures that you see in the subscriber column match what you just saw on the previous slide. In the last column, you see the percentage change in the subscriber or the employee contribution level. Those percentages vary quite a bit, plan by plan. With respect to Group Health Value, the top row, you do see the effects of the Value redesign described earlier. That contribution is dropping. Contribution levels are also dropping for Kaiser. For UMP, the increases you see are due to cost trends. In order of impact, cost trends in medical services, specialty pharmacy, Hepatitis C drugs, and non-specialty pharmacy. From a pure percent increase perspective, costs for specialty pharmacy are increasing the fastest. However, because costs for medical services represent the largest portion of total costs, the increases in medical costs are still the leading contributor to rate increases.

Slide 5 shows the 2017 rates for non-Medicare retirees. In the last column, you can see the percentage increases for 2017. The eight percent increase in rates for UMP plans is driven by the same factors that I just listed.

Slide 6 shows the Medicare retiree premiums. The numbers have already been reduced by the State funded Medicare Explicit Subsidy, the lesser of the \$150, or 50

percent of the plan premium. Per the Centers for Medicare and Medicaid Services (CMS), there are changes that impact 2017 rates specifically: 1) a reduction in the amount paid by CMS for group Medicare plans, and 2) a rule was eliminated that impacted rate setting.

The Group Health Medicare rate from 2014 to 2015 increased 2.3 percent; and then from 2015 to 2016, there was a drop of 8.5 percent. This year the increase is 29.4 percent. The CMS changes are what is creating the rates for this coming year. We thought it was important for you to consider what has historically been happening so that you had a fuller picture through time.

Slide 7 shows dental premiums. There is little change for 2017. The vast majority of our PEBB Program members are in the Uniform Dental Plan. We expect a slight increase in costs for 2017; but for employees, the state pays 100 percent of this cost. There is no rate increase for Delta Care or Willamette Dental Group. They offered a multi-year rate guarantee.

Slide 8 is our life insurance premiums. At the bottom of the slide, in the row named cost per thousand per month, the rate in 2016 is eight cents per thousand per month; and in 2017, it goes up to eleven cents per thousand per month. Again, similar to the information shared about the Group Health Medicare rate changes, for this employee supplemental coverage in 2015, the rate was actually 11.5 cents per thousand. We artificially reduced it for 2016 to use some funds from the Premium Stabilization Reserve (PSR). That is why you see the eight cents listed. Lastly, when the PSR funds transfer to our new vendor, MetLife, we will lock in the rate of eleven cents through calendar year 2024. We want to be transparent and make sure you understood the context of what has occurred over the past three years, and what we are going to be experiencing going forward. It is still a very positive message.

**Greg Devereux:** I have a question back on Page 3 in the footnotes. What is the employer group reduction?

**Kim Wallace:** That relates to SB 6475, the poli-sub surcharge. Are you asking about the \$2?

**Greg Devereux:** Yes.

**Kim Wallace:** That is actually an offset amount to the State active pool we can take in our rate setting, offsetting the fact that the poli-sub employer groups will be paying a surcharge, thereby alleviating a bit of the experience impact that they had in the risk pool.

**Lou McDermott:** Greg, so SB 6475 allowed us to look at our political sub-divisions; that if on average they were costing us more than the average PEBB Program member, we could charge them a surcharge. We didn't have that ability before this bill. If they

were costing us more, we were all sharing in those extra dollars. With SB 6475 passing, we are allowed to charge that surcharge; and that surcharge becomes a revenue stream for us. That revenue stream has an impact on the rates.

**Kim Wallace:** So the \$2 is in a positive direction.

**Tim Barclay:** Kim, on Page 4 where I look at the Group Health premium changes for the members, help me understand the Portfolio Management philosophy. Looking at Value groups, it looks like they are going down 11 percent even if we didn't have benefit changes and Classic is going up 27 percent; but we're now trying to offset that benefit increase change on Classic, but we are making benefit changes on Value. Can you help me understand what the thinking is behind managing those two different offerings?

**Kim Wallace:** When Group Health proposes plan designs for our consideration, one of the things we're looking at is maintaining an array, or a continuum, a spectrum, of offerings in the PEBB Program so our members have choices to make. We have richer and we have not as rich offerings. That is what drives us. We do care about ensuring that we have an appropriate menu of offerings. We have not been overly prescriptive, or aggressive in terms of requiring that Group Health or Kaiser offer a particular design, or stay with a particular range.

