Public Employees Benefits Board
Meeting Minutes

April 12, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

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

Members on the Phone:
Marilyn Guthrie

PEB Board Counsel:
Katy Hatfield

Call to Order
Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

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

Legislative Update
Dave Iseminger, PEB Division Deputy Director, provided a legislative update. Dave described the process the Public Employees Benefits (PEB) Division goes through when analyzing each proposed bill and discussed which bills made it far in the process. Very few have made it completely through the process.

The amount of work the executive agencies and their staff do to review the various policy ideas is quite extensive. In the PEB Division, we have ten bill analysts to which

this task is added to their regular workload every time the Legislature comes to town. We basically review all of the bills that could have some impact. Our division was responsible for shepherding 31 bills through the process and tracking. We're supporting other divisions of the Health Care Authority in understanding impacts throughout the agency on 51 other bills. Overall, we had 248 separate analyses for this legislative session of various iterations of bills.

When the Health Care Authority receives a bill, it comes to our Legislative Affairs team who reviews and assigns the lead division that has the most likely impacts. In addition, they team identifies the supporting divisions and determines if the bill is high or low impact.

The high impact bills have two kinds of characteristics. From an operations perspective, it would require either a change in policy or procedure, add to any kind of current policy, or creation of a policy. From a financial perspective, if it has a cost savings or a cost impact that's greater than $50,000, it's of high impact. For the PEB Division, most ideas would cost at least $50,000. There were 31 high impact bills where the PEB Division was lead.

Slide 4 discusses the funneling effect as the various hurdles are crossed in the legislative process, in both the originating chamber and then the opposite chamber. There aren't many bills from a policy perspective that have made it near the finish line. At the first session cut-off for bills, about half of the bills we tracked made it past the first Policy Committee that reviewed the idea. This year, most of the bills that made it from a Policy Committee to a Fiscal Committee continued on and were considered in some way, at a higher level, by the entire body of that chamber. After the house of origin cut-off, we were tracking seven bills that made it off the floor vote from either the House or the Senate. Six bills went from the House to the Senate and only one went from the Senate to the House. When bills went through the subsequent process in the opposite chamber, four bills made it through the opposite chambers' Policy Committees.

Those four bills then went to the Fiscal Committee in the opposite chamber. From a policy perspective, the legislative forces thought they seemed like good ideas, but were uncertain as to whether or not there is money to support them. These are the bills that are most likely to be rebirthed in the future because they passed Policy Committee votes in both chambers.

Those four bills are SHB 1234, 2SSB 5179, ESHB 2114, and SHB 1421. SHB 1234 relates to contraceptive coverage. Currently the prescriber may get a 30-day fill or a 90-day fill. Under this bill, the default for contraceptive fills would be a full year. This bill has made it the farthest through the process. It passed the House and it's on the Senate floor calendar now. It has not been voted on by the full Senate.

2SSB 5179, ESHB 2114, and SHB 1421 all made it to the Fiscal Committee in either the Senate or the House, but did not make it out of the opposite chambers' Fiscal Committees.

2SSB 5179 is a hearing aid bill. It changes the amount of coverage and the parameters for that benefit in both the PEBB Program and Medicaid. Currently in the PEBB Program, our benefit is $800 every three years for a hearing aid ear mold, batteries, and cords, or follow-up consultation. This bill would change that to presumably a higher benefit level over a five-year period. The bill is subject to appropriation in the budget bill. The Senate budget accounts for this bill and says the PEBB benefit would raise to $1,200 and that the hearing aids benefit would be every five years instead of every three years. It lengthens the time but adds dollars. The House budget is silent on this bill.

ESHB 2114 is the surprise balance bill. This bill addresses individuals that go to an emergency room and learn that after all their services are done, get balance billed because the anesthesiologist happened to be out-of-network. It prohibits balance billing. There were seven different bills this session that had surprise billing connotations. This one went furthest in the process. It is referenced in the House budget; it's not referenced in the Senate budget. However, it could be part of the final budget negotiations and passed.

SHB 1421 relates to payment credentials that are within state agency electronic systems. In PEB's context, when a retiree submits an electronic debit service form, they provide a copy of a voided check. We image that check and keep that in our imaging system to prove we were given the authority to take that money out of their bank account. This bill requires all the executive agencies to look at those various payment credentials in their various systems and make sure they either meet security standards that have been established by the Chief Information Officer, get a waiver to maintain that information, or purge that information. If this bill passed, we would need to review our processes and either apply for a waiver from the Chief Information Officer, or rework our processes to collect less information.

Although not in my slides, I want to highlight the K-12 consolidation bill – SB 5726. This is an idea that has been around for many years and is still being considered by the Legislature. HCA has reported on K-12 consolidation over the years; and to put the current bill into context of the most recent 2015 report, this is a version that, from an administrative perspective, would be among the easier ways to tackle this problem. From an HCA operation and an administration perspective, because it would have put all of the active K-12s into the existing PEB Board benefits, it wouldn't have created a separate Board, a separate benefits structure, a separate premium structure. SB 5726 had a hearing in the Senate Ways and Means Committee and it did not go further than that. There have not been any other proposals as of yet within the Legislature on this topic.

Dorothy Teeter: Thank you. The funnel slide is pretty awesome to see what actually happens and how hard it is to get legislation passed.

Greg Devereux: I was on a panel earlier during the session with Dave and I think he really does a superb job for the Health Care Authority. I think the Agency is really well served.

Dorothy Teeter: Thanks for that recognition. I believe we feel the same way.

Dave Iseminger: Thank you everyone. I appreciate that. Lou reminded me about one thing with K-12 consolidation. There is a trigger in statute that when a threshold of K-12 employees are in the PEBB Program population, currently non-voting members become voting members. So, if a K-12 consolidation bill passes, Myra and Harry become voting members once the criteria's met.

Legislative Update - Budget

Kim Wallace, Finance Services Division Deputy Section Manager, discussed the proposed biennial budgets for PEB from the Governor, the Senate, and the House.

