Public Employees Benefits Board
Meeting Minutes

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 stiches, 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 stiches, 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 not 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.