Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

June 25, 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 12:45 p.m. Sufficient members were present to allow a quorum. Dorothy stated: Pursuant to RCW 42-30-110, the Board met this morning in Executive Session to consider proprietary or confidential non-published information related to development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session began at 11:30 a.m. and concluded at 12:35 p.m. No action, as defined by RCW 42.30.020(3), was taken during Executive Session." Board and audience self-introductions followed.

Approval of May 28, 2014 PEBB Meeting Minutes
It was moved and seconded to approve the May 28, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Agenda Overview
Lou McDermott, PEB Division Director, shared that today we will go over the annual rule making, provide an update on some administrative changes, some ACA compliance issues regarding preventative tests and services that will be added to the Uniform Medical Plan. We will also have an update on the pharmacy benefit and additional information provided on our maximum out-of-pocket (MOOP). We will be asking the Board to vote on sunsetting UMP Health Counts.

Annual Rule Making Brief

Mary Fliss, PEB Division Deputy Director, and **Barb Scott**, PEB Policy and Rules Manager, provided information on 2014 rule making changes. Draft rules will be available in August 2014 as part of our CR 102 filing through the state. Information was also provided on a policy resolution the Board will be asked to vote on at the July 16, 2014 meeting.

The scope of this years' rule making includes addressing benefit administration issues; providing clarity on areas that have been identified either by members, agencies, the plans, or staff; making technical changes; and implementing the PEB policy resolution.

Administrative changes being considered during this rule making will include: Adding rules to govern the administrative hearing process members use to appeal decisions issued by the PEBB Appeals Committee. Currently more cases are being heard externally by the Office of Administrative Hearings and the hearing officers are trying to apply HCA Medicaid rules where gaps exist in the model hearing rules that the program has historically relied on. These rules are intended to provide greater clarity to all parties. There will be a big addition in WAC 182-16, which is our Appeals section.

Changes being considered are to respond to requests for greater clarity in some rules and improve readability in others. These changes include: moving to the more commonly used phrase "employer-based group health insurance" instead of phrases like comprehensive group medical coverage and comprehensive employer-sponsored medical so employees can better understand the rules regarding waiver of medical, deferral of enrollment in retiree insurance coverage, and rules related to the spousal surcharge.

Adding clarifying language to the definition of employee as it relates to inmates as individuals not eligible for the employer contribution is also being considered. We want readers to understand how to interpret the reference to inmates in our rules. This year there was some question as to whether or not PEBB rules would deny coverage to an otherwise eligible employee during pre-trial incarceration. The inclusion of inmates in the list of individuals who are not to be included in the definition of "employee" when determining eligibility for the employer contribution was intended to exclude inmates who are performing some services, like emptying trash bins or working for correctional industries. It was not intended to include those inmates who are performing those types of services within the state correctional facilities as being eligible for employer contribution to PEBB benefits. The intent is to make it clear that we are not intending to exclude, though an otherwise eligible employee, from coverage during pre-trial incarceration.

Technical corrections are also needed to address the gap in our appeal rules identified earlier this year as we worked with Flex-Plan Services, the third party administrator for the medical flexible spending account and dependent care assistance program. Our current rules are very clear that the TPA will hear appeals from employees who are enrolled in the FSA or the DCAP. However, the rules are unclear regarding who would hear an appeal from an employee who is denied enrollment under one of those programs. We plan to amend the rule so it is clear that an employee would appeal an enrollment denial to the PEBB Appeals Committee and not to the TPA.

We've also run into an eligibility issue when applying the rule that prohibits dual enrollment in PEBB and when coverage begins for a new employee. In order to address the eligibility issue, we are looking at allowing dual coverage just for the first month. For a brand new employee, the language in our rule says that the coverage as a new employee begins on the first working

day of the month, and that's not always the first calendar day of the month. Occasionally there is a weekend involved. We didn't intend for someone who is moving or transitioning from dependent coverage on his or her parent's or spouse's PEBB account to employee coverage to have a gap in coverage. We will amend the rule to allow for an overlap in coverage for this specific circumstance so there's not that gap occurring.

