Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

April 16, 2014
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Mary Lindquist
Gwen Rench
Harry Bossi
Yvonne Tate
Marilyn Guthrie
Marc Provence
Melissa Burke-Cain

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 informed the members that Lee Ann Prielipp had completed her term on the Board and she would certainly be missed.

Dorothy introduced two new Board members appointed by Governor Inslee, Mary Lindquist and Marc Provence. Mary represents K-12 Retirees and Marc represents Benefits Management/Cost Containment.

Mary Lindquist retired in 2013, ending a 42 year career as an educator and union leader. In 2007 she was elected president of the Washington Education Association (WEA) and served six years on the WEA Board and WEA's Benefits Services Advisory Board, which dealt with health care issues. While WEA president, Mary served on the board of the National Council of State Education Associations (NCSEA), a council of state presidents and executive directors within the National Education Association, representing the state leadership of eight western states. Mary was elected to terms as vice-president, president-elect, and president of the NCSEA. Prior to Mary's terms as WEA president, she taught English, social studies, and debate for 36 years in the Mercer Island Education Association. She also spent several years as social studies coordinator for the district.

Since retiring, Mary is volunteering as the co-director of the Northwest Teacher Union Reform Network as part of a national effort to strengthen schools through teacher leadership.

Marc Provence is the University of Washington (UW) Administrator for the Fred Hutchinson/University of Washington Cancer Consortium, an NCI-designated Comprehensive Cancer Center with over 500 research faculty across three institutions. He was formerly Director of contracting and Managed Care Systems for UW Physicians where he led the development and operation of a full-risk health plan. Prior positions include Deputy Director and Director of Operations for the Washington Basic Health Plan; and Vice President for Health Services at HealthPlus, the HMO of Blue Cross of Washington and Alaska. He chaired the Washington Basic Health Advisory Council and is a member of the Governing Council of the Pacific Hospital Preservation and Development Authority. Marc is a Clinical Associate Professor of Health Services at the UW School of Public Health. He holds a Bachelor of Arts degree in English from the University of California, Berkeley, and a Master of Public Health degree from UCLA.

Board and audience self-introductions followed.

Approval of January 30, 2014 PEBB Meeting Minutes

It was moved and seconded to approve the January 30, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

2014 Open Enrollment Debrief

Renee Bourbeau, PEB Division Benefits Accounts Manager, provided the Board with a 2014 open enrollment update. The HCA Flexible Spending Account (FSA) transitioned from ASIFlex to Flex-Plan Services for FSA and Dependent Care Assistance Programs (DCAP). Flex-Plan Services is a Washington-based company located in Bellevue. Transitioning to the new vendor was a major undertaking, which we consider a success. We had a virtual 100% conversion to the new vendor, which is 12,300 FSA and DCAP enrollees for 2014 plan year.

The Public Employees Benefits (PEB) Division implemented a new initiative to improve customer service. One of the successes is online access to the Statement of Insurance via My Account. Members now have access anytime and anywhere if they have access to the Internet, providing better, faster customer service. The Statement of Insurance also provides additional benefit information such as basic, optional life, including retiree term life and LTD coverage amounts. The agency saves the cost of printing and mailing.

The PEB Division conducted 26 Benefits Fairs throughout the state providing retiree and employee presentations, as well as vendor information and presentations. Face-to-face interaction with our members is important to us.

My Account security and functionality was enhanced for members to access their accounts in order to make plan changes at open enrollment and to view their Statement of Insurance. At Open Enrollment over 27,000 subscribers were registered for My Account.

2014 open enrollment had minimum account changes in the active pool. From the retiree pool, UMP continues to be the plan with the highest enrollment with 61% of our members and Group Health Medicare with 24%.

Harry Bossi asked about the percentage of those enrolled in FSA and DCAP in relation to those who had the opportunity to enroll.

Renee Bourbeau indicated there are approximately 138,000 employees eligible to enroll in the FSA and DCAP and there are 12,300 currently enrolled. This is about 8.5 percent.

Harry Bossi asked if we were where we thought we would be with enrollment in the Consumer Driven Health Plan.

Action Item: The offering of CDHP/HSA was legislatively required and we did not do an internal review of what the take up rate would be. We did do that somewhat for the switching assumptions and will follow up and get that information to you. While there are only four percent total subscribers in the UMP CDHP, there was a sixteen percent increase from last year and there was a similar statistic last year. While we still didn't have a significant amount of our membership, year over year, we are seeing more people go into the CDHP/HSA products.

Finance Update

Janice Baumgardt, PEB Finance Manager, reviewed the 2014 supplemental budget and provided an historical perspective. Janice also offered to provide the Board members with a PEBB Finance 101 tutorial if they wished. Budget discussions can be complicated.

Janice discussed the 2014 Supplemental Budget. PEBB Program's administrative account, 418, is the appropriated administrative account. It is an appropriation of $35 million dollars for the biennium out of just under $4 billion dollars of revenue per biennium. This account is used for agency overhead, shared services, PEBB administration, and some of the UMP administrative costs.

In the Governor's budget, the FY 2015 Funding Rate was set at $703. The Funding Rate is the funding that is put in agencies' budgets to cover employee benefits. It includes 85% per the Collective Bargaining Agreement of health benefit costs, plus 100% of all the other benefits that we provide, such as long-term disability, dental insurance, life insurance, etc. The Governor's budget proposal assumed funding for a wellness program that includes incentive payments of $125. The Governor's proposed funding rate assumed the entire surplus in the PEBB accounts would be spent down in FY 2015.