Slide 2 shows the agency requests. All three proposed budgets adequately fund the requests agency submitted. These are requests for upcoming special needs and projects. In the House budget there's a note indicating "less one million dollars." We have inquired about that shortfall and awaiting clarification confirmation. These requests cover funding to cover certain costs associated with reprocuring our UMP Third Party Administrator (TPA). We anticipate the new contract will have an effective date of January 1, 2018, and go-live with TPA services being provided under the new contract as of January 1, 2020. We submitted this funding request to support the certain types of services and costs that we would be incurring in this time frame, 2018-2019, for the potential of having to reset things with the current vender under a new contract, or the potential of getting started with a new contractor.

Another funding request example is to fund and to conduct a PAY1 replacement feasibility study. Our current PAY1 eligibility and payroll system is very old and we hope to be able to obtain a new system with the enhancements we need.

The Governmental Accounting Standards Board is requiring a new type of accounting and system of reporting certain PEBB benefits on financial statements. We are requesting funding for that in order to maintain the integrity of our financial information.

Dorothy Teeter: Kim, I did see a couple of quizzical looks around the two years between 2018 and 2020 and why it would take us two years to switch over. Would you talk about that? I think it's important that people know why. We can't just flip the switch.

Lou McDermott: To switch over to a new TPA, much has to be done as far as making sure the TPA system aligns with our current benefits structure. Part of that complexity comes with the Health Technology Assessment (HTA) decisions, which we are subject to when they come out. They look at a clinical process for a new device and they determine whether or not it's appropriate for that to be in our benefit. That must get programmed within the system of the TPA. All of those things would have to be done. We would have to ensure that the TPA is paying our crossover claims correctly and adjudicating the claims according to our methodology.

We're also looking at our Accountable Care Program for our UMP Plus programs. Those are limited networks that are constructed inside the TPA's system. All that would have to be rebuilt. While 24 months seems like a long time, we could go for 36 months to make this a smooth transition. When we went to Regence, we had about three years' worth of clean-up that occurred after the effective date of the contract because there were things in the system we were unware of. When a member brought things to our attention, we would talk with Regence and discover their system wasn't aligned with ours. Then we had to do clean-up. We had to change the system prospectively, look backwards, to make those changes. Two years seems like a long time, but we need all of that two years when switching over to a TPA with all these different HCA decisions and our UMP Plus products.

Greg Devereux: What's the current contract length with Regence?

Lou McDermott: The current contract expires December 31, 2019.

Kim Wallace: Slide 2, row two is labeled, Admin Reduction. There is an administrative budget reduction of $3M per year included in all three proposed budgets.

Slide 2, row 3 is an actuarial value (AV) Reduction, which only appears in the proposed Senate budget. This AV percentage relates to the amount, on average, that a plan will pay for covered services. This reduction is 1% per year for UMP and .6% per year for our fully insured plans. An AV reduction does have a relationship with projected lower paid claims or savings. It's not a direct simple relationship; but there is a directional relationship. Essentially, this is a proposal to lower claims expenditures over what they would be without the reduction.

Slide 2, row four is regarding the Medicare retiree explicit subsidy. For serval years now it's been set at $150 per month, or 50% of the premium, whichever is less. In the Governor's and Senate's proposed budgets, it is still $150. There are increases included in the House's proposed budget. We will be watching the activity that will ensue over the coming weeks. This is just the beginning of the process.

Greg Devereux: Kim, is there a reason why the funding rate is not listed?

Kim Wallace: No. I can look that up.

Greg Devereux: I know the Senate's funding rate is different than the Governor's. I haven't seen the House's, but that's really one of the biggest factors, I think, here.

Kim Wallace: I can step away and make notes on that and come back to the group.

Dorothy Teeter: That sounds good, thank you.

Lou McDermott: On the Senate proposal, there was a difference on the administration reduction. It was $3M per year; but for the Senate proposal, they are including this fiscal year. It's this fiscal year, plus the next two. The House and the Governor's budget only contemplate the next biennium. That's one nuance. Then on the actuarial value reduction, I just want to make sure you are clear on what that means. It basically means cost share. The cost share would need to go up from the members.

Life Insurance Open Enrollment and Implementation

Beth Heston, PEB Division Procurement Manager, provided an update on our new life insurance benefit. This was our first open enrollment for life insurance since 1977. We had an amazing open enrollment. It was a team effort with PEB leading the process, with assistance from Labor, the Governor's Office, other agencies, all of our employer groups, and the higher education institutions. It was one of the most successful enrollments that MetLife has experienced.

The total number of people eligible for our benefit are: 133,068 employees, 50,171 spouses, and 89,534 dependents. I will share numbers on those who chose to participate in the benefit and the value – or total amount covered - of those enrolled.

Slide 3 is a comparison slide. For 2016, we had an employer basic life product of $25,000, with an accidental death and dismemberment policy of $5,000. As of January 1, 2017, we now have $35,000 basic insurance for all employees. Currently, this is the only coverage that about 46.5% of our employees have. The differences between this year and last year is $10,000, from $25,000 to $35,000.

For optional life, the amounts are similar to what we had, but the maximums changed. We formerly had $250,000 guaranteed issue which could go up to $750,000 with a statement of health or evidence of insurability. When we reprocured, the limit was raised to $500,000 guaranteed issue, and then up to a million dollars with evidence of insurability. People immediately had the opportunity to have twice as much insurance without having to go through any health questioning. We also offered a spouse life before and after. Again, it's based on that they can only have half of what the employee has, but we doubled the guaranteed issue on that as well. We went from $50,000 to $100,000 guaranteed issue, but that means the employee has to have at least $200,000.

With Voya, we had a dependent basic plan. However, basic implies that it's paid by the employer. This was not. It was strictly paid by the employee and it covered both

spouses and children. It was a check box that lots of people checked and spent 62 cents or 75 cents and covered anybody who was in their house. While inexpensive, the payout was only $2,500. We didn't know if the spouse or a child was covered until the person passed and a claim submitted. In the new plan, there is a separate child life plan that handles dependents. For 2017, there is a guaranteed issue of $20,000, in $5,000 increments and we know who is insured because the person is named. It covers dependents ages two weeks to 26 years. Now during open enrollment, people who were switching over could only get $10,000 guaranteed issue; but after January 1, 2017, new employees can get up to $20,000. Children don't usually have much trouble passing statements of health, so there are lots of people who got their children the full amount.

