

Public Employees Benefits Board Meeting

April 15, 2020

Public Employees Benefits Board

April 15, 2020

12:00 p.m. – 3:30 p.m.

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

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TAB 1

AGENDA

Public Employees Benefits Board
April 15, 2020
12:00 p.m. – 3:30 p.m.

**Aligning with [Governor's Proclamation 20-28](#),
all Board Members and public attendees
will only be able to attend telephonically.**

To attend telephonically:
Call-in Number: 1-866-374-5136
Participant PIN Code: 95587891

12:00* p.m.	Welcome & Introductions		Sue Birch, Chair	
12:10 p.m.	Executive Session			
1:00 p.m.	Meeting Reconvenes		Sue Birch, Chair	
1:05 p.m.	Meeting Overview		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information/ Discussion
1:10 p.m.	Approval of Meeting Minutes: April 24, 2019 May 21, 2019 June 5, 2019 June 19, 2019 July 10, 2019 January 30, 2020	TAB 3	Sue Birch, Chair	Action
1:15 p.m.	Legislative Update • 2020 Supplemental Budget • Bills	TAB 4	Tanya Deuel, ERB Finance Manager Cade Walker, Special Assistant Employees & Retirees Benefits (ERB) Division	Information/ Discussion
1:35 p.m.	Expanding PEBB Medicare Options Update	TAB 5	Ellen Wolfhagen, Senior Account Manager, ERB Division	Information/ Discussion
1:45 p.m.	Eligibility & Enrollment Policy Development	TAB 6	Rob Parkman, Policy & Rules Coordinator, ERB Division	Information/ Discussion/Action

2:05 p.m.	UMP Additional Plan Proposal	TAB 7	Lauren Johnston, SEBB Senior Account Manager, ERB Division Shawna Lang, UMP Account Manager, ERB Division Tanya Deuel, ERB Finance Manager	Information/ Discussion
2:35 p.m.	UMP Vision Proposal	TAB 8	Shawna Lang, UMP Account Manager, ERB Division	Information/ Discussion
2:50 p.m.	HCA Legislative Report on Consolidating the PEBB & SEBB Programs	TAB 9	Marcia Peterson, Manager Benefits Strategy & Design Section, ERB Division	Information/ Discussion
3:10 p.m.	Public Comment			
3:30 p.m.	Adjourn			

***All Times Approximate**

The Public Employees Benefits Board will meet telephonically on Wednesday, April 15, 2020. Due to COVID-19 and [Governor's Proclamation 20-28](#), Board Members and the public will only be able to attend this meeting via telephone.

The Board will consider all matters on the agenda plus any other emergency COVID-19 items that develop after publication of this agenda.

Pursuant to RCW 42.30.110(1)(l), the Board will meet in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at 12:10 p.m. and conclude no later 1:00 p.m.

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/> by close of business on April 13, 2020, or as soon as possible in the event of additional COVID-19 matters materialize before the meeting convenes.

PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8 th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 sue.birch@hca.wa.gov	Chair
Leanne Kunze, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 leanne.kunze@hca.wa.gov	State Employees
Elyette Weinstein 5000 Orvas CT SE Olympia WA 98501-4765 V 360-705-8388 elyette.weinstein@hca.wa.gov	State Retirees
Tom MacRobert 4527 Waldrick RD SE Olympia WA 98501 V 360-264-4450 tom.macrobot@hca.wa.gov	K-12 Retirees
Tim Barclay 9624 NE 182 nd CT, D Bothell WA 98011 V 206-819-5588 tim.barclay@hca.wa.gov	Benefits Management/Cost Containment

PEB Board Members

Name

Representing

Yvonne Tate
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*non-voting members

4/10/20



Washington State Health Care Authority
Public Employees Benefits Board

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360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

PEBB MEETING SCHEDULE

2020 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.

January 30, 2020 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 18, 2020 - Noon – 5:00 p.m.

April 15, 2020 - Noon – 5:00 p.m.

May 28, 2020 - Noon – 5:00 p.m.

June 17, 2020 - Noon – 5:00 p.m.

July 15, 2020 - Noon – 5:00 p.m.

July 22, 2020 - Noon – 5:00 p.m.

July 29, 2020 - Noon – 5:00 p.m.

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

7/2/19

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 09, 2019

TIME: 1:23 PM

WSR 19-15-020

TAB 2

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

DRAFT
Public Employees Benefits Board
Meeting Minutes

April 24, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:15 p.m.

Members Present:

Lou McDermott, Chair Pro-Tem
Tom MacRobert
Harry Bossi
Tim Barclay
Greg Devereux
Carol Dotlich
Yvonne Tate

Members via Phone:

Myra Johnson

PEB Board Counsel:

Michael Bradley, Assistant Attorney General

Call to Order

Lou McDermott, Chair Pro-Tem, called the meeting to order at 1:31 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda.

Approval of March 20, 2019 PEB Board Minutes

Greg Devereux moved and Harry Bossi seconded a motion to approve the March 20, 2019 PEB Board Meeting Minutes as written. Minutes approved by unanimous vote.

March 20, 2019 Meeting Follow Up

Dave Iseminger: Slide 2 is a link to the Washington Health Alliance report referenced in presentations from the last few meetings, “First, Do No Harm.” Marcia Peterson will address pharmacy questions in her presentation.

PEBB Finance 2019-21 Budget Update

Tanya Deuel, PEBB Finance Manager, Financial Services. There are only a few days left of the regular legislative session. Today's presentation does not have final budget numbers.

Slide 2 – Proposed Funding Rates. These are per employee per month and paid to the Health Care Authority (HCA) by state agencies for employees' coverage of medical, dental, life, LTD, etc. We intentionally left numbers off this slide because, in all three of the proposed budgets, there are different numbers. There are multiple underlying assumptions that develop these funding rates, and they are different in the three versions of the budget. The important issue is all three budgets are adequate to maintain the current level of benefits. We have no significant concerns with those rates or underlying assumptions.

Slide 3 – Medicare Explicit Subsidy. The box on the far left is the current Medicare explicit subsidy amount, which is \$168.00, or 50% of the premium, whichever is lesser. As you move from left to right, the boxes show the three proposed budgets numbers. The \$168 amount is the same in the Governor's and Senate's proposed budgets. The House proposed budget increased the amount to \$183.00.

Slide 4 – Decision Package Funding. There were three decision package requests from HCA. All three proposed budgets agreed on the decision packages.

1. Third Party Administrator Fees (TPA) for the Uniform Medical Plan, Uniform Dental Plan, and Flexible Spending Arrangement admin fees. These are increases to the HCA spending authority for these accounts.
2. Centers of Excellence is associated with our current total joint replacement and spinal fusion bundles, as well as funding for launching a potential third bundle in plan year 2021.
3. ERB Staffing is for additional FTEs and costs associated with customer service staff for retiree support and additional outreach and training for increased responsiveness.

Slide 5 – Other Budget Language. The three items listed are not tied specifically to a decision package. Again, all three proposed budgets agreed on these items.

1. Nutritional Counseling Visits. Beginning plan year 2020, funding was included to increase the nutritional counseling visits in the Uniform Medical Plan from three to twelve, lifetime.

Dave Iseminger: Assuming this is in the final operating budget, we would bring a resolution for the Board to take action on to make the benefit change later in this Board season.

Tanya Deuel: 2. The same would be true for Long-Term Disability (LTD). There was language in all the budgets included to allow the Board to increase the basic LTD budget, as long as it remained cost-neutral within the program.

3. Collective Bargaining Impacts. This transfers funding to HCA for the FSA contribution that was in the Collective Bargaining Agreement, which is the \$250 contribution for represented employees who make less than \$50,004 annually.

Dave Iseminger: Last night we realized there was one typo. Your Briefing Books in front of you are correct. We had accidentally typed \$3 million per calendar year, when it's \$6 million per calendar year. The website will be updated by the end of the week. It's different from the version that was sent to you in advance of the meeting.

Tanya Deuel: Slide 6 – Proposed Budget Differences. This is where the budgets differ. Two decision packages were submitted where the budgets differ. The first one on the left in the green box is the Medicare Retiree Portfolio. This was the administrative dollars associated with HCA procuring a new Medicare product. The Governor's budget included the funding of \$1.5 million, and the house and senate proposed budgets did not include funding.

Dave Iseminger: Our understanding is if there isn't funding in the budget, HCA has the ability to use existing resources for this work. Not putting money in the budget was not intended to prohibit the Board or the agency from doing work in this area. If the agency wanted to work on a procurement within existing resources, that would be allowed.

Tanya Deuel: The last difference was the Pay1 Replacement decision package. The Governor's budget included \$150,000 for HCA to conduct an independent assessment and evaluation in consultation with the Office of the Chief Information Officer (OCIO), and report back to the Governor's Office in September 2019. The House and Senate did not include this funding.

Dave Iseminger: Pay1 is currently 44+ years old. It will probably reach at least 47+ years since there is no anticipated, specific funding for a replacement in the 2019-21 biennium. The earliest there would be funding would be to begin a replacement project in late calendar year 2021. We're currently assessing what types of critical changes might need to be replaced in the interim to ensure the system remains functional as we continue talking about a replacement.

Legislative Update

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division. We are on day 101 of 105 days of the regular session of the Legislature.

Slide 2 – Number of Bills Analyzed by ERB Division. As of this morning, we had conducted 315 bill analyses. Last week's counts were: 125 lead analyses, with 37 being high impact. We were support for 179 analyses.

Slide 3 – Legislative Update – ERB High Lead Bills. We started closely tracking 37 high-priority bills. As of this afternoon, five high-impact bills have passed and been signed by the Governor. House Bill 1913 we won't talk about, but it's related to the occupational diseases for fire fighters and law enforcement, in consideration for their retirements. The others I'll discuss shortly. The numbers have cascaded since the beginning of session and Slide 3 shows bills' status.

Slide 4 – PEBB Program Impact Bills. These bills are not currently moving. They have stalled in their committee or their originating house. The only one of note that may have action relates to House Bill 1220, adding a representative from the Office of the Insurance Commissioner to the PEB Board. It was on roll call last week but did not make it to a vote. We'll continue to monitor.

Dave Iseminger: Generally, the Legislature determines when bills have to pass different thresholds. The funnel on Slide 3 represents that. Pretty much all of the bills on Slide 4 are at a point in the legislative session that if it's not necessary to implement the budget, it can't be voted on under the rules they've imposed on themselves.

Cade Walker: There are two bills identified as having an impact on the SEBB Program. One is House Bill 2140 related to K-12 education funding addressing levies, which goes to financing. Senate Bill 6011 would consolidate all of the K-12 employees into PEBB. We determined the impacts it would perceivably have on the program, combining the entirety of the K-12 population with the PEBB Program, while establishing new criteria for all K-12 employees. It is substantially different from the criteria currently under development for the SEBB population, as well as restricting accessibility to certain groups. Substitute teachers would be excluded from eligibility. We haven't seen any additional movement on that particular bill since it was introduced. However, as of yesterday, Senate Bill 6020 was introduced with a similar flavor to SB 6011, except it does not consolidate the programs. It keeps the programs separate, but the eligibility that was included in SB 6011 was carried forward into this other bill. It would keep SEBB as SEBB and assign a new set of eligibility criteria for the SEBB population. It also has a few technical corrections that would be helpful for the Program but aren't necessarily related to the administration of PEBB or SEBB.

Harry Bossi: Cade, could you tell me on the cascading piece where SB 6011 falls and where SB 6020 falls?

Cade Walker: Because they were introduced after the cut-offs, I don't think they've even made it out of the originating chamber.

Dave Iseminger: That's correct, Cade. They were introduced and referred to their origin chamber Fiscal Committee. They have not had hearings and are not reflected in these numbers because the bills are so new they were introduced after these slides were made.

Myra Johnson: Do you think there will be hearings on SB 6011 or SB 6020?

Dave Iseminger: There is no indication SB 6011 will have a hearing. Senators Mullet and Braun introduced the bill. We provided context to them about some of the extraordinary challenges to consolidating both programs 118 business days before open enrollment. The bill would have made the consolidation effective January 1, 2020. It would be virtually impossible to make that consolidation happen so quickly.

SB 6020 was the next iteration of a bill by the same senators that did a lot of the functional eligibility pieces of SB 6011, but removed the PEBB consolidation overlay. It's fair to say this won't be the last time we hear about combining the programs.

Myra Johnson: I was concerned about that timeline. Thank you.

Cade Walker: We had similar concerns.

Dave Iseminger: On the plus side, Myra, you would have instantly become a voting member of this Board.

Myra Johnson: I know, I was thinking about that! Thanks.

Carol Dotlich: Are you saying all of the SEBB Program impact bills are also sitting idle and not moving?

Dave Iseminger: That is correct, Carol. However, because of the large impacts this has to the operating budget, any changes to the SEBB Program would be necessary to implement the budget. Anything could happen at any point before they adjourn. As a reminder, the SEBB Program and Board were created on June 30, 2017, introduced and passed in House Bill 2242 the day it was introduced.

Until the program is up and running, anything that would alter the financial obligations of the state would likely be deemed necessary to implement the budget. Just because those bills were introduced late does not mean, if there wasn't a critical mass of legislators that wanted to pursue them, they would be bound by their own rules, because they would need it in order to reach a budget agreement.

Cade Walker: We're keeping our eyes on these to make sure we see what's happening with these critically important bills.

Slide 6 – ERB Impact Bills. These bills have a programmatic, administrative impact that touch on both the PEBB and SEBB populations and programs. The bolded bills, 2SHB 1065, HB 1074, HB 1099, and SB 5889 passed and have been signed by the Governor. We are currently evaluating what those impacts are to the program and making plans for implementation of aspects that are necessary. HB 1074 raises the tobacco purchasing age from 18 to 21 and incorporates vapor products into their definition of prohibited sales until age 21. We perceive it will have some potential impacts for the PEBB and SEBB Programs given the state raised the age for purchasing tobacco, but we don't believe it will be significant.

There was additional legislation introduced to amend HB 1074. There may be changes to the overall impact of raising the tobacco purchasing age. It may still come up before the end of session.

Dave Iseminger: The tobacco purchasing age was raised. We don't believe it has a direct implication on the surcharge, the eligibility requirements for the surcharge, and the definition of tobacco products. The other bill that Cade's alluding to is the potential taxation by the state of vapor products. It involves additional taxes that could be passed as part of balancing the budget. If that goes into effect, we'll look more deliberately at vapor products, which you may remember are not included with the definition of tobacco products for the tobacco surcharge. As the world changes around vapor products, we will continue to bring back to the Board any policy refinements for your input.

Cade Walker: We continue to follow Senate Bill 5526 which is the current bill being used to push forward the Cascade Care Governor's public option. We are tracking but we don't believe it will have impacts to the SEBB or PEBB population. We would be lending our expertise as commercial benefits purchasing commercial insurance procurements.

Slide 7 – ERB Topical Bills. Senate Bill 5602 - Eliminating barriers to reproductive health for all. We continue to track the amendments and movement of that legislation. House Bill 2154 – Abolishing abortion, was introduced late in the session. It has not moved from its current position from our last conversation. We are monitoring several pharmacy bills to see where they end up.

Tom MacRobert: Cade, can you just give us an idea of where the pharmacy bills are now?

Dave Iseminger: While Cade's gathering his thoughts, I realized we didn't say in the beginning of the presentation anything that's in italics is still in motion and being debated by the Legislature and, under their own rules, can still pass. Anything not in italics has essentially not met one of those cut-offs; and therefore, unless it's deemed necessary to implement the budget, wouldn't be passed at this point. There are only two of the four pharmacy bills still in play at this point, HB 1224 and HB 1879.

Cade Walker: They are on the potential list of passing before the end of session. They still actively have amendments and working strikers being done to them. They could move very quickly at any moment from the originating chamber and move all the way through the Legislature.

Dave Iseminger: The general theme, Tom, is more about price transparency. They all are generally trying to shine that light on what the cost of drugs are at this point. It hasn't gotten into a substantial policy debate beyond that transparency aspect.

Wellness Resolution

Marcia Peterson, Manager, Benefits Strategy and Design Section. I will review the Wellness resolution previously discussed for you to take action on today.

Slide 2 – SmartHealth Incentive Deadline. I want to remind you what our journey has been with the SmartHealth incentive deadline over the years of the program, which began in 2015. In 2015, members had until June of that year to complete the requirements to earn their incentive for the next year. In 2016, the Board lengthened the deadline to September 30 through 2019, to earn the \$125 incentive for the next year.

For 2020, we're proposing to lengthen the deadline to the end of November. We've worked with the carriers and talked through the operations. We've done this enough years that we feel comfortable extending it until then. We're excited that members will have pretty much a full year to continue with their wellness activities.

Lou McDermott: Policy Resolution PEBB 2019-02 – Deadline for Completing Wellness Activities

Resolved that, effective January 1, 2020, to receive a Public Employees Benefits Board (PEBB) Wellness Incentive in the following plan year, eligible subscribers must complete PEBB Wellness Incentive Program requirements by the following deadline:

- For subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30.
- For subscribers enrolling in PEBB medical with an effective date in October through December, the deadline is December 31.

Greg Devereux moved and Tom MacRobert seconded a motion to adopt.

Tim Barclay: I'm curious why we have this one-month difference between these two. Is the potential confusion for having two different deadlines really a value add?

Dave Iseminger: Right now, if you went back to the resolution that was passed in 2016, there's actually three different sub-bullets. When originally developing the Wellness Program, the Board expressed a desire to have wellness promoted throughout the year as much as possible. Originally, there were core requirements that, if you began at the beginning of the year, you knew what the rules were. But, as you joined the program later in the year based on when you were hired, the time was shorter for you to complete the same robust level of requirements. An alternative deadline set to accommodate those who came on benefits at the end of the year. At the end of the calendar year, we had to be done, award incentives, and move to the next calendar year.

Over time, we went from a six-month deadline with the core population and a six-month alternative shorter window. In 2016, it became nine months for the core part of the population and three months for newly benefits eligible employees. Now we're at eleven months and one month. It still gives an opportunity for people who begin employment in October to meet requirements and get an incentive. The effective dates for medical are really rooted in when somebody is joining the PEBB Program and getting benefits.

We tried to ensure there's at least a 90-day window for people to get all the requirements done. If you were hired after October 1, you effectively don't have 90 days. We wanted to be clear that the 90 days doesn't shift and leapfrog over the calendar year. It just cuts off on December 31.

Did that answer your question?

Tim Barclay: I guess what you're saying is that extra month to go from November to December is material for people who come on in October and later.

Dave Iseminger: Yes. And for the bread and butter employee who's joined, they're only being told about the November 30 deadline. It's people who are hired at the end of the year that get notice they are treated special while they are onboarding onto PEBB benefits. Once January hits, they're treated just like everybody else under the first clause. Thank you for summarizing for me.

Tim Barclay: Okay. Thank you.

Marcia Peterson: Lou, may I make one other point? I said last time that the SEB Board passed this resolution on January 24. I think it was of this year.

Lou McDermott: And we are just modifying it?

Dave Iseminger: The SEB Board passed a resolution that sets up this timeframe. Now we're bringing this as something we've learned after talking with the carriers, to give the same opportunity to you. If this resolution passes, the two programs would align.

Voting to Approve: 7

Voting No: 0

Lou McDermott: Policy Resolution PEBB 2019-02 passes.

Long-Term Disability Insurance

Kimberly Gazard, Contract Manager, ERB Division. Today, we will discuss a long-term disability insurance one-time enrollment opportunity that took place last month, recap the Washington Paid Family and Medical Leave, and the 90-day waiting period adjustment. Beth Heston will review the current PEBB Program plan design and timeline for approving the Basic LTD benefit changes.

Slide 3 – Resolution PEBB 2018-05. The Board passed Resolution PEBB 2018-05 - LTD One-time Enrollment Opportunity, during the first quarter of 2019. In March, the PEBB Program offered all eligible employees a one-time opportunity to purchase additional LTD insurance, increase their optional LTD insurance, and/or change their benefit-waiting period without providing evidence of insurability. Changes made will be effective May 1, 2019.

PEBB Program members had a one-time open enrollment opportunity to enroll in supplemental LTD, or to reduce their waiting period without evidence of insurability. Members were not required to participate in the enrollment opportunity. Members had the option to select from 90, 120, 180, 240, 300, and 360 days as their waiting period. 30- and 60-day waiting periods were not available as an option due to the Washington Paid Family and Medical leave, which starts January 1, 2020.

Slide 5 – When is evidence of insurability (EOI) required? Evidence of insurability is not required during a subscriber's initial eligibility period, within 31 days after becoming eligible for benefits. Evidence of insurability is normally required for any waiting period reduction. For example, if a subscriber had a waiting period of 120 days and wanted to change it to 90 days. It's also required when enrolling in supplemental LTD after the 31-day period when a subscriber becomes initially eligible for benefits.

Dave Iseminger: Effectively, since 1977, those last two pieces on Slide 5 are the rules of the road for every employee that has joined the state. What this Board authorized last July was this one-time fresh bite at the apple where you don't have to go through medical underwriting. It was the first time in roughly 41 years. I know we shared this opportunity with the Board very late in the Board season last year. But when Standard

brought us the opportunity, we wanted to take advantage of it despite all the other work that's going on with the programs. I'm excited that Kimberly is going to share our results to date. Typically, for the last 41 years, those outside the 31-day window have had to go through medical underwriting. This was the first-in-a-generation opportunity to have a new bite at the apple.

Kimberly Gazard: Slide 6 – LTD One-time Enrollment Communication. Slide 6 is a snapshot of the communication approaches that occurred for the LTD open enrollment. It was a team effort by the ERB Division, agencies, employer groups, higher education institutions, and unions. The Standard had direct mailing communications to eligible employees. The ERB Division worked with Limeade to offer a SmartHealth activity tile that provided information about the one-time open enrollment opportunity and a link to the Standard's website to utilize an LTD calculator. This LTD calculator allows you to estimate the amount of income you will need to replace if you become unable to work due to a disability. The ERB Outreach and Training Unit provided employers training and email templates to assist them in communicating with their employees.

Dave Iseminger: We used these communication tactics when the PEBB Program relaunched the life insurance benefit during the 2016 open enrollment. We took those efforts that led to a very successful open enrollment where we had an additional \$9 billion worth of coverage added due to employees' new elections. We didn't want to reinvent the wheel.

Kimberly Gazard: Slide 7 – Employee Supplemental LTD Enrollment Preliminary Results. The Standard typically sees between an 8% and 15% increase in participation during open enrollment efforts. The PEBB Program surpassed the typical percentages with a 16.4% increase. After March 31, 45,838 subscribers enrolled in supplemental LTD out of 138,953 eligible subscribers. Enrollment changes can take up to 90 days to be keyed after the form is submitted, which is June 29, 2019. March is off-season for the benefits activity in the PEBB Program, so we believe keying will be faster. We expect the enrollment number to increase once the results are final.

Dave Iseminger: We made a particular outreach to employers to encourage them to key as fast as possible because the benefit goes into effect May 1, 2019. It would be ideal to have the keying complete before May 1. That will make those deductions taken in a timely manner rather than having to do a double payment in the month of June. This was a paper-based enrollment system. Hopefully, we can modernize the process for future elections through PEBB My Account features. We're building that feature for the SEBB My Account.

Kimberly Gazard: Slide 8 – March 2019 – Preliminary Results. This slide breaks down the preliminary enrollment results by group. The state agencies had 3,492, higher education had 2,618, K-12 had 30, and other employers had 330, totaling 6,470. These results are as of April 18 and do not include individuals who reduced or changed their waiting period.

Slide 9 – Benchmarking our LTD Participation. The Standard typically sees between 25% to 35% participation rates for similar situated public sector clients and plans. As of March 1, the PEBB Program had a 28% utilization. As of March 31, the PEBB Program utilization was 33%.

Slide 10 – Washington Paid Family and Medical Leave Act (PFMLA). The Employment Security Department presented information on the Washington Paid Family and Medical Leave Act to the PEB Board in January 2019. This slide recaps that presentation. Washington workers will be able to use the Paid Family and Medical Leave benefits starting January 1, 2020. These benefits generally allow up to 12 weeks, 90 days, of paid leave per year to care for yourself or your family. This is a statewide insurance program, so workers and employers will contribute premiums together through payroll withholding. The rate for 2019 is 0.4% of a worker's wage, about 63% paid by the worker and about 37% paid by the employer. Premium collection started on January 1, 2019.

Dave Iseminger: We wanted to recap Paid Family and Medical Leave for the next series of slides. It's to focus on the middle bullet that talks about this new benefit which is essentially a 90-day short-term disability benefit. Any income an employee receives under PFMLA gets deducted from the calculations of the long-term disability benefit.

There's a need to no longer allow people to enroll in a 30- or 60-day waiting period. If they did, they would be paying for a benefit they would never realize. The amount of money under the Paid Family and Medical Leave Act gets deducted from their LTD payment. Kimberly will go into more detail about changing 90-day waiting periods so things dovetail better with the new ESD benefit.

Kimberly Gazard: Slide 11 – 90-Day Waiting Period Adjustments. PEBB Program members who have not changed their 30- and 60-day waiting periods to 90 days or longer will be adjusted to 90 days on January 1, 2020. The 90-day waiting period will then dovetail with the PFMLA. The ERB Division will communicate the adjustment to the 90-day waiting period change during the 2019 annual open enrollment.

In December 2019, the ERB Division will audit how many PEBB Program members have not changed their waiting period and we will notify them we have automatically adjusted their waiting period to 90 days and provide the members with their new rate. Members will pay a lower rate after the adjustment. At this time, there are 6,465 subscribers with a 60-day waiting period, and 4,829 subscribers with a 30-day waiting period. The number of subscribers with a 30- and 60-day waiting period, shown on this slide, does not reflect any waiting period changes that occurred during the open enrollment last month.

Dave Iseminger: We are saying these roughly 11,000 subscribers, if this adjustment wasn't made for them the same time the Paid Family and Medical Leave benefit goes into effect, they would be paying a higher rate for a benefit they would never realize. That's why we want to make sure people understand it's not taking something away from them, it's ensuring they aren't paying for something they're never going to receive. Those who are shifted to this 90-day waiting period will have a payroll deduction for LTD go down from what they are currently paying.

Lou McDermott: Actually, they are paying for it out of a payroll deduction. They're double paying.

Dave Iseminger: If we didn't do the adjustment, they would pay their portion at 0.4 payroll tax for the Paid Family and Medical Leave and they would pay for this shorter

waiting period LTD benefit, which they would never realize. They can't opt out of the Paid Family and Medical piece.

Beth Heston, PEB Procurement Manager, ERB Division: The 30- and 60-day waiting periods are the most expensive for premium. It's a win all the way around if people switch to 90 days.

Dave Iseminger: We will bring you final results in July, after the keying period has ended.

Beth Heston: Slide 12 – Improving the Basic LTD Benefit. We've spoken before about ways to go about improving the basic LTD benefit. I brought information today for you to consider.

Slide – 13 – Current Basic and Supplemental LD Design. Currently, Plan A (Basic insurance) pays 60% of the first \$400 of your pre-disability earnings. The maximum it will pay is \$240 a month. Plan B (Supplemental insurance) is meant to add on and pay 60% of the first \$10,000 of your pre-disability earnings. It's reduced by deductible income and any other benefits under Plan A. The maximum it will pay is \$6,000 a month. Supplemental is voluntary and the Basic Plan A is employer paid part.

Slide 14 - Benefit waiting periods. We've discussed these before. There are some implications with two higher education institutions that have unique historical LTD benefits that they bargained a couple decades ago.

Slide 15 – Age Limits. In 2015, we changed the end of the LTD benefit from 65 years of age to social security normal retirement age because we realized we created a donut hole for folks who had to wait longer. We adjusted the plan to ensure no one fell into that hole. Then, depending on your age when you become disabled, there is the how long will you plan work.

Slide 16 – Timeline for Decision Making. In the next month or two, we will present the results of the 2020 annual procurement. The Legislature will still be in session. We have some constraints on what we can do and when we can do it. Budget language will be effective July 1. That will give authority for the Board to adjust benefits within the budget, as long as they remain budget neutral. You can allot different amounts for budget. These are imaginary numbers, but if there is \$5 spent for life insurance and \$4 spent for LTD, you can take a dollar out of life insurance and put it in LTD, as long as you remain budget-neutral.

Dave Iseminger: The way I've described it is once the budget language is effective in the new operating budget on July 1, it sets up your ability to horse trade within the benefits. We will do the estimating for you about what the projections are of the cost of a specific benefit. Beth will go through some examples a little later for how we did this for the SEB Board.

If we change benefit A in this way, what is the value of that in the claims projection that could then be converted to a per subscriber per month dollar allocation to LTD benefit; and then, what would that raise the LTD benefit to? You will have the ability to horse

trade, but you can't spend more money in the overall suite of benefits. You can make a decision to allocate the funds differently across the benefit portfolio starting July 1.

Beth Heston: Any changes made under that budget language during July 2019, or up until that point, would be effective for 2020. However, we also have another timeline for making changes to benefits that revolves around the entire budget making process. That usually begins in July and August of the present year, for budgets for the 2021 plan year. We would take your leads or decisions and prepare decision packages to go into the Governor's budget. Those are submitted fall 2019 to go into the 2021 budget. The Governor's supplemental budget will be released December 2019.

January 2020, the Legislature will be back in session. They will produce their budgets that, along with the Governor's budget, will be a part of the negotiations during session.

Dave Iseminger: There's really two options for improving the LTD benefit. As of this July, you will be able to horse trade within the benefit suite for plan years 2020 or 2021. At the same time, we can ask for more money next legislative session via the supplemental budget process. That option will play out and we'll see after the next legislative cycle if the Governor's budget and the Legislature agrees to add more money to the pot. Absent more money coming in via the next legislative cycle, you have two years to consider any horse trading that you want.

Beth Heston: Slide 17 – PEBB Program Member Income. 81% of employees in the PEBB Program make less than \$81,000 a year. The vast majority earn under \$81,000 a year. Keep that number in mind as we talk through the next few slides.

Slide 18 – Employer-Paid Basic LTD Plan Design. The numbers on this slide are laid out to change all benefit waiting periods in the PEBB Program to 90 days, which would dovetail with the new Paid Family and Medical Leave Act. The Current Plan column shows an annual salary of only \$4,800 covered, which was introduced in 1977 when \$4,800 a year went a lot further than today. A maximum payment of \$240 a month. Our current per subscriber per month (PSPM) and annual cost is approximately \$3.5 million.

We have a possibility as the employer to increase the amount of annual salary covered and the maximum monthly benefit. The cost in the second to the last row (PSPM row) will tell you how many dollars PSPM extra each of those increments will cost. The far right column tells us that if someone makes \$200,000 a year and for coverage up to \$10,000 per month it will cost around \$28.25 per subscriber per month to replace their income. That would cost the state approximately \$51 million.

Dave Iseminger: We wanted to provide several scenarios because over the course of this Board season we want your insight to help inform our decision package writing process. We will be interested in where you would draw the line, recognizing this might be a multi-year process. There might be more tolerance at certain levels. We made sure the salary increments at the top of the Slide 18 match the bar graph on Slide 17 so you could align the amount of the population impacted with the possible increments.

It's also important to realize with Beth's example, it would cost the state \$51 million. You have to take the difference of \$51 million versus the \$3.5 million already in the

system. That means it's an additional \$47.5 million to make the jump. The PSPM row shows the incremental cost and the bottom row is the total cost. You need to subtract the \$3.5 million already in the system to get the difference as to what the request would be to the state on an annual basis to change the benefit to the various levels. Slide 18 is a snapshot of the cost at different levels.

Slide 19 shows more detail in the first few columns than on Slide 18. After going through this exercise with the SEB Board, it's unlikely you will be able to easily find \$8M, \$10M, \$20M, \$30M to make a very extraordinary jump. The information on this slide will help as we tee up different benefit horse trades you might be interested in. These numbers may be tolerable for the types of ideas you could consider. This information was presented at the January 2019 retreat. Slide 19 shows the microcosm of dollar PSPM increments that gets you up to about a \$1,400 benefit. The bigger pieces are on Slide 18 for the bigger jumps you might want in a long-term approach.

Beth Heston: Slide 20 – 2020 LTD Basic Benefit Design Options. The Board can make the budget neutral benefit design changes to increase LTD after July 1, 2019 assuming the proposed budget language is included in the final 2019-2021 budget from the Legislature. The Board would have to reduce the projected claims expenditures and other benefits in the portfolio to make that budget neutral horse trade. The following slides have potentially budget neutral benefit changes.

Slide 21 – Potential Budget Neutral Benefit Trades. The Board could decrease the basic life benefit from \$35,000 to \$25,000. This change could generate sufficient annual premium dollars to support increasing the basic LTD benefit to approximately \$400 per month instead of \$240 per month.

Dave Iseminger: I will walk through how this idea so everyone sees how the two slides relate to each other. We are saying the benefit could increase to about \$400 per month. On Slide 19, you see that is one increment up from the \$240 per month column on the far left, which is the current benefit. If we took the cost associated with that \$10,000 increment of basic life insurance, it essentially gets you about a dollar PSPM in LTD purposes and that gets you to an approximate \$400 benefit.

It's important for the Board not to go to a random odd number for the value of the LTD number, but also to keep nice round numbers for communication purposes. This trade of the \$10,000 reduction in the basic life could result in \$160 per month increase on LTD.

For each of the scenarios we're going through, we're trying to look at that incremental annual cost of claims and see what the benefit change elsewhere in the portfolio produces, plug it back in this chart, and then go to the chart and indicate what the maximum monthly benefit would be. That's the math formula.

Over the next couple of months, we need your ideas of what you want us to look at in our claims date, in our other benefits, in medical and dental. Is there something you are willing to decrease in order to increase this benefit. We'll do that analysis and bring it back in this context. We've already done that in life insurance. There are no other options in life insurance.

Lou McDermott: Is there any consideration if you reduce the life insurance benefit, having another open enrollment event for optional?

Dave Iseminger: We've started to tee up what the general cost could be. We can get started on the full stakeholder analysis and other implications if it's an idea you want information on. You may not find it worthwhile for the agency to go through the effort of doing the full stakeholder analysis as you hone in on potential options. At this point, we're looking at grand ideas to get to the cost aspect. As you hone in on different scenarios you might want to take action on, we would describe the pros and cons and full considerations from the member perspective. The first task is to determine what types of changes the Board is willing to entertain. When you see the dollars, you might determine the "juice is not worth the squeeze" and you need no further analysis.

Beth Heston: I do have some pros and cons. We will probably have negative reaction from employees because we only added a \$10,000 increase from \$25,000 to \$35,000, two years ago. The other thing is 47% of our employees only have basic coverage. 53% have signed up for supplemental, but 47% have not. We would work on having another open enrollment perhaps in either fall of 2019 or fall of 2020, if we took that away.

The second option was the idea of capping the fully insured dental plans' orthodontia coverage at a \$1,750 lifetime to match the current Uniform Dental Plan limits. This change would not generate sufficient annual premium dollars to support increasing the Basic LTD benefit because of the projected enrollment in the fully insured plans.

Dave Iseminger: The SEB Board asked about this, because now in the Uniform Dental Plan, you're capped at \$1,750. The member is responsible for any orthodontia expense beyond that. If you're in one of the fully insured plans, your liability is capped at \$1,750 and the plan picks up everything above that. The SEB Board asked what would be gained if those were made uniform across the self-insured plan and the fully insured plans for the SEBB Program launch. HCA went through the analysis and determined, because of the enrollment mix, most of the enrollment is in the Uniform Dental Plan where that cap is already in place, there isn't enough to make one incremental step in LTD. That idea was tossed! We did the analysis on the SEB Board side, and the enrollment mix that's projected is similar to the PEBB Program. We came to the same conclusion.

Beth Heston: Slide 22. The next potential budget neutral benefit trade that could provide a money source is removing the orthodontia benefit from all dental plans. Based on the calculations we ran for the SEB Program, that could generate sufficient annual premium to raise LTD up to about \$700 a month.

Greg Devereux: So, we're trading children's orthodontia for increasing long-term disability?

Dave Iseminger: We aren't proposing these. We're trying to give you illustrative examples of what horse trading could be. These were three ideas the SEB Board asked about, but I understand that characterization. You are reducing the benefit in one part of the portfolio in order to increase the LTD benefit. The Board will have that authority after July 1, 2019. At the same time, the agency will go forward with the

decision package to ask for more money. Absent more money, the Legislature is giving the Board the authority to reallocate the dollars spent in the PEBB Program from one benefit to another.

Greg Devereux: I get that they're giving us the authority. It just seems like I've heard for decades, even chairs of the PEB Board, describe some of the benefits as sub-standard, in dental, for example. Why we would trade a sub-standard benefit to increase another benefit, I don't know why we would do that. I get that they're giving us the authority. I just hope we are able to increase the pie, rather than bargain against ourselves.

Dave Iseminger: Those are the options for the Board. The authority you have to horse trade will exist July 2019 for plan year 2020 and 2021. You could wait and see approach and not exercise any of your discretion this summer for plan year 2020. Wait and see how the 2020 legislative session works out in the decision package process through the Governor's Office or through the Legislature, and then consider exercising horse trading authority, after you know whether the pie is increased or not. But, absent the pie increasing, if you want to make a change in the \$240 LTD benefit, you would have to go through identifying different benefit pieces to trade. If you want to exercise that discretion, what are other areas that you might want to look at?

We've just started to tee up this question for the Board, in the context of how the SEB Board talked about it. I will tell you that the SEB Board did not take action on any three of these elements. In fact, they kept the same PSPM dollar expenditure as the PEBB Program, and unless they change it in the next two months, they would start their program with a benefit comparable to the \$240 benefit of the PEBB Program. They, too, would have this similar continued authority for horse trading or seeing if the pie gets bigger next session. The SEB Board asked about these three things. We thought we would at least describe to you the context in which one could think about this. Not saying these are decisions that you would or wouldn't want to make.

If there are specific areas you want us to cost out to see if it would be a worthwhile discussion, that is the process we will go through to support the Board in their discretionary horse trading decision making authority.

Yvonne Tate: I feel the same way about the life insurance benefit. We finally got it raised. I would hate to see it lowered, but I would be open to other options if they're out there.

Harry Bossi: I have two questions. Can you give me a sense of how many approved claims there are for long-term disability in a given year and a sense of what percent are able to return to work?

Beth Heston: I can get those numbers for you, Harry. When someone becomes permanently disabled, they go a different route. They may or may not stay on our plan. They may have other options.

Harry Bossi: I understand that. Thank you. I'm trying to get a better idea of the scope. We want to improve a large benefit for a large population, but I have no sense for how many of them actually end up in a claim.

Beth Heston: The national LTD industry says that one in four people in their career will experience a period of disability. About 25% of people will have cause to make a claim.

Harry Bossi: I understand. But our rules have changed in the waiting period and maybe there are some other options that don't exist in other places in terms of Paid Family and Medical Leave.

Dave Iseminger: We'll bring back the PEBB Program claims' experience numbers. For today, this is food for thought. I know we have all been frustrated with the basic LTD benefit. The Legislature gave the Board authority if it wants to make adjustments. We will go back in the supplemental process with a budgetary request about what could be additional expansions of the state-funded portion. We will see how that process works out in the 2020 legislative session. We will definitely bring back to the Board additional time for discussion at a future meeting.

If there are items you want us to cost out, we need it by the June 5 Board Meeting so we can appropriately tee things up in July for a January 1, 2020 effective date.

Tim Barclay: Some additional information, if you could provide it. You have a chart on Slide 17 and on Slide 9. You talk about 33% of the population has enrolled in the supplemental disability. It would be interesting to see how that 33% breaks out by these income distribution categories to see if it's somewhat uniform or not. I think it would help us in assessing how we might modify the benefit.

Beth Heston: That may be difficult because Pay1 does not keep salary information. Salary information is kept in local agencies, but we'll do our best.

Dave Iseminger: We'll see what we can do to answer that question. Our data systems probably don't have it linked as easily as one might think. But we understand the request and we'll see what we can do to link those concepts together.

Tim Barclay: You might be able to get it through just summarizing what is being withheld from their pay in terms of the premium they're paying.

Dave Iseminger: I have about five different thoughts in my head about how we might be able to do this. That was one of them. We'll do the best we can to link those things together. I just know it is not as simple a data request as one might think. But we will do what we can to connect the concepts of Slide 9 and 17.

Tim Barclay: Thank you.

Break

UMP Pharmacy Follow Up

Marcia Peterson, Manager, Benefits Strategy and Design Section. I'm going to follow up on your questions from the last presentation on UMP pharmacy and the changes proposed 2020. Ryan Pistoressi, HCA Assistant Chief Pharmacy Officer and Dr. Emily Transue, Associate Medical Director for the ERB Division are here to assist with clinical information. There are also members of the Moda team here to assist as well. Moda is our pharmacy benefit manager. They helped us with some of your questions. If Emily, Ryan, or I don't answer correctly, we'll go to the source, Moda.

Slide 2 – Purpose. We will follow up on questions from the last meeting, including questions on Tier 3 exceptions. Once we get the Board questions answered, I will introduce the resolution for Board action.

Slide 3 – UMP Tier 3 Exceptions: Longitudinal Analysis. The question was what happens to members who are denied a Tier 3 exception? How many switch to a lower cost drug? How many continue to use that Tier 3 drug? How many eventually get the exception? We also had questions related to the cost impact to the plan and the member of being denied an exception? For members who switch and stay on the lower cost drugs, what is the savings for the plan? What is the savings for the members?

Slide 4 – Lyrica’s Tier 3 Exceptions – A Deep Dive. We are going to do a deep dive into Lyrica because we have talked about it during many of our presentations. We evaluated Lyrica's Tier 3 exceptions in the first quarter of 2018 and found there were 381 members who filled their prescription for Lyrica in 2018 and had a Tier 3 exception request sometime during that year. By the fourth quarter of 2018, 36 members had moved to Gabapentin, which is one of the alternatives, and 264 members remained on Lyrica. There are 81 members unaccounted for who are either no longer on UMP or are utilizing a product not listed on the alternatives. Of the 36 members that switched, the total drug spend, both UMP and member paid, was \$31,000 for Lyrica in that first quarter. The total drug spend for the fourth quarter was only \$1,500, showing the impact for the plan when people switch to the less expensive drug resulting in an annual savings of \$64,000 for the members and \$54,000 for the plan.

Dave Iseminger: Marcia, Ryan, or Emily, can you remind me where Lyrica falls in the hierarchy of our drug spend. Is it in the top five drugs on Tier 3?

Ryan Pistorisi: Lyrica is not one of the top ten drug spend. It is one of the highest for the non-preferred traditional drugs. Most of the drug spend we see, members are good at using the lower tier, lower cost alternatives. But, in terms of some of the non-preferred drugs that we're talking about, it is one of the higher ones.

Marcia Peterson: Slide 5 shows the projected savings to the plan if more members moved to the alternative. For each member moving from Lyrica to Gabapentin, there is \$1,500 in savings to the plan and it's also less expensive for the member. \$1,500 per person multiplied by the 36 members results in that annual savings to the plan of about \$54,000.

Lyrica has very generous copay assistance. The impact that has of trying to encourage people to take the more preferred drugs, it removes that financial incentive. It's possible the generous copay coupons remove the incentive for people to use Gabapentin, which is why you see a low number of people who changed to Gabapentin, about 9.4%. The cost difference for a member, if they're able to use those copay coupons, is about \$36 a year. There's a huge difference in cost between Lyrica and Gabapentin for the member. But, if they use the copay coupons, annualized, it's about \$36 a year. Apparently that's not enough to push people.

