Washington State Health Care Authority

Public Employees Benefits Board Meeting

August 10, 2016

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Public Employees Benefits Board Meeting

August 10, 2016
9:00 a.m. – 10:00 a.m.

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board
August 10, 2016
9:00 a.m. – 10:00 a.m.

Health Care Authority
Cherry Street Plaza
Pear Room 107
626 8th Avenue SE
Olympia, WA 98501

Call-in Number: 1-888-407-5039 **Participant PIN Code: 95587891**

9:00 a.m.*	**Welcome and Introductions**		Dorothy Teeter, Chair	
9:10 a.m.	**Meeting Overview**		Lou McDermott	Information
9:15 a.m.	**Approval of June 22, 2016 Minutes**	TAB 3	Dorothy Teeter	Action
9:20 a.m.	**Response to Public Comments from July 27, 2016 Meeting**		Ryan Pistoresi	Information
9:30 a.m.	**2017 PEBB Procurement Resolutions 1-3 with Public Comment**	TAB 4	Dorothy Teeter	Action
9:45 a.m.	**2017 PEB Board Meeting Schedule**	TAB 5	Lou McDermott	Information
9:50 a.m.	**Public Comment**			
10:00 a.m.	**Adjourn**			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, August 10, 2016, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: board@hca.wa.gov.

Materials posted at: http://www.pebb.hca.wa.gov/board/ no later than COB 8/8/16.

Washington State Health Care Authority

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-583-5353 mjohnson398@comcast.net	K-12 Employees
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@gmail.com	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 maryklindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170th ST Kenmore WA 98028 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Marilyn Guthrie 1640 W Beaver Lake DR SE Sammamish WA 98075 V 206-715-2760 maguthrie52@gmail.com	Benefits Management/Cost Containment
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*non-voting members

5/1/16

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2016 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 7, 2016 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 16, 2016

April 13, 2016

May 24, 2016

June 22, 2016

July 13, 2016

July 20, 2016

July 27, 2016

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 07, 2015
TIME: 7:10 AM

WSR 15-17-011

TAB 2

Washington State Health Care Authority

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board's By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Public Employees Benefits Board
Meeting Minutes

D R A F T

June 22, 2016
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Dorothy Teeter
Greg Devereux
Harry Bossi
Gwen Rench
Marilyn Guthrie
Mary Lindquist
Myra Johnson

Members on the Phone:
Yvonne Tate

Members Absent:
Tim Barclay

PEB Board Counsel:
Katy Hatfield

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Dorothy stated: Pursuant to RCW 42.30.110, the Board met this afternoon 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 and for the purpose of discussing current litigation against the governing body with legal counsel when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency. The Executive Session began at 12 p.m. and concluded at 1:15 p.m. No action, as defined in RCW 42.30.023, was taken during Executive Session.

Board and audience self-introductions followed.

Accountable Care Program (ACP) Expansion Update

Michael Arnis, PEB Division Accountable Care Program Account Manager and **Barb Lantz**, Special Assistant to the Chief Medical Officer, provided an update on the ACP

Expansion into additional counties for 2017. ACP 2016 launched into five counties in the Puget Sound area: Snohomish, King, Kitsap, Pierce, and Thurston. The Accountable Care Program added 11,000 enrollees this first year. One-third of the enrollees are in the Puget Sound High Value Network and the other two-thirds are in the UW Medicine Accountable Care Network.

We asked both of our current networks to look to their partner providers in other counties to see if they could team up to offer those particular counties to more of our eligible enrollees. As a result of that request, starting January 1, 2017, the Puget Sound High Value Network will add Spokane, Yakima, and Grays Harbor Counties. The UW Medicine Accountable Care Network will expand into Skagit and Grays Harbor Counties. This is a fairly significant expansion to our program that's in its first year.

The UW Medicine Accountable Care Network and the Puget Sound High Value Network are not PPOs and they are particular about what providers they include. They are asking providers to take on financial risk, as well as commit to a bevy of care transformation efforts. This expansion is happening at the same time we're launching our first year of the program. The employees we are targeting for these two networks are the UMP Classic enrollees. In January 2017, we will be in seven of the eight counties that have the highest number of UMP Classic enrollees. We are in the significant areas.