We also introduced new plans in the accidental death and dismemberment section. Before, all of the plans were tied to the employee's amount of coverage. The employee could be covered for up to $250,000 and the spouse could be insured for 40% of that. The child, depending on circumstances, was either allowed 5% or 10% of that as well. Three plans were created - one for the employee, one for the spouse, and one for the child. They can each be insured separately and it's not based on what the employee has, other than they have to be eligible.

Retiree life had a plan that started at $3,000 if you were under 65. It had a steady premium cost, but it had age reductions. The maximum coverage was $3,000 and it lowered as you got older. The new plan has no age reductions. It is for people retiring after January 1, 2017 and $20,000 guaranteed issue, in $5,000 increments. During open enrollment, we allowed participants in the retiree coverage to switch to the new plan with $5,000 guaranteed issue and up to $20,000 with evidence of insurability. Some people wanted to stay in what they had, so MetLife created a closed legacy plan that only those participating in retiree life in 2016 were allowed to have the legacy plan. The legacy plan keeps the same age reductions and payment amounts as the former Voya plan. There were some people who stayed in that plan.

Our total coverage value went from $25,000 to $35,000 on the employer paid basic. Our total insurance coverage value for all state workers went from $3.3 billion to $4.6 billion. That's a dynamic increase and we kept it very painless to the budget. Slide 7 is another way of showing the coverage growth and at no cost to the employees.

With optional life insurance, our enrollment in 2016 was 47,476 people. We currently have 71,242 people enrolled. That's a 50% increase. We doubled the amount of coverage people had. MetLife provided the information on Slide 7 that shows what our numbers look like compared to other industries. For government, the average is 44% and we have 61%. Higher education is 35% and we have 46%. For services (employer groups) they average 48% and we have 52%. In K-12 the average is 30% participation and we have 36.6%. Overall, we increased our participation in the optional life insurance from 35.6% to 53.5%. More than half of state employees chose some optional life insurance.

Slide 8 – Enrollment and Total Value Changes – has some significant increases as well. For spouse optional life, we had about 20,000 people enrolled and now we have 37,000 enrolled and 27,000 for optional AD&D. We had no baseline for children since we didn't know who was covered until after a claim was made. But we know now that 21,800 children have life insurance and 20,000 have optional AD&D. Employees went from 30,000 people to 56,000 covered. The increases in amounts of coverage is significant.

Slide 9 shows the total value of coverage graphically. We doubled coverage for all of our members that took part in optional life.

Lastly, Slide 10 shows our retiree coverage. Retirees were either really excited about the new benefit and signed up or didn't even know they had coverage and chose to drop it (about 500 retirees dropped). However, we are still covering more retirees at the end of the day. We still have 11,000 retirees participating in the legacy plan, and we gained 2,300 new retirees into the new plan. The total amount combined increased from $26.8 million to $33.4 million. Some retirees chose to go through evidence of insurability (EOI) to obtain amounts above the $5,000 guaranteed issue.

Gwen Rench: Just to clarify, for people that were in the legacy plan, this was a one-time option?

Beth Heston: For the legacy plan, you had to be participating in 2016. You got the offer, you could either go to the new plan or stay with what you had and many chose to stay.

Gwen Rench: Okay. I'm just concerned there will be a lot of complaints when people realize they were a fool.

Beth Heston: I understand.

Harry Bossi: Beth, can you talk a little bit about the beneficiary designation? Is it a requirement? Or desired and encouraged? And who keeps them – the state or MetLife?

Beth Heston: Yes. MetLife actually keeps them. Part of the procurement was that now MetLife is in charge of the administration of the life benefit. They keep all the paperwork. We messaged the beneficiary information very strongly and 48% of the people named their beneficiary as they should have. If you went online to do it as the majority of the employees did, you couldn't go any further until you named your beneficiary. We had just as many people who mailed in a paper form to change their beneficiary at the same time. MetLife can run reports to see which agencies need to send reminders to their employees. We'll be working on that in coming quarters.

Myra Johnson: The 494 that just quit - did we interview them as to why or what the rationale was?

Beth Heston: Most of them said, “I didn’t know I had that and I don’t want to pay for it anymore.” Many said, “I had no idea I was still paying for that.” Others called and said, “I never signed up for this.” We shared a copy of their enrollment form with them.

Dorothy Teeter: From 35 years ago.

Beth Heston: Exactly. From 1991! That was mainly what we were told.

Greg Devereux: Firstly, kudos, great work, amazing. Secondly, most of us won’t be here; but hopefully we won’t wait 40 years until the next one.

Beth Heston: I don’t plan on doing this again for a while, but I certainly don’t think it’ll be another 40 years.

Harry Bossi: My experience with the beneficiary designation is that the real issues are when people don’t change them when they should. Like they get a divorce and they forget to take the ex-spouse off. Beneficiary’s death payouts.

Dorothy Teeter: This is only a question, but is there any thought to reminding people every few years during open enrollment to double check their beneficiary status so it stays up-to-date? That would be an easy way - once a year – to check on that.

Beth Heston: Yes. We’ve been using our SmartHealth website to message things about that. We made beneficiary set-up a point-earner and we’ll continue to message as we go forward. MetLife will be reaching out to people periodically, as well, as part of their business.

Dorothy Teeter: Thank you. These are fairly astounding numbers. I’ll join Greg in his kudos to the whole team that was working on this.

Lou McDermott: I want to add one piece. The basic life insurance was done in a budget neutral fashion. If we would have just bought $25,000, then it could have been less; but we spent the same amount of money that we spent in the previous year, which entitled us to $35,000 with the new vendor. Just to be clear.

Dorothy Teeter: Right, better value for the dollars. Thank you. Kim is back. Were you able to get those numbers that Greg was asking about?

Kim Wallace: Yes. I’m here to respond to Greg’s question regarding the funding rates assumed in the proposed budgets. I will give you some numbers and then provide a couple comments.

With regard to the Governor’s budget, I’ll give you two dollar amounts – Fiscal Year 2018, which is the first year of the biennium; and then Fiscal Year 2019, the second

year. The Governor's numbers are $970 and $1,029; in the Senate, $889 and $920; and the House, $912 and $1,041.

