Washington State Health Care Authority

Public Employees Benefits Board Meeting

July 16, 2014

Washington State Health Care Authority

Public Employees Benefits Board Meeting

July 16, 2014
1:30 p.m. – 4:05 p.m.

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

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Washington State Health Care Authority

AGENDA

Public Employees Benefits Board
July 16, 2014
1:30 p.m. – 4:05 p.m.

Health Care Authority
Cherry Street Plaza
Sue Crystal Rooms A & B
626 8th Avenue SE
Olympia, WA 98501

Conference Call Dial In: 1-888-450-5996, Participant Passcode: 546026

1:30 p.m.*	**Welcome and Introductions**		Dorothy Teeter	
1:35 p.m.	**Approval of June 25, 2014 Minutes**	TAB 3	Dorothy Teeter	Action
1:40 p.m.	**Annual Rule Making Vote**	TAB 4	Mary Fliss Via phone	Action
1:45 p.m.	**2015 SmartHealth Program Recommendations**	TAB 5	Scott Pritchard	Information
2:00 p.m.	**New SmartHealth Vendor Product Demonstration**		Lora Kerns, Limeade	Information
2:20 p.m.	**2015 PEBB Procurement Summary**	TAB 6	Kim Wallace	Information
2:30 p.m.	**Premium Overview**	TAB 7	Janice Baumgardt	Information
2:50 p.m.	**HIPAA Training**	TAB 8	Melissa Burke-Cain	Information
3:20 p.m.	**Transgender Health Services**	TAB 9	Dan Lessler	Information
3:50 p.m.	**Public Comment**			
4:00 p.m.	**2015 PEB Board Meeting Schedule**	TAB 10		Information
4:05 p.m.	**Adjourn**			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, July 16, 2014, at the Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue 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 email to: board@hca.wa.gov

Materials posted at: www.hca.wa.gov/pebb/Pages/board_meeting_schedule.aspx no later than COB 7/14/14.

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
Vacant*	K-12
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	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
Marc Provence UW Administrator Fred Hutchinson/UW Cancer Consortium 850 Republican ST Seattle WA 98109 V 206-616-5423 mprov@uw.edu	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 2101 Fourth AVE, Suite 600 Seattle WA 98121 V 206-913-4757 mguthrie@qliance.com	Benefits Management/Cost Containment
Harry Bossi* 3707 Santis Loop SE Lacey WA 98503 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment

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*non-voting members

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

2014 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.

December 11, 2013 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 19, 2014

April 16, 2014

May 28, 2014

June 25, 2014

July 9, 2014

July 16, 2014

July 23, 2014

December 10, 2014 (Board Retreat) 9:00 a.m. – 3:00 p.m.

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: July 18, 2013
TIME: 1:05 PM

WSR 13-15-090

Washington State Health Care Authority

2015 PEBB PROCUREMENT CALENDAR

March 19	Board Meeting: Canceled
April 16	Board Meeting
May 28	Board Meeting: Budget, Open Enrollment Summary, & Procurement Brief Request for Proposals Issued to Fully-insured Plans. Initial Proposal Brief & Budget Update. Proposals Due
June 25	Board Meeting: Procurement Update, Eligibility Scope, & Policy Brief
July 9	Board Meeting: Canceled
July 16	Board Meeting: Recommended Resolutions • Plan Design • Employee Premiums • Medicare Explicit Subsidy • Eligibility Policy (if needed)
July 23	Board Meeting: Resolution Vote

Updated 6/25/14/13

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.

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

D R A F T

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.

Washington State Health Care Authority

Annual Rule Making

July 16, 2014

Mary Fliss
Deputy Director
PEB Division

Purpose

- Board Policy Resolution: take action on the Error Correction policy resolution

Policy Resolution
Error Correction

Resolved, that if an employing agency fails to enroll an employee in benefits, medical and dental enrollment will be effective the first day of the month following the date the enrollment error is identified, unless the Health Care Authority determines additional recourse is warranted. If the enrollment error is identified on the first day of the month, enrollment is effective that day.

Questions?

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Policy Proposal for 2014 Annual Rule Making

CORRECTION OF EMPLOYEE BENEFIT ACCOUNTS WHEN AGENCY ERROR

Proposed Policy:

If an employing agency fails to enroll an employee in benefits, retroactive medical and dental enrollment will be effective the first day of the month following the date the enrollment error is identified, unless the HCA determines additional recourse is warranted. If the enrollment error is identified on the first day of the month, enrollment correction is effective that day.

Current Policy:

- Statute directs PEBB insurance coverage to begin on the first day of the month following the date when eligibility for benefits is established.
- Waiver of medical enrollment must occur within 31 days after becoming eligible.
- If an employee fails to return enrollment forms within 31 days of becoming eligible, the employer defaults the employee's medical and dental coverage to UMP and UDP.
- Enrollment in medical and dental insurance coverage as elected by the employee is retroactive up to three months if an employing agency fails to enroll an employee.
- Additional retroactive insurance coverage back to the date eligibility is established is provided through "recourse" as described in WAC 182-08-187(3). The employing agency must work with the employee and HCA to implement retroactive insurance coverage.