The budget passed by the legislature reduced the funding rate from $703 per PEBB eligible FTE to $662. This additional reduction was possible because the projected surplus increased between the time of the Governor's funding rate proposal and the enacted budget. All other assumptions in the legislature's budget remain consistent with the Governor's proposal, including the wellness program request with incentive payments of $125.

The final budget's standard funding rate proviso included new language declaring wellness programs and similar benefits or services as an approved use of funding rate revenues, a nod from the legislature to the wellness program. Something new in the legislature's budget was an appropriation made to the Office of the State Actuary to improve legislative access to independent and objective health care actuarial analysis. This appropriation included both Medicaid dollars and PEBB funding; $227,000 from the PEBB administrative fund to fund two FTEs In the Office of the State Actuary. The Governor vetoed this appropriation.

Janice shared the consequences of spending down the funding surplus. As previously mentioned, the funding rate of $662 is lower than the FY 2015 "pure" need; i.e., need without regard to surplus adjustments. Revenues in the PEBB fund come from the funding rate, self-pay group premium payments, the K-12 remittance, etc. The funding rate is just for state agencies and higher education. With a FY 2015 funding rate of $662, current FY 2016 and FY 2017 funding rate needs are projected at $949 and $1,002 respectively, assuming all things remain the same. That is a $287 increase in the funding rate from FY 2015 to FY 2016. If the projections are correct, the legislature and Governor will have a gap of $363 million for the first year of the new biennium next session when they are grappling with the 2015-17 biennium budget; approximately $162 million of which is General Fund state; again for the first year only.

With the current funding rate, the surplus/deficit position is projected to be $0 at the end of FY 2015. We still have reserves of $106 million for any unanticipated experience we may incur in FY 2015. The amount we keep in reserves increases as projected expenditures increase in subsequent years.

Greg Devereux commented that in his twenty years on the Board, he has never seen the Board have to make up a funding rate increase like the $287 that is projected. Finding $362 million is going to cause unbelievable chaos in the session next year.

Dorothy Teeter indicated that should there be a surplus the gap will close, but certainly not by $362 million.

Janice Baumgardt: It's the Governor and the legislature that will need to come up with the funding, once the rate is set; but it's the PEB Board that will approve plans, benefits, and employee contributions.

Greg Devereux: We are at an unprecedented utilization trough. Utilization is likely to increase, driving costs the other way. The next two years will be quite scary.

Janice Baumgardt: Had the funding rate been provided at the "pure" need, without any surplus considerations, the gap between FY 2015 and FY 2016 would have been about $50 - $60 million.

Marc Provence asked what directs the size of the premium stabilization reserve. Is it actuarially determined or mandated at some level?

Janice Baumgardt: HCA uses an industry standard. It has fluctuated over the years. We figure 9.1% of health benefit costs and 4% for dental. We also have an account for claims that lag. And although we are not required to have this set amount in the Premium Stabilization Reserves, we follow what would be required of us if we were required to follow Office of the Insurance Commissioner (OIC) law or requirements.

Greg Devereux: There have been discussions over the years between HCA and the OIC as to what that percentage should be.

Melissa Burke-Cain, PEB Board Legal Counsel: There are statutory provisions that permit the OIC to evaluate the sufficiency of reserves for the Uniform Medical Plan.

Action Item: Dorothy requests that we come back with some comparisons for the Board regarding best practices and how we relate to that in terms of reserves.

Janice Baumgardt discussed the historical perspective regarding the funding rates. The chart provided displayed, for each fiscal year, the "pure" projected funding rate need without taking into consideration any surplus/deficit adjustments, the enacted funding rate, and the actual funding rate need as evidenced by actual experience. In recent years, the projected need has been slightly higher than actual need, resulting in a surplus. Due to the lag in claims processing, it takes six months after the end of the calendar year to get a true picture what the actual funding rate need was for that year.

Janice Baumgardt shared an historical perspective on the employee/employer sharing of health care premiums. In 2011 we hit the target mandated by the Collective Bargaining Agreement (CBA) of 88% from the employer and 12% from the employee. In 2012, the Collective Bargaining Agreement changed the split from employer/employee to 85/15. The actual average employee medical weighted premium, an average of what an employee paid for their health benefit per month, was $135.58 for 2012. The average tier level; i.e., the subscriber plus covered dependents. For 2012, the actual average employee premium was $135.58 and the average employer share was $762, or 15.1%. Our projections are always aiming to be slightly below the employer share in our modeling. For 2015, 2016, and 2017, we are modeling at 14.9% to make sure that we are under that mark.

Premium Surcharge Update (including updates on Long Term Care, ACA's Play or Pay mandate, and payroll replacement efforts)

Mary Fliss, Deputy Director, PEB Division, provided an update on the wellness program and surcharge implementation.

Governor Inslee signed Executive Order 13-06 in October 2013. The Public Employees Benefits (PEB) Division, in conjunction with the State Employee Health and Wellness Steering Committee, is implementing a comprehensive wellness program for state employees. Members who affirm the completion of three activities by June 30, 2014 will receive an incentive that takes effect in the following plan year. Simultaneously, members have been asked to affirm the application of two potential surcharges that were included as part of the state budget and signed into law June 30, 2013. The surcharge is a $25 per month surcharge from members who use tobacco and a $50 surcharge to members who cover a spouse or domestic partner who has chosen not to enroll in other employer-based group health plan coverage that is comparable in premium and benefits to the Uniform Medical Plan.