A couple comments that are important about these numbers is that there are a number of factors and assumptions that go into deriving these numbers. In addition to the actuarial value reduction that was proposed in the Senate budget, different amounts of the Medicare retiree explicit subsidy being funded; there are other factors as well. One significant factor is assumptions about the use of surplus, the rate of using that surplus in year one and in year two. There are a few other factors as well; and so, it is likely that as the budget considerations and revisions continue, these numbers will change. So, the takeaway regarding the funding rate is that: yes, it is a number that we watch carefully and it's significant, of course; but we are now in the stage of the process where we're going to be watching some changes.

Greg Devereux: Thank you very much, Kim, that's very helpful.

Centers of Excellence Update

Marty Thies, PEB Division Portfolio Management & Monitoring Section Account Manager, provided an update on the Centers of Excellence Program. This program is part of a national movement toward innovation and quality in health care delivery and payment structures. The Affordable Care Act authorized the CMS Innovation Center to run a pilot program across the country using bundled episodes of care. It's approaching 60 hospital systems and implemented bundled episodes of care. Data coming out of that pilot indicated that there was a lot of collaboration amongst providers; there was as good or better outcomes; and cost neutrality, or even cost saving, from bundling episodes of care. By way of contrast, the fee-for-service model pays before it can actually reward quantities of services and complications can result. A provider provides his service, bills, pays. If there are complications, there's more service bills and payments. This is considered a provider-centric model.

Behind a bundled episode of care you're focused on the patient, you're focused upon a health care event for that patient. An arrangement is made with the Center of Excellence to provide that service. The providers focus upon care and services that result in best outcomes for the patient.

In the state of Washington in 2011, the Legislature implemented the Bree Collaborative. The intention of the Bree was to gather stakeholders to address issues in the health care market. The deliverables of the Bree are evidenced-based recommendations for improving health care outcomes. Total joint replacement was one of the first procedures for which the Bree provided those recommendations; and total joint replacement (TJR), is often the place where organizations begin if they want to do bundled episodes of care, usually because of high utilization. Over a number of years in our Uniform Medical Plan (UMP) population, the average number of joint replacements is around 600. That's relatively high utilization for such a serious surgery.

Second is high variability of cost; ranging in the tens of thousands of dollars, and also high variability of outcome from good to poor.

Regarding our specific joint replacement bundle, the most striking element is for our members who go to the Centers of Excellence, have no out-of-pocket expenses. This is available to UMP Classic and UMP CDHP members. For the CDHP members to have no out-of-pocket, they have to meet their deductible first. The bundle includes the surgery, anesthesia, durable medical equipment (a cane or a walker), case management, transportation, and accommodations. The value proposition is if we can funnel our members to the Center of Excellence, we can avoid complications and readmissions. We encourage our members to use the Center of Excellence because of price, no out-of-pocket, and a very engaged patient-centered process. On the provider side, we have contracted to pay a set fee for these joint replacements, and the Center of Excellence has agreed to, for those surgeries they so designate, provide a 90-day warranty on specified complications from those surgeries.

The Center of Excellence is Virginia Mason Medical Center. They are well known for the volume of surgeries they perform, their surgery's best practices are in compliance with the Bree criteria for TJRs, and their level of patient engagement. Premera is the third-party administrator. Premera's job is to usher the member through the process from the time members contact them, giving them information, and pulling together medical records for Virginia Mason. We'll soon be doing member experience surveys after their surgeries.

We believe our marketing has been reaching our members because they've been contacting Premera at a fairly high rate. Premera has a dedicated customer service line and they talk the members through the benefit. If they want to know more, they're sent written materials. If they decide to do the program, Premera collects the medical records that Virginia Mason needs to understand their patient. Once they are formally referred to Virginia Mason, they have a consultation with the surgeon and either scheduled for surgery or recommended to deal with health care issues that could impact the outcome of the surgery. After surgery they have a physical therapy appointment and then discharged. All additional follow-up takes place in the member's local community and is not part of the bundle.

The program was implemented January 1, 2017. Virginia Mason, Premera, and the Health Care Authority are working well together. We meet weekly to address any issues that come up and discuss additional program development and communications. We all want the best outcomes for our members.

Slide 8 lists mostly the marketing we've done so far: the PEB and UMP newsletters that came out prior to open enrollment; attended all benefits fairs in November. Information is also going on the UMP and Premera websites.

Slide 9 tells the story of our program to date. The numbers listed are through quarter one. There have been over 300 customer service calls to date. The TJR website hits are approaching 600, if you include the hits received prior to 2017. From 2011 to 2014, we averaged 24 UMP joint replacements at Virginia Mason. To date, the volume has already increased to 48 referrals to Virginia Mason.

Greg Devereux: Does the average 24 UMP total joint replacements mean actual surgeries?

Marty Thies: Yes.

Greg Devereux: The slide indicates there are only 11.

Marty Thies: Correct. Twenty-four is annual. The 11 surgeries are through March. That's how many have gone through. And 37 are in the pipeline. Their surgeries are scheduled and awaiting consultation with Virginia Mason.

Greg Devereux: So it's quarterly? Between the 48 and the 11, those are rejections because of nicotine or diabetes, correct? It may just be they're in the pipeline.

Marty Thies: They're in the pipeline. They're not considered a participant of the program until Premera formally refers them to Virginia Mason. Once they're referred, we consider them going forward. We probably won't realize 100% of everyone who's referred.

Greg Devereux: So the incentive is low, or no cost.

Marty Thies: Correct.

Greg Devereux: I'm a believer. I think this is great. What if you decide you don't want to go to Virginia Mason? Do you have some cost currently?

Marty Thies: Now, and in the future, if any member wants to go to their chosen provider, they can. This program is just another choice, but they would pay the usual co-pays.

Greg Devereux: Their usual co-pays?

Marty Thies: None of that has changed, but if they go to the Center of Excellence, there's no out-of-pocket.

Greg Devereux: It seems like there's good marketing now, but we really need to market it even more.