As an administrative note, we were also in negotiations with Providence Swedish. We reached out to them and began discussions and negotiations about bringing them into the five counties of the Puget Sound area, as well as any other counties that they might consider. We had very good discussions for about two months and then realized the gap in the care transformation and financial efforts were too great. We were not able to come to an agreement. This ends the initial process that was undertaken over a year ago to build the ACP networks.

Our goal is to add more UMP Plus enrollees for 2017. We will emphasize the providers working together to improve care. Providers have made a significant commitment to work as a team to provide the care transformation that is a step up from what they might see in a normal plan. Some of the enhanced services are: a dedicated call center, virtual care, and online nurse care. Members will also be saving money. During our November 2016 open enrollment, we will still be targeting the UMP Plus networks to offer an enrollee contribution that's about 30% lower than the UMP Plus enrollee contribution and at half the deductible of a UMP Classic enrollee. When a subscriber fulfills the wellness component, the deductible is zero, as well as the same co-insurance for UMP Classic. However, if an enrollee goes to a primary care office visit, there is no co-insurance, whatsoever, to promote the delivery through primary care. By pushing those themes, we hope to pick up enrollment in our five county areas, as well as the four new areas.

Barb Lantz: A big expectation of the Accountable Care Program is to improve the quality of care members receive through care transformation. The Accountable Care Programs and their network partners can accomplish this through the development of plans to improve care. These plans are developed on a variety of topics, are in writing, and developed in partnership with the network providers. As examples, topics include

obstetrical care and lower back pain. This work is done under the leadership of Dr. Dan Lessler, the Health Care Authority's Chief Medical Officer. Monthly meetings with HCA and both networks keep us apprised of the projects that the different networks are working on.

With the Accountable Care Program, one of our goals is for the member experience to improve. To accomplish this, our network providers are prioritizing the role of the primary care provider in delivering quality care. In addition, each Accountable Care Program has a dedicated call center to schedule appointments and answer member questions or concerns they may have. The ACPs have demonstrated innovation through the use of "virtual visits," a link to nurse hotlines. HCA staff have accessed care through visual visits and found it to be very valuable and useful in terms of managing their health issues. We also encourage our members to shop for care, not just based on copays and benefit design, but on the network of providers that are offered to them. We have taken steps to improve the member's network shopping experience by providing better guidance on the Health Care Authority's website on how to access information on the provider network.

Dorothy Teeter: This next year is going to be really exciting in terms of the expansion. Hopefully word of mouth on this product will get even more members enrolled. I want to acknowledge the work of both of you and the whole team that's put this product together.

Total Joint Replacement Centers of Excellence Update

Marcia Peterson, PEB Benefit Strategy and Design Section Manager, provided an update on the Total Joint Replacement Centers of Excellence Program that becomes effective January 1, 2017. We selected two apparently successful vendors, Virginia Mason, for the Center of Excellence and Premera for the Third Party Administrator (TPA). This program covers UMP Classic and CDHP members only. We are working with the vendors on contract development and defining the benefit design. There are many next steps, such as creating a work plan around key milestones, a communication's strategy, Board vote, and implementation. We need to get all the parties together in order to make this a smooth experience for the member.

This proposed program is different than what's been offered in the past. The process begins when the member calls Premera to inquire about the Total Joint Center of Excellence Program. Premera will set up a case file for the member and start assembling their medical records, which then get reviewed by the surgeons at Virginia Mason. The program with follow the BREE Collaborative criteria for appropriateness. Members will be counseled along the way about the need for the procedure and how to resolve any issues they may have that keep them from being appropriate for the procedure or having a positive outcome, such as their BMI is too high, they are a smoker, etc.

The components of the bundle include: the implant itself, the hospital facility fee, the surgeon, the anesthesiologist, and durable medical equipment (DME). Patients are usually released with a walker or a cane. We are still in discussions as to what exactly goes into the bundle, but in general, the bundle covers from the time the member goes through that pre-surgical visit to the time that they are discharged. Currently under the

fee-for-service system under Classic and CDHP, the member is responsible for a fair amount of coinsurance and copay. The proposal under the bundled program is for there to be no cost or coinsurance to the member.