Justification:

- The current error correction policy of retroactive medical and dental enrollment up to three months was a vestige of the operational procedure that allows agencies a three-month window to key employee elections.
- Any retroactive enrollment may have an adverse impact on an enrollee. For example, retroactive enrollment may duplicate coverage for the retroactive period which is particularly problematic in cases of CDHP/HSA enrollment. Or, retroactive enrollment may invalidate an employee's eligibility for premium subsidy for coverage they purchased on an Exchange when not enrolled in PEBB coverage, in error, when the employee was eligible for the employer contribution.
- This policy change does not adversely impact employees; all required retroactive medical and dental enrollment is implemented through "recourse" as described in WAC 182-08-187(3).
- Statute (RCW 41.05.065(4)(h)) describes normal enrollment situations; it does not address error correction.

Washington State Health Care Authority

2015 SmartHealth Program Design

Scott Pritchard
Health Management
Public Employees Benefits Division
PEB Board Meeting
July 16, 2014

Topics

- SmartHealth Guiding Principles
- SmartHealth Activity Categories
- 2015 Program Approach
- Points Approach
- Activity Examples
- Subscriber Scenarios
- Questions

SmartHealth Guiding Principles

Goals:

- ✓ **Engage the workforce in SmarthHealth**
- ✓ **Improve individual and population health**
- ✓ **Achieve a positive impact on the medical cost trend**

SmartHealth Guiding Principles

Design:

- ✓ Create an experience that is **simple to understand**
- ✓ Offer and track **qualifying actions for the incentive**
- ✓ Provide **personalized Individual Action Plans** relevant to Assessment results
- ✓ **Promote PEBB programs & benefits** –
- ✓ Integrate **agency specific activities** into SmartHealth activities
- ✓ Offer **alternative access** to those without access to the internet
- ✓ Promote **sustainable** healthy lifestyle changes

Incentive:

- ✓ Provide an incentive(s) to increase awareness and use of selected benefits and behavior change tools and programs
- ✓ Create equal incentive for eligible subscribers across all health plans

SmartHealth Activity Categories

2015 Program Approach

- Providing behavior change tools that work through a single wellness portal
- Earning points based on completing activities
- To earn the incentive, the eligible subscriber will:
  - Complete the Well-Being Assessment (800 points)
  - Earn activity points (1,200 points)
  - Total of 2,000 points needed

Points Approach

- Value Assignment
  - Points based on activity duration and intensity

- Verification
  - Points are verified in multiple ways: claims, vendor tracking tools, importing tracking apps data, and self reporting

Points Approach

PEBB Subscribers will need to earn the required number of points to qualify for the incentive. Activities must be started prior to June 30 and be completed within the normal timeline of the activity. Completion will be validated.

- Exception:
  - Newly eligible subscribers must complete the Well-Being Assessment and earn sufficient points according to SmarthHealth Program rules within sixty days after the effective date of their PEBB medical, but no later than December 31

Strategy for maintaining engagement after June 30 in development

Activities Examples

Chronic Condition Management	Reducing Health Risk	Keeping Healthy People Healthy
• Tobacco Cessation • Diabetes Prevention Program • Diabetes Control Program • Group Health Living Well Program	• Dental Exam • Address the Stress • Health Literacy • Low Salt Cooking Class • Local Farmers Market Recipe Exchange	• Break the Fast • Miles to Go • Easy Health Recipe • Fun with Food • Sweat for 30 • Washington Walks • Skip the Fast Food • Bucket List • Spring into It

Gail

Profile:

- Female (55)
- 30 yr. UW employee
- Lives in King County
- Health plan is Group Health
- Recently diagnosed diabetes
- Loves to cook
- Interested in becoming more active

- Well-Being Assessment
  - Program Requirement
- Chronic Condition Management
  - Group Health Living Well Program
- Reducing Health Risk
  - Local Farmers Market Recipe Exchange
- Keeping Healthy People Healthy
  - Washington Walks

Earns 2,000+ Points by:

- 800 - Completed Well-Being Assessment
- 150 - Bonus Activities
  - Q1 Assessment Completion
  - SmartHealth Detective
  - Join Your First Activity
- 600 - Completed Group Health Living Well Program
- 500 - Washington Walks
- 200 - Local Farmers Market Recipe Exchange

Xavier

Profile:

- Male (30)
- 5 yr. DOC employee
- Lives in Walla Walla County
- Health plan is UMP
- Smoker; wants help to quit
- Hasn't been to the dentist in a long time
- Fast food junky

- Well-Being Assessment
  - Program Requirement
- Chronic Condition Management
  - Tobacco Cessation
- Reducing Health Risk
  - Dental Exam
- Keeping Healthy People Healthy
  - Skip the Fast Food

Earns 2,000 Points by:

- 800 - Well-Being Assessment
- 150 - Bonus Activities
  - Q1 Assessment Completion
  - SmartHealth Detective
  - Join Your First Activity
- 800 - Completed Tobacco Cessation
- 100 - Completed Dental Exam
- 150 - Skip the Fast Food

George

Profile:

- Male (60)
- Retiree from a Wenatchee school district
- Lives in Chelan County
- Health plan is UMP
- Overweight
- Loves to fish, camp, hike, and bowl
- Concerned about heart disease due to family history

- Well-Being Assessment
  - Program Requirement
- Chronic Condition Management
  -
- Reducing Health Risk
  - Low Salt Cooking Class
- Keeping Healthy People Healthy
  - Sweat for 30
  - Break the Fast
  - Bucket List

Earns 2,000 Points by:

- 800 - Well-Being Assessment
- 100 - Bonus Activities
  - SmartHealth Detective
  - Starting First Activity
- 200 - Low Salt Cooking Class
- 500 - Sweat for 30
- 300 - Break the Fast
- 100 - Bucket List

Questions?

Scott Pritchard
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Policy Resolution
PEBB SmartHealth Program Requirements

Resolved, that SmartHealth Program requirements are:

- Complete the Well-Being Assessment
- Earn the required number of points according to the SmartHealth Program and completion rules

Washington State Health Care Authority

2015 Procurement Summary

Kim Wallace
PEB Procurement Manager
PEB Division
July 16, 2014

Topics to Cover

- Medical Benefit Changes
  - Uniform Medical Plan (UMP)
  - Group Health
  - Kaiser
- Dental Benefits
- Long Term Disability (LTD) Changes
- Life Insurance

UMP Pharmacy Benefit

- Affordable Care Act requires that member pharmacy out-of-pocket (OOP) costs apply towards maximum OOP limit (MOOP), effective 2015.
  - UMP Classic members' pharmacy costs currently don't apply
- Collective Bargaining Agreement (CBA) allows for two methods to address this ACA change:
  - Increasing the $ level of current "Medical only" MOOP and applying pharmacy costs, OR
  - Creating separate pharmacy MOOP

UMP Pharmacy Benefit Changes

- Recommend separate $2,000 Pharmacy MOOP
  - Applies to both Non-Medicare and Medicare plans
    - 0.7% of accounts or 1,325 non-Medicare members
    - 3.1% of accounts or 1,100 Medicare members
  - Total Premium Impacts
    - $0.75 Per Adult Unit Per Month (Non-Medicare)
    - $2.44 Per Adult Unit Per Month (Medicare)

UMP Pharmacy Benefit Changes Continued

- Tier 3 Benefits Exception Policy
  - Allow exceptions via prior authorization for Tier 3 non-preferred drugs to be covered at the Tier 2 preferred level when medical criteria are met

Other UMP Benefit Changes

- Changes to UMP Exclusions to be more consistent with Regence Medical Policy
  - Temporomandibular Joint (TMJ)
  - Circumcision
  - Genetic Testing
  - Orthotics
  - Home Health
  - Massage Therapy

Group Health Benefit Changes

- ACA Compliance
  - Residential mental health treatment programs covered
  - Diabetic retinal screening with no cost to the member
- Other
  - Cardiac rehabilitation covered
- No Medicare benefit changes

Kaiser Benefit Changes

- ACA Compliance
  - Member copays for prescriptions count toward OOP max
  - Member copays for spinal manipulations count toward OOP max
- Other
  - **Eliminate deductible carry-over**
  - Member cost sharing for post-surgical immunosuppressive prescription drugs
  - Add surrogacy exclusion – no coverage for anyone except for what is otherwise covered for a Member who is a surrogate
- No Medicare benefit changes

Dental Benefits

- No dental benefit changes for 2015

Other Benefit Changes

- Long Term Disability
  - Eliminate gap between end of LTD benefits and beginning of Social Security – align with Social Security Normal Retirement Age of the member
  - LTD benefits currently end at age 65

- No benefit changes to life insurance

Questions?