Ryan Pistorisi: No. I was saying I think the copay coupon for Lyrica is not lower than what the Gabapentin copay was. We're just trying to reconcile the math.

Marcia Peterson: That's correct. It's not lower. It still would be more expensive to use Lyrica with a copay coupon, but not all that much. Or maybe they're just not aware of it.

Slides 6 through 8 – Tier 3 Exceptions: Member Examples. The Board asked for examples of what happens to members. Moda wasn't able to do a comprehensive review of every member who went through the exception process, so they chose a random sample from the three drugs presented at the last meeting which most often go through the exception process. They pulled records from at least three members for each grouping for Lyrica, Victoza, and Synthroid.

Slide 6 – Lyrica. One member remained on Lyrica and two switched to Gabapentin.

Ryan Pistorosi: This was a response to one of Sue's questions from the last meeting. We attempted to see what happens to these members once they are denied the exception. Are they able to continue to take the medication? Do they come back and make another request after taking the prerequisite drugs? We attempted to see what that longitudinal analysis was. Slide 6 shows us that for the three random members that requested a Tier 3 exception for Lyrica and were denied, one continued to remain on Lyrica and continued to pay the Tier 3 cost share. Two members switched to and remained on Gabapentin.

Marcia Peterson: Slide 7 – Victoza. Victoza treats Type II diabetes. It moved to Tier 2 this year. The results for the four members reviewed had similar results.

Ryan Pistorosi: Victoza is one of the newer diabetes medications. There are four members on this example. One member had the Tier 3 exception, was denied, was provided a list of alternatives, but elected to remain on Victoza. A second member switched to and continued on Metformin. The third member switched to and remained on Pharcega, a different Type II diabetes medication. The fourth member was no longer on the plan.

When we updated our preferred drug list at the beginning of the year, Victoza was one of the drugs that moved from Tier 3 to Tier 2. The member who was previously denied the Tier 3 exception is now enjoying a Tier 2 copay for this medication. All of the other members could potentially switch back to Victoza and get it at that Tier 2 amount.

Marcia Peterson: Slide 8 – Synthroid. Synthroid treats thyroid issues, among other things. Of the three members reviewed, two remained on Synthroid while the third member is no longer on the plan.

Ryan Pistorosi: In doing this analysis, we looked at when the members were denied in order to determine if they had gone through the Tier 3 exception process. I believe these two members had not tried or switched to the alternatives. These two examples are not getting the Tier 2 cost share.

Marcia Peterson: That's a good example of what happens with the value formulary. If the member goes through the exception process and it's deemed medically necessary for them to use Synthroid, they would get the drug at the Tier 2 level.

Slide 9 – Oregon’s Lessons Learned. The Board asked what lessons Oregon learned from Moda, the Oregon Educators Benefits Board, and Oregon PEBB, about their transitions to a value formulary.

Slide 10. Oregon had some improvement in the drug spend trend and better control over volatility. In one case, slowing the trend. In the other, actually trending negative, holding down costs. These changes are new. One of them was in 2017 and the other 2018, in the implementation. The results are still being reviewed. Initially they’re positive.

Regarding communications, they found it’s important to communicate those changes early and often, offer information about the formulary exception process, particularly to those identified as possibly impacted. Provide significant FAQs.

Slide 11. Oregon also found it’s important to avoid making changes to the list of covered drugs after the list is mailed to members. And we can expect greater call volumes to Moda’s customer service and increased exception requests and appeals once it goes live.

Slide 12 – WA PEBB Program Actual and Projected Moda Call Volumes with Value Formulary Implementation. This table projects call volumes for the PEBB Program based on Oregon’s experience. The blue line represents actual call volumes for the PEBB Program in 2018, for October through March. The green line represents the likely increase in call volumes once they announce the change. It increases when the change goes into effect in January, and continues for approximately five months. They also found the length of calls to Moda increased from about six minutes to eight minutes.

Greg Devereux: So, 2,500 calls a month seems like a fairly big jump. Can the exception process be initiated over the phone, or do you have to do something else?

Ryan Pistorosi: The exception process requires the provider to submit clinical information. If the patient is calling, they could start the process. For the provider, they will be directed to one of the online portals called Cover My Meds where they are able to initiate that exception process and start submitting the clinical information for that request.

Greg Devereux: And the exception process here will be similar in terms of getting documentation?

Ryan Pistorosi: The exception process will be similar to what we’ve had with the Tier 3 exception process. You already have that process up and running. It’s similar to how we currently have prior authorizations for drugs.

Greg Devereux: Was the 2,500 call volume increase a month due primarily to the formulary change? And, if so, what was the general nature of the calls? Was it just people calling and yelling at Moda? I’m curious.

Cole Omberg, Moda Pharmacy Operations Manager. I would like to jump back a second and add on to what Ryan said about initiating over the phone. We also have the

ability, when our members call in and talk to our customer service, to initiate the request for the provider through Cover My Meds and take that first step to get the request to the provider for action.

As for the nature of the calls, they were all over the board. Some members were upset about their drugs that were no longer covered. We also sent out member letters. Some were calling to ask about the alternatives identified in their letters and they worked through that with us, and their provider. Some asked about the formulary exception process in general.

Lou McDermott: Could you describe the process from beginning to end? A member is taking a certain medication and they go in for a refill. Then the letter from Moda comes explaining the new program. What does it look like for the member?

Cole Omberg: When we did it for OEBC and OPEBC, we gave a 60-day notification via mail to the members. The letter referenced the medication they were taking. We provided the date their medication would no longer be covered by their plan. We provided up to 15 alternative medications for the member to take that were on formulary for them to work with their provider to get a new medication that would be covered under the plan with value formulary.

Lou McDermott: So, the member looks at it and says I don't want to do that. I want to keep taking the drug I'm on. That's one of the 2,500 calls?

Cole Omberg: Correct.

Lou McDermott: They initiate the phone call. Then what happens?

Cole Omberg: Customer service discusses the formulary exception process with them and lets them know they need to try the formulary alternatives. We can initiate this request to your provider. There's also the case if the provider thinks there's medical necessity for the medication, they can submit that request to override the requirement to try the formulary alternatives. But they'll call in. Our customer service, through Cover My Meds, now can implement this formulary exception request. On behalf of the member, with the provider, we then send the provider the information saying this member is requesting this exception and the provider will submit the applicable data.

Lou McDermott: I know sometimes with providers it can take a little while for these things to happen. And sometimes it can take members a little while to pick up the phone and make the call. While it's in its back and forth stage, is that medication on hold? Could they get a refill?

Cole Omberg: Yes. That's the importance of sending out the communication early so we can try to get this taken care of before the member actually goes to the pharmacy and the medication is no longer covered. At this point, with the way the program works, we let them know 60 days in advance. We did it January 1 for them. Once January 1 rolled around, they will receive a rejection at the pharmacy, at the point of sale. We've also worked for their clinical team. If there is medical necessity, we have done one-off overrides to make sure the member still gets the medication when they need it while

they work with a provider, or get them a shorter day supply of coverage while we go back and forth to the provider to get all the necessary information.

Dave Iseminger: In general, the date that's communicated where coverage ends isn't tolled or further delayed while the exception process is working itself out. There may be rare one-offs that allow that. But the general rule would be that a date is communicated and that date is not changed because somebody is going through the exception process.

Cole Omberg: That's correct. That's a good summary.

Greg Devereux: What happens if someone gets a rejection and they try one of the alternatives that doesn't work. They try a second one. In your system, they don't have to try 15 different drugs before they go to one that was working for them, do they?

Cole Omberg: Not necessarily. There are different amounts of alternatives for medications. We always ensure there is a substantial amount of alternatives on the formulary for the member compared to the Tier 3 medication that we'd be removing from the value formulary. I would say that varies on a case-by-case basis, on what they need to try.

Greg Devereux: Let's say you tried three things and there are horrible side effects. If your physician says this isn't working for this person and a different drug was preferred, at that point the physician can do something for you?

Ryan Pistorosi: If there are class-wide effects, like with ace inhibitors, if someone is developing a cough, it's likely all of the ace inhibitors a patient would try would result in the same side effect. We do recognize that, especially if it's a safety issue and that's taken into consideration. If it's a general thing, like the medication is not working as well, we would look at other ones in these drug classes, because different drugs within drug classes have somewhat different properties. We've talked about statins in the past and there are different potency levels with the different statins. Some are lower potency but they have different effects. They may have fewer side effects elsewhere. Other ones are much higher potency, but they may have more side effects. There's a spectrum where, when you try one and you don't have a class-wide side effect, you may be able to try another one and actually get the effect.

Another common class where we see different efficacies is with antidepressants. What is challenging about antidepressants is you don't know which ones are going to work until you try one. You wait four to six weeks to see if the patient gets better. If not, they may up the dose or switch to a different one. We do have clinical exceptions in the process.

Dave Iseminger: Even though the example just used is antidepressants, under the policy before the Board, antidepressants and other antipsychotics and depressant medications are not part of this value formulary. People already on refill-protected classes who are currently on drugs won't have to try something that's already on the formulary. But somebody with a new diagnosis would need to try the cheaper drugs first.

Carol Dotlich: It almost sounds like Moda is becoming the diagnostician. In other words, some of those drug classes have 15 drugs in them. Do I have to try 15 before I get to the next tier?

Emily Transue: I appreciate that question and I there is an important distinction there. Based on what that drug does, there is a list of potential medications that could be substituted. Moda would not be making that substitution. The list would be to take back to the doctor. As a primary care doctor, I've had patients come and tell me the drug prescribed is not on formulary and here is a list of what is. I might look at those and identify four potential drugs that would not be a good idea, but these three are pretty much the same as I prescribed. Those three could be a substitute. Moda wouldn't be doing the substitution but they would provide the list of potential alternatives to the provider.

Dave Iseminger: There seems to be the idea that most drugs have dozens of different alternatives. My perception and understanding of the drug world is that most drugs don't have dozens of alternatives. Most drugs have a couple alternatives. The situations where we fear there are 15 or 20 different drugs to try is very rare. I think that's a common misperception that people in general have with drug classes.

Emily Transue: I would say that, particularly, the drugs where there are 15 tend to be all generic. There are some drug classes with lots of alternatives. Typically, in those cases, people aren't coming up with a new brand name one.

Dave Iseminger: Those would be situations where this formulary policy isn't applicable.

Emily Transue: It isn't going to be applicable because they're all going to be at a value level. In these cases, it would be more typical there would be a small number of potential alternatives, or a few would be so closely related there would be more of a safety issue. If you had a really bad reaction to this one, that would wipe out this set of five. You'd be left with a couple others.

Ryan Pistorosi: One other point, if the member has already taken three other medications, there may be drug-drug interactions with other drugs on the list. You may be able to knock off five, six, or seven. These are dependent on the member, the other drugs they're taking, and the disease they have, in addition to what options are available. There have not been many cases where we came back with a letter of 15 alternatives. The letter with 15 is listing the options that are all equally effective and lower cost to the member. It is to give the member and their provider the option to select an appropriate drug.

If you remember the physician panel at our January 2019 retreat, there are thousands of formularies. For every member that comes in, they likely have a different formulary. In fact, one of the projects I'm preparing for the next SEB Board meeting is to look at the current K-12 population and try to say which ones are open formularies, closed formularies, value formularies and provide an assessment of what the current landscape is compared to what we're proposing. Because there are so many different formularies, these providers don't necessarily know what is the lowest cost and the most cost-effective one for that plan. The member letters Moda is sending is attempting to

show what is covered on formulary; and not only are they lower cost to the plan, but lower cost to the member.

Tom MacRobert: Ryan, you made a distinction at one of our previous meetings where we were talking about ten drug classes affected. You said in some cases, there are "true generic." You also said there are generic alternatives, the difference being that a true generic is exactly the same as what you're taking. There should be absolutely no problem with the transition from one to the other. On the other hand, with the generic alternative, it's not exactly the same. There's a lot of switching around that might have to occur because the dosages and some of the ingredients that make up the generic alternative are not the same. Is that a correct summary?

Ryan Pistorresi: Let me see if I understand because there were a couple questions in there and I want to see if I can answer those. The first question was is the difference between a true generic and a generic alternative. A true generic has an AB rating by the FDA. An AB rating means it's interchangeable. When you go to a pharmacy in Washington and your prescription is a brand name, the pharmacist will automatically switch to the generic version of that drug.

Generic alternatives, however, could be the same drug but in a different dosage form. It could be an extended release version, an oral solution formulation, or a same drug in that drug class. Like statins, we can say Crestor's true generic is Rosuvastatin. But a generic alternative could be Atorvastatin, Simvastatin, or one of the other statins. If you go to a pharmacy in Washington with a Crestor prescription, the pharmacy will automatically change it to Rosuvastatin, or if there is therapeutic interchange like we have for the Washington PDL, they could switch to one of the preferred statins in our list, like Rosuvastatin. They also have the authority to switch to Atorvastatin.

What was your next question?

Tom MacRobert: You answered my questions. I wanted to make sure there's a difference between that automatic switch that you can make from a true generic to a generic alternative. Using our example of Lyrica, and Gabapentin is not a true generic. Sometimes you can have complications when you make that switch.

Emily Transue: Agreed. I would just add, one of the sides of the only automatic substitution that wouldn't involve a doctor being involved would be to a true generic. It's the exact same active compound, it's just a difference in what it's mixed with within the pill. I would also say that, when you're shifting to a generic alternative, it's not a shot in the dark in terms of dosing. There are standard expectations for 20 mg of this statin, or equivalent to 10 mg of that. People tend to respond the same way. You start with an educated expectation about what will happen and sometimes you need to adjust. But, just to make clear, it's not a completely start from scratch process.

Ryan Pistorresi: To follow up to your point, yes. That's why we don't have that automatic switch because there could be complications at the pharmacy. That's why we want to make sure the physician is aware and okay with that. That's why we provide letters to the members and providers so they can start reviewing it and make informed and appropriate decisions prior to this potential process going live.

Marcia Peterson: Slide 13 – Value Formulary Exception Process: Additional Details. We've talked about this a bit. How many formulary drugs may members have to try before approved for non-formulary, which is formerly a Tier 3 drug?

Board Members have had concerns about members being harmed by this policy. That's something we all worry about. We've talked about this a lot. I believe our members won't be harmed by this policy because every member will be able to access the drug that is best to treat their condition or disease on this value formulary, if there is such a drug. If their physician doesn't prescribe the most preferred drug in the first place, the value formulary process assists our members in accessing the drug at the lowest price.

Harm would be if a member couldn't access the right drug, or if a member had to pay more for that drug. That's what we currently have. Members have to pay more for the drug they're being prescribed. If they had to pay more for a drug that is equally effective, that would be harm. In many cases, the main difference between the drugs in this class is one of them has had several million dollars' worth of advertising behind it, not because it's more effective. If they're similarly effective but different costs, the real difference is the advertising that's gone into the brand name drug. That's one of the points we're trying to make. I hope the Board will keep that in mind as we move forward.

Slide 14 – Drug Alternatives. We've talked a lot about drug alternatives. Lyrica is one we've discussed at length. It's a single source brand name drug with the advertisement that is has a therapeutic alternative but no generic equivalent. There are two to three alternatives a member may need to try depending on their disease state.

Victoza is no longer on Tier 3. It was moved to Tier 2. Those exceptions would go away. There are 15 Tier 1 and Tier 2 alternatives across seven therapeutic classes. Depending on the therapeutic class you're in, your disease state, you wouldn't necessarily have to try all 15. In fact, that would be extremely unlikely.

Synthroid is a multi-source brand-name drug that has a generic equivalent. There are three formulary alternatives.

Emily Transue: I would say two things from a clinical stand point. First, it's very rare in practice that you would end up going through more than two or three alternatives before getting to the right place. There's an assumption that creeps into this that because there are two or three alternatives, you're going to go through three alternatives and then you're going to get to the expensive one. I want to remind everyone that the vast majority of the time, one of the alternatives picked works and you stop there. It's not as if there are all these inferior drugs you're having to go through to get to the good one. Each alternative is equally likely to work, and chances are you will hit on the right one relatively quickly.

Ryan Pistorresi: We've talked a lot about Lyrica. The one good news that I have regarding that is it will likely have a generic approved later this year. In terms of the value formulary, there will likely be Pregabalin available to our members in a generic form possibly as early as July of this year.

Marcia Peterson: Slide 15 – Why make this change? In summary, we feel it will be clear and simpler for members to understand there is an exception process. It's more equitable and you're paying for value. It may help save on out-of-pocket costs on drugs and potentially protect our member premiums from the extreme volatility we've seen in drug pricing.

Lou McDermott: It seems like when I last touched on this issue, the retirees were the ones disproportionately hit by rising pharmaceutical costs. Implementing this policy should have a dampening effect on pharmaceutical expenditures. And then, again, the retirees will see an increased benefit of it beyond our active retirees. Is that mostly correct?

Marcia Peterson: It could potentially be correct.

Ryan Pistori: One of the things we've looked at with our data is the retirees are about 20% of the UMP population, but about 40% of the drug spend. They are disproportionately affected by the pharmacy costs since UMP is the primary payer. Whereas, for medical spend, Medicare is primary and UMP is secondary. Medicare retirees are taking on the full brunt of these drug costs.

As there are a lot of new drugs, a lot of push, and frankly, pretty aggressive tactics by manufacturers to take up market share with their newer products, that has had an impact on the pharmacy spend. As you've seen, we've had a positive trend year over year that has been pretty high for the Medicare population. Lou, when we originally brought this idea to you in 2016, when you were the PEB Director, we saw this as the direction the marketplace is moving for pharmacy benefit. We've seen that with Oregon PEBB in 2017, and with OEBC in 2018.

I've been reviewing the school employees' plans and noticed many of them already have formulary exclusions. I've been doing a review of the diabetes class and pretty much every single sub class has exclusions for certain drugs. Some of them are extreme in terms of how many drugs they have excluded. This will not only help us with drug spend and controlling for volatility in the future, but also helping us align with current pharmacy benefit management.

Lou McDermott: I'll take that as a yes.

Marcia Peterson: If this value formulary is to be effective January 1, 2020, both the PEB Board and the SEB Board will need to approve it.

Lou McDermott: Do the Board Members want to proceed with a vote today? This has been an issue since I've been the PEB Director and watching those retiree premiums go up over and over again at such a high rate. I do think this will ease that pressure. I think the PEBB Program will take care of its members and ensure that, if members need a medication, there is a mechanism to get them on that medication if they can't tolerate other medications within the class. Thoughts from Board Members?

Greg Devereux: I have a question of Dave. Assuming this does move forward, will we be able to determine the difference in cost year over year?

Dave Iseminger: Greg, you're asking about projected cost year over year? After the fact, we'd be able to do a retro analysis that said, "if the formulary had been X it would have cost this, if it was this, Y." That would be a retrospective aspect. Are you asking about a projected claims savings?

Greg Devereux: I guess what I'm most concerned is if we are saving money. I want to know how much it is and I don't want it to go towards someone else's loophole in the Legislature. I'd like it to go back into benefits. I would actually like to know what the figure is.

Dave Iseminger: You'd like us to track and report to the Board what the figure is even if it's on a retrospective basis?

Greg Devereux: Yes. I don't care whether it's retro, projected, or whatever. I'd just like to know what the predicted savings is.

Dave Iseminger: One of the challenges we have is it's no secret that the Board has been talking about this concept for several years, and the legislative forces are aware of this concept and its potential for helping the volatility of pricing in the future. I think that they're, frankly, expecting something to come from this formulary proposal from the Board. If something isn't done at some point in the future, I would anticipate there would be an explicit directive to the Board to make a change. At that point, you might have less discretion in how it's implemented than you have today. It's important to note, I think legislative folks are anticipating and expecting there will be savings within the future that would be accounted for in the legislative process. I don't think there's anything this Board or the agency could do that would prohibit the Legislature from acting on any savings.

Lou McDermott: I think Greg asked, can we come up with a number.

Dave Iseminger: That's what I was saying before, yes, eventually.

Lou McDermott: The other discussion you're bringing up, that's a separate issue. But can we say, "we implemented this policy and this is what we think the financial impact has been, over a period of time?"

Ryan Pistorresi. Moda has been doing that for OEBC and Oregon PEBB so we would use a similar analysis and report back.

Dave Iseminger: You may be able to get credit for it, but that doesn't mean it becomes your credit card to use.

Lou McDermott: Understood. But knowing what the number is, is important.

Harry Bossi: So, half kidding, you couldn't use it toward long-term disability?

Dave Iseminger: I anticipated somebody might ask that question. I think the challenge is this topic has been predominating the PEB Board cycle for multiple years. As I was just alluding to, there is an expectation something will be done by the Board to take control of some aspects of pharmacy costs. If there isn't, at some point, I would expect

there would be much more explicit direction as something that must be done. That would probably be a world in which you have even less control over the way it's implemented. It's something to be mindful of. I do think there have been enough eyes on this topic from the legislative side, in knowing the longevity of this topic here at the Board, there is an expectation something will be done.

Carol Dotlich: I would like to see the appeal process procedure in writing, something I could share with folks that I represent. When you're dealing with older people, the appeals process becomes very important.

Marcia Peterson: Did you mean the exception process?

Carol Dotlich: Yes.

Marcia Peterson: Yes. Okay, good.

Tom MacRobert: I have a statement. As I'm understanding this, the reason we're doing this is due to the cost of prescription drugs. Is that correct? This is why we have to make the change in the formulary?

Ryan Pistorisi: There are a few different reasons why we're bringing this to you again. One reason is the equity issue.

Tom MacRobert: But it was my understanding that was a fairly insignificant number of people and the real driver behind this is the cost of prescription drugs.

Lou McDermott: Let me go ahead and take a shot at this. What I see in the industry year over year is a cat and mouse game. There is the pharmaceutical industry, we'll call the cats, and we're the mice. What happens is, we implement things to defend ourselves against price increases and the pharmaceutical companies develop ways to increase those prices. They watch and see what we do, and they take counter measures. A good example of a counter measure is the Tier 3 drugs. By giving the member a higher cost share, and the pharmaceutical company giving them a coupon to offset that cost share, they know the member is not feeling much out of pocket. Therefore, the plan is experiencing the cost. Then, the plan turns around and increases the premium to the member to absorb those costs. The member doesn't notice that. They just know their premium is going up and don't understand why.

Pharmacy benefits especially are one of those benefits that will need to be updated every three or four years, forever, because we're going to make this change, and they're going to make a change. We're going to have to make another change, because they're going to make a change. The benefit has been the same for a long time. Pharmaceutical companies have wised up and made appropriate changes from their perspective to enhance revenue. This is our way of combatting that, while trying to ensure our members are getting the services they need.

Tom MacRobert: Good. I think to echo what Carol said, I also represent a vulnerable population. It just so happens the reason I've talked about Lyrica is because I know someone who was on Lyrica initially. She was not an older person. In fact, she was 28 at the time. She was switched to Gabapentin and had multiple problems as a result.

Then she switched to the second one and had more complications from that. Finally, because neither of those were working, she was switched back to Lyrica. Once she switched back, all of the problems she was having from the other two alternatives disappeared. I'm thinking that here's someone who's 28 years old and in relatively good health. Now we're talking about a vulnerable population. We're going to put them through that process. That does not seem to me to be a sound process to go through. That is the heart of my objection. We're doing that for ten different classes of drugs, and we're talking about affecting the most vulnerable people we represent, both as retired state employees and retired K-12 employees.

Lou McDermott: Tom, I'm going to say something a little clinical. And my clinicians are going to jump in if I'm incorrect. We always think the expensive drug, the drug that's on TV, is the magical drug with no side effects, the one that works for most people. That's not entirely true. Sometimes, it works the other way around. Sometimes, they start on the Lyrica. They experience side effects, problems, and they wind up going to other drugs in the class. It just happens that currently Lyrica is the expensive one. I think the scenario you're describing could have gone the other way just as easily. The physician could have started with Gabapentin, experienced the same problems, and worked their way up to Lyrica.

Tom MacRobert: My concern is you take a drug that is working for someone and make them go through this process. That's the heart of the concern. If it works for them, why make them switch? Why make them go through that process? There ought to be a way for them to not have to switch if it works for them to begin with. Because it's okay if you're 30, 28 years old. If you're 88, any kind of change is a fairly significant part of your life. Making that change is a huge thing. If the first alternative you're switched to causes you to have health issues, then you have even more complications for that person. That's the issue for me.

Emily Transue: I can speak to that. I agree. I think it is a more complicated question in someone who is already taking something than someone who is not yet. For someone starting initially, there really is no reason not to start with the most cost effective alternative.

Tom MacRobert: I agree with that, yes.

Emily Transue: I think we have done a lot of work with the protected classes to look at where that risk is highest, that there really could be an adverse consequence from switching. I think the protected classes have really good ones around that. But I agree, there will be, it won't be a large number of people, but there will be people for whom that experience occurs. I think it does come down to, do you have the member and the other retirees bear the cost for the rest of that person's life of staying on a higher drug, a more expensive medication when a cheaper one might work just as well? Or do you put them through that process? I think that's the question before you.

Carol Dotlich: One of the concerns I've had from the beginning of looking at this resolution, and it remains here today, is the word "all." All formulary drugs are ineffective. That's the picture of "27 drugs I gotta try" kind of thing. I agree with Tom. I think when people are older, you have physical health difficulties anyway. Plus your brain may not be as sharp as it once was.

Playing with a drug regimen that's already established in an elderly person, to change it up, has a bigger impact than I think you are taking into consideration. I don't know if there's a way to exempt folks from this experiment or not. But I think it needs to be considered. If you are already having difficulty mentally with managing your life or yourself, and maintaining yourself at home, and you start changing, "am I taking this pill once a day? Or twice a day? Or three times a day? Am I feeling different because the drugs have been changed?" I think that is a huge impact on elderly people, much more than I think you're taking into account. I just wanted to raise that issue.

Lou McDermott: Can I ask this question. How many hands have been on is this? Obviously, there is an opportunity for people to struggle with this policy. When they get their letter and their medication is going to be changed, they now have to deal with their provider. There may be some difficulty. On the other side of the fence, when I talked with retirees and I received the letters as PEB Director, a retiree was saying they were going to have to start skipping medications because of the increased premium rates. I also see that as a problem.

The perfect solution is to have unlimited funds. We can buy all the medications people want and those prescribed to them. That's great. Well, we don't live in that world. We live in the world where there are tradeoffs. My question is how are these transitions going to be taking place? How are we going to make sure we're helping folks along the way to make those transitions? How are we going to make sure we don't ask someone to try ten different medications, that their clinical person is getting involved in the process. How are we going to monitor Moda? How are we going to stay involved so we're making sure our members are getting the treatment we expect?

Yvonne Tate: From what I hear, I think the individual employee's physician is the key driver in all of this. These are physician choices, not ERB or Moda choices. The physician will know how severe of an impact changing these drugs might have on a patient. I'm comfortable with it as long as I know the decision is being driven by their physician more than it is by administrative staff.

Dave Iseminger: As we go forward with any implementation, this isn't a scenario where the Board made a decision and then next year we will get an annual report from Moda. It's the type of situation where we will monitor weekly and have escalation paths where individuals can raise concerns. If they call into the ERB Customer Service 1-800 number and reaching our eligibility folks, it's not an eligibility issue. It's a medication issue. We will get that to the right person in ERB so they can be talking to Moda, talking to Ryan, talking to Emily to work through these different issues that are happening during the implementation.

We're going to have a regular cadence to make sure we are on top of our projections. If our projections were that 2,500 calls were going to come in but now it's 5,000, we need to find out what is driving that. We will work on refinements in the implementation process. Just like any implementation, if something comes up that we didn't expect, we'll find a way to make that process as long as it needs to be to be able to manage the issues that come up in implementation. That's how any of our implementation projects work.

We now have Emily as a dedicated ERB Medical Director whose primary responsibilities are directed toward the ERB Division. Previously Dr. Lessler was here and he had half of his brain on Medicaid and half of his brain on PEBB. Now we have Emily's full brain for PEBB and SEBB, and Dr. Zerzan, who supports Emily but also supports the other parts of the agency.

We have resources available to ensure that, if issues come up during implementation, they can be identified and the implementation timeline can be shifted if it's something systemic. If we're realizing that suddenly all of our projections for the number of people that are going to be impacted are different than we thought, we'll be able to rally during the implementation and have a dedicated team to focus on what issues are coming up and keep in constant contact with Moda during that implementation phase.

Carol Dotlich: Tell me, I asked this question at a previous meeting. Tell me why people who are already on a set regimen of medication cannot simply maintain that. As people come in to requirements for different or new medications, you do your experiment. You do your formulary idea. Why can't people who are already established on a drug regimen remain on it?

Ryan Pistorosi: We've looked at certain drug classes in which there are higher risks, that if we switch someone from an antidepressant or an antipsychotic or a medication for epilepsy, the risks do not outweigh the benefits.

Carol Dotlich: I don't want to interrupt. But I understand that. I understand that you've done that, and I appreciate it. That was important to me, particularly since I worked in a mental health establishment for a long time. But I want to know why, retired people particularly, because that's who I represent, who are on an established drug regimen today cannot remain on that. And, if tomorrow, I go to the doctor and they say, "Oh, Carol, you have a thyroid condition." I follow the formulary, I don't have a problem with that. What I have a problem with, primarily, is if someone's already been on a medication for a period of time, it's an established drug regimen, why can't they stay on that? If there's a new diagnosis of some other illness that needs to be medicated, then use your formulary. Why is that not an option for people?

Lou McDermott: Carol, technically could it be done? Yes. Would it achieve enough downward pressure on the pharmaceutical costs? No. If we start excluding, as part of the compromise, we looked at the exclusionary classes and said, "no antipsychotics, no epileptic medication, no this, no that." You're taking that pie and you're whittling it down. Now, if you say we're going to go ahead and leave everyone who is on one of those medications, we're going to leave them on indefinitely and only pick up the new people, the program is not going to have an opportunity to put that downward pressure for years and years and years to come.

Unfortunately, part of it is a financial reality. With the program you can do anything. But we are trying to pick the way that's best suited for our members to make sure they're getting the medication they need and transitioning them in the best way we can. The ones we can't transition, not transitioning them. I don't want to point the finger at the Legislature and say, "or they're going to do something to us," but back to David's previous conversation. They could do something to us. They could say, "you're going to do it this way." They could eliminate those exclusions. They could say you're going

to do a formulary and you're going to put everyone on it. We are trying our best to put downward pressure on the pharmacy costs, trying to do it the best way we can, trying to address the cat and mouse game of dealing with the pharmaceutical industry. And this is our best effort at what needs to be done.

Dave Iseminger: Lou, you pretty much took the words right out of my mouth. The only piece I would add, if you go back to Slide 5, there's an example. We've quantified the impact of Lyrica. Ignore that Lyrica is probably going to be a Tier 2 drug soon. Whatever drug we picked, the number here as we talk about this topic, the example will change, but the illustration is still there. If you carve out Lyrica, as an example, you've suddenly taken at least \$430,000 off the table. That's the value of whittling the pie smaller and smaller and smaller. Lou did a good job of the macro description of various interests that have to be balanced.

Lou McDermott: I really do appreciate the Board agonizing over these type of decisions. I know it's been going on for multi years, since I've been the PEB Director. I can tell you, the internal staff agonized just as much. There were some very difficult internal discussions about how to do this, what's right to do, what's not right to do. At the same time, we're working with our finance folks, our actuaries, and our legislative partners, seeing the cost trends. Seeing the retirement, double-digit premium increases for retirees. Not a fun message to deliver.

Our hope is this will provide some downward pressure on pharmacy costs. It isn't going to fix everything, but it'll provide some downward pressure in a way that assures members they're getting their medication. We will have members who will switch to another medication and have adverse impact. Our population is big enough where that's going to happen and that's unfortunate. It's also unfortunate when we get these big rate increases and people are starting to make choices in their lives between medication and other needs they have. It's all unfortunate. Our clinical team will work with those members who are not able to use those other medications. We will build processes and work closely with them to make sure people aren't left behind.

Yvonne Tate: The other thing we have to keep in mind is, if we don't achieve, for example, the savings on Slide 5, that cost is borne by every other plan member. We basically take care of a few at the expense of everyone else.

Lou McDermott: Not just borne by every other plan member, borne disproportionately by retirees because UMP pays primary. They feel the disproportionate increase in pharmacy expenditures in premiums.

Tim Barclay: I would like to remind the Board this is not a new conversation. We had this conversation at length last year. In fact, we changed this proposal to include the concept of grandfathering, the term we used for what you're describing because we convinced ourselves that was an issue. But recall, we had the January retreat and we specifically raised this issue with the four physicians that sat and presented with us. None of the four had any concerns, or thought there was any merit in, a grandfathering clause. They all four completely dismissed it and said that, as physicians, they could manage the drugs of the patient.

Not only does this resolution say they need to try all formulary alternatives, it continues to say, "or they are not clinically appropriate." A physician can make a decision that they're not clinically appropriate and not force that person to try a bunch of drugs that they've concluded will not work. I'm not a doctor, but I trust the four people who sat in front of us and said, "as physicians, we can manage this. Just tell us what the formulary is and we will take care of your members." As Yvonne said, it's the primary care physician in the driver's seat. It's not the member. It's not Moda. And it's not the Health Care Authority. It's those physicians. The fact that they're not concerned about it tells me that I shouldn't sit here and create hypotheticals to make me concerned about it. I'm okay with this as it is.

Lou McDermott: Policy Resolution PEBB 2019-01 - Value Formulary.

Resolved that, beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary, and:

- Nonformulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
 - Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and
 - Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
 - they receive or already have gone through the exception process and been approved, or
 - their drug is within one of the refill protected drug classes, which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.
- Thank you. Is there a motion to adopt?

Yvonne Tate moved and Tim Barclay seconded a motion to adopt.

Carol Dotlich moved to table the decision until the June meeting and Tom MacRobert seconded the motion to table.

Lou McDermott: Would the Board like to debate that?

Greg Devereux: Tabling a motion is not debatable. You have to vote on it.

Lou McDermott: Not debatable. There's no discussion. Is that correct?

Greg Devereux: It's not debatable. I don't know whether there can be discussion, but it's not debatable.

Michael Bradley: I would have to look. I'm going to need a minute.

Rachel Lowe: I'm sorry to interrupt. Is there going to be time for public comment for this meeting? I was told we would at 4:30.

Lou McDermott: There will be.

Rachel Lowe: Thank you.

Dave Iseminger: Do we need a brief recess so we don't all sit here awkwardly--

Lou McDermott: Well, we'll see what we've got.

Michael Bradley: Yeah, if we could have just a brief moment.

Lou McDermott: Looks like we're going to have a moment. Let's take a short recess.

[recess]

Michael Bradley: The motion needs to be resolved before moving on to the underlying motion.

Lou McDermott: Okay. And when I say "debate," I might have misspoken. I just meant comment. Does anyone want to comment on it, or just go to a vote?

Tim Barclay: I would ask Carol to tell me why. What do you want to do between now and June?

Carol Dotlich: I asked for some written explanation of the exception process because I want to take it back to my members and I want to talk to them about it. I don't see a reason why we can't take up this resolution in June. There's a June meeting. That's plenty of time for people here to do their work. It's plenty of time for us to go back and talk to people we represent. And just make sure we're okay. I don't see why we shouldn't be allowed to do that. So, that's why I asked to table the decision until we have a chance to do that.

Tim Barclay: Thank you.

Lou McDermott: Other comments?

Yvonne Tate: The only thing that concerns me about that is we are a policy-making Board and we typically rely on staff to explain to members what benefits are, how they'll be implemented, and all of that. It almost feels to me like there's a conflict going on between the policy-making role and the representative role. I would just say, I think our role is more of a policy role overall than purely a representative role. That's my two cents.

Lou McDermott: Any other comment? We're going to take a vote on the motion to table. Starting with Yvonne.

Voting Yes to Table Resolution: 3

Tom Macrobert
Carol Dotlich
Greg Devereux

Voting No: 4

Yvonne Tate
Harry Bossi
Tim Barclay
Lou McDermott

Lou McDermott: Motion to table vote to June PEBB Board Meeting for Policy Resolution PEBB 2019-01 does not pass.

Voting Yes on Policy Resolution PEBB 2019-01: 4

Yvonne Tate
Harry Bossi
Tim Barclay
Lou McDermott

Voting No: 3

Tom MacRobert
Carol Dotlich
Greg Devereux

Lou McDermott: Policy Resolution PEBB 2019-01 passes.

Dave Iseminger: Chair McDermott, we will bring the Board written information on the exception process.

Public Comment

Rachel Lowe: My name is Rachel and I represent the college faculty where I work. I'm also a payroll specialist for a for-profit business. I have been not willingly always a member of PEBB services. And I'm coming to you to tell you a lot of what you discussed today I found very enlightening, very helpful, so thank you for allowing the public to be a part of this process. I very much appreciate this. I came from Seattle on a long drive. Some of you may also make your way here as well. So, again, thank you for your few minutes of time that you've given me.

The LTD that you described earlier also works with the PFML policies with the for-profit business that I'm with. These are places, as you've mentioned, that have a lot of retro type of policies where you're paying for something. Some of this is dual coverage. There is a situation where you can save thousands of dollars from health care that you have right now going on for eligible and ineligible employees.

This comes down to the way that this process, or policies, are written down to people like me that have this big effect. \$2,000 I'm out because of this situation. Dozens of employees where I work have had the same situation. Taxpayers -- maybe your money -- \$18,000 a year. These are savings for each employee that has this happen to them without their acknowledgement. And this is dual insurance coverage as well. I have

some ideas about this. I've shared some of them with Dave as well. I haven't gotten much response from him on that. But there are ways to save money so that you're not taking money from LTD, taking it from long-term health, retirement, in order to pay for something else.

It's a simple policy, not even a policy change, administrative changes that can be made. I'm happy to share that with you with more details. I only have a few moments here for your time. But these are solvable. They don't cost us any money. They don't cost a lot of administrative. In fact, one of them I'll give Dave here is just a simple edit that could be made to some papers.

I would really implore you to listen to, maybe if David is willing to share some of those ideas, or I can send that to you as well, just to represent the place of these eligible employees that are given insurance they don't want, taking the payroll deduction out of their payroll each month. For the period of time that we have coverage with other insurance, we don't need your coverage. Some people do need your coverage and it's great that you have the coverage available to them. But, when we have dual coverage for people that don't need it, you're wasting your money, you're wasting our money.

We're also having a situation where we're having eligible employees that do want insurance have a full month that they're paying for that they don't even know that they're eligible for -- a full month of coverage that no one uses that insurance. You have to pay for it. The employee has to pay for it. But no one can use it because we're not aware of that eligibility or that we could have used that insurance until a full month later. So, that's one month of insurance that's wasted for every eligible employee that becomes eligible during the time period. I personally have been eligible probably four or five times in my 14-year tenure. So, that's a lot of money, just from me, that you've wasted. Not you personally, you as an institution. Thank you.

Lou McDermott: Thank you. I know the agency has been reviewing your questions and we're continuing to review them. At the next Board Meeting maybe we can address some of those concerns.

Next Meeting

May 21, 2019
1:30 p.m. to 4:30 p.m.

Meeting adjourned at 4:28 p.m.

D R A F T
Public Employees Benefits Board
Meeting Minutes

May 21, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:

Sue Birch, Chair
Greg Devereux
Yvonne Tate
Tom MacRobert
Harry Bossi
Carol Dotlich
Tim Barclay
Myra Johnson

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:32 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed. TVW livestreamed the meeting.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda.

April 24, 2019 Meeting Follow Up

Dave Iseminger: At the April 24 Board Meeting, the Board voted 4-3 to pass the UMP Value Formulary resolution. As described in the past several meetings, both the PEB and the SEB Boards needed to act on and approve the same resolution before their respective June meetings in order for the resolution to be effective in the 2020 plan year. The SEB Board took action last Thursday and passed that resolution 8-0. Now that both Boards have passed identical resolutions, the agency is moving forward with implementation.

Carol, you asked for a detailed description of the exception process. We were almost ready to bring it today, but realized our pharmacy staff were unable to attend. We will bring it to the June 5 meeting so you can get any questions you may have answered. This work also jump starts our obligation under a bill that passed the Legislature requiring us to have a written description of the exception process by 2021.

Rachel Lowe provided public comment at the April 24 Board Meeting. I want to describe her foundational concerns, as we understand them. Ms. Lowe is a part-time faculty member at Bellevue College. Her work schedule is such that her PEBB Program benefits eligibility fluctuates. There's a two-year averaging rule where some people may be on the edge of eligibility that, depending on their work circumstances, may bounce in and out of eligibility. As she has engaged with the PEBB Program system over the years, when she's gained eligibility she's been presented with the need to make an affirmative election, waive, or be defaulted into the Uniform Medical Plan and Uniform Dental Plan. She successfully waived several times. Last year she missed that affirmative question to waive. She was defaulted into the plans. From that, she went through the eligibility appeals process.

You received client advice recently from the Attorney General's Office about HCA and PEB Board litigation on this appeal. Miss Lowe withdrew her appeal and the case was dismissed. That portion of her question is resolved from a legal standpoint. She also filed a rulemaking petition with the agency with specific requests about how she would like different rules changed within the eligibility framework. The response from the agency, statutorily, is due by the end of this week. We will meet that timeline to respond to the specific rulemaking request.

Ms. Lowe has raised several core concerns. I will bucket them into high-level pieces and identify which parts you have discretionary authority over, which parts are within agency administrative authority, and the parts within legislative authority.

Fundamentally, from those interactions and fluctuating in and out of eligibility, she's raised several different possible ideas. One would be to have this Board, which is within your power, change the decision that when somebody doesn't engage in enrollment process, they are defaulted into coverage. Instead, she proposes they are defaulted out of coverage.

This Board, years ago, made a decision that when somebody doesn't engage in enrollment processes after 31 days they are defaulted into coverage. It has a very long history in the PEBB Program. You could change course and when people don't engage they would be out of insurance coverage. That is within your policy decision making discretionary authority. We can engage in that discussion. There are strong views about that particular policy decision. It has been revisited a couple of times, based on larger pieces of litigation that have happened with the Program. If the Board wants to engage in that conversation, we will. But I would want specific direction from the Board that you want to revisit that, because of the historical nature of that particular policy decision, we would not bring that to you unless you specifically request it.

A second option Ms. Lowe suggested is when people waive benefits, they be allowed to permanently waive benefits instead of having to turn in a waiver form every time they

bounce into eligibility. There can be a proactive waiver for all subsequent eligibility determinations. We've looked at the statutory framework and believe the legislative intent of the statutes, in whole, leads that to be something that would need to be addressed in the legislative arena. It's not something we believe the Board or HCA can do, even if we think it's a correct policy decision.

A third area where Ms. Lowe raised ideas is when an individual receives their eligibility determination, there's often a lag. If somebody is deemed eligible at the beginning of October, they may start employment at the beginning of October. The agency may not realize the individual is benefits-eligible until the middle of October. They give that individual their positive eligibility determination. The individual has 31 days to elect. They turn in their form in the middle of November. It can be keyed for up to 90 days. There's a retro enrollment where all of the premiums are due in full from the original eligibility date.

Another suggested idea is to change the practice at which an individual is actually enrolled in benefits based on when their elections occur so there isn't this situation where an individual doesn't understand they have coverage they may or may not have been able to access, and may have had other insurance options. They may be in a situation of dual coverage. That is an area we also believe has some legislative underpinnings that would be challenging for the Board to take action on, or the agency to take administrative action on.

Greg Devereux: Would the suggestion in that instance be not to do retro enrollment?

Dave Iseminger: That is part of the idea. An individual would be prospectively enrolled in benefits instead of retro enrolled in benefits.

Greg Devereux: Thank you.