In addition, the bundle includes what is referred to in the BREE Collaborative as a 90-day warranty, which is not currently offered. At present, if there are complications or other issues related to the procedure once the member is discharged, the member is responsible for a portion of that cost. Under the bundled program's 90-day warranty, services for any complications that are related to the bundle would be covered and the member would not be responsible for those services. The Center of Excellence is at financial risk for the cost of those services. Under the deductible and copays, there would be no deductible and no coinsurance for the member with regard to these services; with the exception of the CDHP members who will still need to meet their deductible due to IRS regulations.

We selected one Center of Excellence for the state. In order to remove all the possible barriers we can for our members, both financial and geographic, we are proposing a travel and lodging benefit. We would allow the patient and one caregiver to accompany them to Virginia Mason for the procedure if they live more than 60 miles outside of the Center of Excellence. Virginia Mason has a hotel located next door to their facility. It's part of their system. Premera will take care of the travel arrangements, making it a smooth experience for the member.

Virginia Mason suggested that our team get together and spend the day doing a walk-through of what the member experience would look like. The team included Health Care Authority staff, Premera staff, and Virginia Mason staff. We were all very impressed. At the end of the day, the room was filled with yellow post-it notes tracking the patient flow. We talked about the patient experience and what it would be like throughout. We talked about the roles of the different parties and what would be needed. We kept going back to what the patient would need at each point. We also met with Premera to discuss their case management approach that they will use on the phone.

Gwen Rench: In today's paper, the Seattle Times, there was an unfavorable article on Virginia Mason. Will that have any impact on this in the future?

Lou McDermott, PEB Director: We saw that as well. We are in communication with our partner trying to get all the information. We've heard it's very common for dings to happen on audits and plans are made to take corrective action. We are not alarmed at this point; but we are communicating with Virginia Mason to find out what happened, what's going on, and what are you doing about it. We're on it.

Myra Johnson: Why was it a decision for 60 miles versus 50 miles?

Marcia Peterson: We are proposing 60 miles mainly because about 50% of the members who have had this procedure in the past are in the Puget Sound region. So they are very close. Thurston County (Olympia) would be within 60 miles. We were advised to use 60 because that distance frequently appears in our benefits. It's something people can remember.

SmartHealth Update

Scott Pritchard, PEB Health Management Unit, provided a SmartHealth update. Our SmartHealth program is a comprehensive approach for population health focusing on prevention and risk reduction. We've come a long way, but we still have a long way to go. There are over 134,000 SmartHealth eligible employees Washington. In 2015, 51,710 subscribers registered and of those, 48,688 took the Well-being Assessment and 31,408 earned the incentive.

Our goal for 2016 is to look at both "reach" and "impact." How many people participate and what do they do? Reach and impact are both essential to create value. To raise our value, we continue to focus on increasing the number of participants and focusing on our value; how can we best design the program to meet the needs of the state work organization. Today we focus on reach. The 2016 goal for subscriber registration is 50% (67,000), for Well-being Assessment completion is 50% (67,000), and for incentive qualification is 35% (46,900). As of June 12, 2016, we are at 41%, 19%, and 10% respectively. We changed the deadline for earning the incentive in 2016 from June 30 to September 30. We think it will make a difference. There's opportunity for more activity during the summer. One of the strongest motivators for moving toward incentive qualification is the deadline. When we recognize a deadline, we work toward it as it gets closer. We expect these numbers to increase with that single intervention.

One of the things we know about human behavior is that many of us are influenced by social networks; by the people we are around. We are influenced by the places we work. One measure of this program is to look at the entire population – 134,000, plus another 800 or so individuals. About half of our population work in state agencies and half in the higher education system. A small percentage work in political subgroups and small agencies, which adds up to about 15,000 out of the 134,000. The places people work are very important. There is a big difference in participation between higher education and the agencies. By focusing on the work organizations one-by-one, we can really make a difference. We are measuring how many of those employers with 50 or more employees reach our 2016 goal of 50%, which is 42 work organizations. Currently we have 37. The long-term goal of 70% would be 57. For the Well-being Assessment completion goal of 50%, we have about 42, three of which have reached it so far. But again, we are a ways away from the deadline. Fifty-three is our long-term goal of 65%. So the work organization is a very important part of our program for both reach and impact.