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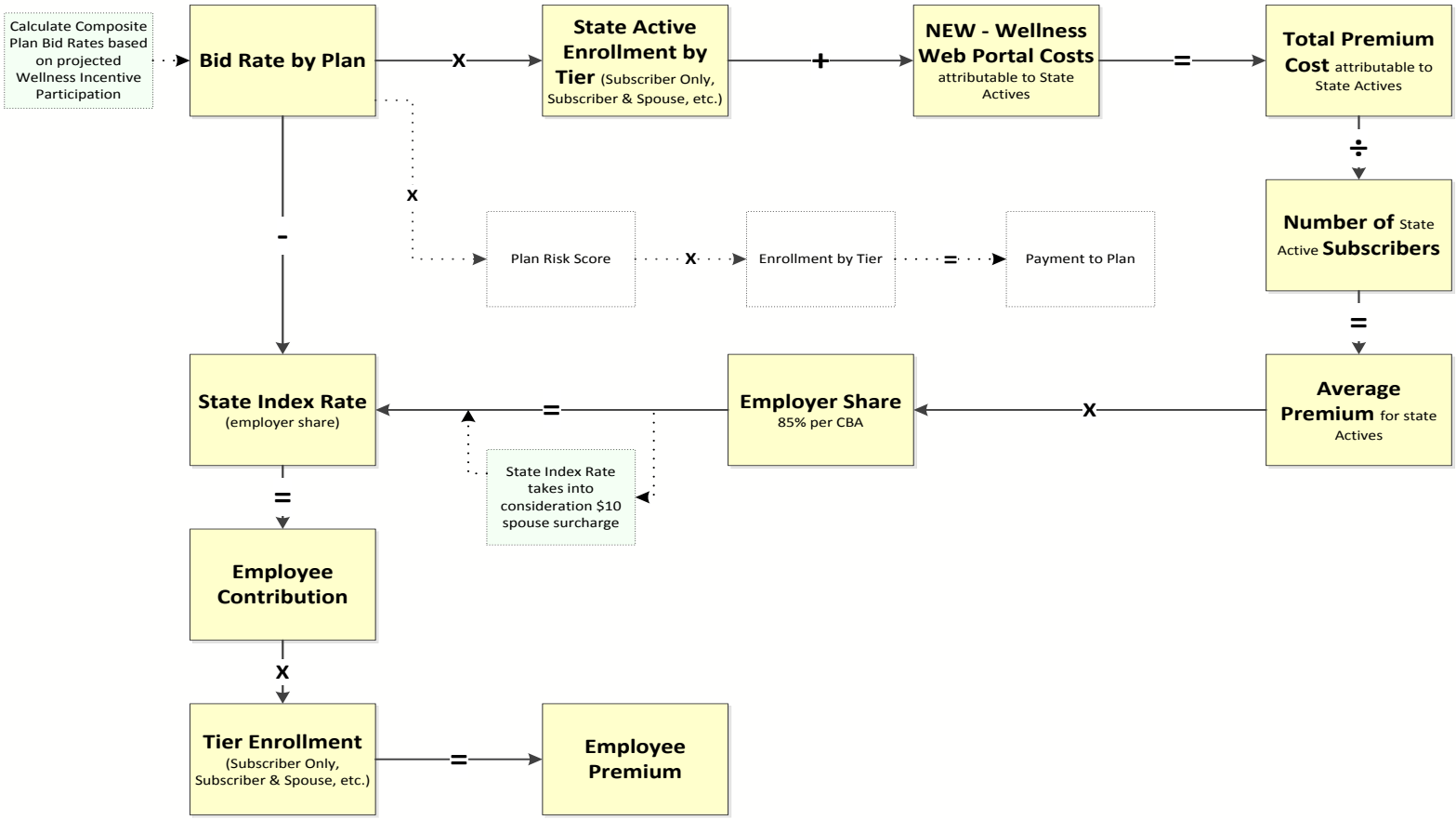
Washington State Health Care Authority

Premium Overview

Janice Baumgardt
PEBB Finance Section Manager
Division of Financial Services
July 16, 2014

Employee/Employer Premium Calculations
Weighted Average Method



Washington State Health Care Authority

SmartHealth Participation
as of July 7, 2014

	UMP Classic*	GH Classic	GH Value	Kaiser Classic	UMP CDHP*	GH CDHP	Kaiser CDHP	TOTAL
Eligible Subscribers	78,747	15,370	24,750	1,829	5,706	15,110	143	**128,055**
Positive Attestations	45,458	9,023	15,989	1,168	4,095	1,083	92	**76,908**
% Attested Positive	*58%*	*59%*	*65%*	*64%*	*72%*	*72%*	*64%*	***60%***
Verified Attestations	34,136	5,427	10,893	800	3,075	783	70	**55,184**
% Verified Eligible	*43%*	*35%*	*44%*	*44%*	*54%*	*52%*	*49%*	***43%***

- *Verification consists of verifying that subscribers who attested they would participate in SmartHealth completed a health risk assessment before June 30, 2014*
- *Subscriber participation will vary from adult unit participation as used in developing the composite rates and the state index rate*
- **UMP Classic and CDHP plan figures reflect HRA counts only – they have not been verified (i.e., cross-checked with attestations)*

SmartHealth Participation Assumptions

in State Index Rate & Composite Rate Development

	Without Incentive Participation Adult Unit Bid Rate	Composite Rate
Group Health Classic	$590.99	$593.32
Group Health Value	$560.06	$562.13
Kaiser Classic	$611.42	$612.56
UMP Classic	$568.34	$571.27
Group Health CDHP	$508.15	$511.88
Kaiser CDHP	$517.10	$520.83
UMP CDHP	$514.29	$518.02

- *Adult Unit Participation will differ from percent of subscriber participation because participation is not uniform among the tiers*
- *CDHP rates include HSA payments*
- *Payments to carrier will be risk-adjusted and based on actual wellness participation*
- *Composite Rate includes $1.14 for SmartHealth web portal*