We also plan to expand the Special Open Enrollment event that allows a subscriber to make certain changes when a dependent has a change in residence from outside of the U.S. to within the U.S. to allow for the reverse circumstance of someone moving from within the U.S. to outside of the U.S. Today we allow for it one direction. It's reasonable that we allow it for the opposite direction as well.

Harry Bossi: Why haven't we considered changing the rule for the enrollment to be effective the first day of the month rather than the first working day? You wouldn't need to have this then.

Barb Scott: That was considered. Eligibility, for most employees, can start at any point of the month, but your coverage usually begins the first of the month following. For PEBB, their eligibility is a little more generous than what you see. In order to accommodate employees who start at the very beginning of the month, we've used that first working day language to accommodate that. Otherwise coverage typically starts the first of the month following the date that you become eligible. PEBB has that, but there is additional language that is the exception that allows the first working day of the month, or the first calendar day of the month, if that happens to be your hire date. It would be a take-away from employees for us to get rid of the first working day language and we didn't feel we could do that without taking that out to a very large set of stakeholders. So instead, for now we're proposing this overlap.

Harry Bossi: As an example, if I move from dependent coverage to employee coverage and started work today, the coverage would potentially start July 2. Would my claim for service be denied if I had an appointment on July 1?

Barb Scott: That's correct. If I was working in the private sector and quit my job, with my coverage ending on June 30, and started as a state employee on Monday, July 2, then my coverage with the state would start on Monday, July 2. I would have that one day gap. I would want to cover that with my COBRA coverage from my last employer that I had so I wouldn't have a gap if I felt like I wanted to cover that day and not be bare. If I were to start on the fifth of July and the fifth of July wasn't the first working day of the month, then my benefits wouldn't begin until the first of the month following the date that I became an eligible employee. That would have been August 1 and I wouldn't have had any coverage for the entire month of July. In that instance, I would have wanted COBRA from my previous job.

Mary Fliss: We have an improvement to make to last year's policy resolution on error correction. Specifically, the difference between the resolution adopted by the Board in 2013 and what's presented before you today is the removal of the automatic three month retroactive enrollment. As we've worked the cases around retro corrections, we now know that employees and agencies have issues with going three months back. We are currently dealing with the individual mandate per the Affordable Care Act where people in coverage leave that coverage and that exit of coverage is prospective. When we go three months back, if they are a dependent on someone else's account, they would then have to pay the premium for some of the duplicate coverage. That's problematic, particularly when we look at CDHP/HSA coverage where you cannot have first dollar coverage anywhere else.

The other issue around automatically going three months back is if you are receiving premium subsidies on the Exchange coverage, there are taxation implications. If you are on Medicare in a locked in plan such as a Medicare Advantage Plan, there are also issues with automatically going back those three months. We are still allowing recourse and that recourse should address the specifics of the situation. An artificial three months back is actually creating more issues. When we were looking originally at the three months back, we were aligning that to agency keying timeframes. That was an oversight on our part.

Gwen Rench: It sounds like there would have to be an appeal if somebody had been employed six months and hadn't gotten coverage. It sounds like there'll be some administrative hearings on this issue.

Barb Scott: In the rule that exists today, it says we will go back three months for medical and dental coverage if there's an error that occurs. What we're talking about is removing that three month going back for medical and dental coverage. Right now agencies are automatically enrolling coverage back three months prior to negotiating with that employee as to how the issue should be resolved. The rule allows for recourse. Under recourse, the employer can sit down with the employee and resolve the error based on individual circumstance. They can then determine whether or not that should be prospective enrollment, should they reimburse someone for their COBRA coverage or spousal coverage under another plan, or some other resolution, but not necessarily an automatic three month retroactive enrollment in coverage.

What Mary is saying is we never should have tied this to that processing period of a three month look-back. We missed that when we put this in place. We are bringing this back to you now and asking you to look at this again and consider our recommendation to remove that three months. It is all handled under recourse which is the employer and employee sitting down and figuring out what's the best course.