**Lou McDermott:** That was a comprehensive answer. We are not in the business of telling fully insured products you will do X, Y, and Z. You will keep it at this price. We work with them as much as we can. If we see something that we feel could have a significant negative impact on the member, we have that discussion with them. We try to articulate to our members during open enrollment what their choices are, what the different plan designs are, what the differences are in premium and cost share, and we let our members select the plan that's right for them and their families.

**Tim Barclay:** Thank you. That's a great answer. I appreciate that.

**Kim Wallace:** You are welcome. On Slide 9 you will see there is no change in the basic long-term disability premiums. There is a change in the rate for the optional coverage. In the bottom right hand corner, you will see a change in the percent of income, which is essentially the cost. This is due to the fact that there will no longer be a subsidy from the claims fluctuation reserve like there has been in the past, and so the actual paid rate will increase.

**Greg Devereux:** Kim, could you talk about the subsidy? You said there is no longer subsidy like in the past.

**Kim Wallace:** Do you mean the claims fluctuation reserve that we built up? There was a sizeable amount in the reserve and it did not appear that it would be necessary to maintain such a high level. We felt we owed it to the employees choosing to purchase

that optional coverage, so elected to use a portion of that money to give them essentially some rate relief.

**Greg Devereux:** The claims fluctuation reserve is just in the LTD insurance program?

**Kim Wallace:** Yes.

**Greg Devereux:** Okay.

**Kim Wallace:** There is a separate premium stabilization reserve in the life, but the claims fluctuation reserve (CFR) is specifically for LTD.

**Kim Wallace:** Moving to Schedule B. The differences appear on Slides 3, 4, and 5, so we will focus there. Slide 3 shows the proposed 2017 single subscriber premium contributions under an unrestricted Hepatitis C drug treatment policy. The first change to note is that middle column, the employer contribution, or State Index Rate. It has gone up by \$3, from \$522 in Schedule A to \$525 in Schedule B, due to the UMP rates going up with the move to unrestricted Hepatitis C and the State Index Rate is 85 percent of the average bid rate. That is the State employer contribution under an unrestricted Hepatitis C. That translated into some premiums going down, some going up, and one staying the same.

In the middle column of Slide 3, the \$525, the employee contribution levels for Group Health Value, Group Health Classic, and Kaiser Classic, those employee premiums have gone down by \$3. Group Health Value was \$72 under Schedule A, for example. This \$3 decrease also would occur for Kaiser CDHP and Group Health SoundChoice.

UMP Classic, UMP CDHP, and UMP Plus all have gone up by \$1. For example, UMP Classic was \$93 under Schedule A, and now it is \$94. Group Health CDHP stayed the same, at \$25. Again, we are looking at the impact, the change going from a restricted Hepatitis C drug treatment policy to an unrestricted policy in Uniform Medical Plan.

Slide 4 is the employee contribution by tier. The dollar figures in the first column match what you saw on the previous slide. This is similar to the Schedule A where we do the math and show you the different tiers.

Slide 5, the non-Medicare retiree rates, has four different dollar figures than Schedule A. UMP Classic went from \$620 to \$624, Group Health CDHP from \$560 to \$563, UMP CDHP from \$559 to the \$563, and UMP Plus from \$592 to \$595. Essentially \$3 to \$4 in the monthly rate.

There are no changes in premiums for the rest of the benefits from Schedule A in Slides 6 through 9.

**Dorothy Teeter:** Kim, thank you for your clear presentation and going slow enough so we could absorb it as you went.

**Kim Wallace:** My pleasure, thank you.

### **2017 Procurement Resolutions**

**Lou McDermott:** Lou reviewed the proposed resolutions we will be asking the Board to vote on at the August 10 meeting.

**Plan Design Resolution 1:** Resolved, that the PEBB program will offer a new Uniform Medical Plan Centers of Excellence program (COE) starting in Plan Year 2017.

**PEBB Medicare Contribution Resolution 2:** 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.

**Employee Premiums Resolution 3:** Resolved, that the PEB Board endorses, (1) Schedule A for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if no judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using fibrosis scores as part of preauthorization criteria to cover Hepatitis C drugs, and (2) Schedule B for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if a judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using a fibrosis score as part of preauthorization criteria to cover Hepatitis C drugs.