Marty Thies: Yes. We have fairly good volume. Thirty of the 48 are from the I-5 corridor, 18 are from Eastern Washington, one from Oregon, and one from Idaho. As anticipated, 83% are in the 45-64 age group. Everyone else is older; 58% are female, 56% are knee replacements. We have no cost data yet nor have we received our first invoice from Premera.

Slide 10 is our plan going forward. We will continue to market and monitor the program. We are working on a video interview with a Virginia Mason surgeon. Our goal is to get that posted to both the Premera and UMP websites. Our participant feedback is very good. We hope to provide participant testimonials as well. We look forward to aggregating and accumulating more data on cost and quality as this program matures.

In the future, we anticipate gathering information from the provider community regarding other bundles and episodes of care. In October, there is a value-based purchasing summit at the Health Care Authority to address bundles. We expect to release an RFP later in 2017 to implement other bundled episodes of care to be effective in 2019.

Tim Barclay: This is great stuff. I appreciate this and look forward to hearing more as it continues to develop. In a future presentation, could you provide baseline data for what we saw in 2016 and 2015 in terms of frequency and cost? That would be helpful.

Marty Thies: We're working on that, thank you.

Tim Barclay: This is great, thank you.

Dorothy Teeter: That's a really great suggestion.

Gwen Rench: You mentioned that there's one physical therapy appointment as follow up, but then the expense goes to the patient after that. I'm surprised. Why only one? It seems too minimal.

Marty Thies: It's done just prior to discharge at Virginia Mason and it is included as part of the bundle. Those who participate in this program don't receive a bill. After that, when they are in their home community, they should probably receive more physical therapy but it is not a part of the bundle.

Dorothy Teeter: To clarify, those ongoing visits are covered under the general benefits. Correct? So, the person doesn't have to pay the total costs of physical therapy visits ongoing. They're just not part of the original bundle.

Marty Thies: Correct.

Harry Bossi: Thank you. Great presentation on these things. Wonderful what we've accomplished. I need a little clarification. Does the PEBB get reimbursed from the

Feds PEBB? Does PEBB get some kind of a reimbursement through the FEDS? Is there something there that should be of concern or questioned moving forward?

Lou McDermott: We do not. There is no incentive from the Federal level to do this.

Marty Thies: There are a lot of projects out there and it's going to take time to pull the data together and have a sufficient number of programs, but they're enhancing, encouraging, and incentivizing collaboration and coordination between all providers with as good or better care, and usually with some cost savings.

Dorothy Teeter: I think maybe the link back to the ACA is that the ACA funded the Center for Medicare and Medicaid Innovation; and out of there, some of the original payment models around bundles were sent out for people to try, but it is not part of the CMMI program, per se.

Lou McDermott: Correct.

Harry Bossi: The focus here really is improving the quality of care, isn't it? So for the patient, I think it gives them a better opportunity to have this surgery done and have it be real good.

Marty Thies: Correct. In fact, the original assumption was when the RFP was released, we'd have a number of Centers of Excellence around the state. When we reviewed the responses and saw what Virginia Mason was doing and what their record of complications and readmissions looked like, we decided on a single Center of Excellence for this particular procedure because we wanted to put members in a place where they could receive the highest quality of care.

Dorothy Teeter: As part of our ongoing messaging, that's going to be an important piece.

Pharmacy Benefit Proposal

Donna Sullivan, HCA Chief Pharmacy Officer, shared information on a pharmacy benefit proposal regarding value-based formularies and formularies, in general. I will talk about the purpose of a formulary, types of formularies, historical use of formularies, challenges to formulary management, review value-based formulary design, review of the UMP pharmacy benefit changes, and then look at a recommendation for 2019 and moving forward.

Slide 3 is the purpose of the formulary, which is to identify and promote the most cost-effective pharmaceuticals in the most appropriate manner.

Slide 4 is looking at different formulary models. Sometimes I say, Preferred drug list, preferred drug, formulary, and non-formulary. Preferred and formulary are the same and non-preferred and non-formulary are the same.

The open formulary is where you have drugs that are usually in different cost share tiers, where the non-preferred drugs, or the non-formulary drugs, are in the higher cost share tiers. Members have access to a broad array of medications; but depending on if it's formulary or non-formulary, they pay more for that medication.

A closed formulary is the reverse of that, where drugs that are not formulary, or not preferred, are not covered. Members don't have access to those medications even at a higher cost unless it has been determined that particular drug is medically necessary for that individual patient for the reason they need to take that medication.

A hybrid formulary is partially closed. Certain pharmacy benefit managers may have what they call their exclusion lists. An exclusion list is where they've gone through different drug classes, picked a preferred drug, and will not cover any other drug in that class. In other drug classes, they have more of an open model where the drugs are just in different cost share tiers and they'll cover all the drugs in the class; but the member pays more or less depending on which product they're taking.

For a value-based formulary, cost is not the primary emphasis of placing a drug. It looks at a drug and its effectiveness in treating a condition compared to the other drugs that are available to treat that condition. It puts that drug in a position or cost shared tier that promotes use of the effective drug, the drug that's most valuable.

Slide 5 provides some background on how formularies have been used by health plans in the past. In the late 1980s and into the early 1990s, closed formularies were common. Managed care plans were the ones that used the closed formularies. It was in the 1990s and into the early 2000s where member access was the issue. In order to accommodate that desire, health plans came up with open formularies providing access to the non-formulary drugs where the member paid more for them.

Now that we're in this era where drug prices are exploding and increasing rapidly, health plans are tending to move back towards the hybrid formulary model, or even going a little bit further and having a closed formulary, in general. In addition, some health plans are adding additional cost share tiers. So, instead of having three tiers, they have five or six where they've put the expensive specialty drugs in the most costly tier to avoid or deter utilization of those drugs.

Slide 6 shows some of the challenges we've faced in managing a formulary. There are manufacture programs that take away member's incentives to choose the equally effective lower cost alternatives. They do this by offering a co-pay coupon which is used after the pharmacy has billed the health plan for their insurance. As an example, if the member cost share is $500, the manufacturer might give a coupon to pay all but $50 of the members cost share. The manufacturer would pay $450. The pharmacy adjudicates this coupon and the member is charged $50 for that medication. That's great for the member, but it encourages the use of these lower value, high cost drugs that put this upward pressure on the health plans' premiums. So even though that

individual member might be benefitting from the coupon, the plan is still paying the same amount for the drug. It gets more expensive for everybody as premiums go up.