Employee Contribution Calculations
Weighted Average Method

	Proposed 2015 Composite Rate per Adult Unit	Proposed 2015 Employer Contribution per Adult Unit (aka State Index Rate)	Proposed 2015 Employee Contribution (Single Subscriber)
Group Health Classic	$593	$487	$106
Group Health Value	$562	$487	$75
Kaiser Classic	$613	$487	$126
UMP Classic	$571	$487	$84
Group Health CDHP	$512	$487	$25
Kaiser CDHP	$521	$487	$34
UMP CDHP	$518	$487	$31
AVERAGE SUBSCRIBER CONTRIBUTION			$145

- *CDHP plans include HSA Payments*
- *Composite Rate includes $1.14 for SmartHealth web portal*

State General Government and Higher Education

Active Employee Monthly Premiums for Single Subscriber

				Amount of Proposed 2015 Employee Premium Attributable to:		
	% State Subscribers (April 2014)	2014	**Proposed 2015**	*ACA MOOP* (maximum-out-of-pocket) *Requirement*	**Add $2000 Rx MOOP**	**Changes to Exclusions**
Group Health Classic	12.1%	$118	**$106**	*n/a*	n/a	n/a
Group Health Value	19.9%	$65	**$75**	*n/a*	n/a	n/a
Kaiser Classic	1.5%	$116	**$126**	*n/a*	n/a	n/a
UMP Classic	60.1%	$79	**$84**	*+$1.15*	**-$1.04**	**$0.02**
Group Health CDHP	1.3%	$21	**$25**	*n/a*	n/a	n/a
Kaiser CDHP	0.1%	$23	**$34**	*n/a*	n/a	n/a
UMP CDHP	4.8%	$24	**$31**	*n/a*	n/a	**$0.01**

Average 15% Employee Contribution of Required Premium

Employer's 2015 CDHP HSA Contribution:

Without incentive: Subscriber only = $700.08 - Subscriber + 1 or more = $1,400.04

With incentive: Subscriber only = $825.08 - Subscriber + 1 or more = $1,525.04

State General Government and Higher Education

2015 Recommended Plan Design and Benefit Changes

	Subscriber		Subscriber & Spouse		Subscriber & Children		Full Family	
	2014	**Proposed 2015**	2014	**Proposed 2015**	2014	**Proposed 2015**	2014	**Proposed 2015**
	Employee Monthly Premiums							
Group Health Classic	$117	**$106**	$244	**$222**	$205	**$186**	$332	**$302**
Group Health Value	$65	**$75**	$140	**$160**	$114	**$131**	$189	**$216**
Kaiser Classic	$116	**$126**	$242	**$262**	$203	**$221**	$329	**$357**
UMP Classic	$79	**$84**	$168	**$178**	$138	**$147**	$227	**$241**
Group Health CDHP	$21	**$25**	$52	**$60**	$37	**$44**	$68	**$79**
Kaiser CDHP	$23	**$34**	$56	**$78**	$40	**$60**	$73	**$104**
UMP CDHP	$25	**$31**	$60	**$72**	$44	**$54**	$79	**$95**
	Some Employees will be subject to the following Surcharges (effective 07/01/14)							
Tobacco Surcharge	$25	**$25**	$25	**$25**	$25	**$25**	$25	**$25**
Spousal Surcharge			$50	**$50**			$50	**$50**

Non-Medicare Retirees
Monthly Premium for Single Subscriber

				Amount of Proposed 2015 Premium Attributable to:		
	% N-M Retiree Subscribers (April 2014)	2014	**Proposed 2015**	*ACA MOOP* (maximum-out-of-pocket) *Requirement*	**Add $2000 Rx MOOP**	**Changes to Exclusions**
Group Health Classic	10.5%	$589	**$600**	*n/a*	**n/a**	**n/a**
Group Health Value	14.1%	$537	**$568**	*n/a*	**n/a**	**n/a**
Kaiser Classic	2.5%	$588	**$619**	*n/a*	**n/a**	**n/a**
UMP Classic	70.6%	$551	**$578**	*+$7.71*	**-$6.96**	**$0.14**
Group Health CDHP	0.4%	$502	**$528**	*n/a*	**n/a**	**n/a**
Kaiser CDHP	0.1%	$504	**$537**	*n/a*	**n/a**	**n/a**
UMP CDHP	1.8%	$505	**$534**	*n/a*	**n/a**	**$0.06**

- *Rounded to nearest dollar*
- *Includes a $6.25 administrative fee per account*