We are up against two things for this rate-setting season. We have a judge who has indicated she will rule on an injunction hearing and tell us whether or not we're going to be covering Hepatitis C at F-zero or something in between F-zero, and where we're at currently. Secondly, we are running up against time. We can't continue to go deeper and deeper into the season with open enrollment coming. We need to print all of our materials for our members, our newsletters, and explain to them what the rates will be.

Testing needs to happen behind the scenes with computer systems and payroll systems for deductions. September 6 is our back door. That is as far as we can go. In essence, what the resolution is saying is if the judge does not rule before September 6, or if she does rule and says we don't have to cover at F-zero, then we will go with the rates that do not include F-zero, and we'll continue at F-three. If the judge rules prior to September 6 and says we will cover at F-zero, then we will implement the rate schedule that includes Hepatitis C at F-zero. If the judge rules after September 6 and says we will cover Hepatitis C, those will not be included in the rates for 2017. Those are the various scenarios. Employee Premiums Resolution 3, while convoluted and two pages long, articulates that.

**Greg Devereux:** Let's say she doesn't rule until after September 6. Does that mean it isn't covered then?

**Lou McDermott:** No, it means we will have to implement whatever the judge indicates. It just won't be reflected in the 2017 rates.

**Greg Devereux:** Thank you.

**Lou McDermott:** The only thing I can foresee that would change these resolutions is if the judge rules between now and August 10. We would clean the resolution up so that it was much clearer and indicate what we are actually doing.

**Harry Bossi:** I just need to understand a little more clearly relative to Group Health and Harvoni, or the Hepatitis C. I understand they currently cover it, the F-zero.

**Lou McDermott:** That is correct.

**Harry Bossi:** Okay, just to make sure I understand the difference between the \$69 for the subscriber versus the \$72. In version A or version B, is that because of the composite? I'm wondering why would their rate change since they're doing it anyway.

**Lou McDermott:** All the rates are interconnected because you're looking at an overall cost of the program. When one of the programs, which also happens to be one of the larger components of the program, has increasing costs, it will have an impact on all the other rates around it. Because Kaiser has a small number of our members, if Kaiser's rate were to change because of some unforeseen lawsuit or some expansion of service, it would have a nominal impact. But because UMP is big and Hepatitis C expenditures are large, it has a ripple effect through the rates.

**Harry Bossi:** Thanks, Lou. That is what I thought the answer would be. I just wanted to make sure in my own mind that I got it. Thanks.

#### **Proposed 2017 PEBB Meeting Dates**

**Lou McDermott:** Behind Tab 6 you'll see a proposed meeting schedule for 2017. We normally aim for Wednesday meeting days. However, due to conflicting schedules, some meetings are on Wednesday and some are on Thursday. People will need to be cognizant.

**Dorothy Teeter:** Due to an agency event happening on August 10, the day of our next Board meeting, Connie will send out parking information and the exact time of our next meeting.

## **Public Comment**

**Sara Eve Sarliker:** Hi, my name is Sara Eve Sarliker. I'm a state employee. I've been a state employee for, next month, it will be twelve years; and I've been a PEBB enrollee and UMP member for that whole time. I'm here not representing my agency; strictly representing myself. And I am here because it's come to my attention that there is a discrepancy between the Medicaid policy and the PEBB policy regarding insulin prescription. And while I completely understand these are two entirely different books of business, I also know that our state is dedicated to using our purchasing power in a more collective way. I have Type 2 Diabetes. I was diagnosed when I was 25 years old—more than twenty years ago. I was able to manage a pregnancy successfully utilizing insulin and found that as I got older that was the best course of treatment for myself - to utilize both insulin and oral medications. I'm probably a very informed consumer as that goes. I know that the same benefit that I have is not available—is no longer available to people who have Medicaid. And I feel this is a fairness issue, and I thought this was the appropriate place to raise it. I know that I do not have Medicaid. That is not my insurance. I am not a Medicaid enrollee. I know there are state employees whose household have both Medicaid and Medicare.

The rule, as I understand it, would require people to utilize syringes and bottles of insulin, which can be more complicated and difficult to manage, and also a different formulation of insulin that is less expensive. So, I know that it would be a penalty to me, as an individual, to have to live under the same rules as the Medicaid enrollees are required to. However, I do believe that would be more fair. I also believe that perhaps there could be better negotiated rates for pens and needles if we had a comprehensive policy that was across all insurance sources for this. So, although it would be not to my favor, I benefit from being able to utilize an insulin pen and needle. I benefit from not having to have syringes in my house with my eleven-year old daughter and my eighty-two year old mother and her caregiver. I'm able to not have to worry about those in the trash can outside of my house, and also don't have to worry about the potential impact of intravenous drug users who might be reusing syringes. So, there are many, many reasons why pens and the needles that are used are preferable both from a clinical standpoint, and from a personal standpoint, and a community standpoint; and I just wanted to raise that today. And, I've taken time, leave, from my job to be able to be here and just represent myself.