Greg Devereux: I would love to see data for Washington State. I know there's national data here, but I'd love to know the usage of coupons or discounts in our program.

Donna Sullivan: That is actually a challenge because, as I mentioned, those coupons are done post-adjudication, so I don't know who's using co-pay coupons. This is not something we search our claims data for to see when co-pay coupons are being used.

Greg Devereux: It makes me nervous to make decisions based on not knowing what the data really is. I have another concern, but that's one of them.

Donna Sullivan: I understand. Another challenge to formulary management is the patient assistance programs that are typically geared toward patients that have either little or no coverage. The use of co-pay coupons for 23 of 85 multi-source brand name drugs accounted for $700 million in drug expenditures nationally in 2007. It increased to $2.3 billion in 2010. The reference for this information is on the bottom of Slide 6. This is just an example of how co-pay coupons are putting pressure on the pharmacy trend.

Slide 7 shows the trend for managed formularies. I looked at Express Scripts, a pharmacy benefit manager nationally, and reviewed their trend report for 2016. They have a variety of different formularies and management styles they use for their different clients. The information on the graph depicted on Slide 7 depends on how tightly managed the Express Scripts formulary was. They had a lower trend. The yellow bar is a tightly managed formulary where they're using the closed alternatives, plus those exclusion lists. The green bar is average and the blue bar was a very lightly managed program. For Express Scripts, the more tightly managed the formulary, the lower the trend.

Slide 8, value-based formulary, will start walking you through how you decide which drugs provide value and which ones don't. It's typically done on a plane. The vertical axis goes from less costly at the bottom to more costly at the top. The horizontal axis is less effective on the left-hand side and the more effective are on the right-hand side. Value is assessed when comparing the relative cost and effectiveness of one drug to another to treat the same condition. The blue arrow going through the center of the matrix is what we're looking at. As we go around this matrix, the red box at the top left-hand side are less effective drugs that cost more. You're not going to pay more for a drug that you know doesn't work as well as something that costs less. The blue box on the bottom left-hand side are drugs that are less effective and less costly. Those are drugs we want to look at. What is their incremental value? Is the difference in effectiveness clinically significant? It might not matter that it doesn't work quite as well if it's less costly. It might be beneficial to cover that medication.

The purple box on the lower right-hand side are more effective drugs that actually cost less. You're going to cover those drugs. They are the highest value drugs that we have.

In the green box on the upper right-hand side are the more effective drugs, but sometimes a lot more costly. That's where you dig in and determine if the effectiveness of that drug outweighs the cost of other, less expensive drugs. It is possible that high cost drugs can achieve a lower cost share tier if the benefits of taking that medication outweighs the cost of that medication. An example of this would be drugs that treat rheumatoid arthritis, like Embril and Humera. Those drugs came out in the early 2000s and were really breakthrough treatments. Over the years, they have shown that they are much more effective for treating rheumatoid arthritis than methotrexate, which was the standard of care at the time. However, they are significantly more expensive. That's an example of where a value-based formulary would be positioned.

Slide 9. There are studies and surveys on value-based formularies and what patients feel about them. Consumers were willing to accept higher co-payments for low-value drugs if it maintained affordability of their overall coverage. They were receptive to the concept of putting low-value drugs in a higher cost share tier, as long as it would help control their overall premium costs. The restrictions are primarily placed on drugs that provide no real value or clinical advantage over other less costly brand or generic drugs that are in the market. An example of this is Glumetza, which is a metformin product to treat diabetes. Recently the cost of Glumetza has gone up. It's now $51.48 per tablet. There's a generic metformin extended release product that is the generic for Glucophage, which is also a metformin, just a different type of tablet, an extended release mechanism. It costs seven cents per tablet. We're not going to pay for Glumetza because it doesn't add value. It's the same drug and it costs more.

Slide 10 addresses the local experience with value-based formularies. There is a large health plan in western Washington that actually implemented value-based formularies for its own employees. They found that reducing, or even eliminating, co-payments for some high-value maintenance medications for treating asthma, congestive heart failure, diabetes, hypertension, they actually improved medication adherence by 1.5% to 9.4% depending on the drug class. They didn't incur any additional costs on the medical benefits side. Sometimes the drug costs went up, but overall there was no adverse medical or clinical problem, or occurrences that happened with their employees.

Slide 11 summarizes and reviews some of the benefit design changes that have occurred over the last fourteen years, 2002 and before for the Uniform Medical Plan. In 2001 and earlier, UMP had no formulary. The pharmacy benefit was structured around whether a drug was a generic, a brand name drug that had a generic equivalent, or a brand name drug without a generic equivalent. In 2003, the Board voted to implement an open formulary and we have had the open formulary design since.

In 2012, we aligned our mail order and retail cost sharing benefit design so there is no out-of-pocket for Tier 3 drugs that were traditional Tier 3 drugs; and there was a $150 maximum out-of-pocket for specialty drugs. That was approved in 2012.

In 2015, after drug prices were rapidly increasing, we started getting more complaints about patients that were taking Tier 3 medications that couldn't afford to take them and none of the preferred alternatives worked for them, or they were unable to take them. We implemented an exception to the out-of-pocket limit for Tier 3 drugs for single source brands. Members could request a medical necessity evaluation and potentially get an exception. If they were granted the exception, they paid the Tier 2 cost share for that non-preferred drug. The current cost share tiers have been listed for your information.

Slide 12 shows our recommendations for 2019. We want to transition to a closed, value-based formulary. Drugs currently listed as Tier 3 on the UMP preferred drug list would not be covered. The non-preferred drugs would not be covered unless the patient had a medical reason for taking that drug. The criteria for that would be similar to our Tier 3 exception process, which is trying all of the preferred alternatives unless the preferred alternative were not clinically appropriate for that particular member for that condition. In addition, we're recommending that we grandfather some Tier 3 drugs. Grandfathering would allow patients currently taking certain drugs that are not preferred to continue, and automatically reduce their cost sharing to the Tier 2 level upon implementation of the formulary design in 2019. They wouldn't have to submit the request and go through this medical necessity and justification. An example of such medications would be seizure medications. We don't want somebody to change their seizure medication and have an adverse event.