To reach that 50% for work organizations, we are looking at how many are in each 10%. There are only two work organizations that are still in the 29% and under. It increases between 40% and 49%, which are pretty close to reaching that goal. There are currently 37 organizations that have already surpassed the 50%. I think we'll easily meet and surpass our goal of work organizations due to senior leadership engagement from the top down and the work of the wellness coordinators. To reach our goal of 50% for Well-being Assessment completions, we need a strong finish as we move towards September 30.

Scott shared information that compared last year's numbers to where we are at the same time this year. We have a long way to go. We have a significantly higher participation rate amongst the agencies. Overall it was 41% of all of the work organizations, but 49% amongst the agencies. We've made a lot more inroads into the participation at the agency level. We are working hard at the higher education level, but their organizations and reporting structures are very different. We're learning how to work with them and looking for leaders amongst the higher education community. The University of Washington has over 30,000 members of the 55,000 higher education employees, so it's a very important part. They are working closely with us to help us improve our reach.

It takes 2,000 points to reach the incentive qualification. The next levels are 2,500 points and 3,000 points. As of June 12, there are 23,932 registered participants between 1 and 1,999 points, 5,543 between 2,000 and 2,499 points, 2,395 between 2,500 and 2,999 points, and 5,679 with 3,000 points or greater. We expect that a large number of those in the next few months will move from just under 1,999 points into the incentive qualification area. They are in the system and most of them have done their Well-being Assessment. They need to be brought into the activity range to really begin to use SmartHealth to improve their health and well-being.

In addition to knowing that there is a drive at the deadline level, we know that we need to keep SmartHealth in front of people in a fun way. We just completed SmartHealth Week. Last year we had a Seahawks ticket give away that worked really well. We wanted to increase registration and Well-being Assessment completions. We promoted through emails from the Governor directly to employees. Dorothy Teeter from HCA and John Weisman from DOH brought to the Cabinet the relative ranking of each of the work organizations, essentially how was that leader doing in engaging their employees in registration and Well-being Assessments. They were ranked from top to bottom so they were able to see how well they were doing against their peers. That was very effective last year. We've already had some movement in that area this year. We'll let them know every two weeks how they are doing – relying on the competitive nature of some of our Cabinet agency leaders. We also had a GoPro Camera incentive for anybody that had completed their Well-being Assessment by June 12, the end of SmartHealth week. The winner was from Central Washington University. We can use that in our higher education group promotions. The increase in registration was over 1,000 participants and the increase in Well-being Assessment completions was about 2,500. Those are good numbers.

Often when you do something you have an unintended impact. We had over 10,000 people do their first activity of the year. These were people that had already done their Well-being Assessment but had not moved on to activities. The activities were promoted through their work site. We think that worked well and got a lot of people going. In summation, we've had a good first year. We are increasing our reach. We will continue to impact to create value for the program.

Dorothy Teeter: We're going for higher numbers and we look forward to the next report.

SmartHealth Draft Legislative Report

Marcia Peterson, PEB Division Benefit Strategy and Design Section Manager, provided an update on the SmartHealth report to the Legislature. Part of the 2016 budget included a proviso directing the Health Care Authority to complete an evaluation of the effectiveness of the Wellness Program. The first report is due June 30 and we are on schedule to meet this deadline. We are required to submit quarterly reports to the Legislature thereafter. We are also required to present the results at a PEB Board public meeting, which we will do at a later meeting. The proviso requires us to do this prior to authorizing 2017 benefits.

We will present findings on the effectiveness of the Wellness Program to include the overall effectiveness, the cost of the Program, and the strategies our vendor Limeade used in terms of communicating to members. They want information about the participation rates, employee engagement, and the effectiveness in terms of health outcomes - is there any improvement in terms of chronic medical conditions.

We were directed to consult with the Washington State Institute for Public Policy (WSIPP) to look at cost effectiveness and how that's evaluated; and any changes that we might want to put in place in order to increase the efficiency of the Program. WSIPP is an agency that Legislators often use for research. They are nonpartisan and they do research to inform legislative issues. They have been a delight to work with. They really helped us in identifying the metrics and helped us understand the literature that's out there and where we might go forward in terms of some of the research we're doing. We've also worked with the Office of Financial Management (OFM). They stepped forward as well to help us with the analysis. We had a good data team from HCA, WSIPP, and OFM.