Dave Iseminger: The last area, which we are working to address, is providing transparent information about the financial implications of not engaging in the system and being defaulted into plans. At the last meeting during public comment, Miss Lowe handed me an enrollment form with language suggestions. We're looking at ways to address that, not necessarily the exact ways that were proposed, but to make it clear if you don't engage in the system, you would be defaulted into a plan and monthly premiums would be deducted from your paycheck and citing the approximate monthly UMP Classic's premium

We're working to include that information on enrollment forms, the enrollment guidebook, and within the worksheets the agency produces and agencies use to make the eligibility determinations, as well as the model notice we provide for an agency to use after it makes that eligibility determination. The agency must provide a notice to the employee with their appeal rights. They either have to use the worksheet we produce or the model notice. If we add it to both of those, it will increase the information provided to individuals when they get those eligibility determinations. We're working at cleaning up and providing more information in all of those communication materials. I'm sure many of you are aware there are a wide range of reasons that there are cycles that

happen in the PEBB Program. We are in the midst of doing that for materials produced for the 2020 plan year.

I also want to highlight assertions about savings in the system during the public comment last meeting because the Board is looking for money to increase the basic LTD benefit. The claim was there are thousands of dollars being wasted, taxpayer dollars, because of this default system.

This gets into how the funding rate is created. I'll remind the Board that foundationally, the funding rate includes assumptions about the population that is going to waive benefits, based on historical waiver practices. Whether an individual permanently waives, if that were an option, versus having to waive every time they were eligible, wouldn't materially change those fundamental assumptions. The funding rate represents an average that's needed to fund the entire system. Agencies and higher education institutions are obligated to pay the Health Care Authority that funding rate even if that individual waives benefits. These proposed changes would not result in additional relief within the employer funding rate that funnels through agencies. While there would be a financial impact from the individual's paycheck and what they're paying for those defaulted benefits, there wouldn't be savings generated on the employer side.

The employer contribution, under the Collective Bargaining Agreement, is 85% on a tier-weighted average. The bulk of the funding coming through the program already has accounted for historical waiver practices. I want to be very clear that we do not believe any of the ideas proposed would result in material changes to the funding model that's been created for the employer-funding rate.

That was the issue described last meeting. The agency is working on the rule-making petition, to explain the various pieces of the ideas we believe need statutory amendments. We are making efforts to improve the communication piece in the various communications agencies are required to use, or that are given to employees, to make it clear about the financial implications of being defaulted into a medical plan.

Sue Birch: That was a very thorough presentation of follow up items. I want to ask for clarification because I wasn't there, did all five of these come from Miss Lowe?

Dave Iseminger: Miss Lowe had an eligibility appeal dismissed out of Superior Court, a rulemaking petition, and has engaged in correspondence with the agency and the Governor's Office with various ideas. I've synthesized the core of the entire package. These weren't all pieces specifically raised last month, and felt I could give you more of a holistic view, now that the Board and the agency aren't under a litigation context.

Sue Birch: Thank you, that's very helpful. Do Board Members have suggestions? I have some thoughts about asking staff to go back, do some work, and bring these issues back to the full Board so we can get more information and staff have more time to thoroughly present to us.

Tim Barclay: Would it be feasible, or how much disruption would it cause, to allow people a window of time that they could later decline coverage once the paycheck adjustment has caught their attention. For whatever reason, they didn't take action and

then we get down the road to the sequence of delays you talked about that are in the system. They notice when it hits their paycheck. If they immediately respond, is there a way we can give them a window to do that and undo the whole thing?

Dave Iseminger: This gets into the IRS Cafeteria Plan election rules. They are stringent in being able to retroactively adjust your elections mid tax year. Even in instances of mistakes or misunderstandings. I think that is why higher education has a two-year averaging rule to help smooth out the fluctuating eligibility that happens on the edge of the PEBB Program eligibility framework. Many people, including in Miss Lowe's circumstance, realize this right at open enrollment. Her out-of-pocket premium was limited to that fall, 3-4 month period. Then, during the annual open enrollment, she waived coverage effective January. When an individual notices this and it is close to the annual open enrollment, they're able to fix it prospectively. But unwinding it under the Cafeteria Plan rules presents significant legal risk.

Sue Birch: Having come now from a decade of trying to make sure that people have access and coverage, it does concern me that everything that's been proposed moves in the opposite direction. I feel like staff need to come back to the full Board with more thorough information if we're going to move in that direction. I certainly have a duty to remind everybody that access, coverage, and moving in the direction of keeping people covered, appropriately, and I understand the affordability piece, but I think we're going to need a little more information if we're going to dive into something of this detail of what's being requested. This is a significant step backwards to what we've been working on for the past decade.

Greg Devereux: I second what Chair Birch said. I think this opens a Pandora's Box and cuts coverage. The chaos it would create in many instances would be negative. I would be reluctant to go backwards. HCA staff time is incredibly valuable. I think there are other things more valuable than this.

Myra Johnson: My question piggybacks off that. How many members would this impact? I'm concerned, too, about actually having the coverage that's needed. I want to know how many people would say, "I need my money and I'm out." I'm concerned about that.

Dave Iseminger: Even if we went down the path of these ideas, I would anticipate the agency would strongly encourage both the Legislature and Board to keep in place the requirement that you can't just waive coverage and not be insured. Right now, you can only waive if you have certain qualifying coverages. You can't waive to not have insurance coverage. We would still strongly encourage that piece stay in place.

When it comes to data, there are a couple of different ways to think about this. In our modeling, based on historical averages, there's around 7%-8% of the population that waive benefits. In theory, all of those people could be individuals who would want to waive permanently, if that were an option. The other way to think about it is how many people are defaulted into coverage? That has turned out to be a data point that does not exist in our data systems. At least not very easily, and the numbers that do exist are underrepresenting the default rate.

We did an analysis of data in 2018 that showed something close to 325-350 people that defaulted. It showed that only 16 people in higher education were defaulted. That seemed like an odd number so we started digging into it. It turns out what we are measuring as a default is after somebody makes a selection, there's 90 days for that form to be keyed. The default we're registering are people who after 90 days the system defaults them. But what happens, and this actually happened in Miss Lowe's circumstance, after 31 days, her agency keyed the default. That doesn't show as a default in our system even though she was defaulted into coverage. Layer on top of that, because of the Workday system and we don't accept empty fields in our interface, none of that data represents anything that's happening at UW, our largest employer.

We are looking at different ways to capture the data. We're trying to tackle that in the IT build we're doing on the SEBB Program side, which we hope to use in the PEBB Program in the future to capture more accurate default rates. As it stands now, it's proving to be quite elusive to get that data without a manual check of files. Even then, it would not prove to be very precise.

Sue Birch: Dave, your suggestion at this point is?

Dave Iseminger: My suggestion is, unless the Board wants something specific back, we continue to work on improving communications. We are going to change the enrollment form, the guidebook, the eligibility notice worksheets that we provide to agencies, and the model notice. All of the other components we've evaluated, with the exception of the Board's decision to default people into or out of coverage, are all things we think require at least some legislative discussion. We could certainly engage about those ideas with the Board, but it would also require, in most instances, legislative action. I could do a status update at a future meeting as to how our communication efforts are going. If the Board specifically wanted to engage in a conversation about what the default position is, we could do that. I'm sensing from at least two or three Board Members there's not a particular interest in going down that path. I want to make sure I understand correctly.

Harry Bossi: I'll be clear. I think the option of improving communication is the only one that requires any real effort.

Sue Birch: Thank you for that, Harry. We'll give staff the direction to proceed with the communications piece. If, over the summer, you were to receive some legislative interest in this, you could bring it back to the Board. I think at this point, I'm seeing folks don't want to go back and revisit these issues.

Dave Iseminger: The overlay of that eligibility appeal in Superior Court was challenging for the agency to engage with Miss Lowe. Now that the eligibility appeal is no longer pending in Superior Court, we can have more direct communications with Miss Lowe to make sure we understand everything I've said today is comprehensive of the concerns and ideas she's raised. We can talk through with her the more detailed challenges related to those issues and what we are able to do to address concerns she's raised.

2019 Legislative Session Debrief

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division. Slide 2 – Number of Bills Analyzed by ERB Division. At the end of session, we completed 336 bill analyses. We were lead on 135 bills and support on 201 bills. Ninety bills had high impact to the agency and 246 had low impact.

Slide 3 - Passed Legislation – Bills signed by the Governor. 2SHB 1065 protects consumers from charges for out-of-network health care services. This balance bill issue is resolved after many attempts. It specifically relates to services received in an emergency setting. Anesthesiologist services. Things that a member wouldn't have any control over whether or not the provider providing those services are in network or out of network.

Dave Iseminger: That's a change across the entire commercial health insurance market and also includes the Uniform Medical Plan.

Cade Walker: EHB 1074 increases the legal age of sale for tobacco products from 18 years of age to 21 years of age. The SEBB Program and PEBB Program tobacco surcharge is assessed to members who attest to using tobacco products. That surcharge is not applicable to those who use vapor products. Given this legislation and the way they have couched the definition of vapor products, and including it in these tobacco increased taxes and increased age of accessibility for tobacco products, we think it warrants bringing to your attention as something that will come before you.

Dave Iseminger: Since you, as a Board, enacted a tobacco definition when the surcharges were required in 2014, we have been watching how various parts and levels of government and agencies are treating vaping products. At some point, there may be a fulcrum passed, and the world has changed enough that we would bring back to you a suggestion to modify your definition of tobacco products. This is another piece of that puzzle. We're not anticipating anything this Board season related to tobacco products and vaping. But we will be looking at this legislation and other things happening in the market in the past couple of months to see if there is something to bring back to you during the 2020 Board season.

Cade Walker: ESHB 1099 requires each health carrier to post on its provider network whether mental health providers are accepting new patients and publish certain information of its network accessibility. A bill we were in support of and our carriers are already in compliance with. We will continue to see enhanced accessibility and transparency related to mental health services in our state's health carriers.

Harry Bossi: On 2SHB 1065, was there a PEBB fiscal note or cost associated with this enactment on PEBB itself?

Dave Iseminger: Yes, we did produce a fiscal note. Our agency identified it as indeterminate, but our best estimates at the time were around a potential \$7 million impact to the claims fund. We will be monitoring closely to see if that warrants any adjustments to the funding rate in future years.

Cade Walker: ESHB 2140. We bring this to the Board's attention because of the impacts it has on the SEBB Program population. 2140 primarily was adjusting the levies for K-12 school districts. However, included in that legislation was a carve out, or a delay, of the Educational Service District employees who are not represented. It carves them out from participating in the SEBB Program until January 1, 2024. It also made sure to include language that allowed permissible participation by the ESD non-represented employees in the PEBB Program. Again, that's permissive and there are some ESD employees currently in PEBB Program benefits as an employer group. They are allowed to remain and any other ESD non-represented employees could join the PEBB Program at their discretion. But as of 2024, they will be required to participate with the SEBB Program. That was the only eligibility change this session to the SEBB population's eligibility for benefits.

Tom MacRobert: Why wouldn't they automatically wish to join? Who are the non-represented ESD personnel? Are we talking custodians, or who makes up that population? What was the rationale behind carving them out?

Cade Walker: I don't have that information readily available. I could give you an estimate on the numbers that shows the split between represented and non-represented ESD employees. From our understanding, there's approximately 300 represented ESD employees and approximately 3,000 non-represented ESD employees. Approximately 9% of them will be participating in the SEBB Program, as of January 1, 2020.

As far as a rationale goes, we did hear from public testimony from the ESD representatives there were significant budget concerns. It's worth noting that their funding model in the ESDs is substantially different than the funding model for K-12 districts. ESDs are funded largely through purchasing of services from the school districts and not through the funding model that funds K-12 school districts in general. That issue was raised on several occasions related to the expense the ESDs would incur for benefits for those employees.

Dave Iseminger: Another part of 2140 requires a new legislative report from the agency to talk about the funding mechanisms of ESDs to help address the concerns related to their funding models and the SEBB Program.

Cade Walker: ESSB 5526 - Cascade Care/Public Option, requires the Health Benefit Exchange and the Health Care Authority, in conjunction with Office of the Insurance Commissioner (OIC), to develop standardized plans, contract with health carriers, and develop a plan for premium subsidies for individuals purchasing coverage on the Health Benefit Exchange. It's anticipated that the ERB Division will lend its expertise to acquire available commercial plans and assist in those efforts as the law continues to roll out.

Dave Iseminger: This doesn't directly impact the PEBB Program or the SEBB Program. We want you to be aware of commercial activity in the products and efforts HCA is doing in its portfolio, even if it doesn't directly impact you.

Sue Birch: I want to applaud your participation particularly, Dave, in the process. I think the Board needs to be aware as we have more defined tools and refined all payer

claims database information. We can look at precise costs. There is a benchmark now in Cascade Care. It gives us the opportunity to look to see if we really are driving the value proposition, and can we get costs down? It will ultimately help our book of business.

Cade Walker: 2SSB 5602 directs the Health Care Authority to administer family planning programs for individuals 19 and over, prohibiting discrimination on the basis of gender identity or expression. Health plans are required to cover certain reproductive treatment and services.

SSB 5889 protects communications between health carriers, providers, and adults covered as dependents on a parent or legal guardian's health insurance. If you have adult children covered under your health benefit plan, they have the same privacy and security as their parents, and the communications are sent directly to those members, not solely to the subscriber.

Slide 6 – Passed RX Legislation. E2SHB 1224 requires health carriers, pharmacy benefit managers, service administration organizations, and drug manufacturers to report certain pharmacy data to the Health Care Authority and provide advance notice of price increases on certain drugs. It also requires the Health Care Authority to provide an annual report to the Legislature on the data submitted related to pharmacy.

Dave Iseminger: As E2SHB 1224 made it through the process, it did not ultimately result in a mechanism for members of the public to look at the information, but the Legislature is able to see that information. It keeps the spotlight on the purchasers.

Cade Walker: ESHB 1879 requires health carriers to use evidence-based pharmacy utilization management criteria and have a clear and convenient exemption/step therapy exemption process.

Dave Iseminger: Carol, that is what I was alluding to in answering your question and being able to prepare that for members as we move forward with the UMP Value Formulary implementation. ESHB 1879 applies to plans that are in the market as of January 2021. We will be doing the steps necessary to describe the exemption process to members long before the law requires it.

Tom MacRobert: There were several bills initially that talked about transparency with the cost of pharmaceuticals. Those bills were fairly specific. They would have to report the rationale for why they were raising the prices of certain drugs. Based on what you said, I assume those bills did not happen, is that correct?

Cade Walker: That's my understanding as well.

Slide 7 – Newly Required reports for ERB. Today we were informed the Governor vetoed the requirement for HCA to submit the report for the Medicare eligibility retirees addressing the rising costs of prescription drugs and member premiums.

Dave Iseminger: I read the veto message today and it indicated HCA has effectively provided this report already to the Legislature. The veto message was about the

Governor's request for funding to be able to add supplemental lower cost Medicare options in the Medicare risk pool. It informed the agency to continue with efforts at looking at procurement activities for moving forward with presenting additional options, rather than using the time to do another report. It didn't veto the idea of moving forward with procurements.

Cade Walker: On February 5, 2020, a report is due to the Legislature regarding the total amount the SEBB Organization's billed for benefits and which districts and SEBB Organizations that did not submit payments by January 31, 2020.

Dave Iseminger: The way the funding mechanism works with K-12, it's similar to the PEBB Program area where the Legislature gives the employer funding rate to the home agencies. The Health Care Authority bills the agency for the number of eligible subscribers and the money comes to the Health Care Authority. It's similar, but more complicated in K-12. The money goes from the Legislature, to OSPI, to the district, and then HCA. A lot of that happens at the end of the month. The Legislature is interested in making sure the cash flow is up and running with the program. HCA is to report to the Legislature who is paying in a timely manner and who is not.

Cade Walker: By November 15, 2020, HCA is to report to the Legislature regarding the feasibility of consolidating the SEBB Program into the PEBB Program, with an anticipated start date of January 1, 2020.

Greg Devereux: Cade, does that imply there was an earlier feasibility study?

Cade Walker: In 2014, Senate Bill 5940 required HCA to submit a report that looked at various options for consolidation of K-12 benefits. I was the lead author on that report so I do know that report included various options for the Legislature to consider consolidating K-12 benefit purchasing into a single program, combined with the PEBB population. It considered a single PEBB Program with two different pools under the same jurisdiction of the PEBB Program. It also looked at a separate SEBB Program in different iterations. The Legislature's asking for a specific report related solely to the feasibility of SEBB as it currently sits being added into PEBB by 2022.

Dave Iseminger: Greg, there hasn't been a SEBB Program in order to do a specific study of the exact program with the PEBB Program. The concept of the various pooling options within a single program has been tossed around in a variety of different reports related to the consolidation of K-12 benefits. This is a specific report about combining SEBB and PEBB. We will be looking at that with the assumption of a consolidation by January 2022.

If this were to happen, it would require legislative action. The Legislature is asking if the the decision was made in 2021 to move forward, could it be in place in 2022. There will be many stakeholders between both programs, both populations, that will have an interest. HCA is working through the planning phases. We will bring this to as many stakeholders as we can to talk about the different pieces as we build that information for the Legislature.

Yvonne Tate: It's a good idea in terms of cost containment to combine the two. It's almost like they're doing duplicate work anyway. I know there's some variation, but from a cost containment and staff workload standpoint, it would be better.

Dave Iseminger: Yvonne, thank you for those comments. Having to keep track of which Board I'm talking to on which day would be a little easier. The prep work for Board Meetings would be a little easier. There are many pros and cons to go through. There certainly are some efficiencies, but other things would be lost having two programs with unique features consolidated into a single pool. I definitely appreciate from the administrative complexity, those comments. Having a single purchasing lever would be beneficial if it was one program. It would be easier from the contracting mechanism to be able to leverage that purchasing power.

Sue Birch: With all the transformation efforts in place and playing out in our state, other variables will play into this feasibility as well. So 2408, public option, movement on cost containment, many issues will play out. This is a long way away and I applaud staff for getting on it, but lots of work to do.

Cade Walker: The last report referenced is due by December 31, 2020 in regards to House Bill 2140. HCA will report on current costs and the health plans offered by educational service districts (ESDs), a comparison of those costs, the benefits of the ESDs that would participate in the SEBB Program, and report on the revenue sources for ESDs. We look forward to working with the ESDs.

Tom MacRobert: There were two bills somewhere in process and I'm assuming they didn't pass. One was to change the risk pool so the K-12 non-Medicare retirees would switch to the SEBB Program. The other was to add a non-voting member from the Office of the Insurance Commissioner to the Board. I'm assuming neither of those passed.

Cade Walker: Correct.

PEBB Finance 2019-21 Budget Update

Tanya Deuel, PEBB Finance Manager. I'm back to give you the final numbers of the 2019-21 Biennial Budget. On April 24, I gave you an overview. Today, I will share the final numbers.

Slide 2 – Funding Rates. The funding rates are the amounts paid by state agencies and higher education, per employee per month, to HCA for medical/dental/life/LTD coverage. These amounts were set for fiscal year 2020 at \$939, and for fiscal year 2021 at \$976. These amounts are adequate to maintain the current level of benefits, plus a few additional ones. We don't have significant concerns with any of these rates or the underlying assumptions.

Tom MacRobert: I am curious if the funding rate for 2018 and 2019 was \$939 also.

Tanya Deuel: No. For the current fiscal year, it's \$916 and I cannot remember what it was the year before.

Slide 3 – Medicare Explicit Subsidy. We had an exciting year when the subsidy increased from \$150 to \$168 for plan year 2019. In plan year 2020, there was an increase to \$183. As a reminder, the language states, "or 50% of the premium, whichever is lesser." You will see those reflected when we come back and present you the premiums for 2020.

Slide 4 – Decision Package Funding. Third Party Administrator (TPA) administrative fees for the Uniform Medical Plan, the Uniform Dental Plan, and the Medical Flexible Spending Arrangement are \$6 million. These accounts are where we need the spending authority to go and increase the amounts we pay these TPAs, mainly driven by the increased enrollment in these plans.

The Centers of Excellence decision package was \$1.3 million. Again, the spending authority for the administration that goes with our total joint replacement and spinal fusion bundles, plus the potential administration associated with a third bundle in calendar year 2021.

Dave Iseminger: HCA does not have a specific service described for the third bundle. HCA is working on identifying that potential topic for this fall to go forward with procurement later this fall or early next year in time to launch for 2021. The funding to support the launch of that bundle was provided.

Tanya Deuel: The ERB Division staffing decision package is to staff Customer Service for retiree support, additional outreach and training, and increased responsiveness.

Carol Dotlich: I'm interested in, at some point, knowing how many patients are using these bundles and what their success rate is. If we could get data about that, I'd be very interested.

Dave Iseminger: Carol, we can bring back two years' worth of the total joint replacement bundle in place and so we have a more robust information about that. The spinal bundle launched January 2019 so as we get further in, we will bring information back to the Board. We can do an update on the Centers of Excellence Program.

Carol Dotlich: That would be very good. I've been talking to people about these bundles and a lot of folks are not aware. Anything we can do to make people aware of that opportunity would be good.

Dave Iseminger: We'll describe the communication efforts and outreach. We will include what the communication efforts are and how we proactively reach out to people that might be interested in the program.

Tom MacRobert: The \$6 million TPA fees are an increase? What is the total amount of TPA fees paid per year?

Tanya Deuel: For the Uniform Medical Plan, approximately \$60 million per year. I don't have the UDP and FSA data with me. They change every month based on enrollment. I'll get you the most recent closed-year numbers.

Dave Iseminger: Tom, when you look at our enrollment, every year we get somewhere between 2,000 and 2,500 members through natural growth in the program, or a new political subdivision wants to join. Occasionally there are larger groups that want to join and be part of the PEBB pool. Those numbers will be even higher. For the past few years, there's been natural growth. Every January there's a bump of about 1,000 to 1,200 new members. On a monthly basis, it's about 200 new members. There is this natural subscriber and member growth that happens. We have been trying to account for that in the spending authorities within the accounts.

Tanya Deuel: You might see this again next biennia that we may have to submit another decision package just to keep up with that increase in enrollment.

Greg Devereux: Is the \$6 million driven mainly by the anticipated increase in the flexible spending accounts, under 50,000?

Tanya Deuel: No. That was included in a fund transfer from OFM that we'll get on the next slide.

Slide 5 – Other Budget Language. These were items funded through the budget but not necessarily through the decision package process. Nutritional counseling was the first one. Beginning in calendar year 2020, in the Uniform Medical Plan will increase the lifetime visits from three to twelve.

Dave Iseminger: I would refine. We'll bring to the Board a resolution to make that benefit change. That benefit change is within your authority but everything is teed up. Everyone agrees you have the financial ability to make that change if you wish.

Tanya Deuel: The long-term disability language allows the Board the authority to increase the basic LTD benefit through changes within the current benefit structure, meaning it stays cost neutral within the program.

Dave Iseminger: At the April 24 Board Meeting we started to set a framework for a discussion about how the timeline looks for potential changes, both within this benefit swap authority, as well as a potential future decision package. We will have another discussion about this authority before the June 5 Board Meeting.

Sue Birch: Dave, can you explain to the Board what we'll be doing to tie in our work and thought process about the new long-term care trust benefit, and how that impacts our LTD coverage? Far out into the future. Four years out, so I know we have plenty of time. Can you help the Board understand a little bit about that, as well?

Dave Iseminger: If you are following the news, Washington is the first state in the country to come up with a long-term care trust, which is setting up a new benefit structure. I believe it's at least five years out, because it doesn't show up in the four-year outlook for the budget modeling of the state. With that change it's having a benefit funded by employee contributions. We're still working on understanding the details. HCA has already identified implications of this long-term care benefit on overall medical spend, and how we're accounting for that in our future trend assumptions, for example, as well as the interplay between this long-term care trust benefit and the disability

products. It does have a fairly long on-ramp, as Chair Birch mentioned. HCA isn't the agency directly charged with creating the Trust. We have a supporting role in administering the benefit, but we will be looking at the implication it has on the disability insurance market, as well as medical spend in future projections.

Greg Devereux: LTD, it says, "allows the Board the authority to increase the basic LTD benefit through changes within the benefit structure." Is that the benefit structure just of LTD?

Dave Iseminger: It's the entire PEB Board portfolio benefit structure. It's similar to the authority the SEB Board has now. We described at the last Board Meeting some of the options the SEB Board asked us to evaluate. That included decreasing the basic life insurance benefit in order to increase the basic LTD benefit, changing the benefit structure in a variety of different ways in the dental benefits in order increase the basic LTD benefit. As Tanya said, it's a cost-neutral swap within the entire portfolio, not just within the LTD benefit.

Tanya Deuel: The last reference is funding for the collective bargaining impacts. This \$6 million funding will be transferred to HCA to fund the \$250 Flexible Spending Arrangement contribution each calendar year for those represented employees who make less than \$50,004. Greg, the \$6 million includes the associated administration costs.

Dave Iseminger: In the budget language, the tobacco surcharge description is slightly different. We will bring you a resolution in June for action in July. Previously, the budget provision said the tobacco surcharge had to be exactly \$25. The budget language just signed says it has to be at least \$25. You have discretion as a Board to set the surcharge amount. It can't be lower than \$25.

Eliminating Hepatitis C Virus in Washington State

Emily Transue, ERB Associate Medical Director, Clinical Quality and Care Transformation. Slide 3 – Background. Hepatitis C (HCV) is the leading cause of infectious disease death in the United States, exceeding deaths from all of the other 59 reportable infectious diseases combined. It's hard to express the scale of the importance of this disease.

Our estimate is about 60,000 Washingtonians are currently infected. It's difficult to get an accurate estimate because most people who have this disease are not aware they have it, typically, until complications develop. To put those numbers in perspective, for the state and for UMP and PEBB, roughly 25,000 are within a state system, 20,000 in Medicaid, 2,000 in UMP, and 1,000 in Kaiser. There's another 3,000 within state systems like the Department of Corrections.

HCV is a curable disease. In 2012-2013, a new class of medications were developed that can eradicate this disease for most people. So more than 95% of people treated with the new highly effective medications can achieve a sustained virologic response, which is ID-speak for "cure." We're always a little careful in our speech.

The Uniform Medical Plan has treated about 477 members for this disease over the last four years. We estimate we would treat about 63 a year.

Slide 4 – Governor Inslee’s Executive Order directed HCA to enter into an agreement on behalf of all Washington State covered lives to contract for these direct-acting anti-viral medications, again, impacting about 25,000 lives. We were instructed to pursue a not-to-exceed arrangement for the Medicaid covered lives, and a larger discount for the non-Medicaid lives. A not-to-exceed arrangement has been referred to as a Netflix model, or a modified Netflix model. You pay a certain amount and then use it as much as you want. It’s not entirely accurate, but generally the Medicaid arrangement will be a strict amount, and then a relatively low incremental cost for people who are getting coverage. On the PEBB Program side, there will be a deeper discount than we currently have based on this agreement. The contracted vendor must also partner with us on a public health campaign.

Slide 5. The second part of the Executive Order involves the Department of Health. Part of the Executive Order is about purchasing drugs and the other part is about a public health outreach effort, with the goal of identifying and treating all Hepatitis C-positive Washingtonians. It’s an ambitious and exciting, but achievable goal. This is happening under the auspices of Hepatitis C-Free Washington, which is shepherding community and provider engagement efforts. They have three major committees making recommendations around clinical strategies. What does the health delivery system need to do around data and strategic information, capturing those screened, capturing everyone with a positive diagnosis ensuring they get treatment to achieve cure, community services, and links to testing and treatment. How do we ensure those working closely with at-risk populations are doing that outreach and linking people into treatment, including those least likely to seek care.

Slide 6 – Current Status. On April 25, we announced an apparently successful bidder for this contracting effort, AbbVie. Currently, we’re in negotiations to achieve that contract. The Hepatitis C Free C committees have developed preliminary recommendations that will soon be out for public comment and then finally approved. Those committees have a very broad range of stakeholders involved, providers, community organizations, patient advocates, local health jurisdictions, the public health teams, etc. Beyond that, in the future we will have the potential to expand this beyond the initial scope of UMP and other publicly funded programs to include fully insured lives. This also could expand to other states and other purchasers.

I talked about the efforts the apparently successful bidder will be involved in, in terms of the public outreach. They have a testing van that goes to places like motorcycle rallies where there’s a high concentration of people who might be at risk, does on-site testing, counseling, links people into treatment. They have support programs for providers who might not be comfortable treating this condition, to make sure that they are trained in how to do so appropriately and get adequate support if they have questions. They also have connections with social media outlets. This will be a multi-faceted campaign.

For the member, there won’t be a lot of change. Members in the middle of a course of treatment will continue that, even when the contract goes into place. The preferred agent will change once the contract goes into place. If all else is equal, we would be

starting with the AbbVie medication. There is currently coverage essentially for all patients who have Hepatitis C. The current requirement is that treatment must be done by a specialist, which will probably be relaxed to make sure other providers comfortable treating this disease are able to do so. The current copay is 10%, up to a 25% copay. UMP has an out-of-pocket member cost of \$150 for a 30-day supply for most specialty drugs. This is a specialty drug, so those limits won't change. There is a potential for a significant cost savings. These are extraordinarily expensive drugs and the total cost of the program will go down. But, since the member costs are already limited, there won't be much of a change for them directly.

Carol Dotlich: You said patients are already undergoing treatment. They're going to stay on their same medication? They're not going to have to switch to the AbbVie brand?

Emily Transue: Absolutely not.

Carol Dotlich: Good.

Dave Iseminger: Emily, is AbbVie a company, a brand, a drug name? Can you clarify?

Emily Transue: AbbVie is a drug company that produces Hepatitis C drugs.

Sue Birch: What is the name of AbbVie's drug?

Emily Transue: Just as he said that it flew out of my head. I knew you were going to ask, and I'm so sorry.

Yvonne Tate: Are they still primarily targeting the baby boomer generation?

Emily Transue: There are a group of at-risk folks for this disease, and baby boomers are one of them. Demographically, and as an age band, the baby boomers are most likely, partly because they didn't test the blood supply for Hepatitis C until a test was developed. That group was most likely to receive a blood transfusion during that period. Additionally, this is a bodily fluids transmitted disease and higher rates of drug use in the 1960s may be a transmission factor. The primary areas of focus include baby boomers, the IV drug use community broadly, and a number of other pockets. It's not exclusive to that, but in terms of outreach to people who may not know they are at risk, that continues to be a significant population.

Sue Birch: I just want to commend Dr. Transue and the team that pushed this forward about a year ago, because Australia has successfully embarked on eliminating Hepatitis C, and Louisiana was just a few days ahead of Washington in announcing their plan. This is extraordinary work globally. The fact that our state is leaning in to try to eliminate this disease, and dent it like was done with HIV/AIDS in the past, with getting that disease under control, it's remarkable.

Several of us were in Washington last week and our federal partners were considering how they might credit us with some shared savings on this work, if we can figure out

how to do that extraordinary complex calculus. I know you inherited this from Dr. Lessler, but you've been part of this since the get-go. This is truly a standout effort, again, for Washington. Thank you all for what you're doing. You can see the beauty of our purchasing power and alignment in working together. This will help reign in costs because I believe we will get a much better deal for our state for this very extraordinarily expensive drug. So thank you.

Emily Transue: The long-term cost savings and the short-term cost savings from this should be substantial. The long-term cost savings in terms of people not needing liver transplants and treatment for chronic liver disease and cirrhosis, the impact on cost and even more importantly on people's longevity and quality of life is extraordinary. This is really a once-in-a-lifetime opportunity, and it's amazing to get to be part of it.

Sue Birch: I believe Washington in 2020 is going to be celebrating its success around HIV/AIDS and getting those viral loads under control.

Emily Transue: We've had tremendous success with programs looking at identification, tracking, and ensuring people who are treated achieve lowering of their viral rates among other things, to a point where they can't transmit it to someone else. That's a harder task in HIV, where you have to keep somebody motivated to do that for the rest of their life. The thrilling thing about Hepatitis C, it's a couple of months and then you can move on.

Sue Birch: You're going to take that good public health effort work and move into our next disease elimination. That's great. Get this one done. Awesome. Thank you so much.

Emily Transue: We've learned a lot. Thank you.

Eligibility and Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator, Employees and Retirees Benefits Division. I am introducing three policy resolutions today. PEBB 2019-01 modifies the resolution that passed last year dealing with CHAMPVA deferral eligibility. PEBB 2019-02 addresses retiree term life insurance for future SEBB Organization retirees. Resolution PEBB 2019-03 came in late and it's an additional type of error correction we're seeing from agencies.

Slide 4 - Proposed Policy Resolution PEBB 2019-01 – Retiree Insurance Coverage Deferral – CHAMPVA Survivors. Beginning July 17, 2018, enrollment in a PEBB Program health plan may be deferred when the subscriber is enrolled as a retiree, or survivor of a retiree, who is enrolled in the Civilian Health and Medical Program of the Department of Veteran Affairs, CHAMPVA.

Policy considerations. The Board passed a policy resolution last year that allows deferral and a PEBB health plan enrollment when the subscriber is enrolled as a retiree, or a dependent of a retiree, beginning July 17, 2018. Upon a closer look last year, we realized survivors needed adding and dependents removed because dependents are no longer eligible as a dependent when the retiree dies. They are eligible as a survivor.

Dave Iseminger: We realized there was an edge of the eligibility framework misidentified and we meant to include all survivors, not just dependent survivors. Fortunately, nobody has qualified under that part of the provision so we feel comfortable putting the retroactive date. Many of you will remember there was a long discussion about retroactive/perspective/instantaneous implementation dates, but here they have not been used. We thought it would be nicer to clean it up.

Rob Parkman: As modified, only the retiree or survivor of the retiree may defer coverage. PEBB Program health plan coverage will defer prospectively, one modification to the resolution that passed last year.

Slide 5 – Proposed Policy Resolution PEBB 2019-02 – SEBB Employees and PEBB Retiree Term Life Insurance Eligibility. Beginning January 1, 2020, an eligible school employee who participates in SEBB Program life insurance and meets the eligibility requirement for PEBB Program retiree insurance coverage is eligible for PEBB Program retiree term life insurance.

Policy considerations. This policy addresses PEBB Program retiree term life insurance eligibility for an eligible school employee enrolled in SEBB Program life insurance who also meets requirements for PEBB Program retiree insurance coverage. Currently, only an eligible employee who participates in PEBB Program Life insurance is eligible for PEBB Program retiree term life insurance. This would include a school employee enrolled in full PEBB Program benefits under a contractual agreement with the HCA at this time.

If passed, this resolution will allow SEBB Program subscribers that have life insurance through the SEBB Program to have access to the PEBB Program retiree term life insurance. The ERB Division Portfolio Management and Monitoring team and MetLife considered the possible increases to enrollment in the PEBB Program retiree term life insurance due to the implementation of the PEBB Program during previous negotiations. This was included in the procurement of the PEBB Program life insurance product at that time.

Dave Iseminger: This would be an example of one of those administrative complexities of having two programs. Essentially, people can only get PEBB Program retiree life insurance if they've been part of the PEBB Program. Now, since we have a separate program, same vendor, and same benefit design, we recommend this Board allow people to access your PEBB Program retiree life insurance benefit when they have access to your sister SEB Board's benefits. We don't anticipate a change in rates as a result. The Board must establish eligibility because you have jurisdiction over the eligibility of the retiree life insurance benefit in your portfolio. We're recommending you honor and recognize the SEBB Program's life insurance benefit as qualifying just like a PEBB Program life insurance benefit.

Greg Devereux: If the two programs remain separate and this goes through, SEBB Program folks would have access to the PEBB Program benefit.

Dave Iseminger: Greg, to clarify, as of 2020, there are completely separate life insurance benefits that happen to be identical with the same vendor with different

eligibility requirements for accessing the benefits between the two programs. Under the current model, with no changes, as a result of the retiree risk report that was submitted and we discussed here with the Board, and no changes to consolidation as envisioned in the next legislative report, when people transition to the PEBB Program as retirees, they have access to PEBB Program retiree coverage. If this didn't pass, when K-12 employees transition into the PEBB Program as retirees, they would only have access to medical and dental. Now you would say, "and you also have access to retiree life insurance."

Greg Devereux: Is there a SEBB retiree program?

Dave Iseminger: No. There are no retirees in the SEBB Program. All K-12 retirees are in your program. That's why you have two voting members - Tom and Carol and one non-voting member named Myra.

Greg Devereux: Okay. Thank you.

Rob Parkman: Slide 6 – Proposed Policy Resolution PEBB 2019-03 – Error Correction Incorrect Information. If an employing agency provides incorrect information regarding PEBB Program benefits to the employee and they relied on that information, the error will be corrected prospectively with enrollment and benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if it warrants additional recourse.

Policy considerations. Employing agencies must correct eligibility and enrollment errors they caused prospectively unless the Health Care Authority determines it warrants additional recourse. Recourse may include reimbursement of dollars paid on claims or dollars paid for other coverage by the employee while the error was in effect. It may also include retroactive enrollment.

Greg Devereux: The word "prospectively" jumps out at me. What is the current system when someone detrimentally relies on the agencies or information. What happens now? Is it prospective or is it retroactive?

Rob Parkman: It goes into the appeal process if the employee appeals based on incorrect information actioned.

Greg Devereux: How often do people in the appeal process get retroactive coverage? I assume you don't have an answer now. To me, that's an important question to answer.

Dave Iseminger: That is a great question and we'll follow up. Last Thursday we had a similar resolution with the SEB Board, and a similar question came up about "prospective." We clarified when an error is identified, the urgent and immediate issue is to fix things going forward and then sort out what is appropriate. We may amend the last sentence and bring back a slightly revised version at the next meeting.

The SEB Board asked us to change the last sentence to include, "if additional recourse including retroactive enrollment," to be very clear that the Board is saying there may be

instances where retroactive enrollment is warranted. It's set up so the Health Care Authority approves all error corrections. We have over 500 employers and closer to 800 employers with the SEBB Program. We want general consistency across both programs. In some instances, it will be coverage. We want to be vigilant about making sure there's consistency to ensure some employers aren't being more generous than other employers. We'll get you that information and revise the last sentence in a way that gives an illustrative example that retroactive enrollment would be allowed.

Carol Dotlich: I, too, was concerned about the “prospectively” word. I was concerned about the idea that somebody could just decide one way or another about the error correction action and additional recourse, if it's warranted or not. I think it's really loose language and leaves the consumers not in a good place. I would like to see improved language here.

Dave Iseminger: We will definitely add that in, Carol. The goal is to identify and fix the error going forward, then everybody huddle together and talk about appropriate action.

Myra Johnson: Will there be a timeline that the consumer would receive that information because it says we'll fix it as fast as possible and we recognize the error. But will they be given a timeline of how much time they wait to listen to hear when it will be fixed for them in the past?

Rob Parkman: They'll be enrolled prospectively. But, immediately, we have a group that works, once we get the facts in, many of the facts are very different in these situations. We gather all the facts and then usually with the employer/employee we make some decisions on the recourse.

Dave Iseminger: I think, Myra, what we'll do is bring back follow-up information about timelines for error correction when we bring back this resolution. That will provide the Board a better understanding as to the pace at which we address the retro situations. I think that's the heart of what you're asking. When a decision is made, it always comes with appeal rights. Even the decision about what HCA's authorizing an employer to do comes with appeal rights.

Sue Birch: Dave and Rob, you might want to think about a flow diagram that shows how those processes play out because this has been rectified in appeal. It's not like there haven't been corrections made. Dave's going to lay that out for us.

Greg Devereux: I understand, Dave, there have been many appeals. I've been a part of many of them when people brought things forward. I think it's a huge change to have the word "prospective" because I understand consistency is important. But all of a sudden it feels like we're substituting an appeal process for "okay, everything's going to be prospective except there may be some exceptions." I get from the employer's standpoint you want to fix it and move ahead. From the employee's standpoint, they want to know when did I have coverage and what am I going to have to pay? Those are two very different perspectives. I understand the desire, but that word really stands out and has broad implications.

Dave Iseminger: We are looking for Board feedback as we refine things to bring back to the Board. I'm curious if there is additional feedback; but we'll take a look at that point, the questions that Greg, Myra, and Carol have raised about bringing back more information and the process flow that Chair Birch asked for. Are there other things?

Carol Dotlich: My other concern is you become corrected effective the first day of the month following the date the error is identified. If my error was identified on May 5, there is going to be no fix until June 1, right? Is that what I'm understanding from this language?

Dave Iseminger: There would definitely be a fix as of June 1. That doesn't mean there wouldn't be a fix that addresses the month of May. Getting back to Greg's question about how clear, or if it's putting up too rigid of a guard rail to say the word "prospectively, but, effectively, what happens is all medical effective dates are pushed to the first of the next month. It's acknowledging, under the current system, when you are identifying an error mid-month, the medical effective date for benefits is always the first of the next month. It's just aligning with the other core effective date that's a central pillar of eligibility within the PEBB Program. Benefits are always effective at the beginning of the month.

Carol Dotlich: I understand that. But if there was an error and I'm supposed to be covered and I'm not, and it's more than two weeks before the first, what's happening to my coverage between May 5 and June 1?

Dave Iseminger: That's where the error correction recourse comes into play. This entire journey the PEB Board rules has embarked on for the last four or five years is to try to put guardrails, timeframes, and processes around that very question. In some instances, it was always addressed prospectively and it was sorting through and building the process by which an individual could say, "these are the reasons why I need this recourse" that isn't just prospective. It also involves retro. This would not be limiting any ability to address coverage in May. It would guarantee the coverage is there as of June in that scenario, then going through the error recourse process and clarifying whether the retroactive enrollment for May or more months, depending on how long the error had been in place, is appropriate.

Sue Birch: As you bring information forward and show us the flow diagrams, you'll be showing people the retroactive action you've been taking through the appeal process, and how you're codifying this going forward so the client/member/patient isn't penalized. I think your presentation in the future needs to include those components, because I hear questions from Board Members. I think staff get a sense of what we're looking for and we look forward to getting that information.

Dave Iseminger: Error correction is one of our favorite topics, as it is for all of you for four years. We'll bring back more information about this policy and additional information.

Rob Parkman: We'll incorporate Board feedback today on the proposed resolutions and bring them back for action at the June 5 Board Meeting.

Dave Iseminger: We will see if the Board's ready to take action on June 5, pending the information we provide. Even if you aren't ready on one resolution, if you're ready on the other two resolutions, you can take action on those resolutions.

SEBB Program Update

John Bowden, Manager, School Employees Benefits Section. There is a tremendous amount of work happening. We have four months until the SEBB Program open enrollment and seven until benefits go live. Today I want to focus on preparing for open enrollment.

Slide 2 – SEBB Program Funded. In the operating budget, the Legislature approved the Collective Bargaining Agreement the Labor Coalition set forward. The Legislature funded the SEBB Program with benefits materially similar to the PEBB Program and in accordance with policies adopted by the SEB Board. One piece in particular is the wellness program, SmartHealth. The Legislature also included surcharges similar to, or the same as, the PEB Board, \$25 per account per month if the employee or dependent uses a tobacco product. There is a \$50 surcharge if a spouse or state-registered domestic partner has access to employer-based coverage but waives, and then is enrolled in the SEBB Program.

Slide 3 – School Employees Moving from PEBB Program to SEBB Program. We've already discussed earlier today House Bill 2140 regarding Educational Service District (ESD) employees. All current K-12 employees in the PEBB Program from school districts that are fully or partially in the PEBB Program will transfer to the SEBB Program on January 1, 2020. Represented employees within the ESDs will also be moving to the SEBB Program. The non-represented employees will stay within the PEBB Program until January 1, 2024. ESDs can either join or continue their participation in the PEBB Program until December 31, 2023, barring any other legislative changes. All retired school employees are staying in the PEBB Program for now. The Legislature did not act to move the retirees into SEBB.