Non-Medicare Retirees
2015 Recommended Plan Design and Benefit Changes

	Subscriber		Subscriber & Spouse		Subscriber & Children		Full Family	
	2014	**Proposed 2015**	2014	**Proposed 2015**	2014	**Proposed 2015**	2014	**Proposed 2015**
	Retiree Monthly Premiums (rounded to nearest dollar)							
Group Health Classic	$589	**$600**	$1,172	**$1,193**	$1,026	**$1,045**	$1,609	**$1,638**
Group Health Value	$537	**$568**	$1,068	**$1,131**	$935	**$990**	$1,466	**$1,552**
Kaiser Classic	$588	**$619**	$1,171	**$1,231**	$1,025	**$1,078**	$1,607	**$1,691**
UMP Classic	$551	**$578**	$1,096	**$1,149**	$960	**$1,006**	$1,504	**$1,577**
Group Health CDHP	$501	**$528**	$992	**$1,042**	$884	**$928**	$1,317	**$1,383**
Kaiser CDHP	$504	**$537**	$998	**$1,060**	$889	**$944**	$1,325	**$1,408**
UMP CDHP	$505	**$534**	$1,000	**$1,054**	$891	**$939**	$1,328	**$1,400**
	Some Retirees will be subject to the following Surcharges							
Tobacco Surcharge	$25	**$25**	$25	**$25**	$25	**$25**	$25	**$25**
Spousal Surcharge			$50	**$50**			$50	**$50**

- *Rounded to the nearest dollar & including a $6.25 administrative fee per account*

Estimated Medicare Retiree Premium
After Employer Contribution

	% Medicare Retiree Subscribers	2014	2015	Amount of 2015 premium attributable to $2000 Rx MOOP
Group Health	25.4%	$145	$148	**n/a**
Kaiser	2.8%	$153	$153	**n/a**
UMP Classic	60.6%	$224	$235	**$2.44**
Premera Med Supp F Retired	11.2%	$106	$113	**n/a**
Premera Med Supp F Disabled		$198	$219	**n/a**

- *Rounded to the nearest dollar*
- *Group Health and Kaiser Medicare Advantage rates subject to federal review and approval*
- *Employer contribution limited to the lesser of $150 or 50% of plan premium, per month*
- *Includes a $6.25 administrative fee per account*

Dental Premiums

		Subscriber		Subscriber & Spouse		Subscriber & Children		Full Family	
	% State Sub-scribers	2014	**2015**	2014	**2015**	2014	**2015**	2014	**2015**
Uniform Dental Plan	79.7%	$44.72	**$45.20**	$89.44	**$90.40**	$89.44	**$90.40**	$134.16	**$135.60**
Delta Care	8.6%	$39.53	**$39.53**	$79.06	**$79.06**	$79.06	**$79.06**	$118.59	**$118.59**
Willamette	11.6%	$43.23	**$42.37**	$86.46	**$84.74**	$86.46	**$84.74**	$129.69	**$127.11**

- *100% Employer-funded dental coverage for active employees and their dependents*
- *Retirees & other self-pay groups pay the full premium*

Life Insurance Premiums

--------BASIC – Employer Funded – No Change--------

	2010	2011	2012	2013	2014	2015
Monthly Premium	$5.07	$5.07	$4.08	$4.08	$4.08	$4.08
Coverage	• $25K Life • $5K AD&D					

--------Employee Supplemental Coverage – Employee Funded--------

Premium	• Based on age & tobacco usage					
Example	• *45-49 year old* • *Non-tobacco user* • *$250K coverage*					
	2010	**2011**	**2012**	**2013**	**2014**	**2015**
Rate per thousand ***Monthly Premium payment***	*.092* *$23.00*	*.078* *$19.50*	*.078* *$19.50*	*.078* *$19.50*	*.078* *$19.50*	*.095* *$23.75*
		2011 – 2014 - Rates artificially low **subsidized from reserves due to favorable experience**				

LTD Insurance Premiums

--------BASIC – Employer-Funded--------		
	2014	**2015**
Monthly Premium	$2.00	$2.10
Basic Coverage	• 90 day waiting period or when sick leave runs out, whichever is longer • Minimum $50/month & maximum of $240/month • In 2014, benefits end at age 65 • In 2015, benefits end when subscriber reaches SSNRA (Social Security Normal Retirement Age)	

--------Optional Employee Coverage--------		
Monthly Premium	• Based upon subscriber's retirement plan & waiting period selected	
Coverage	• Generally 60% of adjusted salary, up to $6000 per month • In 2014, benefits end at age 65 • In 2015, benefits end when subscriber reaches SSNRA (Social Security Normal Retirement Age)	
Example	• *Higher Education retirement plan* • *30 day waiting period*	
	2014	**2015**
Rate --- % of Income	*2.48%*	*2.60%*

NEXT STEPS

July 23: Call for Procurement Resolution Votes

- 2015 Medical Plan Benefit Recommendations
- 2015 Active Employee Premiums
- 2015 Explicit Employer Medicare Contribution

Questions?