The focus then transitioned to implementing the surcharges and wellness program. The new project is called Project SWISS (Surcharge and Wellness Implementation). Our guiding principles have been comprehensive and effective communication to all of our stakeholders, to engage teams through transparency, and public display of activities and progress. We also wanted to develop project outcomes that were both measurable and scalable.

The PEB Division typically communicates with our members once a year during open enrollment. This project offered a new opportunity for us to communicate mid-year. An announcement letter was sent to our members in February giving them a heads up about the surcharges, as well as some action that they can take in the near-term to prepare themselves for the letter and the instructions to come. At the end of March, a call to action letter was sent

outlining the four basic steps of creating the required attestations and the opportunity to participate in our wellness program. We are currently in the attestation period for both surcharges and wellness. The attestation period closes May 15, 2014 for surcharges and closes on June 30, 2014 for wellness.

The surcharges take effect on July 1, 2014. An adjustment period will be offered through August 29, 2014 for those people who did not complete the surcharge attestations. The incentive for the wellness program becomes effective January 2015.

The PEB Division took the policies approved by the Board at the January 30, 2014 meeting and wrote, vetted, and published them through the Washington State Registry. They take effect April 26, 2014. A multi-pronged change management approach was created, trying to tailor our communications to the membership, as well as to our stakeholders. The goal was to raise awareness with our membership and within the members' work place.

An issue log was created capturing more than 100 questions and issues which have been resolved, as well as developing Frequently Asked Questions documents that have been tailored to multiple audiences. Staff did in-person presentations to the membership across the state providing information to members and answering their questions regarding this project.

We are monitoring our progress as we move forward with this project. When we started, there were 27,000 registered My Account users. We currently have 83,000 registered users, or 71% of those whom we targeted. Our goal is to have 116,000 registered users. And as of April 14, 2014, 83,000 subscribers had attested. That is across all state agencies and institutions. 57,000 subscribers, or 44%, attested regarding tobacco use. The agencies are being provided agency employee specific counts so they can do appropriate follow up within their own organizations to make sure that they are providing the needed assistance to their employees.

This project has been our largest call to action for PEBB Program members since the early '90s. We did Dependent Verification 2010 in which we asked the 80,000 accounts that had dependents on them to verify those dependents. In comparison, this is really touching 138,000 accounts. We've had to become more sophisticated very quickly with our communications, and mobilizing across our entire PEBB membership. We want to provide members the information they really need to know so they can be successful and try to be much more concise in our communications.

Moving forward, we expect our members will want more functionality electronically. We expect that our members are going to want to be using My Account and asking about single-sign-on. They are going to have a different standard for us when it comes to creating an easier way to interact with us.

The other result of this work is that our SmartHealth Program does add a proactive element to our health management and changes the role of PEBB. PEBB's historic role is making sure that people had the information they needed in order to make decisions. SmartHealth creates a different dynamic where we are really asking members to be much more proactive and participative in terms of their benefit and their health management. We will need to align our management strategies around that new role.

The PEB Division is also working on three other projects. On April 1, we received a letter from John Hancock, our long-term care carrier. They are getting out of the business of providing long-term care as of August 1, 2014. We are looking to see what is available in the market and to design around what is available. They have assured us that those 1,800 members currently on their long-term care coverage can continue to be covered through that policy moving forward. Employees may continue to sign up through July 31, 2014. As of August 1, 2014, they will no longer be accepting applications.

The statute does require the Board to have a long-term care product offered to our members. We need to work very quickly to identify carriers currently available and licensed in the state and determine our legal requirements and responsibilities. We expect to provide a status report at the next meeting.

The PEB Division is also working on implementing the Play or Pay mandates of the Affordable Care Act. The federal government requires that all employers give their full-time employees benefits. We report to them those full-time employees to whom we have extended benefits that meet the federal requirements. It includes what benefits were, or were not, offered. This, along with their number of hours worked, is also reported to the IRS. We are working with eight different payroll systems and the Department of Enterprise Services (DES), who maintains the statewide HR database. The analysis is complete, the final regulations on information reporting were issued, and we are now developing a comprehensive project implementation plan. The Play or Pay penalties begin in 2016 for those employees covered in 2015.

The PEB Division is working collaboratively with the University of Washington on their payroll replacement project as well. They have selected Workday to replace their payroll system. We have been invited to work collaboratively with them to look at opportunities for creating system requirements and how we can take advantage of those to automate as much as possible.

Greg Devereux asked if this new payroll system was for the University of Washington only.

Mary Fliss indicated it was. The higher education institutions each have their own payroll system. We work with eight different payroll systems on implementation efforts.

Greg Devereux appreciates and fully supports the move to paperless. However, his organization represents 3,000 state employees who make less than $15 an hour. They also represent many state employees who do not have access electronically either at work or at home and still need some kind of paper to complete transactions.

Mary Fliss indicated they still have the paper option if needed. Subscribers can call an IVR line. There is a dedicated phone number that people can call and ask for their surcharge attestations' form, as well as their wellness attestation form, to be sent to them on paper. We did a special line so the forms could be barcoded. Upon receipt, we can easily scan them, get them to the right account, and get the forms into our system. HCA staff are keying these forms. We currently have provided 1,400 paper attestation forms. We are always looking at how to enhance our current functionality.

Greg Devereux: It's critical to get the information out to the agencies, like the phone number. 1,400 seems like a low number. They can't respond if they don't have the information.