In addition to developing the metrics for this first report, this group helped us develop a road map for how we evaluate this Program going forward. 2015 is our baseline year when we started collecting data. In 2016, we are trying to understand sub-population needs and how to engage them. Connecting with leadership is a big piece of what we're trying to do in 2016, as well as establishing the metrics to be used for effective evaluations going forward. By the end of 2017, we hope to begin reviewing those initial outcomes in other areas. We'll have more year-to-year trends to evaluate. We won't be able to look at this year until the end of the whole benefit year. We can then start charting trends, such as behavior and risk. By 2018 and going forward, we want to start a more comprehensive value analysis. It can take some time to identify trends in looking at behavior and risk trends in population health measures.

The process of capturing metrics in these reports is an ongoing process. This first report is a chance to open a dialogue in terms of the metrics that the Legislature would like to have us include in future reports. We've divided our metrics into employee and organizational. Under employee metrics, we're looking at participation, health status, and information about the various activities employees are involved in through this program. For the organizational metrics, we are focusing on participation by work organization and communications. In future reports, we are looking at how we might gather some of this information working with OFM and WISPP. There are several areas under consideration. We would like to look at participation and activities particularly in

the high risk areas. Is that percentage of risk changing over time? We want to look at productivity, organizational culture, and cost effectiveness.

Gwen Rench: Is there consideration being given to expanding this to Medicare recipients?

Lou McDermott: We are not looking at expanding the Program at this time. The Program cost is on a per unit basis. For the upcoming legislative cycle, we have specific instructions for what we can and cannot ask for. We are interested in expanding the Program beyond just the subscriber to spouses and possibly the Medicare population, but there is additional cost to it. We do think there is value there. As we dive into the Program and are able to show results, we think that argument gets easier. The required reports will help us show value, outcomes, and if there is reduced expenditures. It makes it much easier to bring this forward.

Gwen Rench: I would like to put a plug in for an enhanced fitness program. I have a brochure. You can review it by going to the Lacey Senior Center. There's a good instructor there. For the people who are non-Medicare but still covered under SmartHealth, this might be a good program for the state to investigate.

Lou McDermott: We'll take a look.

Dorothy Teeter: We can make tiles for different programs.

Beth Heston, PEB Division Procurement Manager, provided a status report on the Life Insurance Benefit Reprocurement. Our goal is to give employees a more current benefit and to improve benefit design. We've successfully done that.

The existing benefits, employee basic and employee accidental death and dismemberment (AD&D), are paid for by the state. The current plan is $25,000 for employee basic and $5,000 employee accidental death and dismemberment. Those were bundled together. Under the new life insurance plan, it will be $35,000 for employee basic, a 40% increase and $5,000 in AD&D.

For the supplemental insurances, we get even more. The employee supplemental life is paid by the employee. The guaranteed issue changes from $250,000 to $500,000. The maximum went from $750,000 to $1,000,000 with evidence of insurability (EOI) or Statement of Health. The guaranteed issue will be available to all employees without EOI this fall. So, even if you haven't participated in the past, you will get a chance to enroll in this new plan without EOI.

For spouses, the spousal life is tied to the employee coverage. It stays at 50%. We went from $50,000 guaranteed issued to a $100,000 guaranteed issue, and a maximum of $500,000 with EOI.

Our current dependent coverage wasn't a good plan because it put spouses and children into the same pool. It penalized kids because the risk pool was based on the adults in the pool. So we created a new child life plan. That plan is $10,000 guaranteed issue, up to $20,000 in $5,000 increments for dependents between the

ages of two weeks and twenty six years. If there is a disabled dependent, they can continue to be insured after twenty-six years.

I think we won the most in retiree life. We've had a very poor benefit, $3,000, which was reduced by age. After age 65 it went down to $2,100 even though you were still paying for $3,000. After age 70 it went down to $1,800. Under the new policy, there are no age reductions. A retiree who is currently participating can increase from the $3,000 face value to $5,000 guaranteed issue. If they choose, they can undergo EOI and go up to $20,000 in $5,000 increments. That's for currently participating retirees. After January 1, 2017, every eligible retiree can get $20,000 guaranteed issue in $5,000 increments. If they only want $5,000, they can get $5,000. If they only want $10,000, they can get $10,000. However, they can have up to $20,000 without having to undergo EOI.