More Information:

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Division of Financial Services
Janice.Baumgardt@hca.wa.gov
Tel: 360-725-9817

2015 Proposed Resolutions

1. Resolved**,** that the Non-Medicare and Medicare Uniform Medical Plans will administer a separate annual out-of-pocket maximum of $2,000 for members' prescription drug costs.
2. Resolved, that the Non-Medicare and Medicare Uniform Medical Plans will administer a benefit exceptions policy whereby Tier 3 non-preferred drugs that do not have a generic equivalent may be covered at the Tier 2 coinsurance level when medical criteria are met.
3. Resolved, that the Uniform Medical Plan (non-Medicare and Medicare) will change coverage to be more consistent with Regence Medical Policy for the following services:
    - Temporomandibular Joint (TMJ)
    - Home Health Services
    - Circumcision
    - Genetic testing
    - Orthotics to prevent complications associated with diabetes
    - Massage Therapy visits to exceed one hour when medical criteria are met

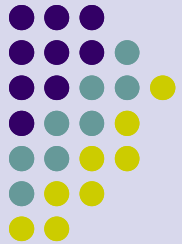
2015 Proposed Resolutions cont.

4. Resolved, effective January 1, 2015, the Uniform Medical Plan (Non-Medicare and Medicare) will cover mental health services and hormonal therapy for members with a diagnosis of gender dysphoria.
5. Resolved, that the non-Medicare Kaiser Permanente plan will not apply members out-of-pocket costs in the last quarter of the year toward the next year's deductible.
6. Resolved, that SmartHealth Program requirements are:
    - Complete the Well-Being Assessment
    - Earn the required number of points according to the SmartHealth Program and completion rules
7. Resolved, that the PEB Board endorses the Group Health Employee Premiums.
8. Resolved, that the PEB Board endorses the Kaiser Permanente Premiums.

2015 Proposed Resolutions cont.

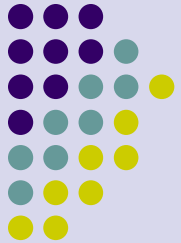
9. Resolved, that the PEB Board endorses the Uniform Medical Plan Employee Premiums.
10. Resolved, that the PEB Board endorses the maximum $150 Employer Medicare Contribution, not to exceed 50% of plan premium, set forth in the legislative budget appropriation.

HIPAA/HITECH—Health Information Privacy and Security



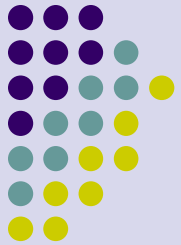
Melissa Burke-Cain, Senior Counsel
Washington State Office of the Attorney General
PEB Board Meeting—July 16, 2014

Goals for this HIPAA/HITECH Training—Just the Basics



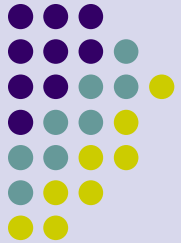
- Ensure the Board's basic knowledge in three areas:
  - HIPAA and HITECH responsibilities for personal and health information.
  - Privacy and permitted use and disclosure.
  - Security for electronic and physical records.
  - What to do if you receive protected health information.

Which entities/functions are subject to HIPAA/HITECH?



- “Covered Entities” including Health Plans, Providers; Business associates;
- Employers have limited access;
- Americans With Disabilities Act protects health information in personnel files;
- Limits on sharing between “covered entities” and employer.
- HCA is employer-sponsor, employer, and plan.

What is “Protected Health Information”?



- Individually identifiable—information received from a covered entity whether written, spoken, or electronic form.
- Related to past, present, or future physical or mental health condition, his/her health care, payment for health care received.
- That identifies the individual or could reasonably identify the person.

PHI Examples

- Individual's name, address, birth date, age, telephone/fax number when associated with health information.
- Medical records, diagnosis, medical imaging, lab and test results, prescriptions.
- Claims records, referrals, explanation of benefits, incident reports.
- Research records containing individual identification.

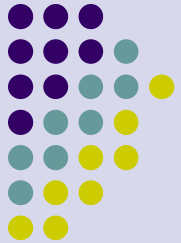
Use and Disclosure

- Exempt from authorization: treatment, payment, plan operations;
- Permissive disclosure; or
- Disclosure required by law; or
- Patient gives written authorization.
- Incidental disclosure—patient sign in, confirming admission, close family;
- Only as required for job responsibilities.

Privacy— Unauthorized Use or Disclosure

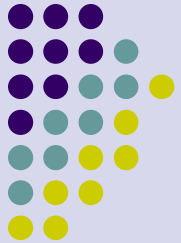
- Civil and Criminal Penalties;
- Federal OCR Audit and Evaluation of All HIPAA procedures for privacy and security.
- Treat PHI as if it is your own PHI.
- Consider surroundings—public places, theft potential, put the file away.
- How secure is the electronic transmission and storage?

Security– Transmission, Use, and Storage.



- Computer theft, paper work left on a bus, misdirected emails;
- Physical and Electronic data or information;
- Limited access work sites, password protected printers;
- Password and encrypted emails, CDs, flash drives;
- Secure within the state's secure network.