Mary Fliss: That is part of our outreach to the agencies. We want to know how we can help and how we can have face-to-face interaction with subscribers. HCA wants to be a presence for them and provide the agencies with different tools so they can assist their members. Although we can't make people complete an attestation form and sign a document, we can do everything possible to make sure they are aware of requirements and have the tools available in order to be successful.

Gwen Rench asked about the acronym BAP.

Mary Fliss: It means "Brief Adjudicative Process."

At the completion of the attestation process, we will be able to compare the final numbers with our estimates, such as number of tobacco users, spousal surcharges, etc., and know the financial implications. This information is needed in order for the payrolls to appropriately load the deductions within the payroll fields, as well as for the wellness assessment. This information is needed to create the rate structure. We will continue to monitor so we can report back and continue to improve.

Dorothy Teeter asked for clarification on the Brief Adjudicative Process.

Melissa Burke-Cain: The general law is the Administrative Procedure Act. It has certain procedural requirements for administrative hearings, like appeals for the PEB Board or the PEBB Program. A Brief Adjudicative Proceeding has a number of requirements that the agency has to fulfill to ensure due process. It is essentially a paper process as opposed to an in-person, face-to-face process.

Harry Bossi asked if we knew how many of the mailings sent were returned as undeliverable.

Mary Fliss: The first letter and the instruction letter were mailed first class, which enables us to get a return. We've relied on U.S. Postal Service technology to assist in rerouting returned mail. We also try to augment all our communications to our members through multiple sources. We don't rely only on mailings. We use other employer-based systems and labor-based systems.

Marc Provence asked if the spousal surcharge comparable premium benefits was defined.

Mary Fliss: There is a standard established. The spousal surcharge is applicable to subscribers who cover a spouse that has chosen not to enroll in other employer-based coverage with benefits and premiums 95% actuarially equivalent to the PEBB-offered plan with the largest membership.

We worked with our actuaries to create tools for people to have available to them. We relied on the Affordable Care Act which creates a certain standard around Summary of Benefit Comparisons. We worked with our colleagues in the legislature, as well as with OFM, to make sure, as this sentence was dissected and certain assumptions made, that we were within the

spirit of the intent of that sentence. We've created a series of yes/no questions which are essentially disqualifiers. If you could answer no to any of the "knock-out questions," then the surcharge does not apply to you. If you answered yes to all of the "knock-out questions," including if spousal coverage costs less than $84.56 a month in premium, then the subscriber has to go into the benefit calculator. We relied on what is available from the IRS. We put in UMP's actuarial value to create a 99% equivalency for people to get their Summary of Benefit Comparison, enter those numbers, and come up with a yes/no answer as to whether it applies to them. We did have a lot of engagement with our testing. We tried very hard to make this a project where we could take that one sentence and create a system where people would be able to know clearly whether they were responsible for paying that spousal surcharge or not.

Greg Devereux had a concern with the Consumer Driven Plans. The plan design is totally different. How are the actuarial assumptions made regarding them? How is the calculation done if there is more than one option? It's a complicated process.

Mary Fliss: The instructions are to enter every plan that meets that dollar threshold. The tool is designed to enable people to put in what the employer contribution is for the HSA, as well as what the other benefit dynamics are. The tool does enable people to use the CDHP/HSA with an understanding of the employer contribution.

SmartHealth Wellness Program Update

Jenna Mannigan, HCA Contracts Office, updated the Board on the SmartHealth Wellness Program. This program adds a new proactive health management dimension. HCA conducted a Request for Proposal (RFP) to select a vendor. We looked for a health and wellness portal and incentive program to administer a health assessment; offer individual action plan options; coordinate with programs and services offered by health plans, vendors, or PEBB; track member participation toward incentives; offer alternate options to an online experience; and provide support to the worksite wellness coordinators.

The RFP was released November 15, 2013. Eleven proposals were received and evaluated. Proposals were evaluated on their technical proposal, management proposal, and cost. The evaluation team included representatives from labor, large agencies, and higher education. The University of Washington was a large stakeholder in this process and state wellness coordinators acted as an advisory group.

Bidders were required to give access to their actual portals so the team could act as end-users and get the look and feel of their portal and understand the communication styles of the portals. The advisory group assisted the team in giving feedback in what they thought of the portal itself, and if they felt it would be engaging to other state employees. Did they think members would want to come back and use it regularly?

Bidders that scored 75% or higher were asked to do an oral presentation. Three vendors were selected for a presentation. The oral presentation provided an end-user experience based on a high, low, and medium levels of health risk of enrollees that followed what their experience would be throughout the process of participating in the wellness program. They were asked to: walk through the different engagement tools and resources that would be provided to them; show the outcome; and indicate how they were going to keep the member engaged and

wanting to come back daily to use this portal. Reference checks were done on the top three bidders. The bidders provided three different employees, agencies, or other private sectors that used their portal. The evaluation team then ranked the finalists in order based on technical competency, strategic alignment, and cost management.

Limeade was selected as the Apparent Successful Bidder. This vendor has a highly customizable and flexible health plan portal. It allows the flexibility of input from different agencies to assist in building this platform. They are an NCQA accredited well-being health assessment. They provide a leading edge engagement tool, resources, and incentive design program. They offer unique mobile, gaming, and social media technologies. They bring the wellness and health management programs under one umbrella. There is one place to go to do your attestations, your incentive management, and also to come back and take a more proactive step in your health.

We are currently in the negotiation phase and hope to have an agreement by May 15. Limeade will provide a demonstration at a future Board meeting. Implementation will begin when the negotiations are concluded. The go-live date is January 1, 2015.