Sue Birch: What is the retired school employees' count?

Dave Iseminger: There's about 50,000 covered lives within the retiree portfolio from K-12. I should say there's about 100,000 in the portfolio and it's about a 50/50 split between K-12 and state agencies/higher education. I was speaking about the subset and not the whole.

John Bowden: Slide 4 – SEBB Procurement and Contracting. Legislation that created the School Employees Benefits Board directed the Board to leverage as much as possible from the PEBB Program. The SEB Board requested HCA submit a Request for Proposal (RFP) for fully insured medical, standalone vision, and long-term disability.

The SEB Board elected to leverage the PEBB Program for self-insured medical (UMP), dental (UMP Dental), and life and accidental death and dismemberment (AD&D).

Dave Iseminger: I will just give you a quick tour of where there are differences. Life insurance and AD&D is identical. For dental benefits, fully insured and self-insured are identical. Self-insured medical is almost identical. The SEBB Program in their versions

of Classic and CDHP have 16 annual chiropractic visits instead of ten. They changed to number of therapies to 80 combining physical therapy, speech therapy, neurodevelopmental therapy, and occupational therapy (PT/ST/NDT/OT), whereas in PEBB it's 60. They've also established another version of UMP Classic.

The long-term disability benefit structure is extremely similar, but because of the occupational differences of school employees versus public employees, the same amount of money makes a slightly richer benefit. The SEBB Program version of the basic benefit, with same dollars spent, is \$400 a month instead of \$240. It's structurally the same. The difference in the benefit is the occupational load differences between the populations.

Vision is embedded in PEBB benefits. We're going to talk about that in the next presentation versus a standalone in SEBB benefits.

In fully insured medical, the SEBB Program has two addition carriers beyond what the PEBB Program has that are still in the running for contracts. The SEB Board has not made its final decision about which carriers, which plans, where they are, or how much.

John Bowden: Slide 5 – SEBB Program Employer Medical Contributions (EMC). In the PEBB Program, the employee contribution is 15% of the tiered weighted average.

Slide 6 – 2020 Employer Medical Contribution (EMC) and UMP Employee Premiums Based on Final Not-to-Exceed Rates. Within the SEBB Program, it's done differently. In the Collective Bargaining Agreement, the SEBB UMP Achieve 2, which is similar to UMP Classic, has an 88% actuarial value, which is the benchmark plan. The employee pays 15% of that plan at each of the tier levels. The employer pays 85%.

In the SEBB Program, the dollar amount generated from that 15% of the total premium, under "Employee Only," is what the employee pays, 15% of \$679. 85% is the employer's medical contribution, 85% of \$679 is \$578. The employee's contribution is \$101 for UMP Achieve 2.

Under the SEBB Collective Bargaining Agreement, that \$578 employer contribution is the same for all plans. On the plans below Achieve 2, again you see the \$578. The employee contribution as percent of the total premium is listed in the far right column on Slide 6. The percentage varies depending on the plan.

Since we haven't finalized the contracts and rates with the other carriers, we are unable to show the percentages for those plans. They could go above the 15% and some will. We'll see a variety of percentages on the employee's contribution.

Dave Iseminger: We wanted you to see what the rates are looking like on the SEBB Program side. If you line them up with today's existing rates, in a month or two you'll be able to line them up with the PEBB Program's 2020 rates and see they are generally comparable. The hypothesis was large employer groups start to look alike. There are slight differences and they bear out in the rates. We're all in the same ballpark when it comes to rates.

Slide 6 also highlights one of the other benefit differences between the PEBB and SEBB Programs. The PEBB Program has four versions of UMP. UMP Classic is the equivalent of UMP Achieve 2, with the exception of the chiropractic and PT/ST/NDT/OT limits I referenced. The UMP High Deductible is the equivalent of your UMP CDHP. UMP Plus is the exact same piece that is the UMP Plus within the PEBB Program. The SEB Board has added UMP Achieve 1, which is similar to UMP Classic, but the deductible and out-of-pocket maximum drops to an 82% actuarial value. The SEB Board was interested in adding another slightly lower AV plan to the portfolio because of the wide range of salaries and incomes that exist across classified and certificated staff within the K-12 system. They wanted to provide additional affordable options and still have a robust benefit at a lower AV compared to UMP Classic.

Sue Birch: Can you say more about the deductibles on the UMP Achieve 1?

Dave Iseminger: I will bring that information back because it's nuanced enough I can't remember it, but they are higher out-of-pocket maximums and deductibles. As we go forward in learning things from the SEB Program, we will present a variety of different opportunities over the next couple of years to this Board of things that you may want to leverage. There may be another UMP version you want to copy and bring into the PEBB Program. We will definitely give you information about UMP Achieve 1.

Harry Bossi: I'm interested in the tier cost. Why isn't the employee, spouse, and family 2.75? Why is it three? Is that different than the PEBB Program?

Dave Iseminger: Yes, it is different in the PEBB Program. There are things to keep track of between the two programs. That is yet another one. The Tier ratio is different when it comes to that Tier 4 rate. Now in the K-12 system, there is currently wide variability when it comes to the Tier ratios. John, in a previous incarnation of his work at JLARC, did a study related to the tier ratios that exist. It showed a robust unaffordability of being able to add dependents. The Legislature, in the consolidation of the SEBB Program, said the ratio shall not be more than 3:1. The SEB Board could have set any number it wanted, just like you could. Megan Atkinson, our CFO, would say, "there is no perfect tier ratio." You're talking about the amount of money needed in the system, and exactly how it's being spread across different enrollment situations. It's not a perfect, mathematical equation.

The SEB Board could have condensed to 2.75 at the family ratio. In fact, they asked about information related to that. The concern the SEB Board had was there's so much change and shock going into the K-12 system at the same time, they were not comfortable to further compress beyond 3:1. It was a deliberate conversation at the SEB Board and there is a long history of the tier ratio compressions within the K-12 system. Changing to 3:1 was a significant enough advancement and to go to that extra quarter people weren't ready to do that.

Harry Bossi: Past experience in open enrollment meetings had employees saying, "my neighbor has seven kids and I only have one. Why shouldn't they pay more?" The feedback we got from actuaries was it doesn't matter. In a large group, one or seven is going to average out to one. Whether you believe it or not, that's what the numbers say. I thought that would hold true, that if it's 0.75, I've got however many

children/dependents, and I was single but then I added a spouse, why would I go up to three instead of 2.75? It's certainly their decision and I'm sure it was a carefully thought-out one. It's different than what we're used to.

Dave Iseminger: Harry, it definitely doesn't change the truism that the actuaries really show the number of kids washes out in the grand washing machine. But the SEB Board was worried about just that extra little piece. You will have some interesting scenarios that individuals often have to think about in the K-12 system. If there are dual eligible spouses that are married and one of them waives to be on the other and they have a child, then they're going to pay three times, which would be different if they stayed on separate accounts and only one of them enrolled the child. Then they might pay 2.75. Then you start thinking about the out-of-pocket maximum, combined family deductibles, and determine its worth? That was a very deliberate conversation. Yet another difference between the two programs.

Greg Devereux: In our system, the weighted average is 85%/15%. The 15% for Achieve 2 is the benchmark. But what would be the weighted average of everything in their system?

Dave Iseminger: We can't produce that weighted average until after the enrollment occurs. That is another fundamental difference you see between the two programs here, is the PEBB Collective Bargaining Agreement is a 85%/15% split of a tier-weighted average. We have the enrollment mix when we started the collective bargaining process for the PEBB Program. PEBB Program benefits have been in existence for years. There was already a general understanding of the enrollment mix. That doesn't exist yet in the SEBB Program and won't exist until after November 2019.

The SEBB Collective Bargaining Agreement was a benchmark plan to apply on all employees instead of a tier-weighted average. That means the number is fixed. The \$578 is a fixed amount across all tiers in this table. If you elect a richer plan from the benchmark, your employer contribution won't go as far. You'll have a greater share as an employee if the premium split. If you pick a lower AV plan, or a less rich plan compared to the benchmark, your employer contribution goes further. Calculations will eventually be done to see what the actual mixed average would be. We aren't there, yet, Greg.

Greg Devereux: So, potentially, the Legislature may be putting in more than 85% for the overall amount even though it's \$578.

Dave Iseminger: I don't think that's the case, Greg. It's a benchmark of, "here are the number of eligible employees and, for each employee, the fixed dollar amount is 85% of an 88% AV plan." It's whether that goes further.

Greg Devereux: Of one plan. But if you look at the employee contributions, 15% is only a benchmark for one plan. Presumably, the weighted average would be less than 15%, which by definition, means the employer share has to be higher.

Dave Iseminger: Greg, I think you're saying if everybody enrolls in UMP Achieve 1, then the state will have paid more than 85%. If the enrollment mix ends up that, then

certainly that could be the end result of the most recent Collective Bargaining Agreement.

John Bowden: If an employee picks a plan with a premium of \$800 and you subtract the \$578, the employee will pay closer to 25%, \$200 out of the \$800.

Dave Iseminger: It's possible, Greg, when the enrollment mix comes in, the money that was promised on the 88% AV benchmark plan will go further than people had anticipated, based on what individuals elect under the current bargaining agreement. Both sides will evaluate that in future collective bargaining. There was no way to start the SEBB Program using a tier-weighted average when the data does not exist for the plans that didn't exist. The procurements hadn't even been completed in the SEBB Program for fully insured. The only thing available at the time of collective bargaining was the framework of these four plans. That was where the SEB Board was in its journey. They established the authority for four self-insured plans just in time for collective bargaining. That was the best information that could be used to craft an agreement in time for the legislative session.

Sue Birch: We simply didn't have the historical data. When we have it, we'll be examining it. We will be revisiting that over time, I'm sure.

John Bowden: Slide 7 – SEBB Program Website and Member Communications. Communications were created for current PEBB Program members transferring to the SEBB Program. We're talking with the SEBB Organizations that have employees enrolled in the PEBB Program and we're sending information to those employees to let them know what the SEBB Program is all about and what their benefits will look like. We are sending toolkits to the employers to help in that transition. One mailing was sent to members letting them know what's happening. They will receive additional mail in September, including the enrollment guide.

Slide 8 – First SEBB Program Open Enrollment. The SEBB Program open enrollment is October 1 through November 15. Employees are getting extra time because of the amount of change they will experience. The current plans of many of the employees will not be available in the SEBB Program. They need to determine where their current provider is located. There is overlap in the provider networks so we're thinking the majority of them will be able to find their provider.

HCA will provide trainings to the districts' personnel/payroll staff in August and September to get them familiar with the changes in order to assist their employees. There will be a toll-free line for technical program support, ongoing phone and secure email support from HCA Outreach and Training staff to help with the process. The required tool for enrollment is through SEBB My Account. There will be limited paper enrollment possible for those employees without access to computers or need an enrollment form in a different language.

Slide 9. School employees will receive newsletter mailings and the enrollment guide. There will be a virtual benefit fair and about a dozen live benefit fairs around the state. There will be a plan selection support tool available called ALEX. HCA will also provide "how to" videos for employees to become familiar with SEBB My Account.

Dave Iseminger: We're piloting the ALEX tool in the SEBB Program. HCA will use the SEBB Program experience and evaluate how it went to determine if we go back to the Legislature and ask for a permanent funding stream for both programs to help people select and understand the benefits before them. With all the changes occurring in the K-12 system, if an employee has access to 17 plans, we want to make sure there is a tool to help in making a decision. We'll evaluate after open enrollment to see if it makes sense to bring it to the PEBB Program, or not use in either program.

John Bowden: Slides 10 – 12 – SEBB My Account. These slides show you what SEBB My Account will look like. It allows you to log in as a benefits administrator or an employee. You can make benefit selections, do attestations, and upload verification documents for dependents. If you have a smart phone, you can take a picture of a birth or marriage certificate, upload it, and have it approved without having to bring in the document. You can make the changes for special enrollments, print a statement of insurance, and access supplemental coverage.

Dave Iseminger: Many of you are familiar with PEBB My Account. It does not have the same functionalities as the SEBB My Account. We were reticent to have an initial enrollment of 130,000-140,000 people with paper, so we used the framework of PEBB My Account and once you're in the system, you're allowed to make certain types of changes. We took that IT system, copied it, and made a vast number of improvements to allow initial open enrollment plan elections electronically.

Our plan is to retrofit PEBB My Account to allow people to enroll in benefits without having to use a paper form and use an online portal for making benefit elections whether they're employees or retirees. Our IT team has spent a lot of time building these pieces.

John Bowden: Slide 13 – SEBB Program Virtual Benefits Fair. This is currently a concept design. I want to highlight the colorful picture in the center. You see booths just like at a benefits fair. The employee can go click on a booth that says, "Medical Coverage," "Dental Coverage," "Vision," etc. From that booth, it takes the employee to videos the carriers will produce about their products. They'll be able to print the information about those different types of services, plans, etc., go into SEBB My Account, and make your benefit selection.

Slide 14 – ALEX – Automated Benefits Counselor. ALEX is a user-friendly tool, highly interactive, and confidential. It follows HIPAA rules so you can enter your personal information knowing it's protected. Once your information is entered, ALEX will make suggestions about plans available in your area and what might be a good fit for you. It does not make a recommendation. You can go online anytime, anywhere, and use ALEX. There are links from SEBB My Account, information, you can go back and make your benefit selection. If you need additional information about what's going on in the SEBB Program, there's an URL, Frequently Asked Questions, and information about what the Board is doing.

Dave Iseminger: There is a lot of work going on developing the SEBB Program. We've done multiple procurements, benefit design, revisited things we haven't looked at

in 30 years, including Pay1 and PEBB My Account. We've made advancements in time for the SEBB open enrollment. During plan year 2020, we'll work with the PEB Board on things within your authority to possibly leverage these advancements for the PEBB Program in 2021, taking those IT investments and other experience tools we've developed for members, evaluating them for use in both programs. It's an exciting time. You get to see the results of some of the pilot pieces being used in the SEBB Program.

Sue Birch: Because our state has made nearly \$400 million of investments into the Health Benefits Exchange, we keep looking to our eligibility enrollment partners there see if there is any bridging, technology, or re-use? Our federal partners are seeing our public option work and suggesting we might want to keep looking at how we harmonize things and stop having different tiers. Even some of our commercial friends who have large businesses are looking at how we use that utility. This is extraordinary what staff have put up. This whole space keeps evolving, about eligibility and enrollment, and we still have miles to go, but it's been extraordinary with how far we've come.

Carol Dotlich: I'm concerned about customer service. I know there have been great improvements and I'm very appreciative of that. But I'm wondering, with all of this new business going on, if the consumers we have that are elderly are going to be able to get the kinds of assistance they need during open enrollment. Everybody's going to be in the system all at once or is it staggered?

Dave Iseminger: There's overlap between them, Carol. The SEBB Program open enrollment is October 1 through November 15. The PEBB Program open enrollment is November 1 through November 30. We deliberately did not align the ends of both open enrollments because we know about one third of all PEBB Program changes happen in the last 48 hours of the month. We didn't want the system jammed. The Customer Service line was built for retirees and was not meant to handle questions from state agency employees or school employees.

We will be very clear about that in the materials we publish. The 1-800 retiree line number won't be published in school employees' materials. That doesn't mean people won't be able to find that there's a PEBB Customer Service line, but we will be clear in the call triage that this is not where you go for these questions. You are to go to your school district. We're trying to be as deliberate as we can to make sure it's clear that the Call Center number is designed for use by retirees, not school employees or state agency employees.

When we implemented a triage tree a year or two ago, it helped. I believe it says, "press one if you're an employee of a state agency." When they press one, it explains where to go for to get their questions answered. We diverted two or three thousand calls just by adding that feature. There will be similar information about school employees and directing them to the proper channels for their questions. That's in the works now because we're starting to get the calls already from school employees on the PEBB retiree call line.

Tom MacRobert: As a member of the PEBB Program, if I live in King County I have multiple plans I can choose. If I live in Stevens County, I have a lot less available to me. It's almost like which county you live in determines what's available to you. Looking at

school districts, they cross county lines. How is that going to work? Is every school district in the state going to have access to the same choice of plans, or depending on where you're located? Are you going to have fewer plans available to you, or will it be equal?

Dave Iseminger: Insurance offerings in our state are on the county-wide level. For school districts within a county, the offering is based on county lines not school district lines. School employees will have access to benefits based on where their home residence is. It's based primarily on your residency and which plans are offered by carrier for that entire county. There is a strong possibility of more carriers and additional choices in the SEBB Program portfolio than the PEBB Program portfolio. I believe there are 14 counties that are UMP only in the PEBB Program portfolio. Going forward with the SEBB Program, there will not be 14 counties with UMP-only offerings. There will be additional choices due to the robust carrier offerings that will exist in the K-12 portfolio. The way we did our procurements, HCA would be able to leverage those contracts for the PEBB Program if they sign and launch with the SEBB Program. HCA will look at that in 2020 for plan year 2021.

Myra Johnson: As a school employee, thank you for all your due diligence and hard work on this. I'm excited to see and hope it goes well and there are no crashes because there are millennials who know how to do this stuff pretty quickly. I wish you the best of luck and thank you for all your hard work.

Vision Benefit Strategy

Lauren Johnston, SEBB Procurement Manager. Slide 3 – PEBB Program Vision Benefits. PEBB Program vision benefits are currently covered within the medical benefits, Kaiser Northwest, Kaiser Washington, and the Uniform Medical Plan. It includes one routine eye exam per year covered at 100%, and an allowance of \$150 every two calendar years for glasses or contact lenses.

Harry Bossi: A little clarification on the one routine eye exam covered at 100%. My understanding is in the Kaiser Northwest. There is a copay of \$15 or \$30, depending on which of those that you're in, as opposed to UMP, which has no cost to the insured.

Lauren Johnston: That's not my understanding, but I will look into that. I'm getting a nod from Kaiser Northwest indicating, yes, that's true.

Dave Iseminger: We'll provide additional follow up.

Lauren Johnston: Previously you asked we would look into a separate vision benefit for the PEBB Program. The Cadillac Tax goes into effect in 2022. When making these considerations for the SEBB Program, we ensured we could leverage them for the PEBB Program. There is potential for current funds to go further for this benefit. The member may save money depending on how they purchase their glasses. Going through this procurement also helped provide insight into the difference between the fully insured versus the self-insured separate vision plan.

Dave Iseminger: Greg and I are chuckling because the Cadillac Tax is like the boy who cried wolf. This is the third or fourth implementation date of the Cadillac Tax. I

bring it up in this context because it is one way the agency has identified that could help mitigate the employer financial penalties related to the Cadillac Tax - when a standalone vision benefit doesn't count against you. An embedded vision plan does. If this Board were to carve out the vision benefit, it could reduce that existing tax liability.

Yvonne Tate: I've been retired five years and I was working on the immediate implementation of that when I was working. I don't believe the Cadillac Tax is ever going to happen. It continues to be delayed.

Lauren Johnston: Slide 5 – SEBB Program Vision Benefit Overview. HCA did a SEBB Program fully insured vision procurement separate from the medical plans. We received ten proposals to our Request for Proposal and contracted with three vendors, Davis Vision, EyeMed, and MetLife. There is statewide enrollment for all three plans and it does not matter where you live.

Slide 6 – Proposed Vision Plan Designs In-Network Coverage. This slide shows the proposed in-network coverage information and what the member pays. A routine eye exam renews every January 1 and covers 100% for all three plans. Frames renew January 1 in even years, same as the UMP coverage. For all three plans, the member pays \$0 up to \$150, and then 80% of the balance over \$150. Lenses covered at 100% for all three carriers. Progressive lenses have a set copay based on the lens tier and carrier.

Dave Iseminger: You said lenses are covered by all three, but MetLife shows \$10. Can you reconcile those statements?

Lauren Johnston: Sorry, Davis Vision and EyeMed have a \$0 cost share to the member and MetLife has a \$10 cost share.

Greg Devereux: How did you do this procurement? Did you say this is the dollar amount we would give you and we'd like you to bid?

Lauren Johnston: It's been an evolving process and a learning experience because we've never done a separate vision contract before. Initially, we set it up as here's how we currently cover things within the PEBB Program benefit. If we were to follow this, what would it look like? What would your bid be? How would you cover things? What would your cost shares be, etc.? From that, we learned about the separate vision benefit and how it's different in the medical benefit where it's embedded in the medical program.

Dave Iseminger: Greg, for procurement purposes, we set up a standard plan that said if you took UMP's vision benefit and pulled it out exactly, price that. We used that as the scoring mechanism. A procurement is winning the right to negotiate a contract. Once we got to the negotiation point, we said, "if this is the amount of money we can spend, what will it buy? Based on your experience with school employees, what do you think fits that price tag?" That information helped determine the benefit design.

Greg Devereux: Is the intent to have multiple options or pick one that is better than the others?

Dave Iseminger: In the SEBB Program, they envision all three as competitive parts of the portfolio.

Lauren Johnston: Slide 7. There are different lens enhancements that can be added to glasses, anti-reflective coatings, scratch resistance, polycarbonate, polarized, transitions, etc. This slide lists the member cost share.

Slide 8. It's similar for contact lenses, but there are slightly different nuances between the three vendors. For conventional or disposable contact lenses, the member pays \$0 up to \$150 for Davis Vision, and then 85% on the balance over the \$150. Or they could choose four boxes from the collection of lenses specific to Davis Vision.

The member pays the same thing for EyeMed as Davis Vision for conventional lenses. For disposable lenses, the member pays \$0 up to the \$150, and 100% of the balance over \$150.

The member pays \$0 up to \$150, and 100% of the balance over the \$150 for MetLife.

Medically necessary contact lenses has a \$0 copay to the member for all three carriers.

Dave Iseminger: Can you provide an example of medically necessary contact lenses?

Lauren Johnston: If you have a certain type of eye surgery, you may need medically necessary contact lenses to make sure the shape of your cornea doesn't change. They aren't elective for the purpose of being able to see. You need them so there is no damage to your eye.

Slide 9 – SEBB Program Pediatric Benefit. This benefit renews every January 1. It includes the routine eye exam and glasses covered at 100% for a standard set of frames. Polycarbonate lenses or contact lenses in lieu of glasses is a \$300 allowance for a year's supply. All three carriers ensure there would be a number of options available under the \$300 allowance.

Myra Johnson: What's the age of the pediatric coverage?

Lauren Johnston: It ends once they turn 19.

Slide 10 – PEBB Program vs SEBB Program Frequency. I identified an error on this slide under KPWA. For PEBB UMP, the eye exam renews every January 1 and every 12 months KPNW and KPWA, not every 24 months for KPWA. For the SEBB Program, it renews every January 1 for all three carriers.

For the glasses and contact lenses, the UMP allowance renews every January 1 on even years. For KPNW and KPWA, the allowance renews every 24 months. If I get my glasses in February 2020, I would have to wait until February 2022 to get a new set of glasses. For the SEBB Program, the allowance renews every January 1 on even years. Each member is different.

Dave Iseminger: For KPNW and KPWA, the allowance is a personal rolling two-year benchmark.

Harry Bossi: Looking at allowance renewals every January 1 on even years for the SEBB Program, does that mean if somebody enrolls in 2021 they have not benefits until January 1, 2022? Is there an exception?

Lauren Johnston: It works the same way it does in UMP. If a member were to enroll in 2021 and use their benefit in 2021, it would renew January 1 of 2022.

Dave Iseminger: They get an advantage in that situation and can use the benefit in the odd year. They don't have to wait two years.

Lauren Johnston: Slide 11 – Differences in Separate Benefit. This slide has a correction, too. KPNW has a cost share.

For routine eye exams, UMP and KPWA cover at 100%. The SEBB Program also covers at 100%. For frames, the PEBB Program allowance applies to frames, lenses, and any add-ons. It covers \$150 total and the member pays 100% of the balance. The SEBB Program pays \$0 up to the \$150, and then 80% of the balance for frames. Lenses are \$0 cost to the member. Progressive lenses are between \$0 to \$175, depending on tier and carrier. Lens add-ons are the same. Slides 6 and 7 show the different cost shares for each of the add-ons.

Dave Iseminger: The money that's being spent on the two programs is the same. These slides show a different benefit richness on the same dollar amounts. The SEB Board didn't reallocate or shift benefit money to this benefit to buy up. It's the same dollars going further.

Lauren Johnston: Slide 12 – Member Experience. I went to Target Optical's online platform to show the difference between what a PEBB Program member and a SEBB Program member would pay. As a PEBB Program member, I selected a pair of frames for \$110, lenses for \$75, and a traditional add-on for \$100. I would pay \$135. The frame, lenses, and add-on comes to \$285 at Target. With my \$150 allowance, I would pay \$135 out of pocket.

As a SEBB Program member, I selected the same frames for \$110, the same lenses for \$75, and the same add-on for \$75. I used the EyeMed's benefit cost share because it is middle of the line. My frame and lenses would be \$0 cost to me and I would pay \$75 for the additional add-on. The SEBB Program member pays \$60 less than a PEBB Program member using this benefit example.

Slide 13 – Separate Vision Plan Advantages. Having a separate vision plan is advantageous because the provider contracts are more efficient when not embedded in medical plans. The number of frames under \$150 a member can choose from and pay \$0 out of pocket varies by carrier, but nationwide, between the three carriers they indicate you can choose from about 13,000 frames depending on which office you select.

Slide 14 – Total Unique Vision Providers in Each County. Many providers are overlapping between all three carriers. Thurston County has 91 vision providers. Columbia and Garfield Counties have no vision providers.

Dave Iseminger: Staff have double checked and there are no optometrists or ophthalmologists in those two counties, period. It's not that it's a gap in any of the provider networks. There's a gap of providers.

Harry Bossi: Are we assuming there are providers in Oregon?

Lauren Johnston: Yes. All three carriers are nationwide. There are providers in every state.

Slide 15 – Timeline for Vision Decision Making. This PEBB Program timeline is between 2019 and 2021. In the fourth quarter of 2019, we will submit decision packets and the Governor's proposed supplemental budget comes out at the end of the quarter. The legislative session is between the first and second quarters. The PEB Board season goes through the first three quarters of 2020.

Dave Iseminger: The timeline roughly represents this time next year for a potential change with the 2021 plan year. This needs to go through the legislative decision making process because under the current Collective Bargaining Agreement, if the vision benefit becomes standalone, the full premium becomes the employer's responsibility. With vision currently embedded in the medical benefit, the state is picking up, on a tier-weighted average, 85% of the embedded vision benefit. The extra 15% has a cost piece we'll evaluate and submit for funding in the decision package process. The current CBA for this program preordains a mechanism for how it's paid if this happens. We will go through that process of the Legislature and the Governor's Office deciding whether they want to put funding towards it.

Sue Birch: This reminds me of what happened with value-based formulary. The PEB Board led and the SEB Board adopted. We're seeing the advantages of the SEB Board leading on policy decisions and we'll have to make decisions about PEBB Program adoption. You start to see the advantage of these entities working in greater alignment.

Dave Iseminger: I brought this back to the Board because there have been intermittent discussions about vision. We finally have this information and gone through the procurement process with the SEB Board to be able to bring something with the level of detail we just provided you about what we've learned, what it could look like, and what the strategy timeline looks like to be able to make this type of change.

Sue Birch: Before this comes back to the Board, we'll be certain there aren't medical or pricing implications if we extract to standalone.

Dave Iseminger: The contracts we negotiate in the PEBB Program now with the medical carriers all have indications as to what the cost is associated in the fully insured plans and Regence for administrative costs that would be released or reduced if vision was removed. We've kept an eye on that for several years as we considered Cadillac Tax implications.

Lauren Johnston: Something to keep in mind is we made sure the SEB Board knew this benefit is only for the ability to see - contacts, frames, routine eye exams. Anything to do with the medical side of your eyes goes through your normal medical carrier. Those claims are submitted to the medical carrier. We worked on our contracts so if your vision provider were to identify a need for a medical follow-up, they would refer you back to your primary care physician making sure you're continuing to get the medical care you need.

Myra Johnson: Because you're still under negotiations with MetLife, does that mean on Slides 6 through 8, the MetLife numbers could change? Or are those solid?

Lauren Johnston: Those numbers are done. We're negotiating the contractual terms and conditions of the contract itself.

Next Meeting

June 5, 2019
Starting at 1:30 p.m.

Meeting adjourned at 4:15 p.m.

Public Employees Benefits Board
Meeting Minutes

Draft

June 5, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:45 p.m.

Members Present:

Sue Birch
Carol Dotlich
Yvonne Tate
Harry Bossi
Tim Barclay

Members via Phone:

Tom MacRobert
Myra Johnson

Members Absent:

Greg Devereux

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:31 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed. TVW live streamed today's meeting.

Executive Session

The Board met in Executive Session, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

Break

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of today's agenda.

Prior Meeting Follow Up

Dave Iseminger: Slide 2 – Prior Year Financial Insights. Last meeting Tanya Deuel presented financial information about the future funding rates and Tom asked what the funding rate was for last year, as well as the annual expenses from the various administrative accounts. The information on this slide is for fiscal year 2018, which is July 2017 through June 2018.

For fiscal year 2018, the funding rate was \$913. The Uniform Medical Plan Administration Account is for administration aspects of the plan, not claims, was \$57,612,000. The Uniform Dental Plan Administrative Account, again, not claims, was \$6,165,000. The Flexible Spending Arrangement Administrative Account with Navia was \$838,000.

Tom MacRobert: I just wanted to clarify the Uniform Medical Plan – Administration rate, the \$57 million, was going to increase to \$63 million in 2019. Is that correct?

Dave Iseminger: Every year that number goes up, in part because enrollment goes up. That is basically the total summation of the monthly per member per month (PMPM) we're paying. As enrollment goes up, that account needs additional expenditure authority and increases over time. Every January we see an increase of approximately 1,200 members in our PEBB Program portfolio. Outside January, on a month-by-month basis, it's approximately a 200 to 225 net increase in enrollment. We usually see the largest uptick in January because political subdivisions will contract with the Health Care Authority for benefits that begin at the start of the plan year. That positive trend has happened the last four or five years, with a need for a continual uptick in the expenditure authority of that account. Does that help, Tom?

Tom MacRobert: Yes.

Dave Iseminger: Slides 3 – 6 – Corrections to May 21, 2019 "Vision Benefit Strategy" Presentation. At the last Board Meeting, Lauren Johnson gave an update about the strategy related to the vision benefit and Harry had questions about if eye exams did or didn't have a copay in the Kaiser plans to UMP. Lauren has updated her slides. These slides are the corrected versions, with the revisions in red.

Slide 4 - PEBB Program Vision Benefits. There is no cost for a routine eye exam in UMP for vision. There is a copay that varies based on the plan in the Kaiser Northwest and Kaiser Washington plans.

Slide 5 – PEBB Program vs SEBB Program Frequency. The correction is on KPWA's eye exam frequency. It is every 12 months, not 24 months.

Slide 6 – Differences in Separate Benefit. The member cost for routine eye exams should be \$0 for UMP, and varies by plan for KPNW and KPWA.

There are no slides for the following question. Tom asked about the legislative update related to Educational Service District employees. All Educational Service District employees were going to be moved into the SEBB Program. However, a last minute legislative change this session changed this and now non-represented Educational Service District (ESD) employees are not required to participate in the SEBB Program until plan year 2024. They can stay in the PEBB Program or access other commercial insurance options.

Tom asked for more information about these staff. The majority of ESD staff are program staff running programs like early learning, learning support, and professional development. The majority of represented staff are in those staffed positions. For non-represented staff, some support those program areas, but they also have other support services such as administrative and janitorial services.

Carol asked for more information about the Centers of Excellence (COE) Program and the utilization of those services. We will bring a presentation on the Centers of Excellence at a future Board Meeting.

Another question was what was the name of the Hepatitis C drug we're looking to procure. It is Maviret, spelled multiple ways. You could Google either M-A-V-I-R-E-T or M-A-V-Y-R-E-T.

The last follow-up concerns information about the SEBB Program portfolio. We made you aware that the SEB Board created another version of the Uniform Medical Plan. They essentially copied, with minor variations, the Uniform Medical Plan Classic, the CDHP, and the UMP Plus plans. The SEBB Program also created a fourth Uniform Medical Plan similar to UMP classic, but with an 82% AV plan. That means there are some cost share differences and the member picks up more than the plan picks up – relative to UMP Classic. There was a question about the deductibles in that plan. If the Board is interested in including this plan in the portfolio, we will bring information to you in a future Board Meeting next year. It's a plan with a \$750 single subscriber deductible and a \$2,250 family deductible. It has a prescription deductible of \$250 for the single subscriber and \$750 for family. These are higher deductibles and higher cost shares, but the plan has a lower premium. Given the demographics of the school population, the SEB Board had interest in a wider range of AV plans within their portfolio.

Ryan Pistori, Assistant Chief Pharmacy Officer. Slides 7 – 10 – Uniform Medical Plan (UMP) Value Formulary Follow Up. Slide 8 – UMP Value Formulary Exception Process. Carol asked for a written version of the UMP Value Formulary exception process, which goes into effect January 1, 2020. Slide 8 is background information that shows what the structure of the UMP preferred drug list will be in 2020. The table shows four tiers and their associated cost shares for the member coinsurance or the member out-of-pocket maximum.

Slide 9 has a link to the UMP Preferred Drug List (PDL). Members can check to see if their medications are covered on PDL and when they qualify for an exception. If a member is prescribed a drug not on the formulary, the member will need to pay the full cost of the drug. Members should talk to their physician about prescribing an alternative drug that is on the formulary.

However, if a member has tried all the alternative drugs and none are found to be effective, or if the alternatives are found to be not medically appropriate, the member can request an exception. If approved, the requested non-formulary drug will be covered and the member will pay the appropriate Tier 2 cost share.

Slide 10 is the step-by-step process and the outcomes of such a process for requesting an exception. Carol, I believe this is what you were looking for, the steps the member and the provider would need to go through. The member or the member's physician can request a formulary exception by contacting Washington State Rx Services Customer Service at the phone number listed. Washington State Rx Services will contact the member's provider and the provider will submit the appropriate clinical information. They will let them know what information is needed for the specific drug being requested. The Washington State Rx Services clinical team will review the submitted information to determine if the formulary alternative(s) the member used were ineffective or were not clinically appropriate. If the member has used all the alternatives and none have been found to be medically appropriate, the member will be approved to use the non-formulary drug. If the exception is not approved, the member will be directed towards the appropriate alternatives on formulary, or the member may select to pay the full cost of the drug.

The Health Care Authority (HCA) is working closely with MODA on developing a comprehensive communication plan to get this information out and available to members prior to open enrollment so they can make the best decisions in selecting their health plans. HCA has met with MODA since the passing of the Value Formulary to develop this communication. We are working on documents for members to help them understand the process and select the right health plans for them.

Carol Dotlich: Under your plan, the members will have the formulary list in time so they're not without their medication? I don't want them to go to the pharmacy and discover they're not covered and then start this process. I want them to know ahead so they're prepared for this.

Ryan Pistorosi: HCA is working on several different aspects of providing this information to members. One is to update the UMP PDL lookup tool referenced on Slide 9. This is the online tool showing what drugs are covered and how they're covered. We're also working on a transition plan to identify members currently using these drugs to send them mailings to let them know they can start this exception process early, or how they may be able to transition to a drug that is on the UMP PDL starting in 2020. We are looking at all the different ways to get in front of this and let members know how they can receive their prescription medications starting January 1, 2020. Whether it's an alternative medication or how to start the exception process and then be approved to use their current medication going forward.

Carol Dotlich: I appreciate the proactive stance very much.

Dave Iseminger: Ryan, to be clear, the PDL lookup tool you're describing will be completed before the November open enrollment so people will have that information in addition to this targeted customized letter campaign for individuals who could be impacted?

Ryan Pistorosi: That is correct. We are working with MODA to get the tool updated prior to open enrollment to let members know there are changes occurring in 2020. It will assist the member in asking MODA questions on the process or their prescription drugs.

Carol Dotlich: I wanted to say I like the idea of the letter going to the people using non-formulary drugs because a lot of the elderly folks don't use a computer and would not look them up online. So thank you for that.

Long-Term Disability (LTD) Insurance Benefit Strategy

Kimberly Gazard, Contract Manager, Employees and Retirees Benefits Division. Side 2 – Timeline for Decision Making. At the April Board Meeting, we looked at timelines for decision making around changes to the LTD basic benefit. After July 1, budget language permits the Board to reallocate funding within the portfolio. HCA could also submit a decision package to the Governor's Office for the 2021 plan year budget.

Slide 3 – Employer-Paid Basic LTD Plan Design. This chart shows small changes to the basic benefit that might be available through horse trading benefits. The maximum monthly benefit ranges are \$240 to \$1,408. The Board will have the authority July 1 to reallocate funding within the portfolio to change the LTD basic benefit for the 2020 plan year.

Slides 4 and 5 – 2020 LTD Basic Benefit Design Options. At the April 24 Board Meeting, we introduced ideas for budget neutral horse trading options but the Board did not seem interested in those options. HCA needs a clear indication at this meeting from the Board about any changes to evaluate for the 2020 plan year because changes for the 2020 benefit will impact the rate setting currently underway.

Dave Iseminger: To add context, at the April 24 Board Meeting, we described benefit options we pursued at the direction of the SEB Board. We looked at reducing the life insurance basic benefit from \$35,000 to \$25,000, and use that offset to increase the LTD benefit. That could generate a \$1 per subscriber per month (PSPM) and make the basic LTD benefit in the PEBB Program \$400 a month.

We evaluated changes in the dental portfolio to cap the orthodontia benefit within the fully insured plans. That was something the SEB Board was interested in seeing. But because the predominant enrollment, roughly 75% to 80% of enrollment is in the Uniform Dental Plan, which already has a cap benefit, there wasn't any savings that could be generated to make any sort of LTD benefit change.

We evaluated eliminating the orthodontia benefit in the dental plans. That would have allowed moving the basic LTD benefit up two or three notches on the sliding scale on Slide 3. But people have become accustomed to and desire an orthodontia benefit. The SEB Board wasn't interested in that idea either.

HCA presented a couple of different ideas we looked at but didn't find anything that felt particularly palatable. We're also working on, from a PEBB Program perspective, an expedited timeline with regards to the authority you're going to have in about 30 days. We're in the middle of rate development now, and it's almost too late to make changes for plan year 2020. If you do a benefit swap on the medical plan, that will be taken into

consideration because we are negotiating with carriers now. We can look at ideas for plan year 2021 later.

Our recommendation at this point is there is not adequate time to take advantage of your benefit swap authority for plan year 2020 unless you have a very clear idea today. We've been struggling with this concept with the SEB Board for a while and we evaluated options for both program portfolios at the same time. We've struggled to find something a majority of Board Members on either Board would feel is a tolerable swap within the portfolio. HCA will continue to look at different pieces, but if you can identify something specific, we will look at that.

We know that legislative staff, OFM, and the Governor's Office are aware the benefit design on basic LTD has not changed in 40 years. Our recommendation is that HCA put forward a decision package for evaluation. Later in Kimberly's presentation, she will ask you what you think the range of incremental steps should be as we prepare our decision package. We will also talk with you about other benefit swaps you can make after the next legislative session when we know whether they added more to the funding rate for LTD.

HCA is in a tough spot with timing and have been looking at this as an agency for both programs for well over a year. We started working on the LTD benefit and the SEBB Program about this time last year after we completed the procurement. None of us like the basic benefit. We're committed to working on it and, at the least, make a run for additional funding. We will also keep the discussion going about benefit swaps that could happen during the next Board season.

Sue Birch: I would ask the Board to give me a signal. Are we all in agreement that we would like to see the benefit moved significantly? I personally think we need to be in the \$700 to \$800 range as the minimum. When you look at the income distribution of our employees, that's still pretty minimal for an LTD benefit.

Dave Iseminger: Chair Birch, we can have Kimberly go through the income pieces to tee that up, and then maybe revisit that question.

Sue Birch: That would be great.

Kimberly Gazard: Slide 6 – 2021 LTD Basic Benefit Design. Dave touched on this slide. Today we're seeking insight from the Board about recommended changes for incremental improvements to the basic LTD benefit.

Slide 7 – PEBB Program Member Income. The last time we showed you the salary ranges of PEBB Program members, 81% earn \$80,000 or less. Only 18% earn \$81,000 or more. We assume the Board would want to shoot for a benefit plan that replaces a higher percentage of that \$80,000 annual salary.

Slide 8 – Employer-Paid Basic LTD Plan Design details the cost of significant changes to the basic LTD benefit that might be proposed in the decision packages. It shows a range of the maximum monthly benefit from \$240, what it is currently, up to \$10,000 for a maximum monthly benefit.

Dave Iseminger: I want to be clear. When we put together a decision package, we usually put forward a specific targeted request. For this decision package, we are envisioning a range of options. We want some progress made, so we want to give what we believe is the appropriate range and the cost for each of those increments and let the Governor's Office and Legislature decide if and what increment to approve.

As we're working on this decision package, what do you think the range should be? The chart on Slide 8 has more dramatic jumps in the benefit than you saw on Slide 3. We have an outdated benefit of \$240. It takes a substantial amount of money to make significant progress to the larger amounts. We knew that as we were evaluating benefit swaps that you were never going to find \$24 PSPM anywhere else to get you to a \$4,000 benefit. We created the chart on Slide 3 to show possible improvements with smaller tweaks. To get a major jump in the benefit, additional funding is required.

As Kimberly said, we focused on the upper range of that incremental target for the decision package on Slide 8, with an annual salary of \$80,000 and a \$4,000 monthly benefit. Slide 7 shows that range of income. We believe the upper end would be an ideal target. Do you agree with that assessment? What do you think the lower end of the range should be?

Sue Birch: My thought is somewhere between \$500 and \$1,000 should be the minimum monthly benefit.

Tim Barclay: I would say the \$1,500 to \$2,000 range.

Harry Bossi: I agree with Sue. It's a good recommendation but also more likely to be achieved. The number might be more palatable for the budget decision makers. I don't know enough about the process that if you went in at \$50,000 and it's not approved, you get nothing. Or will they identify a certain amount. If there is a better chance of getting \$500 to \$1,000, that might be the right place.

Carol Dotlich: I agree with Tim. I think it needs to be more.

Sue Birch: \$1,500 to \$2,500?

Carol Dotlich: I do. I don't know how a family survives a terrible disability.

Tom MacRobert: I would agree with that also.

Myra Johnson: I'm looking at the \$1,500 to \$2,500, as well.

Yvonne Tate: That's about a \$25 million increase in cost. The question is whether or not our decision makers will put that much money into the fund.

Tim Barclay: Dave, can you tell us what our total spend is for PEBB in a year? All benefits, all expenses.

Tanya Deuel: It's about \$2.5 billion.

Tim Barclay: \$25 million is about .1%. I just want to keep that in perspective. What we're asking for is something within the variance of trend assumptions on our medical benefit. I understand to everyone sitting at this table \$25 million is a big number. But in the context of what we're working with, it's not an unreasonable ask.

Dave Iseminger: There is a lot of interest in the LTD benefit from many stakeholders. Both Boards have expressed concern about the existing benefit. I personally have been concerned about the benefit. I knew when I stepped into the director role it was an area I wanted to focus on. I made sure legislative staff and OFM are aware of the benefit. Both Coalitions that bargain for benefits for employees currently have an interest in the employer-paid LTD benefit that's fully paid by the state. I believe many of those stakeholders are interested in pursuing and supporting such a funding request in the next legislative session. Now seems like the time to strike.