Dorothy Teeter: Gwen, I think your question was does the recourse equal an appeal? It sounds like that's not the case. If there are, the Health Care Authority has the ability to sit down with an employee regardless of what agency they're from and determine that recourse. Is that accurate?

Barb Scott: Recourse, as it is written in the rule, agencies and employers are authorized to sit down with their employee and work out what that recourse should look like. They send that recourse option to the Health Care Authority and the Health Care Authority has a certain amount of time to say yes to the recourse or ask them to revisit that recourse. The resolution will say "unless the Health Care Authority determines additional recourse is warranted." If the employee disagrees with the final recourse, they can always appeal.

Mary Fliss: This change doesn't impact that process. This change is removing the automatic retro going back. However, it could be that in the discussion three months going back is the appropriate recourse and that would be administered.

Barb Scott: It doesn't take away the appeal process. This hopefully resolves it before it gets to an appeal.

Gwen Rench: If someone had a dental expense one month prior to the coverage and it had been the agency's error, the agency could solve that problem?.

Barb Scott: Yes

Marc Provence: Does this apply only to errors; failure to enroll an otherwise eligible person? This has nothing to do with disputes with regard to whether or not the employee was eligible. Is that correct?

Barb Scott: This is both. There are instances where agencies determined eligibility incorrectly. We may have some of those cases that are being dealt with under this rule, as well as actual enrollment errors. The difference between those two is that we may have an agency where an employee is brought in on a temporary short-term basis and the agency doesn't expect that they will ever meet PEB eligibility, but that employee does end up satisfying the eligibility requirement and the agency somehow misses that and the error is found later. This is the mechanism for trying to resolve that error. It also would apply in the situation where there is an actual enrollment error. So, I turn in my forms and everything to be enrolled in Group Health and my agency somehow misses keying it.

Marc Provence: So it does apply to both?

Barb Scott: It deals with both.

The next steps for this rule making is to file a CR 102, publish the proposed rules in August, conduct a public hearing, and adopt final rules in September/October with rules amended and effective January 1, 2015.

Administrative/ACA Compliance Update

Kim Wallace, PEBB Procurement Manager**:** I am sharing two sets of information. The first one has to do with proposed changes to exclusions under the Uniform Medical Plan. There are six exclusions. We reviewed the exclusions under UMP and compared them to the Regence book of business policies and determined that there were certain exclusions that it made sense for us to change to match the Regence book of business. These proposals will be on the July 23, 2014 meeting agenda for a vote.

The exclusions are:

1. TMJ: We do have coverage under the current benefit, but the benefit is surgical treatment only. To match Regence's book of business, we're proposing outpatient and inpatient treatment be covered as well.

2. Circumcision: This is currently completely excluded. We're proposing to cover male circumcision.

3. Genetic Testing: It is currently not covered for purposes of predicting adult disease or family planning. We're proposing to cover it for those purposes.

4. Orthotics: We have covered some orthotics when medically necessary for people with diabetes. We are proposing to explicitly cover them to prevent complications of diabetes..

5. Home Health: You won't see a lot of change with Home Health. Our current Certificate of Coverage (COC) has some confusing language and a lack of clarity. We are proposing to revise the COC language and continue to cover Home Health services.

6. Massage Therapy: We currently cover up to four units per visit. A unit is 15 minutes in length. The proposal is to cover more than four units, i.e. more than an hour, when medical criteria are met.

Making these changes will create increased alignment across the PEBB plans: UMP, Group Health, and Kaiser.

Dorothy Teeter: Can you give me an instance where a massage greater than one hour might be clinically acceptable?

Suzanne Swadener, PEB Clinical and Quality Programs Manager**:** It's not common to go beyond an hour. An hour tends to be the time limit. More than one hour can result in more tissue damage. There's a lot of inflammation that comes out of a massage, a lot of good inflammation. More time than that can often result in soreness and other kinds of complications. You might go longer than one hour when you have multiple areas that require attention. If your injury is distributed across your back, or potentially if your back injury is causing radiation down your leg, and you need to go top to bottom. When you have multiple regions or very deep tissue, tissue release might be necessary in which you have to do more work. Those are the more common reasons. It is primarily unusual to see this happen.