Members that have already gone through the Tier 3 exception process and have received authorization for the Tier 2 cost sharing arrangement would continue. The difference would be new users that have been prescribed a non-preferred, non-covered drug. They would have to go through the medical necessity requirement. They would need to document that they tried the preferred alternatives and they were unsuccessful in taking those or the medications weren't clinically appropriate - they had an allergy or other drugs interacted with those medications.

Slide 13. What is the potential member impact? There are about 820 drugs that are currently Tier 3. Three hundred of those have been identified as drugs that we would grandfather. Some for the clinical reasons and some due to the volume of patients taking those medications. It would overwhelm us from an administrative standpoint if everybody were to ask for an exception. In looking at the particular member impacts, some members are taking multiple Tier 3 drugs, so the administrative impact on the plan and to the member isn't necessarily on the individual person. It's on the Tier 3 drug member combinations. We identified 50,511 Tier 3 drug member combinations and removed those drugs that we're grandfathering in, which reduced it to about 19,000. Drug member combinations are Tier 3 medications that a member would

potentially request an authorization or an exception to get a medical necessity override for that particular medication. They would have to do it on a drug-by-drug basis, not on an individual, whole-person basis. At the end of the day, there's less than 20,000 drug member combinations. The total number of members is less than that.

Dorothy Teeter: Donna, thank you for continuing to work with the rising pharmaceutical costs that we're experiencing, not only in this program, but across the country. This starts the discussion.

Tim Barclay: With all you've done, and you've described the volume here and the potential administrative impact of making this transition, does it make sense to take at least a slice of this and implement it in 2018? Maybe grab some obvious low-hanging fruit that you've already identified. Why not take a step in 2018 before you take the big leap in 2019?

Lou McDermott: As we go through our benefit design for the year, we try to determine what's going to happen the next year. There are many ideas that come to the table. We know some ideas take longer to get through the system; they're a little more controversial and have a negative member impact. From the members' perspective, the member might say, "This is a bad thing," and so we try and be careful with our ideas. As we go through the process, we want to make sure people have an opportunity to look at them. Is it possible to implement it in 2018? Yes, it's possible. Was that the original plan? No. The original plan was to bring it up with the Board to discuss and see what the Board's thoughts are. We also have our authorizing environment. We have the Legislature. There are a lot of different folks we have to talk to about things we want to do.

Donna Sullivan: Tim, what I can say is, we are making slight changes to our certificate of coverage. The example with the Glumetza, right now we don't have a means in our certificate of coverage to say that we aren't going to cover that particular drug or high cost drugs. We're making slight changes to our certificate of coverage for 2018 so when we do identify occurrences where there are two different drugs that are essentially the same, but one is significantly more expensive, that we don't have to cover that drug. There are tiny steps that we can take that really don't bubble to the level of needing Board approval or authorizing environment approval because we don't feel that it would be of significant impact by making those changes.

Yvonne Tate: It's very difficult to change medications. Employees go bonkers when you start messing with their medications and there's not a lot of knowledge behind it when they do that. It's more of a deep emotional response, so when you do change the formulary, people are going to go bonkers. I would be thoughtful and patient. I always say this, "The real issue here is big pharma." We all know that.

Lou McDermott: Tim, I think one other thing, too, is the cost impacts. By doing away with Tier 3 and making it all Tier 2 costs, when you grandfather all those folks out, that's

going to be an increased cost for the plan. You have some off-setting cost so you're basically assuming that there will be folks that will not be able to get through the process because they haven't tried that cheaper alternative. They don't have a medically necessary reason that they have to use it. That's a very unpredictable number. It's unpredictable how many will just switch. It's unpredictable how many people will try to go through the process. It's unpredictable how many of those will go through the process and get to the other side. So, on the money side, as well, you can imagine that analysis with all the different underlying assumptions could: a) cost the state more money, depending on how we implement it, or b) save a lot of money if everyone were to switch to Tier 2 medications, no one were to apply, and there were no administrative cost. Then we would have big savings. It's a little dicey.

Tim Barclay: Right. Just to give one thought that maybe that's a good reason to dabble into it in 2018. You might learn a lot if you took a few and implemented it and see what their reaction is. It may make budgeting and setting things up to administer a more massive shift in 2019 a little better. Just a thought.

Harry Bossi: I've got three or four questions, but do want to comment on what Tim said. I think that's a real great idea to do some testing, experimentation, or slow movement. But if we can go back to Slide 10 where it talks about the value-based formulary. I want to make sure I have this right. The local experience is somebody other than PEBB, correct?

Donna Sullivan: Correct.

Harry Bossi: Maybe I'm missing something. On the adherence from 7.9% to 9.4% - is that percentage points?

Donna Sullivan: Their adherence improved from baselines. I don't have the actual numbers, but an example would be it went from 75% to 76.5%.

Harry Bossi: To me that doesn't seem like anything significant. It doesn't strike me as an important factor. What I really would like to know is if somebody paid the cost - if the member wasn't paying in terms of the co-payment, or out-of-pockets, then I'm kind of curious - and you won't have the information - but for me, I want to be analytical. Here's the co-benefit, and here's the cost, and we're kind of flying without any of that information.

Donna Sullivan: There are published articles regarding this. I can share those with you.

Harry Bossi: Okay. And then, if I can get back to the potential member impact, number 13, where you kind of lay out some numbers.

Lou McDermott: Harry, can I make one quick comment on the adherence? Having a nine percent increase in adherence is important. We do think that if people don't take their medications, that's when you can run into big costs. They wind up in emergency room visits, they go acute, so any improvement to adherence would be a goal for us.

Harry Bossi: I agree. But in scale, I've read about some companies that will eliminate co-pays or cost-sharing of formulary drugs and their adherence went up significantly, and ultimately their cost avoidance and the member health improved dramatically. I think that is obviously what we would all like to see happen. I agree with you in principle. I'm just saying that number doesn't strike me as anything significantly impactful. But the other comment I had is if we have a lot of information through claims management, you can model this right?