**Dorothy Teeter:** Sara, thank you very much for bringing this issue up. We will take your comments into consideration.

**Greg Devereux:** I appreciate very much your articulate presentation. I was in health care negotiations with Lou on Monday and one of our members in a caucus said something about insulin had changed for state employees. I wanted to check on that. I know it is different from Medicaid.

**Lou McDermott:** Greg, we'll check into that. We will check into both policies and see if there has been some kind of recent change because I'm personally not aware of any.

**Greg Devereux:** I didn't know anything about it, but somebody I think who does take insulin said it had changed for state employees. I don't know whether that's accurate or not but I wanted to check. Thank you.

**Lou McDermott:** We'll take a look. We will report back at the next Board meeting.

**Dorothy Teeter:** Thank you very much for bringing that to our attention.

Meeting Adjourned.

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

August 10, 2016  
Health Care Authority  
Pear Room 107  
Olympia, Washington  
9:00 a.m. – 10:00 a.m.

**Members Present:**

Dorothy Teeter  
Greg Devereux  
Gwen Rench  
Tim Barclay

**Members on the Phone:**

Harry Bossi  
Marilyn Guthrie  
Myra Johnson  
Yvonne Tate  
Mary Lindquist

**PEB Board Counsel:**

Katy Hatfield

**Call to Order**

**Dorothy Teeter, Chair**, called the meeting to order at 9:00 a.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

**Agenda Overview**

**Lou McDermott**, PEB Division Director, provided an overview of the agenda.

**Approval of June 22, 2016 PEBB Meeting Minutes**

It was moved and seconded to approve the June 22, 2016 PEB Board meeting minutes as written.

**Tim Barclay:** Abstain. Was not in attendance.

**Greg Devereux:** Aye

**Gwen Rench:** Aye

**Mary Lindquist:** Aye

**Marilyn Guthrie:** Aye

**Yvonne Tate:** Aye

**Dorothy Teeter:** Aye

## **Response to Public Comments from July 27, 2016 Meeting**

**Ryan Pistori**, Assistant Chief Pharmacy Officer, responded to the public testimony of Sara Eve Sarliker. Ms. Sarliker spoke about a discrepancy between the Medicaid Policy and PEBB policy regarding insulin prescriptions. After researching her concerns, I am able to clarify that both the Medicaid and PEBB policies cover insulin pens without first requiring vials and syringes. The PEBB Program member has been provided with this information.

## **2017 PEBB Procurement Resolutions 1-3**

**Lou McDermott** reviewed the proposed procurement resolutions.

Resolution 1 has to do with our Centers of Excellence Program which, for this year, will be hips and knees through our Virginia Mason contract.

Resolution 2 has to do with the PEBB Medicare Contribution, the \$150 or the 50%, not to exceed 50% of the premium.

Resolution 3 is a little complex. We are still waiting to hear from a judge regarding our Hepatitis C coverage criteria. Resolution 3 is basically the entire fee schedule calculated both ways, one with our current Hepatitis C prior authorization criteria and one with the possibility that the judge will no longer allow us to use the fibrosis score as part of the authorizing criteria. That creates a differential in the rates because it would allow more people to use the medication if the judge were to rule that we could no longer use that criteria. That medication is very expensive; and therefore, has an impact on the rates. It's a long resolution and takes a time frame into consideration. Because of the things we need to do to operationalize the rates, such as informing our members and printing materials, September 6 is as long as we can wait for the judge to order us to make that coverage change. If it occurs after September 6, we'll be using the fee schedule which does not include the expanded criteria because we run out of time.

**Greg Devereux:** I understand the complicated nature of Resolution 3. I didn't realize, at the last meeting, that all of the rates would be rolled into one in those two resolutions. I thought, as we have in the past, we'd be voting on individual rates. I do understand because of the complicated nature why you're doing it that way. So, unfortunately, I will be voting against those resolutions. Not because I don't support them, but I don't like the decrease in the value of the Group Health plan. The only way to vote against that is to vote against the overall resolutions. I just wanted that to be clear. Thank you.