We're asking what you think is the tolerable minimum/maximum range, hearing something in the \$1,500 to \$4,000 range. We will provide a range of options and preferred targets to hit. We will describe how this makes the benefit competitive or not competitive with the rest of the market. We know many employers pay 60% of salary replacement as a fully employer-paid benefit. Our \$240 is nowhere near that. As we build the decision package, we will indicate if this incremental change is made, it will cost this much and you still won't be competitive with the entire market.

I appreciate your guidance about the range you think is tolerable and we will incorporate that in the decision package. The decision package will include both programs. The occupational differences of school employees versus PEBB Program employees makes it cheaper for school employees to get a higher increment, but I'm sure the Legislature and OFM will look at the total spend between both programs. The combined annual spend for the two programs is closer to \$5 billion.

Yvonne Tate: All the more reason to have just one program.

Dave Iseminger: As Yvonne said, all the more reason to have one program! We'll be doing that report, too.

Tim Barclay: Dave, a while back, I think I asked you for information and I want to remind you of that request. I was hoping to get the distribution of long-term disability supplemental take-up rates by income level.

Kimberly Gazard: We weren't able to provide the breakdown of member enrollment in supplemental LTD by salary as The Standard does not collect that information. We have system limitations within Pay1 to be able to obtain that information.

Dave Iseminger: Not the answer you were looking for, Tim.

Tim Barclay: I'm not surprised, but yet I'm a little surprised there wasn't a workaround. Somebody's collecting premium, right? Somebody should be recording that, right?

Dave Iseminger: Tim, in reality, the premium is collected on a list bill basis. When somebody makes the claim, there is a reconciliation backwards. Why don't we do a little bit of a follow-up for you of exactly how the money flows between an employer and

The Standard. We will set up a separate call to go through exactly how the money flows through the system.

Tim Barclay: I appreciate that. Thank you.

Emerging Medications

Ryan Pistorosi, HCA Assistant Chief Pharmacy Officer. Today I will review six novel pharmaceuticals approved by the FDA since the last emerging medications update. I will provide a quick review of the six drug profiles and present a summary budget impact analysis.

Slide 3 – Spravato (esketamine nasal spray). Spravato was the first medication approved by the FDA for treatment-resistant depression in adults who have not responded to at least two previous antidepressant therapies. This medication is used in conjunction with an oral antidepressant. This is augmentation therapy, meant to help the other oral antidepressant have a better effect. If the name sounds familiar, esketamine is the same chemical but with a slightly different arrangement to Ketamine, which is an anesthetic and an analgesic that has a well-known abuse potential. Because of this, esketamine is a schedule three medication only administered by health care professionals in approved settings. Approved pharmacies ship the drug to approved centers and approved providers administer to approved patients. There is a very strong, robust safety program to make sure everyone knows how this about this medication and how to use it. After administration of this medication, it requires monitoring the patient for at least two hours in case they have sedating or dissociation from the medication.

Treatment-resistant depression is uncommon in the UMP population. Some patients with depression do not respond to traditional oral antidepressant therapies even for different drug classes of antidepressants. However, there are other treatment options available for these patients, which include other monotherapy, other augmentation therapy, and cognitive behavioral therapy.

Slide 4 – Zulresso (brexanolone) is the first medication approved for postpartum depression, which can occur up to 12 months after childbirth. This medication requires a 60-hour continuous infusion. It requires a health care provider to be present throughout monitoring because the medication can cause excessive sedation and loss of consciousness. There is a robust safety program to ensure a health care provider is always present and there are steps to take in case the patient loses consciousness while on this medication.

Fortunately, there are other treatment options available for postpartum depression, which includes traditional antidepressants and psychotherapy. We anticipate severe postpartum depression will be rare in the UMP population because most patients with postpartum depression are treated first with oral antidepressants, which they usually respond to. This is only for very, very severe cases of depression that doesn't respond to treatment.

Slide 5 – Egaten (triclabendazole), the first medication approved for Fascioliasis, which is a parasitic infection of liver flukes. This is a liver infection caused by the parasite Fasciola Hepatica, which is endemic to Central and South America, Asia, Africa, and

the Middle East. It is anticipated that 2.4 to 17 million patients are infected with this parasite in 51 countries across the world. We're bringing this to you today to remind you we have UMP members who live internationally. Many UMP members travel internationally throughout the year. There may be some risk of this infection that warrants the UMP member to use this medication.

Dave Iseminger: We have about 100 UMP members that live internationally in about 15 to 20 countries. They are in the areas where this is endemic. It's often individuals who work in higher education whose work is international.

Ryan Pistori: This is an older medication approved in other countries around the world. If people were traveling overseas, they could get it in other countries. It just wasn't approved in the US. If Americans did contract this infection, they could get this medication through a special program at the Center for Disease Control. The FDA approved it for general use in February 2019. We expect this disease will be ultra-rare for UMP because it's only contracted by members who live or travel internationally.

Slide 6 – Evenity (romosozumab) is approved for the treatment of Osteoporosis and postmenopausal women at high risk for fracture where patients have failed or are intolerant to other therapies. It's the first medication that is a sclerostin inhibitor. Sclerostin is a molecule naturally in the body that inhibits bone formation. This drug was discovered when they noticed people with a mutation in sclerostin, or that had developed antibodies that fought against sclerostin, had very strong bones. They used this target to develop this medication. Unfortunately, there is a higher risk of heart attack, stroke, and cardiovascular death with this medication. It received a black box warning from the FDA. It should not be used by patients who had cardiovascular disease in the past, or who are at risk of cardiovascular disease. For patients without those conditions, this may be an option.

Osteoporosis is a common condition for UMP but this is a medication that will be competing with a pretty crowded market of second line therapies for osteoporosis. Other alternatives include Forteo, Tymlos, Prolia, or raloxifene. This medication is limited to 12 months of use per lifetime. At that point, the patient may be able to step into another treatment, or if they're using another treatment, they may step into this.

Slide 7 – Vyndaqel and Vyndamax (tafamidis) are medications approved for the treatment of cardiomyopathy in patients with transthyretin-mediated amyloidosis. This medication stabilizes the protein transthyretin, which prevents the protein from falling apart in the bloodstream, attaching to different tissue, and accumulating amyloid plaque. This medication helps the heart function normally.

This medication was approved in Europe and Japan in 2011. The FDA rejected it and required additional studies. The manufacturer completed the additional studies, submitted it for re-review, and got it approved earlier this year.

This medication is considered ultra-rare for UMP.

Slide 8 – Balversa (erdafitinib) is approved for adult patients with locally advanced or metastatic urothelial carcinoma with FGFR3 or FGFR2 genetic mutations. Those are specific gene mutations associated with cancer. I wouldn't say necessarily what are

causing the cancer, but are what are associated to the growth and proliferation of that cancer. The most common type of bladder cancer is the urothelial carcinoma. These specific mutations are found in about 20% of the relapsed or refractory cancers. This is a somewhat sizeable cancer population relative to some of the other cancer drugs we've talked about at previous meetings.

However, this medication will compete with many other treatment options for patients with locally advanced or metastatic urothelial carcinoma. Since there are many treatment options available for these patients, it's difficult to anticipate how this drug may be used by this population. It will be a new treatment option available if they have the specific mutations and are refractory to other treatment options.

Slide 9 – UMP Budget Impact. For the six drugs reviewed today, we anticipate these drugs may total an increase of \$2.19 million per year. Medications like Vyndaqel or Vyndamax cost upwards of \$225,000 per patient per year. Remember we consider drug usage for those as ultra-rare. Spravato, which addresses treatment-resistant depression, is likely to have a higher patient population use and a higher budget impact overall. This budget impact is estimated based on plan size and the per member per month estimates from third party analyses.

We've reviewed a total of 19 drugs in Board meetings since the beginning of the year. Combining these six with those 19, the 25 drugs reviewed we anticipate to be \$3.87 million annual impact.

Dave Iseminger: I want to thank Ryan for continuing to do the education of 25 drugs. He'll be at our next meeting to talk about Zolgensma.

Ryan Pistorisi: Zolgensma is the new gene therapy for spinal muscular atrophy.

Dave Iseminger: That is the drug you've seen in the headlines that costs millions of dollars. It is \$2.5 million for a treatment.

Policy Resolutions

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – PEBB Board Policy Resolutions. There are three policy resolutions to take action on today. Slide 3 – RCW 41.05.080(1) is included to show the Board their authority when making decisions on these resolutions.

Dave Iseminger: In particular, the blue highlighted verbiage on Slide 3 is to help you understand where your authority stems from in order to take action on these resolutions. We found this to be a particularly useful context in SEBB Board Meetings adding what your statutory authority is to be very clear where the authorities stem from for the rules that eventually follow.

Slide 4 – Policy Resolution PEBB 2019-03 – Retiree Insurance Coverage Deferral – CHAMPVA Survivors. This is to amend to policy resolution passed last summer for CHAMPVA. Changes since the last Board Meeting: this is a global change for all three policies. We are changing this policy number from PEBB 2019-01 to PEBB 2019-03. We need unique numbers for each resolution so we can track them over history. Earlier this year, the Board already passed two resolutions. We do not want to reuse those

numbers so today, this resolution will change from PEBB 2019-01 to PEBB 2019-03, but the resolution from the May Meeting is located in the Appendix. There are no changes to this resolution except the numbering.

Dave Iseminger: Last year we had a robust conversation about retroactive versus prospective effective dates and we felt it was best knowing there hadn't been a particular instance. If it did come up in an appeal later, it would be clear this was the intent all along. We believe this is what the Board intended last year and it's a cleanup piece to include survivors in addition to the others described last year. Instead of dependents, the survivors.

Sue Birch: Policy Resolution PEBB 2019-03 - Retiree Insurance Coverage Deferral - CHAMPVA Survivors.

Resolved that, beginning July 17, 2018 enrollment in a PEBB program health plan may be deferred when the subscriber is enrolled as a retiree or a survivor of a retiree who was enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Tim Barclay moved and Harry Bossi seconded a motion to adopt.

Voting to Approve: 6

Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-03 passes.

Rob Parkman: Policy Resolution PEBB 2019-04 - SEBB Program Employees and PEBB Program Retiree Term Life Insurance Eligibility. Changes since the last meeting: This was PEBB 2019-02 and has been changed to PEBB 2019-04. The Policy Resolution from the May Meeting is located in the Appendix. There are no other changes to the resolution.

Dave Iseminger: In order to access the PEBB Program retiree life insurance, the current rules require you have to have participated in PEBB Program life insurance. With the addition of the SEBB Program, the same contractor is offering the exact benefit to active K-12 employees. Those K-12 employees, when they become retirees, have access to PEBB Program benefits, if you pass this resolution you are saying the benefit is identical coverage and serves as a qualifier for accessing PEBB Program retiree coverage. It's optional coverage for the PEBB Program retiree.

Sue Birch: Policy Resolution PEBB 2019-04 - SEBB Program Employees and PEBB Program Retiree Term Life Insurance Eligibility.

Resolved that, beginning January 1, 2020, an eligible school employee who participates in the SEBB Program life insurance and meets the eligibility requirements for PEBB Program retiree insurance coverage, is eligible for PEBB Program retiree term life insurance.

Yvonne Tate moved and Carol Dotlich seconded motion to adopt.

Voting to Approve: 6

Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-04 passes.

Myra Johnson: I know I'm not a voting member, but I'm in favor of this resolution.

Rob Parkman: Policy Resolution PEBB 2019-05 – Error Correction Incorrect Information. Changes since the last Board Meeting: the resolution changed from PEBB Resolution 2019-03 to PEBB Resolution 2019-05. We also made a number of changes within the resolution. We added “then” in the third row before the word “relied upon.” We added “at a minimum” in the fourth row before the wording “the error” and added “which may include retroactive enrollment” in the last two rows before the wording “is warranted.” The Policy Resolution slide from the May Meeting is located in the Appendix.

The Board also asked for additional information on retroactive enrollment, the error correction timeline, and the process flow. Slide 7 lists the prior Error Correction Resolutions passed by the Board. The first error correction was in 2013 establishing the error correction process within PEBB Program rules. It provided instructions to employers on how to correct errors. It also established the HCA authority to provide recourse based on each situation.

In 2014, the Board passed another error correction resolution that established once an error is identified, enrollment would be perspective to the start of the next month unless it is identified on the first day of the month, then it would start on that day. This policy also retained HCA's authority to address the effect of the error through recourse.

In 2018, a policy resolution passed addressing employing agency who enrolled ineligible dependents in coverage. The current resolution adds another subject area where incorrect information was provided to the employee and the employee acted upon that information.

Dave Iseminger: At the last meeting there were questions from the Board wondering if what we were proposing in Policy Resolution PEBB 2019-05 was a departure from past practices. We wanted to show the order of the resolutions that set up the answer to a very specific question giving the agency authority to say on a case-by-case basis, work with the employer to decide if additional recourse is warranted. There was concern that might be a departure from the past. It's actually perfectly in line with the prior resolutions that were passed. That's one of the reasons the lines are highlighted in blue on Slide 7. Some Board Members had particular concerns about what that language looked like in the new resolution that's before you.

Rob Parkman: Slide 8 – Error Correction Data. These data are from a couple of different sources. The first source is from our current error correction process. This data is the last quarter of 2018, from September through December 2018. There are four different categories. There's a total of 131 events. The takeaway is that approximately 20% of these actually included retroactive enrollment.

The next bullet deals with appeals data. If we had this issue, it would actually go the appeals route. There is a very small data set on the 2019 data. Of nine appeals, all nine received retroactive enrollment. I hope this data answers your questions.

Slide 9 – Error Correction Incorrect Information Process Flow. This slide is basically a swim lane slide. The top is the employee, the middle is the employer, and at the bottom is HCA. In Step 1, the employer provided incorrect information to the employee. Sometime after that happens, Step 3 is the intersection where a lot of back and forth between the employer and HCA happens. The employer will send a Fuze email to HCA. Fuze email is a secure email system used by HCA. They would describe the issue. Step 4, HCA and the employer and employee gather the necessary information to determine the options available and the best recourse given. Many of these are unique situations. In Step 5, HCA would approve the error correction recourse. Step 6, the employer sends the error correction letter to the employee. Step 7, the employee acknowledges the letter by signing it and acknowledging the error correction recourse. Step 8 is when the employer implements the HCA approved recourse.

Steps 1 and 2 are indeterminate timing on those, but Steps 3 through 8, the average is about 40 days in our current system to execute error correction recourse.

Dave Iseminger: We can't underscore enough how these are all very unique situations. The stake in the ground is what does the employee believe is appropriate recourse? Sometimes they're not interested in retroactive enrollment. By going through the error correction process and putting them on benefits prospectively, or giving them that option, and them acknowledging that option, it's an important piece of reducing liability for the entire program because they acknowledge they don't want a retroactive enrollment.

We have had questions asking why we wouldn't always retroactively enroll. It might not be a recourse an individual wants, or for whatever circumstance, isn't appropriate. This process allows us to document those conversations have occurred; and then if there was any future concern about how something was done, we would be able to show the employee, the employer, and HCA engaged in a process to provide recourse that was tailored in the particular instance.

Sue Birch: Policy Resolution PEB B 2019-05 – Error Correction Incorrect Information.

Resolved that, if an employing agency provides incorrect information regarding PEBB Program benefits to the employee that they then relied upon, at a minimum the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted. Is there a motion to adopt?

Tom MacRobert moved and Tim Barclay seconded a motion to adopt.,

Voting to Approve: 6
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-05 passes.

2019 Annual Rule Making

Stella Ng, Senior Policy Analyst, Policy, Rules and Compliance Section, ERB Division. I will highlight significant changes and rule making actions HCA is considering. No action is needed from the Board.

Slide 2 – Rule Making Timeline. July 2019 we will file the CR102, the proposed rule making on our proposed amendments and new rules with the Code Reviser’s Office. In August, we will conduct a public hearing on proposed amendments and new rules. After the public hearing, we will file a CR103, the rule making order. The adopted rules will be effective January 1, 2020.

Slide 3 – Focus of Rule Making. The focus of this year’s rule making is: administration and benefits management, regulatory alignment, amendments within HCA authority, and to implement PEB Board policy resolutions. HCA is adding clarity to rules to better administer and manage PEBB Program benefits as identified by staff and stakeholders and making changes to implement state legislation and to comply with federal requirements. The amendments are within HCA’s authority. We will implement PEB Board policy resolutions the Board passed this year.

Slides 4 – Administration and Benefits Management. HCA will amend PEBB Program rules to have consistent use of language, to avoid confusion for staff, and to help our communications team as they produce materials. We will provide clarity on HCA’s brief adjudicated proceedings and formal administrative hearing processes. Last year, we amended and updated PEBB Program appeals rules to streamline the appeals process and improve appeal resolution timelines. We continue to work on refining the appeals rules language for clarity.

Slide 5. Under our premium payment rule, we clarify HCA may develop a reasonable payment plan of up to 12 months in duration upon subscriber or subscriber’s legal representative’s request based on hardship. We also have a new rule regarding subscriber address requirements. It clarifies all employees must provide their employing agency with their correct address and update address if it changes. This also applies to retirees. They must update their addresses with the PEBB Program.

Slide 6 – Regulatory Alignment. HCA will make some changes to align with changes in regulations, implement legislation, and align with state statutes. This includes amending rules to align with Engrossed Substitute Senate Bill 6241 from the 2018 legislative session, which includes new definitions such as “school employee” and “School Employees Benefits Board Organization.”

In regards to implementing recent legislation, we are making changes based on Engrossed Substitute House Bill 2140 to include non-represented Educational Service District employees into our rules. We will amend the federal Family and Medical Leave Act rule to incorporate information on the new Washington Paid Family and Medical Leave Program and to describe options when an employee is approved for the federal FMLA and state Paid Family and Medical Leave Program.

We clarify if an employee is eligible for COBRA, they can continue Medical Flexible Spending Arrangement (FSA) contributions if they have a greater amount in remaining benefits than remaining contribution payments for the current year.

Slide 7. We clarify National Medical Support Notice requirements that a dependent can be removed from a subscriber's PEBB Program insurance coverage prospectively when the coverage for the dependent is provided as required by the National Medical Support Notice.

We are aligning with the federal requirement for adding a newborn or a child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption. Currently, a subscriber has 12 months to submit required forms if adding a child increases the premium. To align with the federal requirements, it's being amended to 60 days.

Slide 8 – Amendments within HCA Authority. We are amending PEBB Program rules to implement changes within HCA's authority. However, there is an error on Slide 8. The error correction identified on the slide is not within HCA's authority and is within the Board's authority. That's why the Board was asked to take action regarding this in the previous presentation.

An example of an amendment that falls within HCA's authority is in our special open enrollment rule that a special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB Program benefits.

Sue Birch: Our next agenda item is an update on the Uniform Medical Plan third party administrator implementation by Shawna Lang, our Senior Account Manager for UMP. I want to acknowledge Shawna who the Governor and the leadership at the Health Care Authority recognized as being one of the outstanding leaders in our state.

Uniform Medical Plan (UMP) Third Party Administrator (TPA) Implementation Update

Shawna Lang, UMP Senior Account Manager, ERB Division. Slide 2 – UMP Implementation. I'm here to update you on the UMP third party administrator procurement that first started and was released in November 2016. We signed a contract in early 2018. Implementation began in early 2018 and we go live with a new contract on January 1, 2020.

Slide 3 – Implementation Stages. There were four stages of implementation: Alignment Stage Gate, Definition Stage Gate, Delivery Stage Gate, and Transition Stage Gate.

For alignment, we took the contract and broke it down into initial implementation plans and baseline scope. We took the implementation plan and defined all the deliverables, which took almost nine months because we had to take each line of the contract and really understand what it was as a deliverable and how long it was going to take. We made sure we knew the deliverables and the implementation plan.

We are currently in the Delivery State on all deliverables. We will then go through open enrollment and all the materials must be ready by September 1, 2019. This involved combining materials for both the PEBB and SEBB Programs. The new procurement for

this UMP contract includes both populations. Once we are done with the delivery phase, we will transition to maintenance and ongoing processes and procedures.

Dave Iseminger: Remember the Health Care Authority used to do the direct administration of all parts of the Uniform Medical Plan until approximately 2011. HCA was directed to do a procurement that resulted in the Regence third party administrator contract we have today. That contract expires at the end of 2019. That's why we went through this multiyear procurement and implementation effort. The contract that was just executed, the initial term of it is for the entire decade of the 2020s. It goes from January 1, 2020 through December 31, 2029. It also has a possibility for extensions until the mid-2030s. HCA has been working on implementing this contract, which is valid for 17 or 18 years if it goes to its maximum contract length.

As HCA transitioned from its direct administration of all aspects of UMP, the Board and the Legislature added the high deductible health plan and UMP Plus. We are rebooting the whole thing. When you reboot, you find more efficiencies and better ways to build things and make operations better. This started from the ground up even though it's with a partner we've already been working with. It was also doubling it at the same time because the SEBB Program came on board at the same time this was happening.

Sue Birch: Between Dave and Shawna, they've made this look so easy but it has been extraordinarily complex and detailed. Kudos to you and the whole team because this really is a remarkable achievement.

Dave Iseminger: Shawna first came to me four jobs ago here at the Health Care Authority saying we need to start working on this procurement. That was six years ago. Here we are nearing the finish line on implementation.

Shawna Lang: Slide 4 – UMP Implementation. HCA started out with 13 work streams. The Account Team Infrastructure over the current and ongoing reporting, the operations manual, which takes the contract and breaks it down into the daily processes and procedures. An additional layer defines what that layer does. It defines accounting, invoicing, claims adjustments, reporting, etc.

ACP Reporting goes into what is in the UMP Plus account. HCA has over 72 reports on a monthly basis to review. This stream makes sure all of those reports have processes, file layouts, and ensuring everything is updated and has a maintenance schedule.

Dave Iseminger: The 72 reports don't sit on a shelf and collect dust. These are reports giving real time information to providers. The contracts are designed to coordinate care management. They are the types of data flying over to the providers to help them coordinate and improve health conditions. Providers use them to network on a real time basis to improve the quality of care members receive.

Shawna Lang: Clinical Management includes the clinical programs Regence has for their commercial book of business in the UMP plans. That's part of the new reboot starting January 1, 2020. It includes customized parts of UMP, such as the Health Technology Clinical Committee (HTCC), disabled dependents, and others.

Dave Iseminger: The Health Technology Clinical Committee makes coverage determinations that apply to state purchased health care plans on emerging technologies.

Shawna Lang: Communications incorporates the certificates of coverage, which are contracts with the members that tell the member exactly what benefits are available. As part of this contract, Regence is taking on the actual operations of the UMP public website. The authenticated website goes along with UMP. Once you're a UMP member, it includes all of the personalized information that goes into signing on and seeing your claims, which is also being updated.

Medical Pharmacy Management includes all of the medical drugs administered at hospitals or at doctors' offices. We have rebooted to ensure an extensive list of what those are, as well as rebates coming in and out of that category.

OCIO Design Review is the IT oversight of all the data that goes back and forth to ensure we have privacy, data regulations, and state oversight.

Operations – high priority areas and Operations – other functional areas includes making sure open enrollment, claims, customer service are updated, defined, and specifically scoped for both the PEBB Program population and the SEBB Program population, and knowing the differences between them. We have defined escalation teams at Regence so when we have escalated issues, we have someone defined for UMP only.

Performance Guarantees. There are a lot of performance guarantees on this contract. 40% of the annual administration is at risk on this contract. We want to make sure our TPA is performing. HCA is able to track and audit all of those things.

Provider Management comes to network adequacy, access, and making sure we have not only met the Office of the Insurance Commissioner (OIC) standards, but have internal standards within the contract.

Provider Search. We are upgrading the provider search option to better identify primary care providers for UMP Plus plans and others. We are also customizing the provider search tool.

Reporting and Benchmarking is documenting every report that's coming to us and knowing the layout, the owner, what system it's coming out of, the owner at HCA, and making sure we have documented changes of each of those.

Value-Based Programs is about the total cost of care, the Medicare LAN charts, making sure we have measurements of how we're paying for value, and how we're measuring that in a performance guarantee throughout the contract.

Dave Iseminger: OCIO Design Review is the state security requirements that are important with the level and type of data flowing throughout the different information systems. It's often a security review process we go through for any of our IT work streams and Pay1. When we get to Pay1's replacement, will be subject to that. For everyone, Pay1 is our backend accounting function that invoices, does the invoicing

process with employers, and provides the carriers the enrollment files. It's from 1977. It's as old as the LTD basic life insurance benefit and just as antiquated.

Shawna Lang: Slide 5 – New UMP Clinical Programs Implemented. Radiology Full UM / Advanced Imaging Authorization (AIM) is offered through advanced imaging or AIM. We'll have preauthorization on Computed Tomography (CT), Nuclear Cardiology Echocardiography (SE), and Magnetic Resonance Imaging (MRI). It takes the current utilization management program and makes it a requirement. This is an actual preauthorization for every one of these.

Sleep medicine is actually through AIM not EviCore, as noted on the slide. That's a mistake. Preauthorization is required for site testing, where the sleep study will take place, if it's at home, sleep center, in-patient, or out-patient; the equipment and supplies; and for the first 90 days for a C-PAP machine. They want to make sure the member is using the equipment on a regular basis and checking in on a case management level.

Physical Medicine is through EviCore. This is preauthorization of pain management, joint surgery, back surgery, physical therapy, speech therapy, and occupational therapy. In this program, the consult and first six visits don't require a preauthorization. After that, the provider, it's not on the member, needs to make sure the member has submitted a preauthorization for the rest of the visits. It is also a provider write-off. It doesn't get billed back to the member.

Dave Iseminger: What we found is over the years, Regence has other parts of its book business and it will develop utilization management techniques for other programs and other benefit offering suites. What we negotiated in our contract is that as they develop those, we have the right to include those, and they are already included within our payment structure. We don't have to go back and ask for additional funding to implement other great ideas that they have already been implemented across their book of business. It's already going to be included. We will roll those into our plan as we go forward. Shawna is highlighting several of them that have been in Regence's other administrative services contracts that will be incorporated by the nature of what I just described.

Shawna Lang: Slide 6. 24-hour Nurse Advice Line (excluded for UMP Plus plans). This is a toll-free number that members can call any time and get advice.

BabyWise is available to our pregnant members over age 18. It's maternity management, support, and education. There's also an application with information on the first trimester, second trimester, and education of the pregnancy phases.

Carol Dotlich: What if this is the daughter of a member who's below the age of 18?

Shawna Lang: There are privacy issues for members' dependents between the ages of 13 and 18. That's why we've chosen to offer it above the age of 18.

Dave Iseminger: There are services available to those under the age of 18. It's just not this particular program.

Shawna Lang: Regence would not reach out to those under age 18, but if someone reached out to Regence indicating they wanted these services, that would be different.

Myra Johnson: I was wondering if 18, is it possible to have that go to 16? I know there's the privacy act, but I was just wondering if the programs are available. I heard you say from 13 to 18 they would still be eligible somehow.

Shawna Lang: The algorithms aren't going to identify anyone under the age of 18 and proactively reach out to them. Yes, we can offer these programs, but the member has to reach out.

Sue Birch: I believe where staff is going is BabyWise is independent. You wouldn't want a 13-year-old attaching to a program without parent or household involvement. Thank you for that input. There are all sorts of very specialized programs in the state for that age range, in addition to what we have going on. My guess is we're dealing with that in a different way, but we didn't want that algorithm to create adverse impacts.

Myra Johnson: Thank you.

Medicare Retiree Health Benefits Project Update

Molly Christie, Project Manager, ERB Division. I will provide an update on where we're at with the project and identify next steps.

Slide 2 – PEBB Program Medicare Retiree Portfolio. I want to provide a recap of what we discussed at the January 2019 Retreat. We looked at why we're evaluating the Medicare portfolio; retiree benefit options other states have pursued; results from the Request for Information performed last September on Medicare Advantage Plus Prescription Drug plans (MA-PDs); and HCA's recommendation to the Board to procure at least one national MA-PD.

Slide 3 – Today's Agenda includes: RFI recap, RFP status, Funding, and Timeline.

Slide 4 – MA-PD Request for Information Recap. MA-PDs are private insurance plans that cover all Medicare benefits like Medicare Part A and B covering hospital and then professional services, as well as Medicare Part D, prescription drug coverage under Medicare. Medicare Part D is not necessarily the same as prescription drug coverage under an employer group plan. CMS pays the plan for these at a capitated rate for coverage under Medicare Part A and B. CMS also separates capitated subsidy for Part D coverage as well. MA-PD plans have a lot of restrictions by CMS so they have to cover all of the services covered by original Medicare. They also have to cover at least two drugs in every drug class for those drug classes that have two drugs for Part D coverage.

Where they vary is they can offer supplemental benefits and can change cost-sharing levels. Member cost sharing can be different than it would be under original Medicare. It's usually more generous because these plans are competing for enrollment. Last year we saw CMS expanded the definition of supplemental benefits. The standard supplemental benefits are enhancements over original Medicare that a lot of these plans offer, like vision, dental, hearing, alternative therapies, etc. This expanded definition is looking at non-primary medical benefits, things that will essentially help

keep members in their homes longer and out of the hospital. We are looking at those types of things in the RFP.

Sue Birch: Molly, I would add there are things like transportation services. There are the social determinate type things, and because Medicare Part C is moving in this direction, it's giving lots of opportunity for other partners to start looking at these nonmedical things that save on medical expenses.

Molly Christie: Exactly. Like any private health plan, MA-PDs can operate in different ways. You can see HMOs, PPOs, HMO point of service. There are different variations. Through our RFI process, we also learned that some large Medicare advantage organizations can offer plans under a federal waiver that allows for national PPO coverage. These plans are called different things, non-differential PPO ESAs, passive PPOs, there's all kinds of terminology. Essentially, what it means is the non-differential piece, the members are able to receive care from any Medicare participating provider that also accepts the plans payment terms and the member's cost-share levels are the same. If they see an in-network provider or a Medicare participating provider out of network, it doesn't make a difference in terms of cost sharing.

Slide 5 – MA-PD Request for Proposals Status. We are preparing an RFP for one or more fully insured MA-PD plans, at least one of which operates as a national PPO. Based on our research and analysis, this option aligns best with a goal to transition to a more sustainable and affordable health benefits portfolio that maximizes federal funding. It's that funding for private Medicare plans that covers a lot of the cost of original Medicare benefits and the Part D prescription drug.

Responses to the RFP are due at the beginning of August. We'll provide more details on the range of plan designs and rates as we work through negotiations.

Slide 7 – Evaluate Funding. The RFP timing will provide the opportunity to evaluate specific financial information on regional and national MA-PD plans before the next legislative session. We'll evaluate potential funding needs in the fall. These may be requested as part of the 2020 supplemental budget process.

Slide 8 – Timeline. Our objective continues to be to launch new plan options in 2021. If all goes according to plan, we will release the RFP in June or July and receive proposals in August. Depending on these results, we'll move forward with negotiations between September and December. We'll update the Board on the progress at the January Retreat and potentially present rates for a vote around July 2020.

Public Comment

Next Meeting

June 19, 2019

1:30 p.m. to 3:30 p.m.

Meeting adjourned at 4:21 p.m.

Public Employees Benefits Board
Meeting Minutes

Draft

June 19, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:

Lou McDermott, Chair Pro Tem
Yvonne Tate
Harry Bossi
Greg Devereux
Myra Johnson
Carol Dotlich
Tom MacRobert

Members Absent:

Tim Barclay

PEB Board Counsel:

Michael Tunick, Assistant Attorney General

Call to Order

Lou McDermott, Chair Pro Tem, called the meeting to order at 1:32 p.m. Sufficient members were present to allow a quorum. Audience and Board self-introductions followed.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits Division (ERB), provided an overview of today's agenda.

June 5, 2019 Meeting Follow Up

Dave Iseminger: We had a request for a Centers of Excellence presentation, which we've scheduled for July 10.

There was a question about nutritional visits. The Uniform Medical Plan with the rates you see today includes a change from three lifetime visits to 12 lifetime visits. No referral is needed in the Uniform Medical Plan to get nutritional counseling visits.

Tim asked questions about aspects of long-term disability. A long-term disability presentation is coming in July to wrap up those questions.

2020 Rates Overview

Beth Heston, PEBB Program Procurement Manager, Employees and Retirees Benefits Division. I will be talking about changes to the Uniform Medical Plan (UMP). Slide 2 – Uniform Medical Plan. To meet federal requirements, we are pointing out an out-of-pocket maximum for prescription drugs of \$4,000. For the Classic, Plus, and Medicare plans, the individual out-of-pocket maximum is \$2,000. During the year, IRS and Health and Human Services made changes to the pharmacy and maximum out-of-pocket amounts. Late last year, while we had an individual out-of-pocket maximum posted as \$2,000, we discovered that in larger families, there was a chance a family could exceed the family out-of-pocket maximum if they all needed expensive drugs. We monitored it to make sure families didn't pay more than \$4,000. This year, we recommend making it explicit by putting the \$4,000 maximum on the Classic, Plus, and Medicare plans.

Greg Devereux: Was there a family maximum prior to this?

Tanya Deuel, ERB Finance Manager, Financial Services Division. There was no family maximum. There was an individual maximum of \$2,000 each. If seven people in the family all hit that \$2,000 individual maximum, they would have paid \$14,000 out-of-pocket. The \$4,000 as a family puts HCA in compliance so we won't exceed the \$4,000 maximum. This is not a takeaway or an increase.

Greg Devereux: It certainly sounds like a takeaway.

Tanya Deuel: Now the member is only responsible for a total of \$4,000 versus the example of a potential \$14,000 cost. The member out-of-pocket cost on a family account now stops at \$4,000.

Greg Devereux: Okay, you're right.

Lou McDermott: Is the definition of family more than one? Is it two or is it subscriber, spouse, and a dependent? I guess what I'm getting at is subscriber and spouse the \$4,000 maximum? Before it was \$2,000 and now it's capped at \$4,000?

Tanya Deuel: I believe so, yes. Capped per family.

Dave Iseminger: Still with an embedded \$2,000 each. It's a scenario where if you have a family that consists of three or more people, your maximum combined will be \$4,000 with an embedded individual maximum of \$2,000 each.

Lou McDermott: So a single person is still \$2,000. A single person and a spouse are \$2,000 each, but capped at \$4,000. Add one child and it's up to \$2,000 each, but capped at \$4,000 for the family.

Tanya Deuel: Exactly.

Dave Iseminger: This was actually a change late in 2018. Our fully insured carriers accounted for this federal requirement. As Beth said, we monitored the charges over this plan year to make sure if anybody in UMP started to hit the maximum, HCA would have taken care of and contacted the member to ensure they didn't exceed the federal

cap. We're just now memorializing in writing this change to comply with federal law. Even though it wasn't in writing, we were complying with federal law.

Lou McDermott: So we took care of everyone in plan year 2018. No family paid more than \$4,000 for drugs in 2018.

Dave Iseminger: Correct. HCA monitored costs over the appropriate period to ensure we complied with federal law.

Lou McDermott: Did we monitor this year as well?

Tanya Deuel: Correct.

Beth Heston: Another UMP change was the number of nutritional counseling visits. They are going from 3 to 12 per lifetime. This change better aligns UMP coverage with the United States Preventative Services Task Force (USPSTF) recommendation. Studies show that comprehensive high intensity nutritional counseling services are among the most effective interventions for diet-related chronic disease.

Lastly, the Board voted to add the value formulary to UMP.

Slide 3 – No New Benefit Changes. There are no changes for 2020 for Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington (formerly known as Group Health), Uniform Dental Plan, DeltaCare Dental Plan, and Willamette Dental Group. However, as a reminder, last year there was a change to Kaiser Northwest's durable medical equipment (DME) charges. HCA asked them to step that change. They added a 10% coinsurance and this year they will add another 10% coinsurance to reach the agreed upon level.

To comply with Senate Bill 6219, Kaiser Northwest will cover male contraceptives and sterilization, such as condoms and vasectomy benefits, at zero dollars after reaching the \$1,400 deductible for self-only high deductible health plan (HDHP), or what we call CDHP plans. If they are meeting a family deductible, it's \$2,800. The Senate bill says members must meet their minimum deductible before they pay zero dollars for contraceptives.

There is a typo on Slide 3. The Willamette Dental Group rate guarantee runs through December 31, 2022, not December 31, 2021. The dental plans all have rate guarantees so there are no changes to the plans.

Tom MacRobert: Excuse me, Beth, I just want to make sure. The rates for Uniform Dental, DeltaCare, and Willamette are the current rates we have in 2019 which will continue through 2022.

Tanya Deuel: On the Uniform Dental Plan, our self-insured dental plan, the third party administrative (TPA) fee we pay is in a rate guarantee. Because it's self-insured, we go back and look at claims experience. The rate does have a slight change in the overall rate that retirees would pay. But the TPA fee is in a rate guarantee. I have that in my slide a little bit later to show you.

Tom MacRobert: Okay, thank you.

Beth Heston: Slide 4 – Service Area Changes. Kaiser Permanente of Washington will no longer be covering San Juan County pending federal approval, or Grays Harbor County.

Lou McDermott: How many members does that effect?

Dave Iseminger: It's approximately 250 to 275 members.

Lou McDermott: I know we previously had experience with a county being dropped. I assume there will be a communication plan, talking to members, making sure they understand open enrollment and signing up for different plans.

Dave Iseminger: Yes to all of those. About four or five years ago, especially in Southwest Washington, we communicated with members as coverage must be on a county level, not on a zip code basis. HCA went through an exercise of working with individuals in Pacific, Wahkiakum, Lewis, and Skamania Counties, and maybe one other county, helping them understand their options. We will do the same outreach to the members in these counties for transitioning to other options. It means that going forward, San Juan County would be a UMP only county. The only plans available will be UMP.

Once the SEBB Program launches, we are hopeful there will be opportunities to bring additional competition and choice to members in many of those UMP only counties in future years, but not in 2020. SEBB Program service areas for 2020 have not been announced.

Lou McDermott: I assume Kaiser Permanente (KP) will put extra attention around our members who might have complex medical conditions so the transition of care goes well.

Beth Heston: Yes, we're somewhat handcuffed at the moment because of the need for federal approval. HCA and KP have action plans to reach out to members. We used it last year with the change in Lewis County for retirees. We have a strong communication plan in place.

Slide 5 – Network Update – Puget Sound Health Value Network (PSHVN). There will be changes to UMP Plus. HCA has new partners for 2020. For the PSHVN, those include the Rainier Health Network, which includes CHI Franciscan, Pediatrics NW, and others belong to that network. We also have the Physician Care Alliance at the Poly Clinic, and then the exiting partners for 2020, Multicare and Eastside Health Network.

Dave Iseminger: When we launched UMP Plus, the original term of the contract went through December 31, 2019. In the last week, HCA finished negotiations and executed one contract. The other contract is in the inking process, but we have the handshake agreement. This will extend UMP Plus through December 31, 2024. With this transition from the original term to the extension is where the significant network aspects are changing. We wanted to highlight those.

The loss of Multicare is because they're going to be exclusive to the UW network.

In Pierce County, CHI Franciscan is coming on and the Rainier Health Network continues to address provider access in Pierce County for the PSHVN network.

Beth Heston: Slide 6 – Network Update – UW Medicine. Multicare will be an exclusive partner to the UW network. HCA will let members know of this change and what plan they can choose to continue to see Multicare doctors, particularly in Pierce County. Also, Eastside Health Network is exiting the UW network.

Slide 7 – Spokane County Update. Beginning in 2020, Spokane County Multicare is partnering exclusively with UW. The Puget Sound High-Value Network served Spokane County through Multicare, but UMP Plus will only be available through the UW network in 2020. Members will be notified of that change. Slide 8 – UMP Plus – UW Medicine Accountable Care Network (ACN) 2020 Counties Served is a visual representation of the counties covered by the UW CAN. Slide 9 – UMP Plus – PSHVN 2020 Counties Served is a visual for the PSHVN.

Dave Iseminger: Spokane County is switching from being a Puget Sound High-Value Network county to a UW county, in part because of the exclusivity of Multicare being in UW. It looks like a big transition but it's not as profound a transition as you might think. HCA will make sure to communicate to members the need to switch plan names to continue care and do the similar outreach described for KP.

Carol Dotlich: I'm afraid I'm quite lost. I basically don't understand what you're telling me. If somebody has UMP today, they cannot use Multicare unless they switch to a different plan? Is that what you're saying?

Dave Iseminger: We're talking about the Uniform Medical Plan Plus, which is the more coordinated care network embedded within the UMP network umbrella. For the general UMP Classic population, nothing is changing. It's specific to this Uniform Medical Plan Plus, which has core providers that have coordinated care systems and a different in-network, out-of-network pricing structure for the members' out-of-pocket expenses for visits. We're saying that embedded network within the Uniform Medical Plan Plus treats Multicare differently between the networks going forward in 2020 versus today in 2019.

If an individual wants to continue in Uniform Medical Plan Plus in Spokane County and see Multicare providers, they will no longer be able to enroll in a high-value network. They need to choose the UW network. HCA will communicate with them to help ensure a smooth transition for them.

Carol Dotlich: Does this have an impact on the Centers for Excellence plan?

Dave Iseminger: No, it has no impact on those Centers of Excellence, total joint or spine bundle. It's solely with the UMP Plus networks.

Tom MacRobert: Just to make sure I understand this, let's say I am a Uniform Medical Classic member and I get all of my health care through the Overlake Hospital and Overlake network surrounding that area. I am not affected. It would only be if I'm UMP Plus.

Dave Iseminger: Correct. If you are in UMP Plus and you go to Eastside after January 1, 2020, that will be treated out-of-network. If you're in UMP Classic, you're in-network because UMP Classic is the broad PPO versus the embedded network in UMP Plus.

Lou McDermott: That's a good message for our members when they do sign up for a limited network. Because of contracting, negotiations, market share, and all the things that happen in our community, things change year to year. If you're in a limited network plan, you should always contact the plan to make sure your doctor is going to be in that network next year. That communication is a little bit tricky and I think the last thing we want is members showing up in January to their doctor they've seen for years and find out they are no longer in their network. That's going to be key.

Dave Iseminger: To be clear again, none of the service area changes described impact UMP Classic, which is the plan most people are in.

Beth Heston: Slide 10 – Premera Plan F and Plan G. We've spoken to you before about the required change from our Medicare Supplement Plan F to Medicare Plan G. These are Medigap or Medicare Supplement plans. Our Plan F will close after January 1, 2020 to future enrollment. The Medicare Supplement Plan G will open to replace Plan F. Plan G will be identical to Plan F, except subscribers must pay the Medicare deductible. The calendar year 2019 deductible is \$185. The Centers for Medicare & Medicaid Services has not released what the 2020 deductible will be, which could change depending on what the federal government does.

Dave Iseminger: Importantly, no one is going to be required to change from Plan F to Plan G. It will be important for members in future years to watch the pricing because since future enrollment is closed, over time fewer and fewer people will be in that plan, which will drive different pricing structures within that plan. They can stay in Plan F as long as they are satisfied with the premium associated with that plan.

Tanya Deuel: Slide 11 – Employee Premiums. I'm going to walk through the plan year 2020 proposed premiums and rates. I will start with state active employees. I think it's important to revisit how the state calculates the state index rate, which is basically the employer's portion of the medical contribution set in the Collective Bargaining Agreement. It's set currently at 85% of the total projected health care costs.

