Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

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.