Harry Bossi asked if the health risk assessment will be part of this platform moving forward.

Jenna Mannigan confirmed that it's tied to the SmartHealth Program which will be going through Limeade.

Dorothy Teeter noted that we are starting to build the culture we need for wellness.

Diabetes Prevention Program Update

Michele Ritala, Manager, PEB Benefit Strategy and Design: Michele provided an update on the Diabetes Prevention Program (DPP), a program that the Board approved last year. The goal of the DPP is to identify people who are at risk for developing diabetes and then offer them a program that has been proven to help reduce the risk of becoming diabetic. It was developed by the Centers for Disease Control (CDC). For people completing the program, there is a 58% reduction in them converting to diabetes. The Health Care Authority has contracted through the health plans with a provider called the Diabetes Prevention and Control Alliance, who in turn contracts with the instructors who provide the program, most of which are conducted through the YMCA or other community-type organizations. The program is sixteen sessions in a small group environment and they follow a training program developed by the CDC.

The primary engagement strategy is through biometric testing events that are hosted at worksites. HCA staff interacts with agency wellness coordinators to help promote the program. They set up testing events and provide the awareness program. The engagement strategy includes a series of emails that make employees aware of the risks of having diabetes or pre-diabetes. It includes a risk quiz. If you score nine or higher, it's recommended that you attend a biometric screening event. Once tested, if you screen positive for being in the pre-diabetes realm, you are offered the program right then and there, or you can sign up for it at any time.

The Washington Wellness goal is to have a testing event offered to at least 60% of all state and higher education employees in 2014. We have data from our first event on January 13, 2014 through February 11. Out of 54,000 agency employees, 12,600 people work at employers that have offered a testing event. For higher education, 2,500 employees have been offered the testing event. We've conducted 25 testing events with 36 worksites participating. Some events included multiple worksites. In that four week period, 946 employees were tested and 76 enrolled in classes. From January 13 to February 11 about 8% of employees tested enrolled in a class. The higher education figures include classified, faculty, and management.

Greg Devereux: An important aspect of this program is getting the stories out that we have prevented hundreds of diabetes situations. That's incredibly powerful.

Dorothy Teeter: Once we get through the first cycle, communication will be important. We can share the success stories and the numbers about the findings.

Yvonne Tate was curious as to how much statins affect the onset of diabetes. If you are pre-diabetic and your doctor prescribes a statin, there is the risk of getting diabetes.

Dr. Dan Lessler, CMO: There is evidence that statins increase the risk. It is a very small increase in terms of the risk of diabetes. I think you have to step back and look at people who have a high risk of cardiovascular disease, who start on statins. A small portion of those people may develop diabetes as a result. But when you look at the end points of cardiovascular outcomes, MI, stroke, and even cardiovascular mortality, it's lower in people who are on the statins. There is some small increase in risk, but overall, when you are looking at it in population terms and identifying people who have cardiovascular risks, there is a net benefit starting them on a statin. You may get diabetes but you live longer.

Michele Ritala: What's next? We want to do this more. We are confident we're going to meet that 60% goal, and I think we're going to exceed it. We're going to be expanding outside of King and Thurston counties. We've focused first on the closer areas that have the larger populations. There is a challenge in some of the rural areas with the smaller employers. We will need to have combined events. Basically you need to have 100-150 employees to be able to hold an event. We are going to continue to collect and analyze the data. It will be several months before we can begin to look at the outcomes data, which is a 5-7% reduction of weight as a result of the DPP.

Greg Devereux asked if a small political subdivision could join another agency if there are less than 50 employees.

Michele Ritala: Yes. We conducted several events where multiple, smaller agencies were combined. Scott Pritchard would be the contact for arranging that.

Legislative Update

Nathan Johnson, Director, Health Care Policy Division, provided a legislative update.

The State Health Care Innovation Plan work began and was in process for about eight months leading up to session. Well over 1,000 stakeholders, many individual contributors, and over

twelve state agencies participated. They arrived at several key goals for a healthier Washington: Paying for value and outcomes instead of volume of services; empowering communities to improve health and better link with health delivery, a key component of our triple aim; and then integrating physical and behavioral health to address the needs of the whole person.

As part of the Innovation Plan or following it, the Governor proposed two main pieces of request legislation. House Bill 2572 dealt with some of the higher-level themes of the Innovation Plan and Senate Bill 6312 dealt specifically with the issues that related to behavioral health purchasing in Medicaid. Both of those pieces of legislation passed and were signed into legislation by the Governor.

Starting with HB 2572, there were several key provisions. The Health Care Authority is the lead agency for coordinating both the public and private efforts related to implementation of the five-year innovation plan. The second element was creating a joint-select committee on health care oversight. There's been a long-standing select committee that has gone through several name changes, exercising some level of health care oversight. This puts it into statute for the first time. Previously it was under a concurrent resolution and this puts it into statute to be in existence through 2022. It's a long-term venture, both to exercise oversight on some of the implementation of the Innovation Plan itself, but also broader health care issues in state government.

Third, it gave the HCA the ability to award two grants for pilot projects around the concept of accountable communities of health. This speaks to the community engagement and mobilization effort that's contained within an Innovation Plan looking at social determinates of health and what happens in the community as about 80% of the equation in terms of effecting overall population health and individual health. These communities of health are a key component and the legislation enables two pilot projects. Ultimately we would intend for these to be a statewide demonstration of what mobilized communities can mean for overall health. It also gave the Department of Health the responsibility to establish health extension programs for providers, giving tools, training, resources, and practical assistance in moving along this continuum of health care transformation. The intent would be to align these practice transformation support offerings with the regionally deployed accountable communities of health.