Slide 12 – Calculating the State Index Rate. Going across this slide, starting at the top, it says "Plan Bid Rates." These numbers are illustrative only. I made these up for easy math. In the green box is Plan A at \$550, tan box is Plan B at \$500, and the blue box is Plan C at \$450. We project what enrollment will be across these different plans (Adult Units). In Plan A, there are three adult units, Plan B, one adult unit, and Plan C, six adult units. The math for Plan A is $\$550 \times 3$, Plan B is $\$500 \times 1$, and Plan C is $\$450 \times 6$ that equals the total monthly cost. Add the total cost for all three plans and divide by those ten projected adult units to get a weighted average of \$485. Take \$485 times the state's contribution per the Collective Bargaining Agreement of 85% to get a state index rate of \$412. Remember, \$412 is just illustrative. The actual number is more likely \$571, which you will see in a couple slides.

Dave Iseminger: This is all related to the employee contribution. This doesn't impact retirees.

Tanya Deuel: It doesn't impact retirees at all. We will go through those in a few slides. Slide 13 – Determining Employee Premiums. Now we take each plan bid rate, Plan A at \$550, Plan B at \$500, and Plan C at \$450, and subtract \$412, the 85% weighted average employer's contribution. That makes the employee contribution for Plan A \$138, Plan B \$88, and Plan C \$38.

Dave Iseminger: One disclaimer because I know many people are paying attention to both the PEBB and SEBB Programs. This math formula is not applicable in the SEBB Program population. It's very different in the SEBB Program.

Tanya Deuel: Slide 14 – Determining Employee Premiums by Tier. This slide shows how we develop premiums by Tier. The single employee contribution for Plan A is \$138. For Tier 1, it's $\$138 \times 1$ (single subscriber) = \$138 monthly premium. For Tier 2, it's $\$138 \times 2$ (subscriber plus spouse or state-registered domestic partner) + \$10 admin fee = \$286 monthly premium. For Tier 3, it's $\$138 \times 1.75$ (subscriber plus child(ren)) = \$242 monthly premium. It doesn't matter how many children you have, it's still just .75. For Tier 4, it's $\$138 \times 2.75$ (subscriber, spouse or state registered partner, child(ren)) + \$10 admin fee = \$390 monthly premium. The math is the same for Plan B and Plan C.

Harry Bossi: The plus \$10, like the surcharge, adjustment, whatever you want to call it. How long has it been \$10? How many years?

Tanya Deuel: A very long time.

Harry Bossi: I didn't know if going forward, it needs to be considered for an adjustment.

Tanya Deuel: I can follow that up next time.

Harry Bossi: That's okay. It just wasn't new this year.

Tanya Deuel: No. Slide 15 – Employee / Employer Premium Contribution. This slide shows the breakdown of the employee and employer split for a single subscriber. I'll orient you to each slide as we move through. The dark blue column on the left lists the plan names and they will stay in the same order throughout the slides. The next column over is the proposed plan year 2020 employee contribution for a single subscriber. The middle column is the state index rate or the employer's contribution of \$571. It is the same amount for all plans. The far right column is the proposed plan year 2020 composite rate.

The composite rate, if you work backwards, for example, on Kaiser Northwest Classic, the composite rate is \$711. If you subtract the \$571 employer contribution, the single tier subscriber only rate is \$140.

Dave Iseminger: I want to explain the very last sub-bullet in the footnote area. About three or four years ago, the legislature changed the rules for political subdivisions contracting with the agency to join PEBB Program benefits. There used to be a function to determine if an entity was riskier than the PEBB Program pool. If they were, they

couldn't come in and make rates worse. The Legislature flipped it and let anyone join, but provided the ability for HCA to evaluate the political subdivisions as a whole to determine if they had a rate risk impact than the rest of the pool. If they did, HCA could charge back that impact via a surcharge. A surcharge for political subdivisions results in an offset here for the pool of \$1. The surcharge itself is more than \$1, but the offset to the pool is \$1.

Lou McDermott: Does it go the other way? If they were less risky and healthier, would we write them a check?

Dave Iseminger: No.

Tanya Deuel: Haven't had that happen yet either.

Slide 16 – Employee Contributions by Tier. This slide walks the single subscriber rate through the math of all of the tiers. Again, the plan names are on the left and there is a comparison of the plan year 2019 versus the proposed 2020 rate. As you move across the top, there's the subscriber tier, the subscriber and spouse tier, the subscriber and child(ren), and the full family tier (Subscriber, spouse/state-registered domestic partner, and child(ren)). On the far right is a comparison of plan year 2019 to 2020 as far as a percentage and dollar change. The percentage change is solely on the single subscriber rate. While these rates are smaller, the percentage change may look higher. In a couple slides, we'll look at the overall rate, which will have a different percentage because it's off of a bigger number. The numbers in red are a decrease so the rates are going down.

Lou McDermott: I know we had a conversation before the Board Meeting about the increase in UMP Plus and I was part of the new negotiations. I understand why this is happening. Do we want to provide that explanation?

Tanya Deuel: The change in UMP Plus is due to the recent contracts Dave referenced. Due to the nature of the accountable care plans, there is risk assured between the network and HCA. There are changes to that methodology in those contracts we are executing and waiting for signatures. I cannot discuss those details here in a public meeting.

Dave Iseminger: Tanya can't discuss the level of detail of the methodology changes but we did have financial changes within the methodology. It's important to note that from the beginning, we've been trying to target at least a 30% premium spread between UMP Classic and UMP Plus. Last year, the claims suggested a different rate that grew to approximately a 45% change. This year, with claims experience and changes in some of the financial methodology, we're closer to getting back to our 30% target.

Lou McDermott: To extend those contracts through 2024 and maintain the favorable benefit design, there were concessions made, the nature of the contract change. That's what's bringing the rate back to the 30% range. In our negotiations, our goal was to maintain the target of 30%. A correction has to happen between the 2019 rates and the 2020 rates to get it back to 30%, which is unfortunate.

Dave Iseminger: HCA would not anticipate a 38% increase every year. This is a one-time correction.

Tanya Deuel: The 38% is just on the employee contribution. 38% on \$50 is \$69. It's a higher percentage than the total rate in a slide or two.

Slide 17 and 18 – Non-Medicare Retiree Rates and Non-Medicare Retiree Rates by Tier. Non-Medicare retirees pay the full plan cost. In the column on the far right, there are smaller percentages of change. Typically, there is a 3% to 5% increase year over year. What we see here is on the lower end of an increase.

Dave Iseminger: Many times when you see reports from the Office of the Insurance Commissioner talking about rates year over year, this rate is what they're talking about. The overall plan cost. They're not talking about the individual employee contribution from our prior slide. When the Commissioner talks about the commercial market, rates are either going up or down a percent or two. This is the comparable metric to be looking at for the PEBB Program.

Tanya Deuel: This rate does not receive any contribution from the state towards their premiums. It is the actual bid rate plus an approximate \$5 admin charge.

Slide 19 and 20 – Medicare Retiree Rates. This is the Medicare retiree premium, not the overall rate. This slide looks like the slide we saw previously for the actives with the plan names down the left. The single subscriber premium, in the next column is after the subsidy. The subsidy column is the employer's contribution towards medical for our Medicare retirees, which was increased in plan year 2020 to \$183 from \$168 in plan year 2019. The 50% language still exists. The subsidy is set at \$183 or 50% of the premium, whichever is less. As you look down the middle column, Medicare Explicit Subsidy, only two plans have the Medicare explicit subsidy listed at \$183 because the total composite was not over \$366 (2 x \$183).

Slide 21 – Medicare Retiree Premiums. This slide takes the same plan year 2020 rates and has a comparison of plan year 2019 to plan year 2020. There is a percentage and dollar change for the single subscriber premiums. The numbers in red parentheses are a decrease. Where you see Premera Medicare Supplement Plan F Disabled, it actually goes down \$10.53.

Slide 22 – Impact of Medicare Explicit Subsidy. This slide shows the impact of the Medicare explicit subsidy on rates. Moving from the far left to right, you see plan year 2016 through plan year 2020. These are UMP Classic rates with plan year 2020 being the proposed rate. The number on the top is the total rate. The orange box is the retiree premium with the blue box being the Medicare explicit subsidy. As you look at plan year 2018 versus plan year 2019, \$483 versus \$481, they are relatively flat. The Medicare explicit subsidy increased from \$150 to \$168. The orange box decreased slightly because the member pays the full rate minus the Medicare explicit subsidy. When there are extreme rate increases and the Medicare explicit subsidy doesn't increase at the same trend, the Medicare retiree absorbs the increase.

Carol Dotlich: These increases in cost, are they due to the increasing pharmaceutical costs?

Tanya Deuel: A good portion of it is pharmaceutical costs. Our Medicare rates, as a whole, are over 61% in pharmacy costs and the rest are medical based on the nature of how UMP works.

Dave Iseminger: It's fair to say the structure of the Medicare plan is the UMP pays primary on pharmacy but secondary to Medicare for medical. The vast majority will always be driven by pharmacy costs because of the structure of the plan itself inherently as a primary payer of pharmacy. HCA will always pick up the first dollar coverage as an insurer on drugs compared to the medical. Pharmacy always is going to be a predominant driver of any rate change, up or down.

Greg Devereux: Why is that, Dave? Why is PEBB primary on drugs?

Dave Iseminger: It's almost like asking why the sky is blue. It's fundamental to the relationship that the plan has --

Greg Devereux: Why is the sky blue? [laughter]

Dave Iseminger: I could actually answer why the sky is blue better because of the refraction of light. But for your Medicare question, we take on a credible plan that qualifies under the Medicare rules. It comes with federal requirements. You can have a plan that has prescription drugs; and if it does, it has to meet certain requirements. Fundamentally, the way a plan is packaged under the federal rules, it does inherently require you to be a primary payer on pharmacy. If you include prescription drug coverage, it comes with different requirements such as offering and ensuring the plan is at least as good as part D. Part D would be the primary payer if it was your only plan. If you are picking up drug coverage, you are picking up being the primary payer of pharmacy.

Beth Heston: In many cases, our prescription drug coverage is much richer than Part D.

Carol Dotlich: I'm going to make a statement. Because you implemented the value formulary, you've heard this from me before, I don't think our rates should go up because by implementing the value formulary, which I didn't agree to, but your plan is to keep the cost of the drugs low. Since you've implemented that plan, I think the premiums should stay the same for retirees because you're going to recover that cost with your value formulary.

Dave Iseminger: One of the challenges we have, Carol, is we are about to implement it, but the way it's being implemented, for the most part, will impact future diagnoses and future drugs people will take. There's a lot less disruption for the current member. Because we build our rates based on prior claims experience, we don't have a way to do the projection for the exact way the formulary is being implemented. A year from now, we'll have more experience to factor into the process. The way it's being implemented, we aren't anticipating or able to quantify a specific attributable savings to bank on for purposes of setting rates for 2020.

Tanya Deuel: The costs we're expecting for the value formulary, the savings will increase as the years go on because in the beginning, there'll be more exceptions. We will realize those savings starting in next year's rate build.

Dave Iseminger: For example, Carol, if the value formulary had passed two years ago, it would've been able to be accounted for in these rates. It just can't be done in the rate setting process for 2020.

Lou McDermott: One thing we always run into, is the balance between taking care of our members and making sure they have continuity of care, continuity of medications, and wanting to implement new things. When we go back and do our modeling, if we make sudden dramatic changes, we don't grandfather people. We create no exceptions. We can achieve immediate savings and we know that. But at the same time, these are our members. We care about these people. They're taking these medications for chronic conditions, for acute conditions, and we take it into consideration. It is always a struggle to try and find that balance between taking an action, which eventually will save money and make sense clinically to do, and yet taking care of the member. In my conversations with staff about the savings assumptions, because it's very unpredictable how many people are going to get the exception, how many people are going to come in and start new medications, and start at the medication within the Preferred Drug List (PDL). That's a tough one. It is a tough balance, but there will be savings achieved. It will take time, unfortunately.

Carol Dotlich: I would like to push back on that. I could agree or accept what you're saying better had we adopted a plan where we grandfathered the patients on their drugs currently and just moved on new diagnoses and outcomes rather than taking existing patients off of their existing meds and putting them through the value formulary process. That's not what this Board voted to do. We voted that there was no grandfathering of those people. To get an exception, they had to go through this whole different process. They're not grandfathered. That's my objection. I could understand your point of view if you had agreed to grandfather but the Board did not agree to that.

Lou McDermott: Ryan, do you want to come up and talk about implementation and medications that folks are probably going to be filling at the end of the year that are going to go for 90 days and all the different things that are going to cause us not to get the full financial impact of the change?

Yvonne Tate: I have a comment. Just because they weren't grandfathered doesn't mean they're going to be thrown off the drug. They're going to go through a process. If the only thing that works is that drug, they're going to keep that drug. It isn't a fait accompli that they're not grandfathered.

Harry Bossi: I want to check in, too. This is a cost containment process we're going through. The cost containment doesn't start until 2020. You're not likely to see savings right away. Hopefully, this will help offset for 2021. I think the whole idea is long-range and not short-term benefit for our plan members.

Ryan Pistorisi: We have been working closely with Moda. We've had weekly meetings and will continue to have meetings throughout the rest of the year about the implementation of the 2020 UMP PDL. We are going through and trying to identify

members currently taking these medications that may qualify for an exception. There are patients that have already gone through some of these drugs and progressed to other drugs. We are trying to reach out to them to let them know about the process early on. We are going to work with the existing claims history to identify those members and start the process so there is no disruption for them on January 1, 2020. They can continue to get their medication if they qualify. For members that don't qualify, we will reach out to them and identify alternatives so they can start the process this year so there is no disruption for them at the start of the next plan year.

Carol Dotlich: Are you saying you've implemented the value formulary this year already?

Ryan Pistorosi: No, we haven't implemented it yet but we're starting the process to implement. There's a lot of work between now and then to identify members to get the drugs set up correctly in the different tiers because for certain medications, two or three may move to Tier 2 based on experience that MODA has recommended from when they implemented their preferred drug list for Oregon Educators Board (OEB) and Oregon Public Employees Benefits Board (OPEBB). We're still in the process of implementing. We're looking at ways to mitigate some of the potential disruption at the start of the next plan year.

Dave Iseminger: Once the SEB Board voted, because they were the second of the two Boards to vote, that started an implementation project at HCA. That project began in late May and now goes through and ensures implementation goes into effect January 1, 2020. That requires the identification and outreach to members. When Ryan says we're implementing, we're working on that implementation project and informing people about the change that is coming. The effective date of that change is in the resolution, which is January 1, 2020. Ryan's not talking about implementing today. He's talking about the steps necessary to implement the policy effective January 1, 2020.

Tom MacRobert: I don't want to revisit all of our arguments about it in the past. I do have one comment and one question. The comment, basically, is there is going to be some disruption to people moving off drugs they currently are taking if it's a drug affected by the value formulary. Even though, as Yvonne pointed out, they will have the ability to go through the appeal process, that doesn't mean they won't have to leave the drug they're taking to try generic alternatives. If those don't work, they go through the appeal process. We're talking about a process that could have some very long-term effects on those people affected by it. That's just the point. The question I have is, moving forward, if this value formulary is to have a positive monetary effect for the Health Care Authority, how are you going to present that information to us such that we understand where those savings are coming from as we go forward?

Dave Iseminger: Tom, as we get into next year, that is the prime question people are going to ask. As HCA is presenting rate information, what would the table have looked like if that wasn't there? We know there's a vested interest from everyone in a lot of different arenas, but in particular, the Board as to what really can we attribute to that piece. Again, I want to make sure the Board realizes in future years, the further out you go, the more we would anticipate seeing savings. Just like any time you make a stab at trying to bend trend. I can't commit to the exact way we're going to visually represent it. It depends on how everything shakes out. I anticipate we would proactively bring

forward information about what the attributable savings is in a future projection and a future rate development.

Tom MacRobert: Okay, thank you.

Lou McDermott: At the end of the day, by not having aggressive savings targets associated with the plan, it gives the clinical folks an opportunity to implement it to the favor of the member, trying to make sure we take care of our members. The harder line we put on the fiscal implications of the change, the more we hold their feet to the fire and the more they have to make tougher and tougher decisions with regard to our members. They're going to ease into this program and over communicate with members. Some members will see the writing on the wall and get a 90-day refill in December. You can't do anything until April anyway. Those things are going to happen because when you make a change, people react. We're trying to give the clinical team room to do their thing. We will start seeing positive effects on this. We can parse that out financially and during the next rate-setting phase, some of those will come to fruition and be baked into the projections for the next year. We'll get to reap the benefit of that without an extreme cutover.

Dave Iseminger: I appreciate your comments, Tom, about the impact individual members will have. I don't want to leave the other side of the story on the table. The generic equivalents are supposed to be just as efficacious and cheaper. Those who do try another generic drug alternative that works for them as it is anticipated, would have a positive impact of paying less out-of-pocket month over month going forward. There will be positive out-of-pocket savings that people will realize by going to the lower cost, equally effective drug.

Yvonne Tate: The point I was trying to make is this decision is on an individual basis. For example, there may be members who have already tried all the generic equivalents. They're not going to go through that again if they can document it. They've tried them and they didn't work. That's all I'm saying is it's an individual case-by-case basis as to what the path they take. They will look at their medical records and consult with the third party administrator and their medical doctors as to where it's going to go. The only other thing I'd like to say is just reminding the Board Members that with any kind of rate setting, generally what happens is you look backwards to project forward. You have to have trend in order to project future rates. With this change, there is no trend right now. That's part of the dilemma. The longer this change is in effect, the more trend data we'll have.

Carol Dotlich: I would just like to say from a consumer point of view, what it's going to look like to people with these rate increases is they're paying more for less choice, for less opportunity. That's my objection to the increase in rates.

Myra Johnson: What I'm hearing is I think the key to this is truly going to be about communicating and a transparency of how this came about to the membership and the end user. I am hoping a lot of the generics work, but I also going with what Yvonne says in that members will know if they've tried something and it didn't work. Their primary care provider will also know and help the member walk through this process quicker because they already know. I think if that's a win for anybody, that's a plus. I'm hoping, as we look deeper into pharmaceutical costs and how that impacts the end user

and as long as we're communicating that effectively, there's not going to be 100% win on any of this, but I think I'm happy we're going in the right direction. Thank you and that's my comment.

Dave Iseminger: I'll add one more piece related to specialty drugs. We've said these numbers before but I was in an annual meeting with Moda earlier this week. For 2018, 54% of the drug spend was driven by .3% of prescriptions. That was a growth from .24% specialty prescriptions in 2017. A growth of just .06% drove an additional 4% to 5% in overall drug spend. That is what's also factored in here driving rates up. It continues to be specialty drugs and that small utilization has profound cost.

Another piece the value formulary is attempting to smooth out is the future volatility in the market that comes with specialty drugs. Although Ryan and Donna try to have crystal balls, we don't all know exactly what's going to come down the pipeline, how clinical trials will work, which drugs will tank in the clinical trial process, and which will ultimately get approved.

With our rates, there's at least three or four major drivers. You have your explicit subsidy and what portion the state picks up. You have drugs overall, but in particular, specialty drugs that are driving trend. There are small changes in percentages within specialty drugs that end up driving huge increments in the dollar-for-dollar increase in rates. Those things all come together into the rates.

Tanya Deuel: We are also trying to be aware of being too aggressive that we don't have the yo-yoing in rates between years, like you can see on this chart between plan year 2017 and 2018. That was a \$55 increase to the member, a 20% increase. We don't want that to happen in the future where we're too aggressive and then next year's rates go up because those savings weren't actually realized.

Greg Devereux: On page 16, I assume this is because of the waiting, but the subscriber, spouse, and children for UMP Classic, that's the only one that -- let me look for a second.

Tanya Deuel: UMP Classic is going down on the single subscriber.

Greg Devereux: All four go down, correct?

Tanya Deuel: Right, because the single subscriber goes down by \$3. We then work through the math of times 2, 1.75, or 2.75. They all go down.

Greg Devereux: All right, thank you.

Tanya Deuel: Slide 23 – Dental, Life, and Long-Term Disability. Slide 24 – Dental Premiums. These dental premiums have rate guarantees, which Beth referenced earlier. The plan names are on the far left and the subscriber comparison rates for 2019 and 2020 are in columns 2 and 3 for the single subscriber. The Uniform Dental Plan is in a rate guarantee for our TPA, our third party administrator. We actually do a full rate build on this like we do on the medical. We look back to 2018 actual experience and trend it forward. This rate actually has a slight increase where the other two rates do not. As a reminder, this is 100% paid by the employer for state active employees.

Retirees pay these rates. If a retiree enrolled only in dental but not medical, there would be an admin fee charged. Retirees are charge the admin fee once if they are in medical and dental. If they're in dental only, it's still charged only once.

Slide 25 – Life, AD&D, and LTD Premiums. Basic life, AD&D and LTD are employer-funded and there's no rate change for 2020. However, the optional and LTD is employee funded. While there are no rate changes for 2020, the individual rate you may pay if you're paying optional could change if change your waiting period or your age band changes. If you get older, the age band rate changes slightly.

Slide 26 – 29 - Proposed Resolutions. There is one resolution for each carrier. They are grouped by non-Medicare, both active and retiree; and Medicare following. I'll read the first one so you can see what we have.

Slide 27 – Proposed Resolution PEBB 2019-07 – Non-Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

This is what the resolution will look like for each carrier.

Slide 30 – Proposed Resolution PEBB 2019-10 – Medicare Premium. I want to draw your attention to the Medicare explicit subsidy resolution. It reads: The PEB Board endorses the monthly Medicare Explicit Subsidy of \$183 or 50% of premium, whichever is less.

The Board has the authority to set this lower if you choose. We have written it at the full amount, thinking that's what you want.

Dave Iseminger: We are assuming you would exercise your discretion to give retirees the maximum allowed in the budget. But you do have to formally ratify that amount because in theory, you could lower the subsidy. You can't raise it but you can lower it.

Tanya Deuel: Slides 31 – 24. The next resolutions are by carrier for the Medicare premiums. The first one is Proposed Resolution PEBB 2019-11 - Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums. Following that are resolutions for Kaiser Permanente of Washington, the Uniform Medical Plan, and Premera.

Slide 35 – Next Steps. We plan to bring these resolutions to you for action at the July 10 PEB Board Meeting.

Eligibility and Enrollment Policy Development

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – Introduction of Policy Resolutions. I am introducing one policy resolution today. Proposed Policy Resolution PEBB 2019-06 - Tobacco Use Surcharge.

Slide 3 – ESHB 1109 (Budget Bill). This slide is an extract of the current budget bill that goes into effect July 1, 2019. Included is relevant language from the bill for you to have available as we talk about the policy related to the tobacco use surcharge. Prior budget language expressly stated \$25 is the amount of the monthly surcharge. The language

changed in the state operating budget that starts on July 1, 2019. The Board can establish the amount of the surcharge provided it is not less than \$25 per month. Because of this change, we're bringing a policy resolution to you for consideration.

Dave Iseminger: Rob will review considerations and share why HCA recommends leaving the surcharge at \$25. If the Board wants to have the agency consider additional points, we will. The spousal surcharge had similar language when it was originally enacted that said it must be at least \$50 so we brought you a resolution to set it since you have discretionary authority. We've never brought you a tobacco surcharge resolution because the original budget language effective until this July expressly set the surcharge at exactly \$25. Now that the language changed, we're asking you to take action once you have authority, which is after July 1.

Rob Parkman: Slide 4 – Considerations. This slide presents considerations for the Board. Approximately 26% of employers with 500 or more employees have a tobacco surcharge according to a survey conducted by the Mercer consulting firm. The median differential payment for smokers and nonsmokers is about \$600 a year, or about \$50 per month. The \$25 surcharge is comparatively low.

Currently, about 3% of PEBB Program members pay the surcharge, compared to a national average of about 15%.

The American Lung Association is opposed to tobacco surcharges. They feel they're ineffective in causing smokers to quit, and in fact, there's evidence that if they're high enough, people will forgo insurance altogether so they don't have to pay the surcharge. While surcharges have not proven particularly effective, there are other methods that have worked, including taxing tobacco products, adopting smoke-free laws, both of which Washington State has done, as well as making tobacco cessation treatment accessible, which the Board has done by including the most effective programs within medical plans offered by HCA.

Slide 5 – Proposed Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge. Beginning January 1, 2020, the tobacco use surcharge will be \$25 per month for a subscriber with a member enrolled on their medical plan that uses tobacco products.

Carol Dotlich: Currently, are the Medicare population included in the surcharge and would this resolution change that?

Rob Parkman: No.

Greg Devereux: I've always been opposed to both the spousal surcharge and the tobacco surcharge. This just gives further evidence there's no real need for the tobacco surcharge. To me, these are simply taxes on state employees, both of them, and when 88% of state workers are behind their counterparts in the public and private sector in terms of wages, I think it's ridiculous the state exercises this and takes more money back from them. I know we can't do anything here but I think it's ridiculous to take it out of people's paychecks.

Tom MacRobert: I have one question. If the data shows surcharges are not effective, why are we doing it?

Dave Iseminger: There is definitely data that says there are more effective tools and a fair amount of data that questions surcharges. We have a relatively small surcharge compared to others. There is definitely a deterrent effect. We can't exactly attribute a specific correlation, but when the tobacco surcharge was originally implemented, there were more people paying it than are paying today. Either they're accessing tobacco cessation programs so they can appropriately attest they are trying to seek better lifestyle choices that can decrease their tobacco usage, or they've actually quit. I guess they could not be telling the truth on their attestation, which gets us to if you were to raise it, you might incentivize potential false attestations. I think there is some data, although it might not be perfect, that says surcharges are not effective. In fact, it might be a significant amount of data that says overall surcharges aren't the best tool. It is something that can at least create a deterrent effect. Having something that's lower than the rest of the market, continuing forward and promoting healthier lifestyle choices, or accessing tobacco cessation is at least a tool.

Lou McDermott: I think there's a camp out there that's suggesting people who smoke have higher health care costs and this is to help offset some of those costs. I think that's the rationale. But is it a deterrent? I don't think so.

Tom MacRobert: I'm not arguing that. I'm just arguing that based on what Rob said, not only is it not a deterrent, but you used the example of people actually sometimes will forsake other things that would be healthily effective so they can continue. That doesn't sound to me like it's a program that works effectively. I'm just pointing out the logic behind it.

Greg Devereux: I appreciate your answer, Dave, but to me, a more accurate answer is the state senate in a particular year decided they needed different ways to raise money. They decided the spousal and tobacco surcharges were ways to get money for the state budget. I don't think it was based on policy considerations. They hid behind policy considerations. But it was simply a money grab to get from the state workers in my opinion.

Dave Iseminger: One thing I'll add, Tom, at some point, it can become a deterrent to accessing insurance at all. I believe under federal law you can add an additional cost up to 50% of the premium. You can increase the premium by 50% solely for tobacco users. States have the authority to set different parameters. I can't remember what our state's commercial market insurance laws allow. There are instances across the country where a premium might be 50% more, not \$25 a month, but a total 50% of the premium added on. That could be what's driving the statements about deterrence of accessing insurance. I would say in the grand scheme of 50% of a premium addition versus a \$25 a month charge, there is definitely a gradation there. I don't want us to say because we have it, some people forego coverage. We're not saying that in the PEBB Program population. That's from a national perspective. Keep in mind the ceiling at the national level is up to 50% of additional cost associated for tobacco use.

Lou McDermott: Rob, I think you're hearing the Board say to go with the minimum \$25. Thank you for bringing us this information.

Rob Parkman: Slide 6 – Next Steps. I will take your feedback, hearing a \$25 surcharge, and bring it back to the next meeting.

Emerging Medications

Ryan Pistori, HCA Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation Division. Today I have one medication to share with you, onasemnogene abeparvovec, also known as Zolgensma, which is the new gene therapy approved late last month.

Slide 2 - Spinal Muscular Atrophy. This slide is background on the disease. Spinal muscular atrophy is a rare neuromuscular disorder characterized by muscle weakness. The neurons do not function correctly. Over time, the neurological function begins to degrade and fail, which leads to progressive muscle weakness. This is a rare disease and it affects approximately four to ten patients per 10,000 live births.

Dave Iseminger: To skip to a much later slide, we have about 2,500 births per year in the PEBB Program. This is something we would project to happen once every three or four years in the PEBB Program population.

Ryan Pistori: There are a few different types of spinal muscular atrophy within this umbrella of a disease. As you see listed here, the different types of the disease depend on when the symptoms manifest in the different patients. It also depends on the number of copies of an SMN 2 gene that we all have in our bodies. The disease is caused when the SMN 1 gene, also known as survival motor neuron one, is either mutated or deleted and it doesn't function properly. These patients need to rely on these SMN 2 genes in order to have these neurons survive.

Just looking at the list from Type 0 to Type 4, patients with Type 0 typically have zero or one copy of the SMN 2 gene and that's why they usually die within weeks to months after birth. If you go down to Type 4, those are usually patients that may have upwards of eight to ten copies of this SMN 2 gene, and they usually don't even know they have spinal muscular atrophy because they have ambulation throughout all of life and have normal life expectancy. Unless you had a genetic test for this specific gene, you wouldn't know because you don't suffer any of the symptoms known for spinal muscular atrophy. The ones we'll be talking about for this presentation are Types 1, 2, and 3 because those are the ones that have onset of symptoms usually early in life or around the teenage or early adulthood.

Type 1. These children are never able to sit unsupported. They usually have to be put on permanent ventilation between year one to 15 months. They usually don't survive past their second birthday.

For Type 2, the symptoms usually appear between three months to 15 months. They are able to survive a little bit longer but many have to have permanent ventilation in their 20s. One study showed about 70% of patients with Type 2 were alive at 25 years of age.

Type 3 patients usually manifest more mild diseases, usually losing ambulation and requiring a wheelchair, but their life expectancy is about normal.

In terms of the different types relative to the number of live births, about 60% of all births are Type 1 and 30% are Type 2. Type 0 and Type 4 are the least common forms of spinal muscular atrophy.

Slide 3 – Spinraza (nusinersen) is the first medication approved for spinal muscular atrophy just a few years ago. This was a medication approved by the FDA in 2016. Prior to this treatment, there were no pharmacological therapies for spinal muscular atrophy. It was just supportive care and making sure the patients are comfortable. As of 2016, there is an approved therapy. This medication requires about six doses in the first year and then three doses every subsequent year. You begin doing doses a few weeks apart. After that, you progress to every couple of months. This is a medication that costs about \$750,000 in the first year and \$375,000 every subsequent year.

I am going into detail because it's challenging to compare between Spinraza and Zolgensma. Spinraza was studied in symptomatic patients, which is analogous to Type 1 spinal muscular atrophy and the pre-symptomatic patients, which are types two and types three. So on the genetic test they were identified to have spinal muscular atrophy but because they didn't develop symptoms at the time of the trial, they were considered pre-symptomatic but were likely to develop symptoms in the next couple years of life.

In one of the trials, about 50% of Type 1 patients that received Spinraza achieved motor milestones relative to 0% of the placebo. It shows there is this difference from when the medication is administered to when it isn't. It is worth noting of the 73 patients who received Spinraza in the trial, six were able to sit independently and one was able to stand. These patients were never expected to sit unassisted.

I want to touch on the motor milestones. These patients had at least one improvement in one category of a specific motor neuron test and more categories of improvement than no improvement. When you think about this drug, there is a wide spectrum from patients, how they respond. On one end, you have a patient that is able to stand and a couple patients that are able to sit. You also have about 49% that really didn't see any improvement with this medication. There is a wide range of how patients respond when they receive this medication.

Very few patients have received this medication under UMP since it was approved in 2016. As Dave mentioned, we don't see many births in the UMP Program population for patients with this disease.

Slide 4 – Zolgensma (onasemnogene abeparvovec) is the drug we're talking about today, the newly approved gene therapy. This is the first gene therapy approved for spinal muscular atrophy and the second gene therapy approved for use in the United States. It's approved for patients who are less than two years of age with certain mutations in SMN 1 and sufficient copies of SMN 2. The Type 0 that don't have enough copies are not eligible for this drug. Theoretically, any other type of SMA could be eligible for this gene therapy. So far, only one published clinical trial studied Zolgensma in patients with Type 1. Only 15 patients were in the trial that received this medication.

The published data includes outcomes on survival ventilation status, sitting independently, healthcare utilization, looking at how these patients may utilize in-patient hospital visits or other healthcare services, adverse events of the safety of the

medication and a few other things. It's worth noting the Spinraza trials looked at motor milestones, whereas this trial only looked at safety, were there any deaths, or any need for permanent ventilation. Permanent ventilation requires ventilation for at least 18 hours per day. There are no outcomes for us to look and compare between these two drugs since they were studied in very different ways, even though they were studied for the same population.

It is worth noting that all 15 patients were alive at 20 months, compared to about 8% of the historical control. Following the end of this trial, about 40% did begin to use Spinraza. It looks like there is potential transition for these patients to go from this gene therapy to Spinraza. There is not much data on why or who transitioned over, but it looks like there may be need for additional medication to improve mobile milestones and other functional assessments for these patients. There is going to be a 15-year follow-up study. Since this was just finished earlier this year, we won't know until about 13 years down the road what the long-term outcomes are of these gene therapies.

Slide 5 is SMA Type 2. There is no published data on this type. Type 2 is for those pre-symptomatic patients I mentioned for Spinraza. These patients develop symptoms later in life, may live into their 20s or live a normal life expectancy, and may require a wheelchair. What's interesting about this study is they use a different route of administration. It's interesting that this gene therapy was approved for all types of SMA when it was only studied in Type 1. But all studies in Type 2 are using different methods of administering the medication. We are closely monitoring that to understand why there is a difference in how this drug is used for these types of patients. Unfortunately, there won't likely be published results for this until approximately April 2023. There's not much data on this new gene therapy, or Spinraza in general, just because of the rarity of this disease.

We continue to monitor and evaluate these drugs for use in our patient population.

Lou McDermott: But we do know how much it costs.

Dave Iseminger: Ryan, it still could be administered for these individuals, even though the clinical trial was only on Type 1. Individuals in the US will be able to receive it and we know how much it costs, even if we don't know the full clinical data. We're talking about a \$2 million drug that's been in the news after one clinical trial of 15 people.

Ryan Pistori: Correct.

Tom MacRobert: Novartis is the company that is going to be at some point, hopefully, in their mind, selling Zolgensma? Are they the ones doing the research?

Ryan Pistori: Yes. Zolgensma was developed by AVXS, a small biopharma company. When this drug was going through clinical trials, Novartis bought them out. It's a joint partnership between Novartis and AVXS.

Tom MacRobert: Who pays for the research?

Ryan Pistori: This research is being paid for by the manufacturers. They are the ones that fund and design the clinical trials. Once they're finished with that, they submit

that information to the FDA for review for potentially changing the drug label or the prescribing information.

Emily Transue, MD, HCA Associate Medical Director. There is an open question on some of the FDA approval. We would be looking at what we would create in terms of coverage criteria to make sure this was directed at people who could benefit from it.

Ryan Pistori: Novartis announced the price of Zolgensma will be \$2.13 million per dosing kit. Given that this is a very expensive medication, they are trying to work with payers to set up a pay-over-time option, which would be the first time the US has had that option. It would be about \$400,000 per year over the next five years. One of the challenges with that is if a member were to get the drug through UMP, change employers, leave UMP to work in the private world, UMP would still be on the hook for the cost of the drug. There are inherent challenges with this type of payment structure, which is why we haven't seen it before.

Using more than one dosing kit has not been evaluated. During the clinical trials, they were only looking at patients of a certain weight, children six months of age or less. Since this was approved for children up to two years of age, HCA could potentially be looking at patients with larger body weight. The amount of the dosing kit may not be sufficient and may require multiple. HCA is evaluating that for determining the appropriate medical necessity criteria for when these medications should be approved.

Dave Iseminger: I'm curious if those payment plans will be interest-free or not.

Ryan Pistori: Slide 6 – UMP Budget Impact. HCA anticipates the budget impact for this new drug would be the \$2.13 million, but only once every three to four years. It depends on the incidents of Type 1 SMA in the UMP population. Dave mentioned we have about 2,500 births per year, so we may see one of these every three to four years, once we reach 10,000 live births for our population. Since it is possible, it could be less, it could be more. It depends on our patient population and how this is diagnosed.

To summarize all the 26 medications talked about since the beginning of the year, the anticipated budget impact is \$4.4 million. This is easily the most significant budget impact drug of the year.

Pubic Comment

Fred Yancey, Washington State School Retirees. Two basic points and then one opinion as a citizen. I happen to agree with the logic, illogic if you will, behind the issue of tobacco surcharges. If evidence shows it's ineffective, if you're doing it for health reasons, and I never said this, but then why don't retirees pay? They smoke as well. It's illogical. It does not make sense.

Where does the money go? Nobody has said our rates are cheaper in UMP, as an example, because they're offset by X amount of money that we get from the tobacco surcharges. Mr. Devereux suggested it just goes into the state general fund but I think it goes to Health Care Authority. What happens to that money and how much are we talking about?

Ms. Deuel did an outstanding job educating somebody like me on how you get the rates and how it works in terms of the tiers. My only question is, when the Board is asked to certify the Medicare rates, they don't have a tier sheet similar to that for the Medicare rates. What you're given is a sheet showing just the subscriber rates. I think you need to see what a subscriber and spouse pay and family pay and so forth for Medicare because it's pretty shocking premium costs.

Tanya Deuel: I can actually address those now. I saw your email about the retirees by tier. This question was asked last year so I looked at how we addressed this. Just so the Board is aware, with the Medicare premiums by tier, it's not just the four tiers anymore because it's a combination of how many Medicare eligible are on each account. It's not four tiers, it's many tiers because it's a combination of Medicare and non-Medicare. We don't produce this until the Board has adopted the rates because it is a lot of math that's long and we usually don't go through this QA process with the actuary until after the Board adopts the rates. That's the answer to that one.

Fred Yancey: I understand that but the Board is being asked to adopt by resolution the rates and they don't have them in front of them. At least based on current rates, it looks like it's two to three times higher as you go across tiers. I understand your spouse may not be Medicare eligible so that's a certain rate. Maybe both of you are Medicare eligible and that's a certain rate. But I think you need to see the shocking cost of a Medicare insurance coverage for retirees.

Tanya Deuel: It follows the same tiers as the actives that were in the beginning of the presentation where it's times one, two, 1.75, or 2.75 if they're both Medicare eligible. When you add the non-Medicare children in the equation, it becomes a combination.

To follow up on the tobacco surcharge, it's about \$3.3 million, based on the last fiscal year.

Lou McDermott: Tanya, is that just tobacco or is that all the surcharges?

Tanya Deuel: That is just tobacco. It's \$3.3 million, which is about 11,000 people paying that surcharge. It goes into our general account, not the general fund but our main benefits fund, which is used as general revenue to offset the entire cost of the program. It reduces the cost to the state and everybody.

Fred Yancey: Thank you for your time.

Preview of July 10, 2019 PEB Board Meeting

Dave Iseminger provided an update on potential topics scheduled for the July 10 PEB Board Meeting.

Lou McDermott: I want to recognize and thank Fred Armstrong, our account manager from Kaiser Washington, formerly Group Health, for his years of service working with the Health Care Authority and this Board. Fred is retiring and this is his last meeting today.

HCA would deal with Fred on issues that happen all the time. We have rate season, which everybody is aware of where we're talking benefit design and money. But during

the year, lots of stuff is happening with the OIC, lawsuits are being filed, regulations are changing, the federal government's doing their thing, members are having issues, and Fred was our primary contact. He always did a great job for us and always very responsive. I just want to thank you for all the work you did over the years.

Fred Armstrong: Thank you. It was my pleasure.

Lou McDermott: Am I allowed to share your retirement plans?

Fred Armstrong: You are.

Lou McDermott: Fred is going to be a babysitter to his grandchildren. He is packing up and moving closer to the children to help with daycare. I think that is an awesome retirement. It beats going to meetings all day, Fred. Believe me! [laughter]

Next Meeting

July 10, 2019

1:30 p.m.

Meeting adjourned at 3:16 p.m.

Public Employees Benefits Board
Meeting Minutes

Draft

July 10, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:45 p.m.

Members Present:

Sue Birch, Chair
Tom MacRobert
Greg Devereux
Harry Bossi
Carol Dotlich
Yvonne Tate
Myra Johnson
Tim Barclay

PEB Board Counsel:

Michael Tunick, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:31 p.m. Sufficient members were present to allow a quorum. Audience and Board self-introductions followed.

Meeting Overview

Dave Iseminger, Director, Employees and Retires Benefits Division (ERB), provided an overview of today's agenda and noted the meeting schedule for 2020 is behind TAB 1.

June 19, 2019 Meeting Follow Up

Dave Iseminger: We answered most of the questions from the June meeting in real time. I do want to provide additional insight to one of the questions. When Tanya presented rates, Harry asked how long the plus \$10 has been in existence. Any Tier that has a spouse, you take the rate factor and add \$10. We checked our records and we have documentation back through 2000. It has been around at least 20 years. We'll continue to see if we find any documentation that goes into the last millennium. Every plan year in this millennium had the plus \$10 factor.

2020 Premium Resolutions

Tanya Deuel, ERB Finance Manager, Financial Services Division. There are eight premium resolutions for action today. I've included the medical premiums in the Appendix.

HCA heard your concerns from the last meeting regarding the value formulary and the fact there is no adjustment included in the rates for 2020 for the impact of the value formulary. Our team had multiple discussions with executive leadership about the ability to make changes to the rates regarding the value formulary. At this point, the modeling is not at the level we deem necessary to put anything into a rate. Unfortunately, this year there will be no impacts on the rates for the value formulary. We do anticipate by this time next year when we do rate setting, we will be able to incorporate any necessary changes for the actual utilization as a result of the value formulary.

Dave Iseminger: I want to reassure the Board, since the last meeting, typically when we present the resolutions and then bring to you for action it's a much shorter time frame than when we presented them at the June meeting. We had a variety of conversations about the ability to include any piece of projections and we couldn't get to a point where we had enough quality checks within the projections necessary to wrap it up into the actual rate setting for this year.

Carol Dotlich: When we met last, letters were going out to people so they could start to apply for their exceptions if they desired one to the med changes. Have you had any response yet to those letters?

Dave Iseminger: The letters haven't gone out yet. The intent is to send those letters as we go into the open enrollment process. So, no, we haven't had any responses yet because we haven't sent those letters. That is part of that implementation plan over the next six months as we get into open enrollment and the plan year starting in January 2020.

Carol Dotlich: Thank you.

Tanya Deuel: By voting on the entire resolution by carrier, the Board is adopting the rates for all plans underneath that carrier. There is a set of resolutions for each carrier for Non-Medicare and a set for each carrier by Medicare.

Sue Birch: Thank you for the clarification.

Premium Resolution PEBB 2019-07 – KPNW Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

Tom MacRobert moved and Tim Barclay seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-07 passes.

Premium Resolution PEBB 2019-08 – KPWA Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington employee and Non-Medicare retiree premiums.

Greg Devereux moved and Yvonne Tate seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-08 passes.

Premium Resolution PEBB 2019-09 – UMP Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Uniform Medical Plan employee and Non-Medicare retiree premiums.

Tom MacRobert moved and Greg Devereux seconded a motion to adopt.

Dave Iseminger: Chair Birch, I want to acknowledge this resolution includes UMP Classic, which is dropping from the employee contribution at the subscriber level by \$3. It's going down a bit. There have not been too many times where UMP Classic, the predominant enrolled plan in the portfolio, had a reduction in rates.

Carol Dotlich: I would like to request the \$3 decrease be added to the retiree Medicare people, for UMP.

Sue Birch: I'm looking to my AAG about that discussion point. Carol, I'm not exactly sure what you're intending to do there.

Carol Dotlich: Well, if UMP is going down for the actives, I would like to see a \$3 reduction for the retirees as well.

Sue Birch: Give us a second to determine our next procedure.