Marc Provence: Does Dr. Dan Lessler, CMO, get involved, to review medical necessity from the HCA perspective as well?

Kim Wallace: Absolutely. Dr. Lessler and the clinical team did review each of these recommendations and concurred with the proposals.

Dorothy Teeter: That's a really good question. Dan is hand in glove with these so that there's a clinical rational under each of them.

Dorothy Teeter: We'll be voting on these at the July 23, 2014 Board meeting.

Kim Wallace: The next set has to do with new preventive services for 2015. These are Affordable Care Act (ACA) driven changes. There are nine of them. The ACA requires that all recommendations from the U.S. Preventive Services Task Force (USPSTF) that are graded A or B be implemented as preventive. The grade A and B has to do with the certainty of, and the degree of, a net benefit. The USPSTF makes that determination and then establishes it as an issue, provides guidance with the recommendations, and requires that those recommendations be implemented as preventive. The ACA requires they be implemented as preventive, which means no member cost sharing. All of our PEBB plans will be doing this. The services I mention are services that are currently covered. The distinction is that they will be covered with no member cost sharing as preventive, no later than January 1, 2015. They are: Alcohol misuse screening, Hepatitis C screening, HIV screening – non-pregnant adolescents and adults and pregnant women, Intimate partner violence screening, Tobacco use interventions with young people, BRCA screening, Lung cancer screening, and Breast cancer drugs as a preventive service.

These will not require a vote because they are required by the ACA. We wanted you to be informed.

UMP Pharmacy Benefit Update

Elizabeth James, Special Assistant to the CMO: I will answer some of the Board member's questions from a previous meeting. I'm going to talk about the members who may meet the $2,000 out of pocket maximum for pharmacy cost, and I'm also going to talk about the Tier 3 coverage for drugs on all of the PEBB plans. Currently, UMP classic is the only plan that does not have pharmacy as part of its combined out of pocket maximum. As proposed, we will be adding a $2,000 out of pocket maximum.

Our non-Medicare UMP members are who may meet this $2,000 out of pocket maximum for pharmacy costs. Unfortunately, there's not some great, easy, thread to say this group of members all have this condition or take these drugs. The only thing that did seem to tie them together was a combination use of various opioid analgesics, as well as other medications that contribute to pain control. Some of those might be some of the psychotherapeutic agents, whether it's an anti-depressant that's being used also for pain control.

The other category of medications among those who paid more than $2,000 out of pocket in 2013 is compounded drugs. This is like the old-fashioned, pharmacist-behind-the-counter-with-a-spatula making a drug preparation. These are instances where there's probably some FDA approved drug already available for the condition with the primary ingredient used in the compound but the patient and/or provider prefers the compounded preparation. These tend to be expensive and are reviewed by our clinical pharmacists at MODA. This is the general group of medications. When I went and tried to understand a bit more about the actual members, again there wasn't really any disease state or condition that tied the members together. Some had very complicated chronic conditions, some did have cancer, some had terminal illness. One thing that I didn't see was chronic infection which was really exciting to me. That told me we are covering our chronic infection drugs very well and our members are not penalized or burdened there. Also, a member with only specialty drugs did not appear in the list because those drugs do have a cap per prescription.

Marc Provence: Can you give an example of a specialty drug?

Elizabeth James: Specialty drug might be an injectable drug for rheumatoid arthritis, for multiple sclerosis. There are also some very expensive inhaled drugs in that category.

And finally, the other question that I was asked was to compare the Tier 3 drug coverage among all of the PEBB plans. This particular question came from the Tier 3 benefit exemption policy that's being proposed for members who are taking Tier 3 drugs but have some sort of a medical necessity that can be proven in documentation by the provider. This would include disabilities associated with supplies or products that are used for a number of conditions in addition to drugs. Again this is our 2014 prescription drug coverage among all plans.