We also increased the amounts for AD&D and Supplemental Accidental Death and Dismemberment and tied it to the individuals being insured rather than the employee.

Greg Devereux: Does this apply to political sub-divisions that are part of PEBB, too?

Beth Heston: Yes.

Harry Bossi: I have a question on the employee component, the basic life and the supplemental. Is there a benefit reduction for age?

Beth Heston: No. There are no age reductions on any of our plans.

Yvonne Tate (via phone): I just wanted to say great job. I'm really pleased with the work you've done in that regard.

Beth Heston: Thank you, Yvonne.

Greg Devereux: She beat me to it. Great, great work. It really is tremendous. Thank you.

Lou McDermott: I'd like to take a moment to thank the team for all the work they did on this project. I'd like to stress the guaranteed issue. That is going to be a big deal because there are a lot of state workers with spouses who have diseases that would not qualify them for life insurance; a lot of state workers who started with the state when they were young, had no families, got married, had kids, and now have accumulated some diagnosis which prevents them from getting insurance. Basic was their only insurance. With this fresh start during open enrollment, they'll have the opportunity for subscribers to get up to $500,000 of insurance no matter what conditions they have. The key take away is that this is a fresh start for employees and their spouses.

Harry Bossi: Would a new employee that comes on in 2017 have 60 days to make a decision?

Beth Heston: Active employees have 31 days and retirees have 60.

Marilyn Guthrie: That was going to be my comment, Lou. This is great. But it's only great if people realize it's great. Communication and education will be a challenge, as open enrollment always is.

Lou McDermott: The good news is that we've been communicating a lot with the Accountable Care Programs. With SmartHealth, we've already built a lot of pipelines, one of those is our Labor meeting. Our Labor contacts are willing to communicate this information. It's good for their membership and we've had good participation there. Dorothy has a good relationship with Cabinet. I don't see any problem in getting this communication out. We are beginning discussions with the Governor's Office to see if there is any role there to get the message out. Getting the message out is the key. It would be very unfortunate for someone to miss this window of opportunity because they just didn't get the information in time. It's a wide group of people that we're talking about accessing and we're doing everything we can.

Dorothy Teeter: If people don't activate this, what happens to them?

Lou McDermott: Are you talking about what happens if they currently have a benefit but they do nothing?

Dorothy Teeter: Yes, and they don't take advantage of this, to Marilyn's point.

Lou McDermott: They will be grandfathered in. Whatever level they are set at automatically transfers over. We're not dropping people who think they have enough. If they do nothing, their current level is maintained.

Dorothy Teeter: I'd like to add my thanks to this. I remember when this conversation came up, I think it's been forty years since we procured.

Beth Heston: This year's our fortieth year with Voya.

Dorothy Teeter: We took something that's been sitting for a really long time, looked at it given today's market, and found new ways of doing things. So, thanks very much, Beth, to you, and Lou, and your whole team.

Beth Heston: Thank you.

Barb Scott, PEB Policy and Rules Manager, provided information on three policy proposals the Board will be asked to take action on at a future meeting.

The first proposal would add a definition of the word "season" to rule as it relates to seasonal employees. We recommend adding a definition so it will be clear that 12-month period are not eligible for off season benefits, even if the combined length of the season equal nine or more months. The proposed definition reflects how the program has administered eligibility and is being proposed to ensure clear alignment between PEBB rule and RCW. We are responding to an example that was brought to us of an employee hired to work a seven-month season followed by one month off, after which they return to work for another two-month season. Then the employee is off again for another two months after that. When you put the seven months and the two months

together, it equates to nine months; but those two seasons are not consecutive seasons. The proposed definition is consistent with the concept of consecutive stacking to attain or maintain eligibility as described in WAC 182-12-114 (2) and with the definition of seasonal employee. The policy proposal states "season" means any reoccurring, annual period of work at a specific time of year that lasts three to eleven consecutive months.

Greg Devereux: In your example, does that mean the seven and the two would not qualify because they are not consecutive?

Barb Scott: Because they are not consecutive, the employee would not get off-season benefits in between.

Greg Devereux: If you're a nine-month employee now, do you get benefits in the three off months?