Dave Iseminger: Chair Birch, I would make a suggestion for everyone to think about the context of this. This resolution is about setting the Non-Medicare premium rates. It's not about setting the Medicare premium rates. At this point I think it's a question of if you want to make a motion to change the Medicare rates, I would suggest that would be more germane to the resolution on Medicare premiums, which is Premium Resolution PEBB 2019-13. We could certainly entertain discussion and debate and answer a question if that's possible.

Carol Dotlich: I would be amenable to discussion and debate.

Dave Iseminger: Without it being an actual motion on the table, let's just talk about this topic. Carol, I understand your question is related to if the non-Medicare rate is able to go down \$3. Is it if the Medicare rate go down by \$3 -- or \$3 from the \$7.45 that is proposed. I don't exactly understand your question. Is it to reduce the net change by \$3

or have Medicare rates go down \$3 -- which would be a \$10.45 swing from the rates as presented.

Carol Dotlich: The latter.

Dave Iseminger: The latter, to have a \$10.45 swing.

Tanya Deuel: Just a reminder the rate that went down is the single employee tier, not the overall plan rate, which is different than how we calculate retiree premiums on the Medicare rates. The overall rates are different than the premiums we're seeing here. It is not one-for-one.

Dave Iseminger: There are two things to talk about. One is the bid rate versus the employee contribution. The bid rate for UMP Classic actually went up \$5, it didn't go down. But between the collective bargaining split, and the fact Non-Medicare retirees pay 100%, that changes what the member is paying. Carol, you're asking if we can apply what the member contribution is for Non-Medicare to the bid rate of Medicare. I think that's the actual question.

Sue Birch: I'm asking staff to slow down just a little bit to bring the Board along as we try to flush this out. Carol, I believe we're referring to Slide 18 where you see employee contributions. I do think this is an important point Dave is trying to drive. We're asking employees that are getting a \$3 relief -- Carol's suggestion is to say to those employees, "your \$3 savings now is going to cross-subsidize the carriers' bid rate on the retiree pool." I am really concerned that we don't have the authority to do that. I'm trying to understand how it is we would have that authority, Carol.

Again, I look to my legal team to say not just procedurally how are we handling this, but within our fund pools, Dave, and I'm reaching here. I don't believe within our fund pools we have that authority to cross-subsidize. We can recess if we need to take a break before we call for a vote. I think the simplest thing to do right now would be to finish up with the motion on the table, then take a break while we seek legal guidance and then resume before we vote on the Non-Medicare resolution.

Yvonne Tate: Procedurally, if Carol hasn't made an amendment to the current resolution, don't we go ahead and vote on that resolution? She would have to recommend an amendment, it would have to be seconded, and voted separately. She hasn't made an actual amendment recommendation.

Greg Devereux: I thought we were still in the discussion phase, though.

Yvonne Tate: But my point is we're discussing something that is not in the form of an amendment to the current resolution. Unless it's made in the form of an amendment it shouldn't affect the vote on the current resolution. That's my point.

Tim Barclay: I just wanted to clarify, I think the way you made the comment about the \$3, you made it sound like there's this savings, there's this bucket of money, this saving, which to Carol's point, I think in that context, makes sense of, "hey, let's spend that and give it to a different group of people." There is no \$3 savings anywhere. According to the index rate and the way the index rate calculations work out, some people's

premiums go down, other people's premiums go up. It just so happens this one segment went down \$3. There is no money here. There is no savings bucket of money to spend somewhere else. To lower the premiums for the Medicare people would be new money that we would be spending outside of anything else happening here. I think the way you said it led to some confusion and I don't know if I'm on the same slide as you or not, but there's no money here to reallocate and spend.

Tanya Deuel: There's more to it than just that, Tim. There's also switching assumptions, where we have to decide how many people are going to move out of a specific more expensive plan to a less expensive plan. There is no extra money just sitting there to reallocate to the Medicare pool.

Tom MacRobert: I had some questions, although I was going to wait until we got to the actual Medicare portion of this conversation. I would like to do that because I think it might get confusing. I would propose we finish the Non-Medicare conversation/votes first. What you're talking about, Carol, is definitely relevant to the Medicare resolutions and not to the Non-Medicare. If it's okay I'd like to finish the Non-Medicare. When we get to Medicare, I do have some comments and questions.

Sue Birch: I see heads shaking. And to Yvonne's point --

Yvonne Tate: If there's no actual amendment then we shouldn't be considering it.

Sue Birch: Any further comments on the resolution on the table? We will take a vote on Premium Resolution PEBB 2019-09.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-09 passes.

Premium Resolution PEBB 2019-10 - Medicare Subsidy.

Resolved that, the PEB Board endorses the monthly Medicare Explicit Subsidy of \$183 or 50% of premium, whichever is less.

Tom MacRobert moved and Carol Dotlich seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-10 passes.

Premium Resolution PEBB 2019-11 - KPNW Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Yvonne Tate moved and Harry Bossi seconded a motion to adopt.

Dave Iseminger: Chair Birch, just for everyone's direction, we're talking about the rates that are in the Appendix on Slide 23.

Greg Devereux: Tom raised the point about discussing Carol's discussion in the Medicare area. We now are in the Medicare area. Are we going to have this discussion before we vote on any Medicare rates?

Yvonne Tate: Wouldn't it be under the context of Carol suggesting an amendment to a resolution, and then we discuss that amendment?

Sue Birch: I believe that's correct. Rather than a verbal amendment, I'd like to get that in writing as well. I want to be very clear about what is being suggested.

Tom MacRobert: The conversation I wanted to have is actually an attempt to make sure that I understand, and by doing so, hopefully everybody understands the proposal. I want to go back a little in history. In 2018, the Medicare Explicit Subsidy was \$150. In 2019 it went from \$150 to \$168. For 2020, it went from \$168 to \$183.

When the Explicit Subsidy went from \$150 to \$168, we saw Medicare premiums across the Board either slightly decrease or remain flat. I think there was only one of the list that actually saw a tiny increase. In 2019, the subsidy went from \$168 to \$183, which is a \$15 increase, yet most of the premiums saw modest increases. What accounts for that?

Tanya gave good mathematical explanations of how you come up with rates. But is that all that drives it, is simply plugging numbers in? Or is this something that is negotiated with, for example, Regence, Kaiser Permanente -- to establish those rates that you come up with.

Tanya Deuel: The overall bid rate is negotiated. We work with both Kaiser plans on their rates, just as we do on the Non-Medicare side. We have a few-month process where we're looking at their rates, what their administrative load is, all their trend assumptions that are built into those underlying rates. We go back and forth on rates. The simple math is once we've gotten to a final bid rate, it's that simple math of bid rate minus explicit subsidy -- which is the flat dollar amount or 50% of the premium, whichever is lesser, to equal the retiree premium. That's the simple math.

Tom MacRobert: The bid rate is what is negotiated, and that drives the final premium costs, okay.

Tanya Deuel: Yes. As that increases at a different rate than the explicit subsidy, you're going to see an increase on the member side because the increase on the subsidies may not be at the same rate.

Tom MacRobert: Since Regence is supposed to be a nonprofit and that subsidy increased by \$15, what was their rationale for increasing?

Tanya Deuel: Regence doesn't actually negotiate with us, UMP being a self-insured plan. HCA does the rate development. Remember, we pay Regence a per subscriber per month fee to administer the plan. We do the rate development in-house with our contracted actuary Milliman. The rate development is HCA. We use our contracted actuaries to develop trend assumptions, as well as Moda, our pharmacy benefit manager, to develop the pharmacy side. On UMP Medicare, we pay secondary on medical but primary on pharmacy. 61% of this rate is pharmacy costs. We rely on Moda and their trend assumptions to inform the rates.

Tom MacRobert: Is it fair to say then that what has significantly driven those small increases is prescription drugs and what we've negotiated with Moda?

Tanya Deuel: Over half of it is pharmacy, yes.

Dave Iseminger: It's not what we've necessarily negotiated with Moda. When we say we're setting up a bid rate for UMP it is to be able to have the total cost on a per member basis, to be able to create a member premium. We're creating a number that, based on all the actuarial projections, will cover the total claims cost plus the small admin fee -- small in the relative picture of the entire cost of the entire plan, to make sure all claims are covered for the next plan year. There's no profit padding built in. That's why we're self-insuring, to make sure we are getting the amount of money that's the projected needed to cover the cost of the plan.

Sue Birch: Tom, I want to comment that the Board had information about delivering on a value-based formulary a year ago. We voted it down and it stalled our efforts to control pharmacy pricing. It's part of what has happened -- we weren't able to control that component of the cost that goes into the bid rate. We brought this on ourselves by not taking earlier action on a value-based pharmacy.

Greg Devereux: With all due respect, Chair Birch, I think the jury's still out on the formulary. What savings it will yield in the future we don't know yet.

Sue Birch: Fair enough -- although staff made recommendations to attempt cost containment strategies, and this is one other industries brought to bear to try to control costs. We're not seeing it yet, and it's why staff advised us that we aren't going to see it now because we need more run time to build that into next year's rates. I think that's part of the frustration, is we hear you saying, "we want these costs to come down," but we have to give our staff the tools to reign in some of this cost. Hopefully our value-based formulary strategies will bear fruit next cycle.

Dave Iseminger: Chair Birch, I do want to add more context. Tom, you were talking about the relationship when the explicit subsidy goes up and what happens on the member premium side. Slide 24 is a slide Tanya produced to show visually what's happening. The setting of the explicit subsidy and the bid rate are independent actions. They come together and are part of the formula as seen here. When you see that the explicit subsidy from plan year 2018 to 2019 went up \$18, the reason that you saw plan decreases was the bid rate, reflected at the top of the bar, was flat. It actually went down a couple of bucks. When the bid rate went down and the subsidy went up, that directly offset dollars coming out of retirees' pockets.

When you move from 2019 to 2020 and you see the bid rate went up about \$22 when the explicit subsidy went up \$15. That insulated retirees from the additional impacts of the bid rate going up, but didn't fully cover and subsidize the total cost of that incremental increase of the bid rate. There are completely different independent levers that come together in the final math formula. There isn't a direct relationship that when subsidy goes up and costs go down from members' out-of-pocket because you have to factor in what the bid rate was, and what direction the bid rate went. I thought you were trying to see if there was a way to tie those together when the explicit subsidy goes up, that means premiums go down. Those aren't directly related to each other.

Tom MacRobert: No, I wanted to make sure I understood how you arrive at the rates you do. That was what I needed to find out.

Michael Tunick: I want to add that the \$183 was budgeted by the Legislature. That's part of the constraints of what you're working with here. Within the budget provided by the Legislature, you are not going to be able to increase that subsidy. I don't know if that's part of what you're thinking of here or where that \$3 is coming from. Just make sure that the subsidy has that cap.

Carol Dotlich: It's my understanding that Kaiser people already have a formulary. Is that true? A value formulary sort of plan? That's my understanding. I have a friend who is a legislator who has this plan and he tells me they routinely have to get certain meds. Can't get other meds because of the Kaiser plan. If that's true, if there's a value formulary in this Kaiser plan and Kaiser's rates are going up, can you explain that?

Sue Birch: For clarification, Carol, are you asking what's the difference between the proposed value-based formulary through Moda versus Kaiser Permanente's formulary? I don't know if that is an apples to apples comparison. Staff, if you could speak to that or if we need to call in our pharmacy --

Dave Iseminger: I can speak to that. Kaiser plans are fundamentally HMO plans that have things in place like the value formulary. If I travel back in time to the January Retreat, the Board will remember that we had a panel of physicians -- two from Kaiser and two from components of the Uniform Medical Plan's networks. One of the themes during the physicians' presentation was that Kaiser already manages everything that way. Their internal formulary and systems are integrated together and when the patient is present and deciding between drug A and B, the doctor's talking with them about what is on the formulary. They physician knows what is covered under their plan because Kaiser is an integrated system. Then the physician talks about the side effects of the drug, not the cost of the drug. That's the bread and butter of what they've done and they've done that for years.

The impact on rates is embedded within their rate development and has been for decades. The Kaisers' are not implementing a value formulary today or tomorrow. They've integrated the principles of integrated care from the beginning of their model of building up a health plan. To answer your question, Carol, yes there are value formulary principles within their integrated care model. It's not something new and didn't have to be accounted for in these 2020 rates because it's baked into what they do as they build their rates every year.

Carol Dotlich: Before you go on, that's my point. If this formulary saves money and this method of integrating everything saves money, why are the Kaiser rates going up as well as the UMP rates?

Dave Iseminger: What I'm trying to say, Carol, is anything related to those formulary pieces are embedded within the rates from years ago. There's nothing that's changing from today to tomorrow. There is no incremental piece impacting this. What's impacting Kaiser's rates aren't necessarily formulary related. It's more the utilization within the plan on different services.

Tanya Deuel: Right. There's more than just pharmacy, obviously, in the Kaiser rates. The Medicare rates have different subsidies from the Centers for Medicare & Medicaid Services that are a whole different ballgame than our Uniform Medical Plan. It's a completely different story with Kaiser and the Uniform Medical Plan on the subsidies they receive in those rate-setting processes.

Dave Iseminger: The reasons individual plan's rates change aren't the same carrier to carrier, or within each plan. The reasons for an increase in one plan may be completely different in another plan. We see reports from our carriers where X drug is increasing in this plan and utilization is increasing in this plan, but it's decreasing in a different plan. There's a whole host of differences within how a plan is managed. What drives rates up or down in one plan is not indicative or comparable for other plans.

Sue Birch: Being a very pragmatic nurse, Carol, there could be plans that have a higher propensity of head injuries and associated medications and treatments that impact rates and rate build. There are many variables staff are sharing with you that tease that out. I think the KP model is different, since it's the HMO kind of construct. Again, I caution the value-based formulary we proposed, approved, and built is a little different than what KP's formulary is all about. They are not apples to apples comparisons with lots of variables at play.

Carol Dotlich: I have one more technical question. Yvonne suggested that the only way to change anything is to create an amendment to the resolution that's before us. That's my understanding.

Yvonne Tate: That's my understanding of Robert's Rules of Order.

Sue Birch: Yes, it's my understanding that we will take a vote on the current motion on the floor unless somebody moves to amend, and then we will take a vote on that amendment and see if it passes.

Carol Dotlich: So my question, it's just a question not a motion. My question is if I made an amendment to this resolution, I don't have the ability to go back and renegotiate rates. So what would be the technical point of making an amendment to change this resolution? What would be the purpose, since I have no ability to change the work that was done?

Sue Birch: It's my understanding that if this Board failed to approve these rates, staff would be redirected to go back and renegotiate. But I'm looking to Dave.

Dave Iseminger: Chair Birch, I'll remind the Board, and I think everyone was on the Board two years ago. I think that was the first cycle for both Tom and Carol and everyone else was on the Board. We had a point where we said if a resolution isn't passed, the plan wouldn't exist. Now that we are on July 10 and we've brought these to you a little early, I still think we're at a point where it would be very challenging to make any sort of modifications, especially when it comes to the UMP bid rate. We are not negotiating with anyone except ourselves. We're setting the rate based on what is necessary to cover the entire plan's expenses for the next year. There wouldn't fundamentally be something that could change on either the UMP bid rate or changing the retiree subsidy to a number that's higher than \$183 because the Legislature's set that as the cap. There isn't a way to change those two fundamental numbers today, tomorrow, or at the end of the month. For impacting UMP, which I believe, Carol, is your question even though the resolution we're on is KP Northwest, your fundamental questions I think are about UMP. There wouldn't be a way to go back and change those rates.

Tanya Deuel: Over the last three weeks, since the last Board Meeting, we revisited the rates to see if there was a place to find even a dollar or two. We re-evaluated the total bid rate and found nothing we felt comfortable changing. The fact that the explicit subsidy is set in the operating budget bill by the Legislature, we essentially would be increasing the amount the state pays, which would be drawing the total PEBB Program fund into a deficit, which ultimately would trickle through an increase in funding rates in future years.

Sue Birch: I believe Carol's asking what would that do to the offerings on Slide 23? I hear staff saying if the Board voted down the Kaiser Northwest, Senior Advantage would be eliminated. It would be one less option or choice under the retiree selection. Is that correct?

Dave Iseminger: It is correct. I'd make it a little broader. On each of the subsequent resolutions before the Board, if the Board chose not to adopt the rate, you would strike the applicable plans that fall under that resolution out of the retiree Medicare offerings. Right now, the resolution is about the top line on Slide 23. Fundamentally, I think the questions have all been around line three of Slide 23, which is a subsequent resolution that will come to the Board. By not passing a resolution, you essentially are saying we are not endorsing a premium; and therefore, not endorsing a plan to be in the portfolio.

Sue Birch: Eliminating choice.

Greg Devereux: I guess academically I have to disagree with that analysis. I'm not sure there's the votes to do anything here today anyway, but I think it could be voted down. There's not a lot of time. I understand it's a self-insured plan, but Milliman is extraordinarily cautious in their estimates. Something could be done to look at that estimate. I understand you have to move heaven and earth to go to the non-self-insured plans, timing wise. But something could be done, I believe, in a very short period of time. I'm not suggesting that, but I think something could be.

Harry Bossi: I'd like to comment that nothing can be done about past utilization. Nothing can be done about medical inflation that's associated with the future or the past. What could be done, which I don't think this Board wants to take on, is to look at the

principles within the plans, the coinsurance, the deductibles, the cost sharing, the limitations on the drug out-of-pockets. Those are things that would affect the premium. So if you want to drive premium back down, you're going to have to shift. It's fairly simple. It's a see saw. It's made up of two sides. To affect one side you have to offset it on the other side.

Yvonne Tate: I want to say two things. I still think this discussion is inappropriate without having an amendment on the table. But after having said that, we spent this entire first half of the year looking at these issues. We had many opportunities to raise questions like this. It seems like we're not paying attention if we wait until we get to the point of voting on the resolution to raise issues about the rates and how they were formulated. I think staff have done an excellent job of bringing us along every step of the way, tearing these whole plans down, piece by piece, and showing us what drives the costs. I think those were the appropriate times to have these kinds of discussions.

Carol Dotlich: I would like to say that I have raised these questions and these issues, I believe, every single meeting I've attended. I've been very clear about the stress and pressures placed upon people who have retired from public service and are struggling to put food on the table, pay their medical bills, and stay in their own homes. I know that people watch the news and you're well aware of what's happening with housing costs. And what's happening -- the PERS One people did not get a cost-of-living increase this session, again. People are seriously struggling financially. I think I have adequately explained my position and my desires on behalf of the participants in these plans. I've been very clear that I wanted to see the rates stay the same or go down. I did not want to see rates go up because if you can't afford this health care plan, then you've got to go somewhere else to get a health care plan. I don't think that serves this group or those consumers well. And so if there's a way to save a dollar, or \$3 or \$5, then I want to see that happen for these people. I really do. And my point that I was raising, for the record, is that no matter what we do as a Board, we don't have any choice. If we vote these things down, we have nothing to offer the consumers, right? And if we vote to support them then it appears that we're kind of obtuse to the struggle that some of the people that use these plans have, in survival. And so I would say that every single meeting I've been very clear about what I think is necessary to represent the retirees that are on Medicare, and even those that are not. That's my statement. Thank you.

Tom MacRobert: I just want to note that part of the reason we are having this conversation, though, is because we just saw those rates for the first time at our last meeting. Therefore, we haven't had a chance to really digest and talk about what we would like to see happen, which of course is what Carol's bringing up. Now I understand having had the conversation that we've had, a better understanding of how that came about. But I think that conversation needed to happen in order for us to move beyond it. So that's my point.

Sue Birch: I will take a roll call vote.

Voting to Approve: 5

Tim Barclay
Yvonne Tate
Tom MacRobert

Harry Bossi
Sue Birch

Voting No: 2
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-11 passes.

Premium Resolution PEBB 2019-12 – KPWA Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington Medicare premiums.

Tim Barclay moved and Yvonne Tate seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-12 passes.

Premium Resolution PEBB 2019-13 – UMP Medicare Premiums.

Resolved that, the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Yvonne Tate moved and Harry Bossi seconded a motion to adopt.

Fred Yancey: Thank you, Chair Birch and members of the committee. I'm not sure where this fits but it seems like the conversation is pretty broad. I would like Mr. Bossi's remarks to be planted in the committee's mind because the issue you're talking about is premiums. Carol is talking survival. And the issue really is how to make these plans less rich but more affordable. You need to look at the average income of what a pensioner, Non-Medicare gets in this state, and then realize the impact. If you're a single subscriber and spouse, 50% of the average pension a pensioner gets in this state goes for Medicare. How can you do that? I think I would like to see the committee spend some time to scale back maybe the luxury within some of these plans in order to drive down the costs because our members are faced with the decision of either something or nothing. Somewhere in between would be much preferred, given the economics. But the committee needs to look at the economics of who these pensioners, non-Medicare and Medicare-eligible people -- what their incomes are, and reflective of the insurance. Great insurance, that's not the problem. The problem is it's probably too great for the realities of the economy. So thank you very much.

Yvonne Tate: I somewhat felt offended by some of your comments, Carol. If you think that I don't care, you're missing the boat all together. I've been on this Board longer than anybody but Greg, and it's been over 20 years. And I care deeply about retirees and actives, and what they pay for health care.

The other thing I will say is, as a retiree myself -- but not a state retiree -- I pay far more for health care under Medicare than what the people you care about do. But my point is the reason we're on this Board is because we do care, not because we don't. That point I want to make strongly. I think staff have gone the extra mile, trying to get water out a rock, if you will, to come up with the best rate they can. The problem is in a word -- pharmacy. That's a problem. Pharmacy costs are what are driving these costs. I don't know how you deal with that. You can't tell people we're not going to let you have the medicine you need to stay alive. And that's my two cents.

Greg Devereux: I have to weigh in. I do appreciate Yvonne's comments very much. Over the years, she has voted for workers' interests and has an incredible heart for these issues. I have to take exception, though, with Mr. Yancey's earlier comment about a seesaw. It seemed like it was either the employee -- things are taken away from the employees or not. I don't think this is a zero sum game. I don't think these benefits are too luxurious. I think there are all kinds of other things. The formularies are one thing to do. There's bulk purchasing. There's all kinds of things. They're hard to do. That's why this country hasn't done them. But there are a lot of other things that can be done besides simply moving the costs back on employees. I think many of these benefits for years have been described as substandard. I guess I have to take exception to the characterization of them as luxurious benefits.

Voting to Approve: 4

Tim Barclay
Yvonne Tate
Harry Bossi
Sue Birch

Voting No: 3

Tom MacRobert
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-13 passes.

Premium Resolution PEBB 2019-14 - Premera Medicare Premiums.

Resolved that, the PEB Board endorses the Premera Medicare premiums.

Tim Barclay moved and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 5

Tim Barclay
Yvonne Tate
Tom MacRobert
Harry Bossi
Sue Birch

Voting No: 2

Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-14 passes.

Tobacco Surcharge Policy Resolution

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – PEB Board Policy Resolution. Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge is before you for action today. Slide 3 has the relevant language from the budget bill so you'll have it available as we talk about the policy resolution related to the tobacco use surcharge. Prior budget language expressly stated \$25 is the amount of the monthly surcharge. This language changed in the current state operating budget, which started July 1. The Board can establish the amount of the surcharge, provided it is not less than \$25 per month. Because of this change, HCA is bringing this policy resolution to you today.

Slide 4 – Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge. We made some changes since the last meeting. We added “thirteen years and older” before the word “enrolled” on the fourth line. The policy, as presented at the last Board Meeting, is included in the Appendix.

Why did we make this change? Our current practice is to only have a surcharge for members 13 years and older. We wanted that to be clear in this resolution.

Dave Iseminger: Rob, I believe part of the reason it's set at 13 years of age is because of the availability of cessation programs. There aren't specific cessation programs targeted to individuals under 13 years of age; and therefore, that's why the original policy was set up to say that we will start evaluating tobacco use as of 13 years of age. Under federal rules, you have to offer cessation programs when you offer a tobacco surcharge. There are no such things as tobacco cessation programs targeted to people younger than 13 years of age.

Harry Bossi: Is the current surcharge policy \$25?

Dave Iseminger: Correct, Harry. That's because the Legislature previously said it shall be \$25.

Harry Bossi: Okay, so why do we need this change now if we're keeping it at \$25?

Dave Iseminger: We followed our prior practice. When surcharges were originally created legislatively in the budget back in the 2014 legislative session, the spousal surcharge had language that said the surcharge shall be *at least* \$50. At that time we brought a resolution to the Board and said because you have discretion we want to make it clear whether you've exercised that discretion to go beyond what the minimum is that's set in the legislative budget. At that time in 2014, the Legislature didn't give this Board discretion on the tobacco surcharge, so there was no question to bring before the Board in that context. Now that language has changed in the operating budget. We brought something to show affirmatively that you did not exercise your discretion to set it at a higher level. We wanted to bring something to the Board to have that equally clear on the record -- the Board recognized they had discretion but did not take an extra step to go beyond and exercise that discretionary authority.

Tom MacRobert: Do I understand correctly that if we vote in favor of this resolution as is, we make no change to what currently exists.

Dave Iseminger: That is correct.

Yvonne Tate: We still have the option in the future to make a change if we so choose, by adopting this resolution.

Tom MacRobert: If we so chose, it would give us the option of adding more money to the surcharge. But the \$25 is a minimum, no matter what.

Dave Iseminger: Yes, Tom.

Sue Birch: Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge.

Resolved that, beginning January 1, 2020, the tobacco use surcharge will be \$25 per month for a subscriber with a member, thirteen years and older, enrolled on their medical plan that uses tobacco products.

Yvonne Tate moved and Tim Barclay seconded a motion to adopt.

Greg Devereux: I would say I'm voting against it just because, as I said at the last meeting, I believe it's a tax. I think the staff even indicated the tobacco use surcharge doesn't do what it's supposed to do. I simply think it's a tax. Yes, the money stays with HCA, but if it wasn't there, the Legislature would have to come up with the money. So that's why I'll vote against it.

Tom MacRobert: How do we know people are honestly answering the question? The assumption is you're a tobacco user, you're going to let people know you're a tobacco user. You have a member of your family who is a tobacco user and you're going to let them know that's happening. How do we know that ever occurs?

Dave Iseminger: Tom, we at HCA and ERB Division, do not have an enforcement policy for tobacco users. This question came up during the initial implementation and it comes up periodically, that if an individual attests falsely and is brought to our attention, we refer that to the employer because the employer can decide whether it is a personnel issue they want to take action on for a false attestation. HCA defers to the employer.

Over the years, co-workers, neighbors, ex-spouses who are upset and know somebody didn't tell the truth, they tattled. We also have guilty consciences that come forward and write us a check. They said, "I lied in the past." I know of at least one specific instance of that. We do take people at their word. It is an attestation-based system and we defer to employers for anything that may be permissible or allowable under personnel policies at the employer level.

Carol Dotlich: I spent many years when I was an active state employee representing members who faced disciplinary action for things even less serious than this. I guess I would like to say, on behalf of those people that I represented in the past, most of them are very fearful of attesting or lying, making a false statement because the threat of losing your job when you have a family to care for is a huge, huge threat. I can't speak

for everybody, but I would like to stand up for the state employees who try to be very honest in their employment.

Voting to Approve: 4

Tim Barclay
Yvonne Tate
Harry Bossi
Sue Birch

Voting No: 3

Tom MacRobert
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-06 passes.

Long-Term Disability (LTD) Insurance

Kimberly Gazard, Contract Manager, Employees and Retirees Benefits Division. Slide 2 – Agenda. Today we will discuss the updated March LTD open enrollment numbers and follow up on data questions.

Slide 3 – LTD One-Time Enrollment Opportunity is a recap of the March LTD open enrollment opportunity when changes took affect May 1. PEBB program members had the opportunity to enroll in supplemental LTD or to reduce their waiting period without evidence of insurability.

Slide 4 – Employee Supplemental LTD Enrollment Results. After open enrollment, we had 47,690 subscribers enrolled in the supplemental LTD, out of 138,555 eligible subscribers. The Standard typically sees between 8% and 15% increase in participation during open enrollment efforts. The PEBB Program surpassed the typical increase with 19%. Enrollment changes can be keyed up to 90 days after submitted by the employee. Keying for this LTD open enrollment concluded on June 29.

Dave Iseminger: It's really profound. When you step back and think 7,600 people have additional coverage because of an opportunity the carrier brought forward and the Board authorized, which was a result of the Board and the agency going out and doing a procurement on life insurance. That's where this journey began, as we started to revisit the development and the adequacy of the life insurance benefit. We had amazing results in that open enrollment that didn't have medical underwriting. The Standard approached us. We brought that to the Board at the end of last season, and in under a year we now have 7,600 people who otherwise may not have had coverage or would not have pursued getting coverage.

Kimberly Gazard: Slide 5 – March 2019 Open Enrollment Results. The results are as of July 1, broken down by group. State agencies had 4,203; higher education had 2,965; K-12 had 34; and other employer's group had 399, totaling 7,601. New enrollments keyed since the April presentation totaled 1,131. The total for April was 6,470. New enrollment during the March open enrollment for state agencies was about

20% of their total supplemental LTD enrollment. Higher education was about 13%, K-12 was about 9%, and other employers was about 13%.

Slide 6 – Benchmarking our LTD Participation. The Standard typically sees between 25% and 35% participation rates for similar public sector clients and plans. The PEBB Program, prior to open enrollment, had a 20% utilization rate. After open enrollment, the PEB Program enrollment had a 34.4% utilization rate.

Dave Iseminger: This was a paper-based enrollment. We didn't have the advantage in the LTD open enrollment that we had with life insurance. We doubled the amount of coverage in life insurance – \$8 billion in additional elected coverage. That was when we transitioned from paper to online enrollment and had the advantage of syncing it with the annual November open enrollment. This LTD open enrollment was off-cycle, in March. There were reasons for that. Even with it being March and paper-based, we had additional increases in participation and coverage that people elected. It was a successful experience where the carrier, Board, and HCA were able to work together to bring to PEBB Program members.

Kimberly Gazard: Slide 7 – Follow up on Data Questions. Slide 8 – The Number of Approved LTD Claims. The Standard suggests looking at the last five years for a truer picture of utilization, because there is always a lag with claims' filing when you have multiple and extended benefit waiting periods. The PEBB Program has up to 360 days as a benefit-waiting period.

For the January 1, 2014 through December 31, 2018 five-year period, there were 9,509 claims. For the 2018 plan year, there were 403 claims. Included on this slide are the dollar amounts for claims for basic and supplemental for your reference.

Slice 9 – Approved LTD Claims Resulting in Being Permanently Disabled. The Standard considers members who have reached the end of their benefit period as permanently disabled. For the past five-year period, 41.5% of claims have closed due to the member reaching the end of their benefit period. This includes the mental health limitation claims as well. For reference, the mental health limitation is limited to 24 months per each period of disability caused or contributed by a mental disorder. In the past five-year period, 531 or 11.3% of claims have closed due to the member passing away.

Slide 10 – Income of Employees Enrolled in Supplemental LTD. HCA's LTD plan is a self-administered plan. The PEBB Program is the record keeper; therefore, The Standard is unable to provide the breakdown of member enrollment in the supplemental LTD plan. Despite PEBB Program system limitations, we were able to work around these limitations the past several weeks to gather salary information for the supplemental LTD. We are presenting this information using the same salary brackets used in the January, April, and June PEB Board presentations for consistency. The salary information in this chart is as of June 30 and does not include higher education salaries and the salary reported may not reflect the most up-to-date salary. This chart shows the large majority of PEBB Program members are in the 51K-80K salary bracket for the supplemental LTD. The salary chart for basic also reflects the majority of members also fall into the 51K-80K bracket.

Sue Birch: I'll just comment that this is a fabulous benefit to have in place for those that took advantage of it and participated. I thank staff and the Board for moving this forward because it really closed that loophole. Tim, I feel like it was under some of your leadership this was revisited. So thanks to staff and the Board for moving this forward on behalf of state employees.

Dave Iseminger: This was the first part of our journey together on improving the LTD benefit. When HCA brought this to the Board last year, we said this is an opportunity on the employee paid supplemental benefit, but at least this would be a way for people who want to opt into a benefit to have an opportunity without medical underwriting. We've had discussions at the past couple of Board Meetings about some strategies to be able to go back and evaluate improving the employer-paid basic benefit. That's phase two of our journey. I want to thank the Board for insight over this Board season as we work on decision packages and bringing other information forward during the next Board season, to see how we can further improve this benefit for plan year 2021.

Centers of Excellence Program Update

Marty Thies, Account Manager, Portfolio Management and Monitoring Section, ERB Division. I'm going to give you a quick update on the Centers of Excellence (COE) Program. The program now provides access to two bundled episodes of care to the Non-Medicare UMP Classic and CDHP membership. I'll first discuss the total joint replacement bundle followed by the spine care bundle.

Carol Dotlich: The Centers of Excellence is for whom?

Marty Thies: It's for the Classic and CDHP populations who do not have Medicare as their primary insurance.

Slide 3 – Background. I like to underscore how the Centers of Excellence Program has at its foundation a set of clinical standards developed by the Bree Collaborative, authorized by the Legislature in 2011. The Bree Collaborative established the appropriate fitness and clinical criteria pertaining to joint replacements and lumbar fusion, our two bundled procedures so far.

In 2014, the Legislature encouraged HCA to increase value-based purchasing. This Board approved a resolution for the Centers of Excellence Program in 2016. HCA went live with our first bundle January 1, 2017. The program is about 2½ years old.

Slide 4 – TJR: Benefit Design. The design of this benefit is of great value to PEBB Program members. HCA incentivizes members to use the COE Program by providing this surgery with zero to low out-of-pocket costs. CDHP members who take advantage of this program do need to pay their high deductible first, but then they pay no out-of-pocket. It includes the surgery, inpatient services, the implant, a walker if that's needed, and concierge case management from the first phone call to a post-discharge survey. They also get transportation, airfare, mileage, parking, and lodging. In addition, the Centers of Excellence Program provides HCA with a warranty for a specified set of complications over 7-90 days, post-discharge. The COE takes on that risk, if something goes awry with the surgery.

Slide 5 – The COE-TJR Team. For the total joint replacement bundle, the Centers of Excellence is Virginia Mason Medical Center in Seattle. They are also the COE for other organizations and employers like Walmart and Boeing. They have a lot of experience bundling joint replacements. Our Third Party Administrator (TPA) is Premera Blue Cross. They walk interested PEBB Program members through the process from start to finish. They all but literally hold hands with participants, making the journey as smooth and positive as possible.

Slide 6 – Member Volume. On this slide are numbers for completed surgeries. We are quickly reaching 200 surgeries for TJR. The second year saw a drop in our numbers. Time will tell what that means, exactly. But according to our data from Regence, we also dropped in the total joint replacements performed for this population not at the COE. Even though 95 surgeries in the first year and 71 surgeries in the next looks like a big drop, actually the market share for the total amount of surgeries was only about 2%. We'll see what happens this year. HCA asked Regence and Premera to run the COE surgical recipients through the Regence data to see if they experienced complications they didn't take back to Virginia Mason. To date, there are none. We've incurred no post discharge expenses at Virginia Mason in the last 30 months.

Slide 7 – 2018 Comments from UMP Members. These are new 2018 comments recently received from Premera drawn from the post-discharge surveys participants complete. The PEBB Program members who participate are largely very positive. Both years we received some comments about the quality of their hotel experience and sometimes participants think it takes too long to get their surgery. We take those comments seriously and address them whenever it's in our power to do so. The comments are extremely positive. Members are enthusiastic. They can't think of how their experience could have been better.

Slide 8 – 2018 Member Survey Results. This slide has quantitative results from the post-discharge surveys. There are more than a dozen questions, and these few are the most telling. I indicate whether they reflect on Premera or Virginia Mason. We had an 84% response rate, which is phenomenally high and can be an indication that those surveyed are either ecstatic or irate. Here, it's definitely the former.

The percentages are those who responded to these questions with an 8, 9, or 10 on a scale of 1-10. These are extremely important to our members: I understood my recovery plan. My case manager was courteous and helpful 100%. I think these are passing grades. PEBB Program members appreciate the service greatly after going through the program and receiving a significant surgical procedure.

Slide 9 – Age and Gender. The lion's share of those participating, predictably, is the 45-64 year old age group. Old enough to need a joint replacement and young enough to have Classic or CDHP as their primary health insurance. The upper left chart, the portion in blue, are those older than 64 who continue to work, which wouldn't be a huge cohort but would be the cohort with the oldest joints making up 25% of those utilizing the bundle. By gender, the chart at the lower right indicates females receive nearly three fifths of the joint replacements, which is in keeping with the national data, especially for knees, as women experience osteoarthritis more than men, as well as arthritis with worse symptoms and greater disability.

Slide 10 – 2017-2019 Member Savings. On the financial slide, using the 192 completed surgeries up to the middle of last month, multiplied by an approximate average of \$1,000 out-of-pocket had they not gone through the program, we've saved members nearly \$200,000.

Slide 11 – Cost Comparison with non-COE TJRs. Looking at 166 total joint replacement surgeries paid through the month of May and using the paid inpatient and professional costs for the equivalent non-COE surgeries performed, the plan continues to save more than 15% on each COE surgery. As far as what UMP is spending on Non-Medicare classic and CDHP joint replacements, it's important to consider both cost and utilization because a rise or fall in annual TJR costs may only reflect the rising or falling number of TJRs performed. The clearest way to take both cost and utilization into account is finding the average cost per surgery. From 2015 to 2018, looking at the utilization and total spend on joint replacements in the Non-Medicare Classic and CDHP population, and TJRs in COE and not COE, the per surgery cost across the board has dropped 8.6% in those five years. We'll see what happens as time goes on, but I think it's a good indication.

Harry Bossi: The population here is a mix of UMP Classic and UMP CDHP. They have a little difference in the out-of-pocket potential liability. I'm not sure how you come up with \$1,000 as the average. You must have mixed it over time, because the CDHP, don't they have a \$2,000 minimum they have to reach to start getting the benefit?

Marty Thies: They may have spent some before. They might wait until the end of the year to engage. I think the participation is 95%-97% Classic. I'll have to re-check that.

Harry Bossi: I do think it's a wonderful program. But I drill into the number because in Classic isn't the maximum out-of-pocket for a year, Dave, do you know what it is, off the top of your head?

Dave Iseminger: You're asking for out-of-pocket maximum or deductible?

Harry Bossi: Out-of-pocket. Isn't it like \$2,000?

Dave Iseminger: I've looked at so many charts lately at so many programs that I'm afraid I'm going to answer wrong.

Harry Bossi: I've answered my own question. I was thinking it was well below \$1,000. These are great numbers, thank you.

Sue Birch: Marty, what sort of data do we have on the ones referred to the program but then went away to do exercise therapy, weight loss, or were advised they weren't fit?

Do we have any cost avoidance, cost savings, or do we have any other qualitative, quantitative data on those that were diverted from unnecessary procedures?

Marty Thiess: We are working on that. I think it's 91% of people referred by Premera to the Centers of Excellence follow through with their surgery. Sometimes people have to cancel because of family emergencies or they couldn't quit smoking.

Dave Iseminger: As we're talking about a small number here, we have to wait until the data gets to a number where we're able to report it. When you're only talking 10-15 people, it's not anonymized enough even in its aggregate form. We have to wait until the numbers are large enough to do that aggregate reporting.

Tom MacRobert: Let's say I get my health care at Bothell Memorial Clinic, which no longer exists, and my doctor refers me. He says you're going to need hip replacement surgery. He says now I can refer you either to Overlake or Evergreen Hospital for that surgery. How am I going to know about the Centers of Excellence as a Uniform Medical Plan participant?

Marty Thies: Every year it's in our Certificate of Coverage, which probably isn't an easy place to find it. When we first introduced the program, we highlighted it in our open enrollment materials. At all of our benefits fairs, Premera makes the effort to have a table. They get some traffic that way. When we introduced the spine care bundle, open enrollment nine months ago, it was a chance for us to highlight the successes of the joint replacement bundle as well. ERB Communications created a video in collaboration with Virginia Mason, posted on the Premera site. Other than that, all they have to do is call the Premera number.

Dave Iseminger: Marty, could you describe any proactive outreach Premera does? I know when we originally launched the program we were able to send letters to members based on diagnosis code of people who might be interested in learning about these types of things. We would do a claims and diagnosis code draw and send a generic letter asking if they know about this benefit.

Tom MacRobert: Would my doctor know about this program? Should my doctor know about this program?

Marty Thies: Well, I think everybody should know about it. But if your doctor performs surgeries like this, they might not want to refer outside of their own provider or hospital setting. Dave is right. I forgot that it's going on behind the scenes, finding likely candidates looking at data to identify services rendered that indicate a joint replacement may be considered by a member. They would receive something. Thank you.

Myra Johnson: I'm liking your 84% return rate on your surveys. Can I ask whether they were paper, online, or both?

Marty Thies: I think they send those out email, about 30 days post-discharge, with a follow-up call.

Dave Iseminger: When we presented this to the SEB Board, they appreciated the work this Board had done in authorizing the program. I believe the words were "no brainer" when it came to adding the Centers of Excellence Program to the new School Employees Benefits Board Program. There were direct comments appreciating the trailblazing this Board has done in creating the program that they were able to leverage.

Sue Birch: Just to echo that, this COE Program is one of the hallmark strategies Washington is known for around the country, and being a pacesetter. I find it interesting, the volume dipping down, but I also can tell you in talking to the providers,

there's been a move to raise the bar on the COE concept. In the spinal care bundle, you will hear how it brought other providers up in bringing the bar up to a new level of excellence. I'm wondering if that's cutting into the numbers, too, because other programs followed suit, and while they might not be deemed COE sites yet, we're seeing more interest in their ability to do these types of COE concepts.

Marty Thies: Time will tell but looking at the drop in 2018, it's a question of how many people are thinking they would love to get a joint replacement but the out-of-pocket is too great and put it off. This program came along, and it could have pushed a number of people through in 2017 that we're not going to see in 2018. We're at a quicker pace than last year so far this year. We'll see what the final numbers tell us.

Slide 13 – Centers of Excellence Program: Spinal Care. 2018 was the year we pulled this bundle into shape, including the RFP, building and getting the contracts signed, and implementation. It went live January 1, 2019.

Slide 14 – Spine Care Centers of Excellence. The benefits design is very similar to the joint replacement. It's a voluntary program. You don't have to go to the Centers of Excellence. Members using the Centers of Excellence will have little to no out-of-pocket expense. There's a travel benefit for easy access to the services. It requires the participant to have a care companion to assist them while they're at the facility, and must meet fitness and appropriate standards, per Bree.

There are differences, too. Lumber fusion has a much lower utilization in the eligible populations, and the spine care bundle actually has two destinations, surgery and an evaluation only. We want members to come to the COE for spine care. We definitely do not want members to get a fusion if it's not an appropriate procedure for them, or they're not fit to be successful afterward. For those who entered the program but don't get a surgery, the evaluation provides them a full clinical assessment and care plan.

Slide 15 – Spine Care Centers of Excellence (cont.). For this bundle, there are two Centers of Excellence. Virginia Mason responded to the RFP and was successful. Capital Medical Center in Olympia was also successful as a COE. Through mid-June, there are nearly 20 people engaged in the program any given week. That's people engaged at some point in the process. Eighteen evaluation only bundles have been done so far, and only one surgery. Time will tell what it's all going to look like.

Slide 16 – Centers of Excellence: Future. There's a consideration to expand the spine care bundle to offer a second surgical destination, maybe laminectomy. This would make the bundle a little more versatile and meet the needs of more members. Implementation of a third bundle on the table could possibly be bariatric surgery and an oncology treatment planning bundle.