Next, very importantly, it established a Governor appointed committee to identify and recommend standard performance measures across the state looking at public and private delivery systems. This was a critical response to a very vocal cry for this type of work from both delivery systems, payers, and many employers who were part of the innovation planning process. Importantly this is about identifying and recommending measures. It is not about restarting the measures discussion. There are many national, statewide standards well established. This is getting clear about those core metrics by which we want to measure health system performance.

It provides permissive authority to HCA and DSHS to restructure Medicaid procurement to better integrate physical health, mental health, and chemical dependency treatment; all delivery systems that exist in silos at the current moment. It also takes the state's first significant step toward the creation of an all-payer health care claims database, initially requiring Medicaid and PEBB data to be used; but the notion is to encourage broader

voluntary participation in this database and ultimately the legislature has left for future sessions as to whether to compel participation from the commercial market.

The HCA is required to submit annual progress reports to the legislature, a requirement in the bill. That section of the bill that contained the requirement was vetoed, but the Governor insisted on this requirement moving forward.

Senate Bill 6312: The main focus of this bill is on Medicaid, but I believe it will have implications for broad delivery systems. This adjusted the scope, work, and membership of the Adult Behavioral Health System Task Force, which was originally conceived in the previous years' session. It provides more details for what DSHS and HCA are to do with both the physical and behavioral health delivery systems and the way we purchase those services. It sets a dual track approach, one track allowing in counties or groups of counties that would prefer a fully integrated approach earlier on. It both incentivizes those counties and regions to select the approach, and instructs the agencies to work together on introducing that more fully integrated purchasing approach to the delivery of Medicaid services in all other regions or counties of the state that are not so-called early innovators. It prescribes a more collaborative approach between newly constituted behavioral health organizations that build on the state's present mental health delivery system through RSNs, adding chemical dependency services to those managed care contracts, delivered largely through county-based systems. It also requires regional purchasing from the Health Care Authority and its Medicaid managed care procurement. Currently we procure Medicaid services on a county basis.

6228 was actually a very nice companion bill to House Bill 2572, sponsored by Senator Mullet. It requires commercial insurers to provide to their consumers some generalized health care cost and quality transparency tools. It's very complimentary of the broader all-payer claims database work that's meant to serve the entire marketplace.

There was also a state Alzheimer's plan in Senate Bill 6124. Some work around border communities specific to Medicaid and another look at health care prior authorization in Senate Bill 6511.

The budget bill had some items of interest, especially for Public Employees Benefits, but certainly for the broader innovation plan as well. Importantly, it gave us some initial staff resources and funding for the implementation of the State Health Care Innovation Plan in the amount of about $2.3 million. It funded four project positions. The intent is to bridge to a future federal grant. The hope and ambition of the state is to pursue an up to $60 million grant through the Center for Medicare and Medicaid Innovation.

In a variety of sections of the budget bill read together, the state contribution for public employee insurance was lowered. This was the successful attempt of the legislature to spend down the available reserves within PEBB. Section 106 specifically provided some HCA resources to the State Actuary's office, which is actually a part of the legislative branch and has historically dealt with pension issues. This provided some instruction in Section 106 for both resources and a shared approach to the actuarial rate setting process, looking both at

Medicaid and PEBB programs. The Governor had some concerns with this mandatory approach and vetoed the section and the funding that went with it. However, he did leave intact Section 914 of the budget, which gives us permissive authority to use some of those

same funds to fund the Office of the State Actuary if the two agencies can come to terms on what that approach would look like.

There are also some bills of interest relevant to this Board that did not pass. House Bill 2436 dealt with contracting efficiencies and would have allowed direct contracting approaches for some of the various solutions we've been discussing today around wellness, for instance. This continues to be an issue. Almost more technical in nature in some regards, but it would bring a great deal of efficiency to the way that HCA presently has to administer these types of portal services, which today is through each individual plan with some kind of double administrative overhead involved.

The next is a long-standing, technical corrections' bill that over the last six or seven years has been very well stakeholdered and broadly agreed to, but has never made it through both chambers of the legislature.

There was a bill passed by the legislature, but ultimately vetoed and replaced with an executive order of sorts, dealing with inter-agency disputes, specifically looking at issues related to health care reform. Instead of the provisions of the legislation, very similar provisions are to be created through an inter-agency MOU. A Governor's directed network is already underway.

Senate Bill 5964 passed which provided some broad requirements related to the Public Records Act, training for all public boards and commissions. Those requirements will be for any new members of the PEB Board. There are some specifics that we will be getting to you. We are still in early implementation stages. This will be guided through standards being developed by the Attorney General's office. More details to come.

Public Comment

David Ward, Attorney at Legal Voice: Legal Voice is an organization that works to advance women's rights in the northwest. We also have worked to advance LGBT equality issues. We're here to talk to you about an issue that is gaining more attention in states across the country. It concerns health plans that include exclusions that have the effect of denying medically necessary care to transgender people based simply on the fact that their gender identity does not match the gender they were assigned when they were born.

Washington State prohibited discrimination based on gender identity in 2006 after a multi-year effort by the legislature to get such a bill through. But many health plans in Washington continue to have exclusions in insurance policies that have the effect of denying medically necessary care on a wide range of issues. It can deny coverage for gender transition care, such as hormone treatments, surgeries, mental health counseling. I actually met someone this weekend at a forum who is a state worker who is being denied mental health counseling because she has a diagnosis of gender identity disorder, which is a recognized medical condition. It's now known as gender dysphoria. She's being denied coverage for mental health counseling simply because she has a diagnosis of gender identity disorder.