The Kaiser plans do not cover non-formulary drugs at all unless they're under review which is essentially a similar type of review that the proposed UMP policy would be doing. All other plans do have a non-formulary benefit. UMP already covers the Tier 3 drugs, but the exception process would be to cover them at the Tier 2 co-pay.

Harry Bossi: If I were in UMP and my physician thought it would be in my best health interest to take a medication that had a generic medication, but felt medically in his or her opinion that I would benefit most by having a brand drug, is there any override capability for that, under something other than Tier 3?

Elizabeth James: Drugs that have a generic equivalent are not eligible for the Tier 3 process. They are covered without the ancillary charge additionally as they used to have the ancillary charge.

The meeting recessed for five minutes in hopes that Greg Devereux would return from a meeting in order to vote on the policy resolution before the Board.

Sunset of UMP Health Counts

Michele Ritala, PEB Benefit Strategy and Design Manager: At our June 25, 2014 PEB Board meeting I gave a presentation that summarized PEB's request for Board approval to cancel the Health Counts Program at the end of 2014. The primary reason for that is the initiation of the SmartHealth Program which was started this year under the Governor's Executive order 13-06. We intend to spend the administrative funding we currently spend on Health Counts on SmartHealth administration through the new health portal and the vender services associated with that. The costs are roughly equivalent and it doesn't make sense to have two different wellness programs for UMP members.

Sunset of UMP Health Counts Vote

Policy Resolution: Resolved, that the UMP Health Counts Program will end effective December 31, 2014. Eligible UMP members can participate and earn points toward an incentive in the program for activities completed by 12/31/14.

Dorothy Teeter: Any comment from the audience?

Melissa Burke-Cain: Typically, Madame Chair, since this wasn't scheduled for a vote until 2 o clock, I hesitate to take a vote early, especially with Mr. Devereux's absence.

Dorothy Teeter: I'm sorry that I misunderstood if we took a break we could come back and vote.

Melissa Burke-Cain: You can take a break that's equivalent to the time to get us to 2 o'clock, the time on the agenda for the vote, because it's an action item.

Yvonne Tate: Then I misunderstood you before when Dorothy made the question earlier on, could she move things around on the agenda I thought you said it was OK to move things around. Did I misunderstand you?

Melissa Burke-Cain: When you come to an item on the agenda and you're not ready to take it up and you want to wait, so that would be 2 o'clock or after. Then you would table the item for later. If it's something you want to take on earlier, that's more problematic. You would have to provide for it in the agenda.

Dorothy Teeter: Here's Greg!

Yvonne Tate: Do we still have to wait till 2?

Melissa Burke-Cain: Technically, we still have to wait till 2:00 o'clock to take this vote.

Dorothy Teeter: If that's the case I think we should table this item until the next meeting. I don't want to have people wait for fifteen minutes just to take a vote.

Melissa Burke-Cain: Are you going to take public comment before the vote?

Dorothy Teeter: It's not scheduled.

Melissa Burke-Cain: If you're not going to take public comment and the Board is all here that would vote, then I think you are safe. While it's not completely in order, I can't see who would be able to object.

Dorothy Teeter: Let's take the vote and if there are objections, we can reconsider it at our next meeting.

Melissa Burke-Cain: That's fine.

Dorothy Teeter: To get this right, let's re-do the motion to adopt. May I have a motion to adopt? Any discussion from the Board?

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

Yvonne Tate: Aye.
Greg Devereux: Aye, Thank you for your forbearance.
Marilyn Guthrie: Aye.
Marc Provence: Aye.
Mary Lindquist: Aye.
Gwen Rench: Aye.
Dorothy Teeter: Aye.

Dorothy Teeter: Just a reminder that our July 9, 2014 Board meeting is cancelled. The next meeting is the July 16, 2014 here are Cherry Street Plaza starting at 1:30. We will also meet on July 23, 2014.

Greg Devereux: Both Gwen and I will be in Chicago on July 16. If you call in, are you actually in attendance?

Melissa Burke-Cain: Yes, by your bylaws, you can attend by phone and vote by phone. If we have absences from two members, we'll still have a quorum on July 16.

Meeting adjourned at 1:50 p.m.