HIPAA Breach Presumption—Breach Mitigation



- Unauthorized access, use, or transmission of PHI is presumed a HIPAA breach.
- 4 mitigation factors:
  - Information nature, scope, identifier type;
  - Who is responsible for the error;
  - “theoretical” vs. actual use or receipt;
  - Fast and effective mitigation efforts;
- Caution—shared password, forwarding, reply all.

Where does the PEB Board fit in?

- What is the PEB Board's role and responsibility under HIPAA/HITECH for use and disclosure of protected health information?
- Privacy
- Security
- Breach

PEB Board and HCA

- The Board is part of the HCA—RCW 41.05.055.
- Board authority is statutory—RCW 41.05.065.
- All Board members have non-board positions that may include access to protected information.
- Consider function and business purpose for receipt and use of protected information.

PEB Board Membership

- 41.05.055
- (1) The public employees' benefits board is created within the authority. The function of the board is to design and approve insurance benefit plans for employees and to establish eligibility criteria for participation in insurance benefit plans.

PEB Board Authorizing Law

- The board shall study all matters connected with the provision of health care coverage…employees and their dependents (and retirees) on the best basis possible with relation both to the welfare of the employees and to the state.

Development of Benefit Plans

- The board shall develop employee benefit plans that include comprehensive health care benefits for employees. In developing these plans, the board shall consider…

- Board responsible for design, structure, scope, eligibility within statute's limits; HCA administers the benefits and promulgates administrative rules.

- (a) Methods of maximizing cost containment…access to quality health care;
- (b) provider arrangements…prepaid delivery systems and prospective payment methods;
- (c) Wellness incentives…
- (d) Utilization review procedures…

- (e) Effective coordination of benefits; and
- (f) Minimum standards for insuring entities.

- (3)…maintain the comprehensive nature of employee health care benefits, benefits provided to employees shall be substantially equivalent to the state employees' health benefits plan in effect on January 1, 1993.

Employee Share of Cost

- …changes or increases in employee point-of-service payments or employee premium payments for benefits or the administration of a high deductible health plan in conjunction with a health savings account.

- But…there are additional limitations as part of labor relations…

- The board may establish employee eligibility criteria which are not substantially equivalent to employee eligibility criteria in effect on January 1, 1993.

- (4) Except if bargained for under chapter 41.80 RCW, the board shall design benefits and determine the terms and conditions of employee and retired employee participation and coverage…

- Employer groups obtaining benefits through contractual agreement with the authority for employees defined in RCW 41.05.011(6) (a) through (d) may contractually agree with the authority to benefits eligibility criteria which differs from that determined by the board.

Other State Laws

- Board work conducted in public—Open Public Meetings Act RCW 42.30.
- Board records subject to Public Records Law—RCW 42.56.
- Ethics in Public Service—RCW 42.52.
- State health records privacy law—RCW 70.02.
- Attorney/Client privilege and work product.

Bottom Line

- Protect as if it were your own information.
- HCA has all procedures in place—privacy officer, security officer.
- Use/disclosure includes looking at PHI, talking about PHI, using PHI, sharing PHI with others in hard copy, electronically.
- Contact Lou McDermott with questions and need for help; also contact AAGs.

If you need help be ready with:

- How you received the information;
- Who sent it to you and why;
- Is there a business purpose for use;
- part of non-PEBB function or PEBB role;
- How has it been disclosed and to whom.
- Err on side of caution/non-disclosure.
- Notify as soon as reasonably possible—quick action for more effective mitigation.

Summary —PEBB risk is low but not zero

- Privacy—individual identity and health status.
- Minimum necessary and de-identified information.
- Password protect and encrypted transfer.
- Physical and electronic security—misplaced in public places, lost or stolen devices.
- Ask questions; err on side of protection.
- Notify HCA as soon as possible.

Washington State Health Care Authority

Transgender Health Care

Dan Lessler, MD
Chief Medical Officer
July 16, 2014

Transgender Benefit

- Diagnosis and treatment of gender dysphoria is consistent with best evidence
- HCA will implement a comprehensive transgender health care benefit
- Designing a medical benefit will require stakeholder input, a thorough evaluation of clinical evidence and potential costs, and thoughtful implementation strategies

Transgender Health Care Benefit

- January 1, 2015
  - Implement mental health and hormonal therapy benefit for people with gender dysphoria
- January 1, 2016
  - Implement surgical care benefit for people with gender dysphoria

Questions?

Daniel Lessler, MD, MHA
Chief Medical Officer
email@hca.wa.gov
Tel: 360-725-1612

Non-Medicare and Medicare Plan Design Resolution #4

Resolved, effective January 1, 2015, the Uniform Medical Plan (Non-Medicare and Medicare) will cover mental health services and hormonal therapy for members with a diagnosis of gender dysphoria.

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

2015 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 29, 2015 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 31, 2015 (10:00 a.m. – 12:00 p.m.)

April 15, 2015

May 27, 2015

June 24, 2015

July 8, 2015

July 15, 2015

July 22, 2015

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

Updated 7/15/14