Other states are working to address this issue. California's system, CALPERS, removed all exclusions that affected transgender people in their health plans last year. Oregon's PEBB did the same thing last year. This followed a lawsuit that was filed against them in 2011 based on

allegations that the denial of coverage, equal coverage to transgender people, violated their equivalent state law that bans discrimination based on gender identity in employment and in insurance. We would hope that the PEBB can join Oregon, California, and states like Colorado, Vermont, Connecticut, and the District of Columbia that have taken steps to remove transgender exclusions in their health plans.

Public Comment

Roberta Dalley, Associate Professor of Radiology, University of Washington: I'm a Neuro-Radiologist by specialty. I'm also a board member of the GLMA, which is health professionals advancing LGBT equality, which is the only LGBT organization in the AMA House of Delegates. I've been employed at the University of Washington for about 23 years when I began my gender transition in 2011. I checked with my health insurance plan, which was Uniform Medical Plan. I looked up my coverage to see if the policy would cover my gender transition needs. Under the Uniform Medical Plan, what the plan does not cover, item 68 Sex Reassignment, Drugs, Surgery, Services, or Supplies for gender sexual reassignment. What that means is that medical and surgical expenses that would be excluded, would be things like hormone therapy; estrogen and testosterone; gender affirming psycho-therapy, a requirement of the standards of care for trans-sexual, transgender, and gender non-conforming people; any type of breast reconstruction; facial feminization surgery; and sex reassignment surgery. I want to emphasize at this point that every transition is different. Not everyone chooses all of these procedures and the actual utilization of these procedures in an insurance plan is really small.

After I researched the insurance plans at UW, I contacted my HR representative and they confirmed that I would not be able to claim these services. So, I paid all of my gender confirming procedures out-of-pocket, which amounted to many thousands of dollars. For HIPAA privacy regulations I am not going to specify what procedures that I did have done, but I was extremely fortunate as a physician to be able to afford these expenses out of pocket. Many, many people in the trans-community cannot afford these things and they need health insurance. I was able to recoup a little bit, about 25%, on my federal taxes because of changes in the federal tax return laws in 2009 with the Obama Administration.

Finally, as a physician, I want to emphasize the medical necessity of gender-affirming, medical surgical procedures. First, suicide prevention. Up to 41% of transgender people have attempted suicide compared to 1.6% of the general population. It's phenomenally large. For safety reasons, blending in as one's affirmed gender reduces the significant risks of violence, harassment, and even murder. Major medical organizations have issued policy statements recommending coverage, including the American Medical Association. They said, "It resolved that our American Medical Association support public and private health insurance coverage for the treatment of gender identity disorder, as recommended by the patient's physician."

I think that the current state is clearly discriminatory against transgender people based simply on who they are, based on their gender identity, and many trans-people suffer because of this, because they cannot get insurance coverage. I think as an academic physician, these insurance exclusions are a deterrent to the University of Washington's goal of diversity and attracting talented transgender people, who would look elsewhere in other states and municipalities. And finally, I have testified at the University of Washington Faculty Council on Benefits and Retirement, and just last week at the UW Faculty Senate Executive Committee,

both of which voted to approve a resolution recommending that transgender exclusion or transgender health care services be covered by the UW faculty insurance plans.

Public Testimony

Laura Harrington, Administrative Coordinator for the Air Force ROTC Program at the University of Washington: When I started my job at the UW, I had two daughters, ages 19 and 4 and a domestic partner. Fast forward to the present and I'm still in the same position, but now I have a 27 year old daughter, a 12 year old son, and a husband, not a domestic partner. I feel incredibly blessed to be the wife of a transgender man and mother to a transgender son. They are incredible human beings who have so much self-determination that it's truly awe inspiring. Having said that, we struggle financially around the issue of the medically necessary procedures that they need, that the exclusions in the PEBB health insurance plans prevent access to. As an Admin Coordinator, I'm the primary earner for our family. There simply is no money to fund the procedures that they need without the help of insurance. My husband overcame years of family issues and societal taboos and he began transitioning seven years ago at the age of 40. He hasn't been able to afford the main procedures that would allow him to complete his transition and live as the man that he is. There have been times when we've had to decide between paying the electric bill or paying for his hormone therapy. The electric bill has necessarily won out. As a result, he suffers bouts of depression, anger, frustration, stagnation, all of the logical outcomes for someone who isn't living the life they need to live. As a result, our entire family is negatively impacted in a way that is truly unnecessary.

My son, who has had a very different support structure than my husband had, doesn't know how much his parents struggle to figure out how we are going to afford his medically necessary and age appropriate procedures. We've been lucky so far in that we've had physicians who have figured out ethical ways to code for billing, but the luck is starting to run out and we have no idea how we can continue to pay for his procedures. For my son, medically necessary goes beyond just a process. Children who are living with bodies that don't match their self-knowledge sometimes start hurting themselves. The known suicide attempt rate is 50% among transgendered youth who do not receive the medically appropriate procedures to help them transition successfully. Medically necessary can become life necessary for children like mine. I refuse to allow my child to become part of that statistic. I love my job. I'm really good at it. In fact, I was a distinguished staff award winner in 2009, one of five people recognized by the UW each year. But as a parent and a wife dealing with these medical issues, I know I can take my well-educated, highly experienced resume to the City of Seattle, the state of Oregon, San Francisco, any one of an increasing number of state and local municipalities who no longer block access to the care my family needs.