Donna Sullivan: Yes.

Harry Bossi: Based on past claims, to come up with what-ifs - if we eliminated, reduced, or moved certain things to a closed component, what would be the impact on the member, because ultimately we come back to somebody's got to pay. Or go back on the plan. If we had some testing, couldn't we demonstrate analytically what could happen?

Donna Sullivan: Right. We are working on developing just that. It's not ready for public disclosure at this point in time. We are working with Moda Health, who is our pharmacy benefit manager for UMP, to do just that and make it so we can change the different scenarios to say what if 25% switched, what if 50% switched. It's complicated and there's multiple situations that could happen. We're trying to make sure that we make each one of those inserts into the model so we can get a good picture.

Harry Bossi: The last question or comment I had goes back to what Yvonne was bringing up. The members are really very important and concerned. Do we have a sense for what the fully-insured plans might be doing because this would only apply to the self-insured, correct? We would want to be careful with members. We will always want them to weigh the options, but not fleeing from one plan to another in the hopes of saving a few bucks for fear of some formulary change. That's just an observation or comment. I know you'd consider it.

Donna Sullivan: I think what we would do is ask Kaiser what their current benefits are. It was my understanding that they might actually have a closed formulary in one of their plans. I would have to double check that. I know when Group Health was first contracting with the State, they had the closed formulary model and that was one of the reasons why we actually recommended the Uniform Medical Plan at least have the open formulary model. I think Group Health transitioned to an open model after that.

Harry Bossi: Thanks.

Greg Devereux: I appreciate the discussion so far. I don't think anybody on the Board would disagree with trying to reign in the specialty drugs in Tier 3. I do have a number of concerns and I think Tim's comment, Lou's, and Yvonne's all tie together. A member, when they hear we're moving from open to closed, the word closed to a member means code for take-away. So, regardless if it is or not, that's how it's perceived. To Yvonne's point, it may or may not be, but I think we'd have to do a really good job of explaining that.

The other word that really jumps out at me in this discussion is recommendation. I understand. Lou talked me off the ledge earlier today when I called him about this. It's not a recommendation right this minute, but a recommendation is a loaded term. It's an important term, so I think we need to be careful with that. I guess I would want to see what the usage is, what is the effectiveness, what's the cost of these drugs. It may not be 19,000 people, because of its combinations; but 15,000 is a lot of people - 10,000 is a lot of people. There'll be a lot of people jumping up and down. I think there has to be a lot more transparency to what these drugs are. I don't think people would be opposed to certain things if they could see there is an alternative, it's effective, very cheap, and we don't have to pay $50 per tablet. I think a lot has to be done. I wouldn't be opposed to trying some things in 2018 if that transparency was there and people really had a chance to look at it. I'm not sure there's time, but I think that's really important.

Lou McDermott: Internally when we discussed coming to the Board and bringing this issue, we know that in the past, we've brought fully baked items to the Board and said, "Here's the cake, it's baked, we've thought about all the issues." We knew this one wasn't one of those. It's our attempt to bring you something that hasn't been fully vetted or looked at from a marketing standpoint, how we would roll it out; what we would do, whether we would phase it in or not. We're intentionally bringing you something that isn't baked so that we can get your input and try and go back and figure out what the various components are. I know there are specific rules and regulations about how we interact with the Board and what is and isn't appropriate. We'll be talking with Katy on how to continue the conversation and provide you with the information you want.

Greg Devereux: If we're going to spend some time in the next year, or some portion of it, I would recommend having some members/users actually involved in the process talking about it and getting as much information about specific drugs as possible. I can defend it if I can sit and show the differences. I can defend that, but if people are being told 15,000 people are getting lopped off the program, folks will be really up in arms.

Lou McDermott: One aspect to this looks like a take away, but there are many members who are paying a very high Tier 3 cost for their medications. They have tried all the other medications and there is a medically necessary reason why they need that particular medication. They haven't gone through the exception process either because they don't know about it, or they're afraid to engage the process. This would, in essence, force their hand. If it all worked out for them and they got through the process, at the end of the day they would be paying a Tier 2 cost share. There will be some

members that benefit from this now that their hand is forced. No one really enjoys that, but there will be some benefit to our members.

Mary Lindquist: I appreciated your analogy about the baked cake. I am grateful to be invited into the kitchen to have a hand to do with the baking of this cake. I hope we'll find ways for us to have some really in-depth conversations about this and address some of these concerns because I share the experience of how upset members get when something is taken away; and yet, there's some obvious reasons why we want to look at this. So, thank you for inviting me in.

Marilyn Guthrie: This is always a tough kind of situation in balancing, maintaining the trend, so I want continued dialogue about this.

Dorothy Teeter: Thank you. It sounds like we'll be getting some advice from Katy about how to integrate some of these suggestions for moving forward in a way that's got the public piece of it baked in. One note of appreciation I'd like to make to Donna is the quadrant model you showed. That really helps us differentiate what value is and what it isn't; and it may be that will be a really helpful guide for us going forward so we can see what happens with the examples you've given and others. We're doing different things, how does that work? I think at the end of the day, we're going to have to balance this and people's attachment to their current way of getting their health care. What does that ultimately mean for overall premiums, for better health? What does it mean in general?

I really appreciate you laying this out. It's never an easy topic to explain. I appreciate that, and we'll continue to move forward with this, taking into account all the suggestions about piloting, not piloting, going forward with more modeling, etc. Thanks very much for that. I will be looking forward to hearing a lot more from you, Donna.

Dave Iseminger: Dorothy? May I comment, or make a correction, on my presentation? Several people pointed out to me that I made an error when I was presenting on the legislative report. I wanted to correct the record. I indicated that the K-12 bill just had a Fiscal Committee hearing in the Senate, and that was not correct. They actually did pass out of the Fiscal Committee on a bi-partisan vote, but it did not advance to the floor calendar; and so it did not have a full debate on the floor of the Senate.

Dorothy Teeter: Thanks for doing that for the public record during this time so we don't have to do a bunch of corrections later. With that, the next meeting is May 18 from 1:30 p.m. to 3:30 p.m. here.

Meeting adjourned.