**Lou McDermott:** Thanks, Greg.

**Gwen Rensch:** I'll be voting yes on the resolution about the Medicare retirees; but the issue has been raised, and I understand we might be able to discuss this at the retreat, that it doesn't actually address the rates for the retirees and whether there's a legality involved in it not specifying, or referencing, the exact rates that are being voted on. So, thank you.

**Dorothy Teeter:** We will proceed to voting on these resolutions. I will do a roll call vote since there are Board Members on the phone.

Three resolutions were presented for a vote before the Board. All resolutions were approved.

### **Plan Design Resolution 1**

Resolved, that the PEBB Program will offer a new Uniform Medical Plan Centers of Excellence program (COE) starting in Plan Year 2017.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

### **PEBB Medicare Contribution Resolution 2**

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: 7

Voting No: 0

### **Employee Premiums Resolution 3**

Resolved, that the PEB Board endorses (1) Schedule A for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if no judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using fibrosis scores as part of preauthorization criteria to cover Hepatitis C drugs, and

(2) Schedule B for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if a judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using a fibrosis score as part of preauthorization criteria to cover Hepatitis C drugs.

**Gwen Rench:** There is concern about the great level of increase for the non-Medicare retirees and the discrepancy even between the Group Health and Kaiser Advantage Plans on the Medicare Retiree part.

**Dorothy Teeter:** Thank you Gwen. I will proceed with a roll call vote.

Moved. Seconded. Approved.

Voting to Approve: 5

Voting No: 2

**Tim Barclay:** Yes  
**Greg Devereux:** No  
**Gwen Rench:** No  
**Mary Lindquist:** Yes  
**Marilyn Guthrie:** Yes  
**Yvonne Tate:** Yes  
**Dorothy Teeter:** yes

**Dorothy Teeter:** This has been a complicated set of resolutions because of the Hepatitis C Schedule. I appreciate people's perseverance with us on this issue.

**Proposed 2017 PEBB Meeting Schedule**

**Lou McDermott:** The 2017 PEB Board Meeting schedule is included in today's information, starting with the Board's Retreat on January 17, 2017. If we need to add additional meetings, as we did this year, we will let you know and make those adjustments as necessary. The majority of the meetings are on Wednesdays, but there are some on Thursday. I ask that you take a close look at your calendars for these days.

**Dorothy Teeter:** We've talked about the next meeting being our Board Retreat in January. I would like to personally thank everyone on this Board, the staff, and those that come faithfully to every single meeting. I appreciate your high level contributions and commitment to this really important program. I wish you all a wonderful rest of the summer.

Meeting Adjourned.

**TAB 4**



# Policy Recommendations

June 21, 2017

Barb Scott  
Policy and Rules Section Manager  
PEB Division

# Purpose of Briefing

To provide information on four policy proposals

# Proposed Policy 1 - Season

“Season” means any recurring, annual period of work at a specific time of year that lasts three to eleven consecutive months.

Existing in WAC 182-12-114 (2)(a):

[...] A season is any recurring, cyclical period of work at a specific time of year that lasts three to eleven months.

## Proposed Policy 2 – Surviving dependent eligibility

The surviving dependent of an employee who receives a monthly retirement benefit no later than one hundred and twenty days from the date of death of the employee satisfies the requirement to immediately receive a monthly retirement benefit.

# Proposed Policy 3 – Retiree insurance coverage eligibility for statewide elected officials and appointed officials

The following employees are eligible to continue enrollment or defer enrollment in PEBB insurance coverage under the same terms as outgoing legislators when they voluntarily or involuntarily leave public office.

- (1) A statewide elected official of the executive branch;
- (2) An executive appointed directly by the Governor as the single head of an executive branch agency; or
- (3) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed as the Secretary of the Senate or as the Chief Clerk of the House of Representatives.

# Proposed Policy 4 – SmartHealth

Effective January 1, 2018, all SmartHealth eligible subscribers will receive a separate PEBB wellness incentive after completing their SmartHealth well-being assessment on or before December 31 of the current plan year. This separate PEBB wellness incentive may be earned only once per plan year.

# Next Steps

Next Board meeting we will ask the Board to take action on these policy proposals and brief the Board on our annual rule making activity.

# Questions?

Barbara Scott, Policy and Rules Manager

PEB Division

[Barbara.Scott@HCA.WA.GOV](mailto:Barbara.Scott@HCA.WA.GOV)

Tel: 360-725-0830