Barb Scott: Yes. The statute reads that an employee who works a season of nine months or more receives the employer contribution during the office season following each season of employment.

The second proposal is related to domestic partner eligibility the Board grandfathered effective January 2010 when the Board established a policy that limited eligibility to state registered domestic partnerships. Prior to Washington State enacting a statewide domestic partnership registry, the Board established an eligibility policy that afforded same-sex couples in a committed relationship access to PEBB Program benefits equal to that afforded to opposite-sex couples who were married.

The eligibility for domestic partnerships evolved over time. The PEBB Program's eligibility that was in place prior to January 2010 evolved from criteria that required demonstrating there was a committed relationship in place and being based on the couple's sexual orientation to requiring that couples be barred from legal marriage. The change to requiring couples be barred from legal marriage was the result of litigation that questioned eligibility being based on sexual orientation.

In 2010, when the PEB Board changed eligibility and aligned it to the domestic partner registry, we moved from eligibility that was really based on being barred from legal marriage to aligning eligibility to the registry. At the time, the PEB Board decided to grandfather those domestic partners already enrolled under employees under that older criteria. We've maintained that grandfathered eligibility since then.

This second proposal would move away from that. With the passage of R-74 in November 2012, legalizing same-sex marriage in Washington State, and the United States Supreme Court ruling in Obergefell v. Hodges, the eligibility is no longer necessary. The environment that prompted the Board to grandfather the earlier eligibility no longer exists; and because of these changes, there is now a risk for claims of reverse discrimination by opposite-sex couples. The proposed policy states, "eligibility for Domestic Partners qualified under PEBB criteria in place prior to January 1, 2010 is removed effective January 1, 2017."

Based on enrollment data, there are approximately 113 domestic partners enrolled under the grandfathered eligibility today. If this policy is adopted, to maintain the partner's enrollment as a dependent, the subscriber would need to marry, or if eligible, register their domestic partnership with the state. In the event that a domestic partner does lose eligibility, they would be eligible to continue coverage on an individual basis for up to 36 months. This is consistent with the continuation option that's offered to domestic partners who lose eligibility through a dissolution.

Greg Devereux: So they have the option for three years that they pay for?

Barb Scott: Yes.

Greg Devereux: You're saying this applies to 113 people, some of whom may have married and not notified us?

Barb Scott: Yes, approximately as of today. However, it has not been verified against marriage records. The data is collected differently.

Marilyn Guthrie: Is this a housekeeping issue?

Barb Scott: Yes.

Harry Bossi: There is an option for those who continue to live in an unmarried state. There is a legal option that is also a dependency issue. Those who have chosen not to, have a coverage option called COBRA.

Barb Scott: That's true.

The third proposal is related to the definition of tobacco products. In 2014, the Board implemented a tobacco surcharge based on a state budget proviso. At that time, most states and the federal government had not addressed e-cigarettes within different parts of their regulatory authorities, or in tobacco surcharges where such surcharges exist. Accordingly, the current definition of tobacco products for PEBB Program members was crafted to say e-cigarettes are not included until the FDA makes a determination about their tobacco status. Thus, the Board and HCA intended to re-evaluate e-cigarettes if and when the FDA made a policy decision. Early last month, the FDA issued final regulations related to e-cigarettes. The FDA deemed e-cigarettes as tobacco products and will begin folding them into parts of their regulatory authority beginning mid-August 2016.

Given the FDA's new rules, we are revisiting the topic of e-cigarettes and their relationship to the tobacco surcharge. We have internally reviewed the FDA's action and it appears the FDA is regulating e-cigarettes mainly to stop their sale to minors rather than because of clear scientific evidence that they cause ill-effects. In discussing this topic with the agency's Chief Medical Officer and reviewing information available to us, we are recommending that the Board continue to exclude e-cigarettes from the definition of tobacco products until more studies develop a clearer picture of both the impacts, as well as any role e-cigarettes may play in harm reduction. The exclusion of e-cigarettes within the proposed definition being presented to the Board will continue to

exclude e-cigarettes from triggering the tobacco surcharge at this time. The tobacco surcharge is governed, in part, by HIPAA wellness program regulations. For a tobacco surcharge to be valid under HIPAA wellness rules, there must be a reasonable alternative to avoid paying the surcharge. For e-cigarettes there is no cessation program currently available. This is one of the main reasons why we are recommending this resolution at this time.