I will always be a dedicated public servant and my passion is with helping create the best Air Force officers, and the best military in the world. It's what I do best, but I'm in a position where if the state of Washington doesn't change its policy, I will be forced to put my family first. The cost of providing these benefits is negligible for agencies like the PEBB. The cost of not providing the benefits is devastating for my family. It's time for the PEBB to please step up and do what's right for all of us who give our best in service to the state.

Public Testimony

Danielle Askini, Policy Director at Basic Rights Oregon in Portland and the Advocacy Director at Gender Justice League, which is a transgender justice organization in Seattle. I brought some studies from the state of California, Department of Insurance for you. I'm the sweeper-

upper with statistics and actuarial data. And then a study from the Williams Institute at the University of California, Los Angeles School of Law.

I just wanted to touch briefly on the cost of these benefits and to quote the analysis by the California Department of Insurance when evaluating for CALPERS, the cost of requiring all insurers in California, both public and private to cover these benefits would have an insignificant and immaterial economic impact, but that preventing the four types of discrimination listed in this study, would be a significant benefit to transgender people. There are a number of municipalities that have offered these benefits starting with San Francisco in 2001 and looking at their cost utilization from 2001-2006, they initially thought the cost would be $1.70 per person, per month. But after four years of setting that aside, they discovered that in fact the utilization of these benefits was so low, they did not need to have any additional cost to continue their plan in perpetuity. The University of California, which is a much larger employer, to employ between 92,000 and 111,000 people over six years, found that their utilization rates were as low as .011% - .093% depending on the year, per thousand claims per year.

As the point is, I think, struck home here by these stories. The impact on these individuals is huge. We know from a study, the best study that we have which is in the Netherlands where this is state funded and has been since the '70's, and the META analysis of 28 different studies, most of which were in Europe, that 78% of transgender people had improved psychological functioning if they receive medically necessary care and that suicide rates drop significantly. I've included in my written testimony some more statistics. I won't go over all the detail with you right now. Suicide rates went from roughly 19 – 0% or 24% to 6% in those studies. And as I think both Bobbi and Laura touched on, the benefit to the state is increased worker productivity, recruiting more talent, reducing the impact on work places of having transgender employees who see this incredible barrier and are suffering greatly. We also know that long-term health outcomes are greatly improved: substance abuse is reduced; people's rates of depression, which is a chronic, manageable, long-term management disease that you all are paying for, is greatly reduced; anxiety is reduced. So, we really would encourage you to consider in your process for securing 2015 bids, asking insurance companies to quote you on these benefits. They're vital to the community, and as David said, our position is that we basically believe, we hope, that you all will consider the implications of other states and what they have decided. We would encourage you to get in touch with the folks in California. This study is really amazing and they did a great job doing it.

Board Comments

Greg Devereux: The testimony of those four individuals to me was some of the most succinct, compelling testimony I've heard in 20 years. And a number of years ago, this Board had to make a decision about domestic partner benefits and there was some controversy at the time about cost. In the end I think the uptake on domestic partner benefits is quite large compared to transgender treatment issues, and the cost was negligible for domestic partner benefits. And to me, as was stated repeatedly, the human cost of this for individuals is high. The procedure cost is probably high, but I would imagine very few people would actually take it up, so over 320,000 lives in the system, the cost for this too would be negligible. I would hope that the Health Care Authority could look at this and expedite that examination because there are people out there suffering now and hopefully bring that back to this board fairly soon so we could do something fairly quickly.

Yvonne Tate: I just wanted to say when I was working at Group Health, I had the opportunity to help an employee who had gender dysphoria make the sexual change and part of my role was to help his co-worker understand what this is about and what it meant. In the process of doing that, whenever I ran into a situation where I wanted some expertise beyond what I had, I'd always call my colleague at Boeing. And at the time when I called Boeing, we had one employee in a workforce of 10,000, but Boeing actually had 75 employees at the time who were making the gender switch. I got a lot of insight from them about how they manage it. Health care wasn't an issue, because we got free health care at the time. But I wasn't aware that there were these health care barriers here with PEBB, so I appreciate you all bringing it up; and like Greg, I would certainly hope there would be something we could do on this issue.

Marilyn Guthrie: I would like to concur with Greg's comments. In my previous role as a Benefits Manager, we were often asked to make very difficult decisions. We also had to do the analysis around the cost impact; but at times there are decisions that are just the right thing to do, and I think that's one of them.

Dorothy Teeter: I do want to let you know that Dr. Dan Lessler, our Medical Director, is looking at this issue not only for PEBB, but also actually for our Medicaid program. He has done a tremendous amount of work on this issue; and so in the spirit of what I think is being expressed around this table, an intent to seriously consider, if it's the right thing to do. We need to start from that perspective. Lou McDermott and Dan can prepare something for our next board meeting on this topic.

The other topic that we will address at next month's meeting is going to become very large for all of us. There's a new drug out that can be very effective in treating Hepatitis C. There is a huge fiscal impact. What are the ethics of that? Clinically it works. We are working on that ahead of this meeting, but you might hear about this issue. We are doing an analysis on this drug from a legal, fiscal, clinical, ethical perspective, and we'll be briefing you on the implications of that at our next meeting.

The next Board meeting is May 28, 2014 at the Health Care Authority starting at 1:30 p.m.

The meeting adjourned at 3:40 p.m.