The proposed policy states: "Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, chewing tobacco, snuff, and other tobacco products. It does not include United States Food and Drug Administration (FDA) approved quit aids or e-cigarettes."

Greg Devereux: How complicated is it to put a cessation program together for e-cigarettes? I don't know how many studies have been done; but, from what I've read and heard, the additives in e-cigarettes are really bad for you. Really bad.

Barb Scott: I don't know how long. I don't have an answer for that one.

Lou McDermott: We need Dr. Lessler to answer this one. I don't think we can answer that today.

Barb Scott: If I remember correctly, we did reach out to our partners to see if something like that was available as part of our internal review. That's how we know that one isn't available today. We didn't ask them the question of how long it would take to put something in place.

Harry Bossi: I wonder if pipes should be included with tobacco products because you mention cigars.

Lou McDermott: Pipes are considered tobacco. I understand and you're saying call it out for clarity.

Dorothy Teeter: Two things. Harry was suggesting that we include pipes. Greg is curious about what it would take to create an e-cigarette cessation program. We will come back with a response to that once we confer with Dr. Lessler.

Lou McDermott: I want to make sure I understand Greg's request. You're asking, have we done any work to design a smoking cessation program for people who use e-cigarettes?

Greg Devereux: Or is there one out there that we can quickly use? I don't want to wait ten years while the FDA looks at this to determine if it is significantly worse for people. From what I can tell, these things aren't very good.

Lou McDermott: We'll have Dr. Lessler respond to that at the next available meeting.

Barb Scott: And our recommendation to exclude the e-cigarettes at this time was with the intention that we would continue to monitor the scientific evidence and reevaluate this annually. At this time though, based on what was front of us, we were proposing that they be excluded for now.

Lou McDermott: Can we take a five minute recess?

Dorothy Teeter: Yes, we'll be back in five minutes.

Recess taken.

Dorothy Teeter: Meeting reconvened.

Our next meeting is July 13 from 1:30 to 3:30.

Meeting adjourned at 2:50 p.m.

TAB 4

Washington State Health Care Authority

2017 Procurement Resolutions

Lou McDermott, Director
Public Employees Benefits Division
August 10, 2016

Plan Design Resolution 1

- **Resolved**, that the PEBB Program will offer a new Uniform Medical Plan Centers of Excellence program (COE) starting in Plan Year 2017.

PEBB Medicare Contribution Resolution 2

- **Resolved**, that the PEB Board endorses the maximum $150 employer Medicare Contribution, not to exceed 50% of plan premium set forth in the legislative budget appropriation.

Employee Premiums Resolution 3

- **Resolved**, that the PEB Board endorses (1) Schedule A for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if no judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using fibrosis scores as part of preauthorization criteria to cover Hepatitis C drugs, and

Employee Premiums Resolution 3, Cont.

- (2) Schedule B for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if a judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using a fibrosis score as part of preauthorization criteria to cover Hepatitis C drugs.

Questions?

Lou McDermott, Director

Public Employees Benefits Division

Louis.Mcdermott@hca.wa.gov

2017 Procurement Resolutions

1. **Resolved**, that the PEBB Program will offer a new Uniform Medical Plan Centers of Excellence program (COE) starting in Plan Year 2017.

2. **Resolved**, that the PEB Board endorses the maximum $150 employer Medicare Contribution, not to exceed 50% of plan premium set forth in the legislative budget appropriation.

3. **Resolved**, that the PEB Board endorses (1) Schedule A for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if no judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using fibrosis scores as part of preauthorization criteria to cover Hepatitis C drugs, and

   (2) Schedule B for the Uniform Medical Plan, Group Health, and Kaiser Permanente employee premiums if a judicial order is entered against the state on or before September 6, 2016 preventing the Uniform Medical Plan from using a fibrosis score as part of preauthorization criteria to cover Hepatitis C drugs.

TAB 5

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2017 Public Employees Benefits Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 17, 2017 (Board Retreat) 10:00 a.m. – 4:00 p.m.

March 16, 2017

April 12, 2017

May 18, 2017

June 21, 2017

July 12, 2017

July 19, 2017

July 27, 2017

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856