Carol Dotlich: I want to thank you for the update. I really appreciate it. I've been really interested in this program. I think it's wonderful that we're working on this.

Greg Devereux: Marty, when we're considering a bundle what attributes, it seems like they're pretty small numbers so far. Is that to focus on excellence initially and then maybe broaden it over time.

Marty Thies: I believe the impetus behind the total joint replacement bundle was high utilization and high variability. A lot of people are doing it and the price is from low to sky high. We have a prospective price on this. We are controlling our costs. With spinal fusion, the Bree criteria for lumbar fusion are essentially prefaced on the idea that spinal fusion is over utilized, perhaps it's performed two times the amount it should be. It's a real service to our membership to provide a Centers of Excellence to look at their spine before surgery. Cost and utilization are key factors.

What's interesting about the possibility of the oncology bundle for treatment planning, it's almost like a second opinion. You get diagnosed for something where there's not a lot of traffic, when it comes to oncology. At the Centers of Excellence, you get an evaluation, a treatment plan, and work for a time. The Centers of Excellence will work with local providers to implement the treatment plan. That's a very interesting concept. It has to do with an extremely expensive regimen of treatment. The average oncology treatment is approximately \$157,000. We could certainly provide a valuable service to our members if we are sure of diagnoses and treatment plan.

Sue Birch: If I can add to what Marty's describing. For the quality alignment, not only do we see a huge variation in cost, we have seen huge variation in the quality. The warranty piece and the decision support tools, or the client engagement, really getting somebody to understand their role in this process and/or screening out unnecessary procedures, to me those are hallmarks of the COE Program.

Board Season Wrap UP

Dave Iseminger: We're essentially at the end of our Board season. I want to give you an update on the SEBB Program. I want to make sure the Board is aware we are releasing to the SEB Board, and publicly on Monday, Board materials with rates, plans, and service areas for all the medical plans in the SEBB Program portfolio. As we finish launching the program, it is one of the key areas we're going to talk with this Board about. There are more plan options from SEBB Program procurements. We crafted those procurements and contracts in a way that this Board could leverage opportunities to incorporate and bring additional plan choice into the Non-Medicare population of the PEBB Program portfolio.

We are at a very significant stage in the SEBB Program, where people will finally be able to know those answers of how much, where, and what plans. Once the SEB Board takes action, that information will be going out to school employees.

There are three major areas when I think about 2020, that this Board and the PEBB Program can learn from and have opportunities to leverage from the SEBB Program.

First is the additional plan options we'll be able to talk about with you. In the PEBB Program portfolio for 2020, there are 15 UMP only counties. While it's a great plan option, it's not robust choice. For the SEBB Program portfolio, I can't say the number publicly until we get the materials out, but it's much fewer than 15 counties. There may be an opportunity to bring significant amount of choice to PEBB Program members who live in different parts of the state where their only choice next year is UMP.

Secondly, we've spent a lot of time in the SEBB Program launch on IT development. In the PEBB Program, we're very paper based in initial enrollments. On the SEBB

Program side, we're not going to be paper based. There are opportunities for people to make plan changes and do enrollment through an online portal. We've gone through a lot of testing, and that program launches very soon. After we've worked through that in the initial enrollment for the SEBB Program for 2020, we'll talk about ways to incorporate that for PEBB Program members.

Finally, with school employees being more geographically diverse than PEBB Program employees, it creates new innovations and thought processes about how to communicate with such a geographical diverse population. We do have PEBB Program employees all over the state, but we have a high concentration in the Thurston/Pierce County area for many reasons. Most state agencies have major operations in the Olympia/Tumwater area. We'll have a lot of communication ideas we are testing within the SEBB Program population that we'll be able to learn from and incorporate as we move forward in the PEBB Program.

I want to acknowledge that when you reconvene in January, the structure of your Board will have changed because Myra's nonvoting K-12 active employee position is no longer statutorily part of this Board. When the SEBB legislation created a separate Board for active school employees, that legislation retired the position Myra currently holds on the Board. I want to acknowledge that our Board composition is changing. Myra has been with us for five full Board seasons and I've appreciated the insight she's provided and the questions she's raised along this process. I want to acknowledge Myra's service. Thank you, Myra, for serving on this Board.

Sue Birch: On behalf of the Board, we're going to give you this tiny little token of thank you for all you've done for our state. We have appreciated your perspective.

Myra Johnson: I learned a lot being on this Board. When I first found out about it five years ago, I was like, the what? The where? Who? As a school employee, it wasn't relayed to us at all. I have learned a lot. I really am inspired by what's going on in SEBB. I will be watching them, listening to them, appreciating, and I will have a different perspective than most in the audience. I do appreciate it and continue with all the hard work. I will be a retiree one day so keep pushing for us! I appreciate that. And again, thank you very much. I've enjoyed working on this Board and I will miss you.

Sue Birch: Thank you. [applause]

Next Meeting

January 30, 2020 Retreat
9:00 a.m. – 3:00 p.m.

Meeting adjourned at 3:20 p.m.

Public Employees Benefits Board Retreat
Meeting Minutes

Draft

January 30, 2020
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 3:34 p.m.

Members Present:

Sue Birch, Chair
Tom MacRobert
Harry Bossi
John Comerford
Yvonne Tate
Tim Barclay

Members Absent:

Greg Devereux

PEB Board Counsel:

Michael Tunick, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 9:00 a.m. Today's meeting is the Annual Retreat where the Board is presented with broader health care topics that impact the membership. No action taken at the Retreat. Audience and Board self-introductions followed.

Chair Birch introduced our newest Board Member, John Comerford, appointed to a non-voting position that has been vacant for some time.

Carol Dotlich completed her term on the Board and we expect her replacement to be appointed by the Governor's Office before our March 18 Board Meeting.

Greg Devereux was unable to attend the Retreat, but called in for a few minutes to introduce his replacement, Leanne Kunze. Greg also wanted to acknowledge his work retirement on January 31 and his retirement from the PEB Board after 25 years of service. There was much accomplished in those 25 years! Sue thanked Greg for all his contributions. The Board and audience applauded Greg's many years of service and gave him a standing ovation.

Meeting Overview

Marcia Peterson, Manager, Benefit Strategy and Design Section, Employees and Retirees Benefits Division (ERB), provided an overview of today's Retreat agenda.

PEB Board Clinical Update

Dr. Emily Transue, Associate Medical Director for the Health Care Authority, provided a clinical update for the Board. Her presentation spoke to roles and opportunities of improving care, experience, and value for the PEBB Program; market transformation using HCA's influence and market share to improve health care for all Washingtonians; and expanding choices, improving care, and empowering consumers.

She focused on primary care, shared decision making, Hepatitis C elimination, and public option/Cascade Care.

Behavioral Health Panel

Marcia Peterson, moderated a panel on Behavioral Health. The panel consisted of: Keri Waterland, Ph.D, MAOB, Assistant Director of the Behavioral Health and Recovery Division, Health Care Authority; Charissa Fotinos, M.D., Deputy Chief Medical Officer, Health Care Authority; Michael Garrett, MS,CCM, CVE,NCP, BCPA, Mercer; Dustin Howard, LMHC, MBA, Program Director of Behavioral Health, Regence Health Plans; and Alicia Eng, RN, MBA, MHO, Vice President of Clinical Operations for Western Washington, Kaiser Permanente of Washington.

There was an emphasis on whole-person care. There is a need to build a foundation for integrated care that's patient-centered and provides case management. Privacy concerns in the current system not being able to share information.

The panel members expressed the goal of removing the stigma that accompanies a diagnosis associated with behavioral health. It would be great to lose the term of "Behavioral Health" and treat all patients the same, regardless of diagnosis by treating the whole-person.

Tim Barclay asked if the Board should do a targeted attempt at solutions now as a PEBB Board or continue to look at the big picture.

Charissa Fotinos suggest targeting the program. Identify people. The highest risk is the intervention point. The Board could ask its members what their challenges are by doing focus groups or a survey.

Sue Birch: What should we think about this year as a Board? What data do we need? What can we provide the family for help – case management? Think about universal consent. And how are we going to generate funds as a Board? What do we need to keep going?

2020 PEBB Program Open Enrollment Summary

Renee Bourbeau, Benefits Account Section Manager, shared information on the Open Enrollment that concluded on November 30, 2019. Renee provided engagement information, changes going into effect January 1, 2020, customer service strategies, and improvements from last year's open enrollment.

Customer Service improvements included lowering the wait time for a member on the phone from 24 minutes and 44 seconds to 12 minutes; the number of calls answered improved by 17%, and Customer Service satisfaction improved by 18%.

SEBB Program Update

David Iseminger, Director, Employees and Retirees Benefits Division, provided an update of the School Employees Benefits Board Program. The new SEBB Program launched January 1, 2020. Their Open Enrollment was October 1 through November 15, 2019. Agency staff spent two years preparing for this launch. It took 23 SEB Board Meetings with action on 68 policy resolutions. Three procurements took place with contract negotiations with 24 vendors. IT systems were built, tested, and rolled out.

The Legislature established the funding rate and SEBB Program medical plans' rates and premiums were set. Prior to the SEBB Program, some school employees could not afford to cover dependents or had monthly premiums of \$1,500 - \$2,000 to cover them.

2020 Supplemental Governor's Budget Update - PEBB

Tanya Deuel, ERB Finance Manager, Financial Services Division, provided an update on the proposed supplemental budget. The funding rate for fiscal year 2020 stayed the same at \$939. The funding rate for fiscal year 2021 increased from \$976 to \$980, which is adequate to maintain the current level of benefits.

The Medicare Explicit Subsidy maintained the level from calendar year 2020, which is \$183 per Medicare retiree per month.

2020 Legislative Session Debrief

Cade Walker, ERB Division Executive Special Assistant, debriefed the Board on what's happening with the Legislature. Topical areas introduced were: provider/health carrier credentialing, pharmacy regarding diabetes medication and prescription tourism, and expanded durable medical equipment coverage like hearing aids and prosthetics/orthotics.

Several bills would have impacts to the SEBB Program. They were:

- SB 6189 – Eligibility for school employees' benefits board coverage
- SB 6290 – Contribution to and eligibility for school employee benefit plans
- SB 6296 – Health care benefits for public school employees
- HB 2458/SB6479 – Optional benefits offered by school districts

Leveraging SEBB Medical Plan Contracts in PEBB Program

Lauren Johnston, SEBB Procurement Manager, informed the Board of advantages and disadvantages to future leveraging the SEBB Program fully insured medical plan contracts for the PEBB Program (non-Medicare).

The SEB Board Medical Plans are: four fully insured medical carriers – Kaiser Northwest (3 plans), Kaiser Washington (4 plans), Kaiser Washington Options (3 plans), and one self-insured option – Uniform Medical Plan (5 plans).

Advantages to members could be more plan options with different cost share levels and two more preferred provider organizations to choose from, Kaiser Washington Options and Premera Blue Cross.

Disadvantages could be too many plan options and not being able to distinguish the differences between them.

Impacts to the Program are the ability to leverage provisions that are in the SEBB Program contracts, which are not in the PEBB Program contracts; potential to eliminate confusion; and the potential need for an active open enrollment.

Examples of differences between the two programs are:

- Deductible, out-of-pocket maximums and coinsurance and copayment amounts.
- Chiropractic, acupuncture, and massage therapy visit limits.
- Physical, occupational, speech, and neurodevelopmental therapy visit limits.

Expanding PEBB Program Medicare Options Procurement Update

Ellen Wolfhagen, Senior Account Manager, ERB Division, shared the Health Care Authority's progress on bringing options to the PEB Board about expanding Medicare retiree plan choices.

Apparently successful bidders (ASBs) from our Request for Proposal, were selected and are in contract negotiations with the Health Care Authority for Medicare Advantage plus Prescription Drug (MA-PD) plans. The ASBs are United Healthcare and Regence BlueShield. These are national and regional MA-PD PPO plans to supplement the current PEBB Program Medicare retiree portfolio.

UMP Formulary Update

Ryan Pistorosi, HCA's Assistant Chief Pharmacy Officer and two of our colleagues from MODA, **Sital Patel** and **Cole Ahnberg**, provided an update on the implementation of the UMP formulary the Board approved last year.

One of the goals of the UMP formulary is to provide value-based purchasing to get the highest value and most affordable prescription drugs.

MODA sent a drug specific letter to members informing them of the changes to the UMP formulary. Changes were also published in Open Enrollment information, communicated in PEBB and UMP newsletters, the Certificate of Coverage, and the UMP website.

Annual Rate Process

Tanya Deuel, ERB Finance Manager, Financial Services Division, proposed a new resolution for the Health Care Authority rate development process. Proposed Resolution PEBB 2020-01 identifies that the "PEB Board will not review or consider unsolicited revised rates after proposed employee premium contributions are published publicly by the Health Care Authority on its website."

This proposed resolution will go out to stakeholders to get their thoughts on the verbiage and will then come back to the Board for action at the March 18 PEB Board Meeting.

Board Discussion: Policies for Next Year

Marcia Peterson, Benefits Strategy and Design Section Manager, ERB Division, shared the annual benefits planning cycle with the Board to give them an idea of what needs to happen for changes to become effective January 1, 2022 in the PEB Board plans?

Sue Birch: Some new ideas are case management, respite care, peer support. How can we help families?

What disruptions keep members from going to work? Climate control, corona virus, global risk (emergent infectious diseases) are a few.

Tim Barclay: \$1,250 deductible UMP plan is another thought could possibly fund long-term disability. An 83% actuarial value (AV) would be a 5% AV savings to tie the benefits together.

Tom MacRobert: Meditation is another potential benefit. If a doctor prescribes meditation, it should be covered.

John Comerford: Long-term care / concierge, education plan, end-of-life planning. If a dementia diagnosis, resources to find care.

Sue Birch: Evidence-based home visitation models for low income, first-time moms, in addition to their doctor visits.

Personal Health Record = IT modernization = digital. Need a modern technological platform.

Public Comment

There was no public comment.

Next Meeting

March 18, 2020

12:00 p.m. – 5:00 p.m.

Meeting adjourned at 3:24 p.m.

TAB 4



Legislative Update: PEBB 2020 Supplemental Budget

Tanya Deuel
ERB Finance Manager
Financial Services Division
April 15, 2020

Final Funding Rate

FY20 - \$939 FY21 - \$976
(unchanged)

Per employee per month

Adequate to maintain current level
of benefits

No significant concerns with funding
rates and underlying assumptions

Medicare Explicit Subsidy

Calendar Year 2021
\$183/month
(unchanged)

*or 50% of the premium,
whichever is less

Final Conference Budget Funding

\$233,000

Audit Capabilities - Staffing to support audit functionality.

~~\$119,000~~

~~**Medicare Resources** – Staffing to support the ERB Medicare plans within the PEBB portfolio. *Vetoed*~~

\$75,000

Diabetes Management Request for Information – One time administrative funding to complete an RFI related to diabetes management program.

Final Conference Budget Funding (*cont.*)

**\$1.7
Million**

ESSB 6189 Funding – Funding for technology changes to implement ESSB 6189 which prohibits dual enrollment in PEBB and SEBB coverage.

NA

Hearing Aid Benefit – Language provided to align E2SSB 5179 which states hearing instrument coverage must include a new instrument every five years.

Questions?

Tanya Deuel, ERB Finance Manager

Financial Services Division

Tanya.Deuel@hca.wa.gov



Legislative Update: Bills

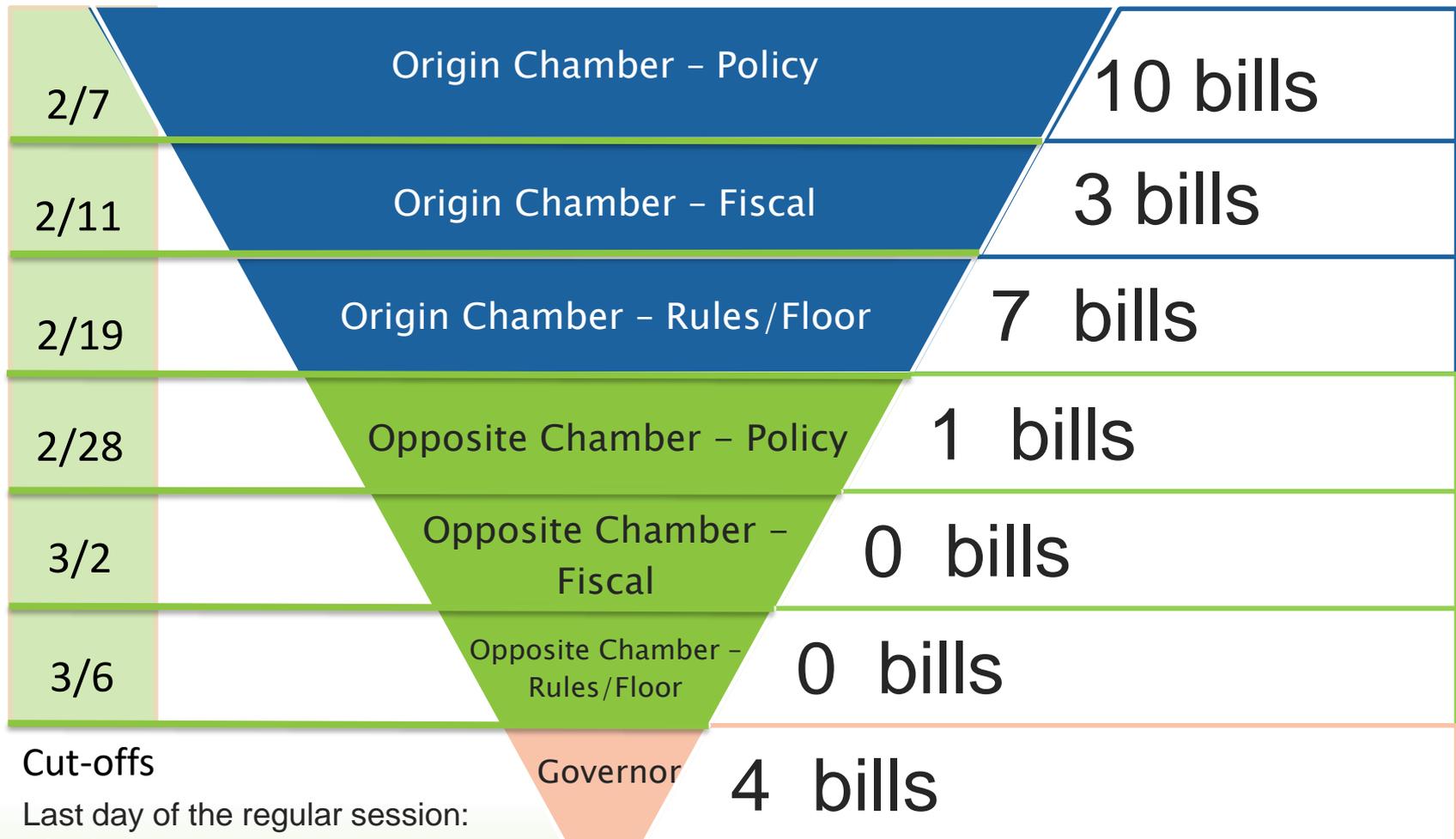
Cade Walker
Executive Special Assistant
Employees and Retirees Benefits (ERB) Division
April 15, 2020

Number* of 2020 Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Impact	43	58	101
Low Impact	115	168	283
	158	226	384

* As of 3/25/2020, includes bills from 2019 session that were reintroduced by rule.

Legislative Update – ERB high lead bills



PEBB & SEBB Program Impact Bills

- ESSB 6189 (Eligibility for school employees' benefits board coverage) – signed by Governor

SEBB Program Impact Bills – Eligibility

- ~~SB 6290 – Contribution to and eligibility for school employee benefit plans~~
- ~~SB 6296 – Health care benefits for public school employees~~
- ~~HB 2771 – Clarifying contributions to and eligibility for SEBB coverage~~

SEBB Program Impact Bills

- ~~HB 2208/SB 6144~~ – ~~Implementation credits and performance standards~~
- HB 2458/SB 6479 (Optional benefits offered by school districts) – signed by Governor

Topical Areas of Introduced Legislation

- Provider/health carrier credentialing
 - EHB 1552 – signed by Governor
 - 2SSB 5601 – partially vetoed by Governor
- Pharmacy
 - Diabetes medication
 - E2SHB 2662 – signed by Governor
 - ~~SSB 6113~~
 - Rx tourism (~~SB 6111~~)
 - Rx importation (~~SB 6110~~)
- Substance Use Disorder
- Expanded DME coverage
 - Hearing aides
 - Prosthetics/orthotics

Questions?

Cade Walker, Executive Special Assistant
Employees and Retirees Benefits Division

cade.walker@hca.wa.gov

TAB 5



Expanding PEBB Medicare Options Update

Ellen Wolfhagen
Senior Account Manager
Employees and Retirees Benefits Division
April 15, 2020

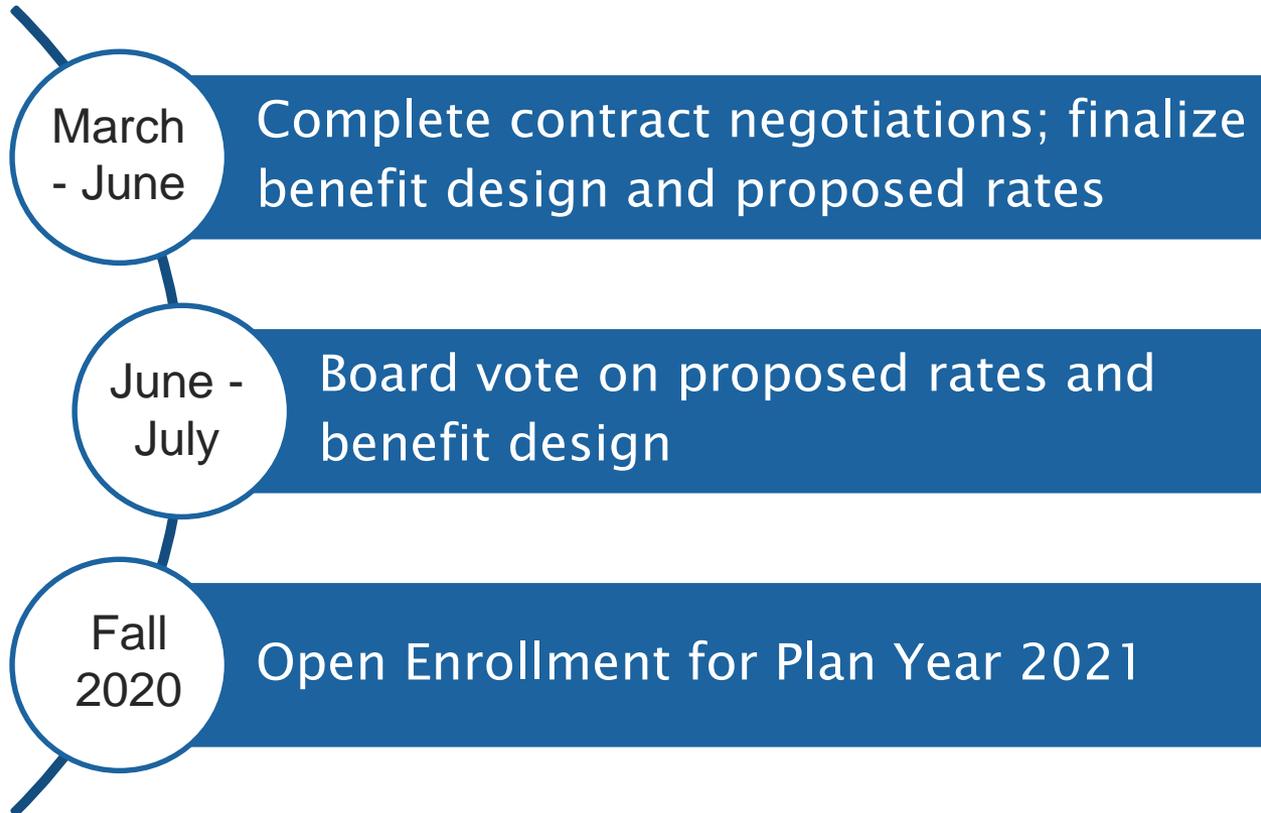
Today's Agenda

- **Recent Developments**
 - Current status of negotiations
- **Updated Timeline**
 - Next steps

Recent Developments

- **Negotiations continue with United HealthCare**
 - Significant progress being made
 - Some areas still need discussion
- **Negotiations suspended with Regence**
 - Can be restarted if there is a significant change, but unlikely for Plan Year 2021

Updated Timeline



Questions?

Ellen Wolfhagen

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TAB 6



Eligibility & Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 15, 2020

Introduction of Proposed Resolutions

- PEBB 2020-04 Default Enrollment for An Eligible Employee Who Fails to Make A Timely Election
- PEBB 2020-05 Medicare Advantage Prescription Drug (MAPD) Plan Enrollment

Proposed Resolution PEBB 2020-04 Default Enrollment for An Eligible Employee Who Fails to Make A Timely Election

The default election for an eligible employee who fails to timely elect coverage will be as follows:

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in basic life insurance;
- Enrollment in basic AD&D; and
- Enrollment in basic long-term disability insurance.

Proposed Resolution PEBB 2020-05 Medicare Advantage Prescription Drug (MAPD) Plan enrollment

If a subscriber elects to enroll in a PEBB Program MAPD plan, any non-Medicare enrollees on the account will be enrolled in the Uniform Medical Plan (UMP) Classic.

Next Steps

- Incorporate Board feedback in the proposed resolution and start the stakeholdering process
- Bring a recommended resolution to the Board for action at the May 28, 2020 Board Meeting

Questions?

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Appendix

Historical Resolutions Related to Proposed PEBB 2020-04

Resolution Related to Medical Plan Enrollment (As Approved on July 20, 2011)

Employees who fail to choose a medical plan within the required timeline will, by default, be enrolled in UMP Classic.

Resolution Related to Plan Enrollment (As Approved on November 14, 1995)

New employees have 31 days to return enrollment forms with their plan selections. If a plan selection is not made or a waiver form is not returned, the employee will be defaulted into the UMP and UDP which may automatically initiate a payroll deduction.

Example Clarification Related to PEBB 2020-02

Proposed Resolution PEBB 2020-02 COVID-19 and Enrollment Timelines

Beginning February 29, 2020, the date that Governor Inslee declared a state of emergency in Proclamation 20-05, any enrollment timelines established for continuation coverage and retiree subscribers will be extended to 30 days past the date the Governor terminates the state of emergency.

The Health Care Authority is authorized, during the state of emergency as described above, to extend this deadline further and extend any other enrollment deadlines as needed to meet the needs of the state and PEBB Program subscribers.

COVID-19 and Enrollment Timelines

Example #1

If (hypothetically) an employee's last day to enroll in PEBB continuation coverage was April 30, 2020, and the state of emergency terminated on May 15, 2020, then the enrollment period for that subscriber will be increased to June 14, 2020.

COVID-19 and Enrollment Timelines

Example #2 (old)

If (hypothetically) an employee's last day to enroll in PEBB continuation coverage was May 31, 2020, and the state of emergency terminated on May 15, 2020, then the enrollment period for that subscriber would not change and the deadline would remain as May 31, 2020.

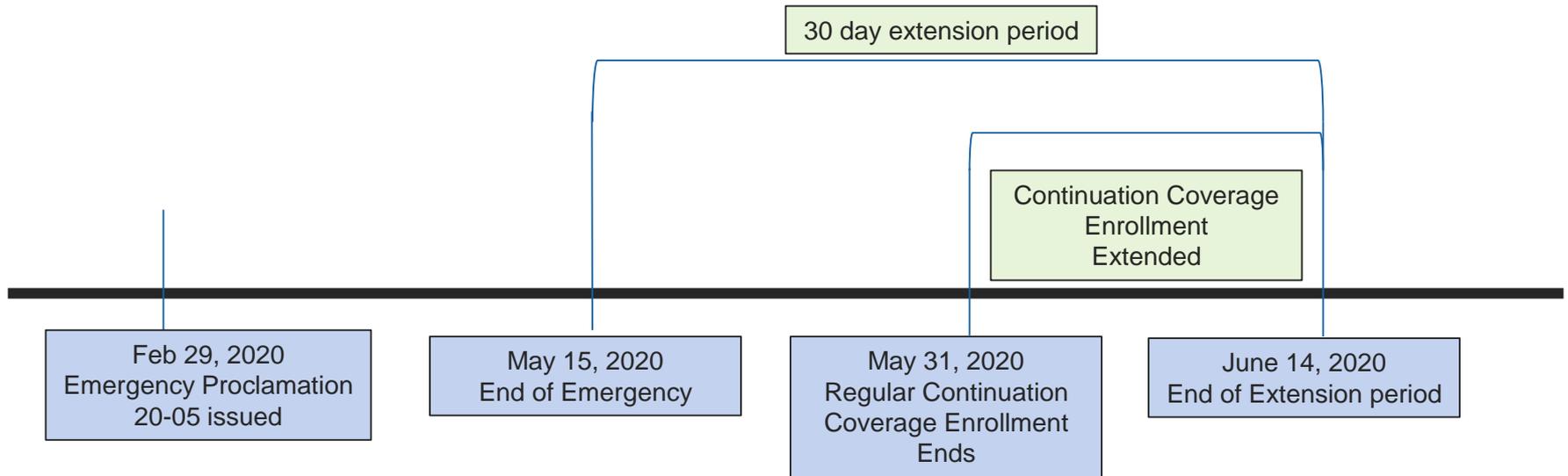
COVID-19 and Enrollment Timelines

Example #2 (Updated)

If (hypothetically) an employee's last day to enroll in PEBB continuation coverage was May 31, 2020, and the state of emergency terminated on May 15, 2020, then the enrollment period for that subscriber ~~would not change and the deadline would remain as May 31, 2020.~~

~~will be extended to June 14, 2020 because the subscriber's continuation coverage enrollment period ended following the end of the emergency period, and before the end of the 30-day extension period.~~

COVID-19 and Enrollment Timelines Example #2



Resolution PEBB 2020-02

COVID-19 and Enrollment Timelines

Resolved that, beginning February 29, 2020, the date that Governor Inslee declared a state of emergency in Proclamation 20-05, any enrollment timelines established for continuation coverage and retiree subscribers will be extended to 30 days past the date the Governor terminates the state of emergency.

The Health Care Authority is authorized, during the state of emergency as described above, to extend this deadline further and extend any other enrollment deadlines as needed to meet the needs of the state and PEBB Program subscribers.

TAB 7



Washington State
Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

UMP Additional Plan Proposal

Lauren Johnston
SEBB Procurement Manager
ERB Division
April 15, 2020

Shawna Lang
Senior Account Manager
ERB Division

Tanya Deuel
ERB Finance Unit Manager
Financial Services Division

Objectives

- Considerations for proposed UMP ~82 Actuarial Value (AV) Plan
- PEBB benefit design comparison
- Proposed UMP ~82 AV sample rates

PEBB Portfolio Employee Only Deductible Levels

	\$125	\$175	\$250	\$300	\$750	\$1,400 (CDHPs)
Uniform Medical Plans	X		X		X (Proposed)	X
Kaiser WA	X	X	X			X
Kaiser NW				X		X

Subscriber's deductible can be reduced by \$125 or \$125 is added to HSA account for CDHP enrollees, when SmartHealth incentive is earned.

Proposed UMP ~82 AV Plan

Member Considerations:

- An additional plan option with a mid-range deductible level (\$750), higher coinsurance (20%), and lower monthly premiums.
- A higher deductible means a lower premium, therefore, subscribers should be prepared to meet this deductible prior to the plan paying for services.
- Same provider network as UMP Classic.
- The UMP ~82 AV plan has the third highest SEBB Program enrollment during the first year of the Program, with 29,180 enrollees, of which 2% (or 691) defaulted into the plan.*

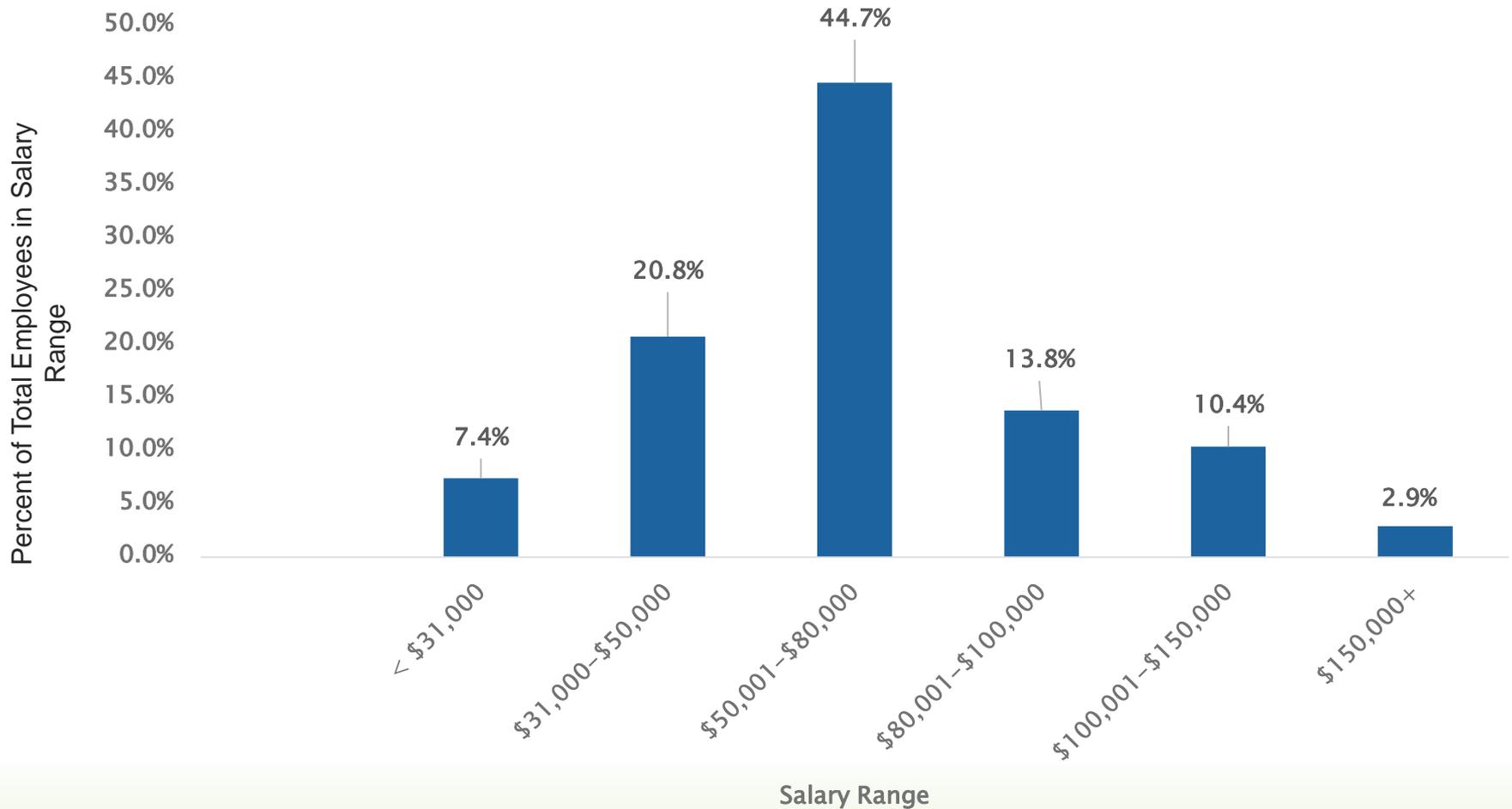
* Enrollment data as of 3/6/2020

Proposed UMP ~82 AV Plan (*cont.*)

Program and Board Considerations:

- This additional plan option could help add to the breadth of plan options for all income demographics within the PEBB Program population, but especially for employees who have less pay.

PEBB Program Member Income (State and Higher Education Employees)



Proposed UMP ~82 AV Plan (*cont.*)

Program and Board Considerations (*cont.*):

- Without an active open enrollment, it may take time for enrollment to grow in a new plan.
- Adding a UMP ~82 AV Plan could offer a new default plan option.
- HCA will select a new plan name.

UMP Benefit Design Comparison

	PEBB Program			
	Uniform Medical Plan			
	Classic (~88 AV)	CDHP** (~88 AV)	UMP Plus (~89 AV)	UMP ~82 AV (Proposed)
Deductible (single / family)	\$250/ \$750	\$1,400/ \$2,800*^	\$125/ \$375	\$750/ \$2,250
Out-of-pocket Maximum (single/family)	\$2,000/ \$4,000	\$4,200/ \$8,400*^	\$2,000/ \$4,000	\$3,500/ \$7,000
Coinsurance	15%	15%	15%	20%

^ Combined medical and prescription drug deductible.

* Out of pocket expenses for a single member under a family account are not to exceed \$6,900.

** Employer contributes \$700/individual, \$1,400/family annually in an HSA.

UMP Benefit Design Comparison

	PEBB Program			
Annual Costs/Benefits	Classic	CDHP	UMP Plus	UMP ~82 AV (Proposed)
Ambulance (air or ground, per trip)		20%		20%
Diagnostic tests, Laboratory, and X-rays		15%		20%
DME, Supplies, and Equipment		15%		20%
Emergency Room	\$75 + 15%	15%	\$75 + 15%	\$75 + 20%
Hearing (annual exam)	\$0	15%	\$0	\$0
Hearing (hardware)	\$800 benefit every 36 months	\$800 benefit every 36 months Subject to medical deductible	\$800 benefit every 36 months	\$800 benefit every 36 months
Home Health		15%		20%
Inpatient Services	\$200/day, up to \$600	15%	\$200/day, up to \$600	\$200/day, up to \$600
Outpatient Services		15%		20%

UMP Benefit Design Comparison (*cont.*)

Annual Costs/Benefits	PEBB Program			
	Classic	CDHP	UMP Plus	UMP ~82 AV (Proposed)
Office Visit (primary care)	15%	15%	\$0	20%
Office Visit (urgent care)		15%		20%
Office Visit (specialist)		15%		20%
Office Visit (mental health)		15%		20%
Office Visit (chemotherapy)		15%		20%
Office Visit (radiation)		15%		20%
Preventive Care		\$0		\$0
Spinal Manipulations		15% Max 10 visits/year		20% Max 10 visits/year
Acupuncture		16 visits		16 visits
Massage Therapy		16 visits		16 visits
Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST), Neurodevelopmental Therapy (NDT)		15% (60 combined visits)		20% (60 combined visits)

UMP Benefit Design Comparison (*cont.*)

	PEBB Pharmacy			
Annual Costs/Benefits	Classic	CDHP	UMP Plus	UMP ~82 AV (Proposed)
Rx Deductible	Tier 2 and specialty; \$100/ \$300	Applies to medical deductible	None	Tier 2 and specialty; \$250/ \$750
Rx Out-of-Pocket Limit	\$2,000 per member; \$4,000 family maximum	Applies to medical maximum	\$2,000 per member; \$4,000 family maximum	\$2,000 per member; \$4,000 family maximum
Retail: Value Tier	5% up to \$10	15%**	5% up to \$10	5% up to \$10
Retail: Tier 1 (generics)	10% up to \$25	15%**	10% up to \$25	10% up to \$25
Retail: Tier 2 (preferred brand)	30% up to \$75	15%**	30% up to \$75	30% up to \$75
Most Specialty Rx	30% up to \$75	15%**	30% up to \$75	30% up to \$75

*Waived for preferred generic prescription drugs

**After deductible met.

UMP ~82 AV Rate Considerations

- Currently evaluating assumptions for the upcoming UMP rate build, including:
 - membership changes assumed to come from UMP Classic only, at the average UMP Classic risk score
 - Level of switching
 - Impact to the state index rate
 - Only impacts non-Medicare plans

Proposed Resolution PEBB 2020-06 Self-Insured Plan Offering

Beginning January 1, 2021, the PEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Classic. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic, except for the following:

Proposed Resolution PEBB 2020-06 Self-Insured Plan Offering (*cont.*)

- Annual Deductible (medical): \$750/\$2,250 (single/family)
- Annual Deductible (drug): \$250/\$750 (single/family)
- Out-of-Pocket Maximum (medical): \$3,500/\$7,000 (single/family)
- Coinsurances: 20%/80% (member/plan)

Questions?

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TAB 8



UMP Vision Proposal

Shawna Lang
Senior Account Manager
Employees and Retirees Benefits Division
April 15, 2020

Background

- In CY 2018, UMP was re-procured and Regence included Vision Service Plan (VSP) in the bid for vision care
- For 2020, UMP's former Regence vision solution was continued for PEBB Program members for a term of one year only
 - This was done because of the many procurements needed for the SEBB Program and resource constraints

PEBB UMP Current Vision Benefit

	Current PEBB UMP Benefit (Adults)	Current PEBB UMP Benefit (Children)
Frequency	12/24/24*	12/12/12*
Benefit	<p>\$150 maximum per 2 calendar years (limit resets every 'even' year)</p> <p>Contact fitting fee of \$65 every two years</p>	<p>1 set of frames and lenses is covered per child (through age 18) per benefit year or contact lens</p> <p>Scratch-resistant coating & polycarbonate lenses are each limited one pair of lenses per year</p>
Out of Network	60% (50% for UMP Plus)	60% (50% for UMP Plus)

* Exam/Lens/Frames or contacts

Proposed PEBB UMP Adult Vision Benefit

Plan Option	Adults	Total Exam and Glasses Copay		Contact Lenses Exam and Fitting Copay		Frames or Elective Contacts Allowance	
		In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
VSP Option	Frequency						
	12/24/24*	\$0	See Schedule	\$30	See Schedule	\$150	See Schedule
Out-of-network schedule		Eye exam: Up to \$45 Single-vision lenses: Up to \$30 Lined bifocal lenses: Up to \$50 Lined trifocal lenses: Up to \$65		Lenticular lenses: up to \$100 Elective contacts: Up to \$105 Necessary contacts: Up to \$210 Frames: Up to \$70			

*Exam/Lens/Frames or contacts

Standard lenses are covered in full with a single exam and glasses copay and include single-vision, lined bifocal, trifocal, lenticular, and standard progressive lenses.

VSP is on a calendar year basis, for example, if a member used their hardware benefit in March 2021, the member would become eligible again in January 2023.

Administered by VSP® Vision Care

Proposed PEBB UMP Pediatric Vision Benefit

2021 Pediatric Plan – ACA Compliant (ATTACHED ONLY TO REGENCE CHOICE OR EXAM PLUS ALLOWANCE)

Pediatric Vision Exam plus Allowance Administered by VSP

	Frequency	Cost Shares for All Covered Services		Dollar Limit
Vision Benefits (limited up to age 19)	12/12/12*	VSP Doctors \$0	Out-of-Network N/A	100% of Allowed Amount for Eligible Frames or Contacts (see benefit details below)
Out-of- network schedule	N/A			

Frames: Once Per calendar year
Frequency: One frame per calendar year
Out-of-Network: Not covered

Administered by VSP® Vision Care

*Exam/Lens/Frames or contacts

Overview Summary

Advantages UMP Members

- Lower out-of-pocket cost for UMP members when using VSP providers
- Lower claims cost because of provider discounts
- Nationwide network of over 96,000 access points including popular retail chains like Costco[®] Optical, Walmart[®], and Visionworks
- Collaborative management of members with a chronic condition like diabetes through Eye Health Management

Possible Concerns

- Some members may need to find a VSP Choice network provider to receive highest level of benefits

Proposed Resolution PEBB 2020-07 UMP Vision Benefits

Beginning January 1, 2021, the vision benefits for all UMP plans in the PEBB Program will align with the coverage as presented at the April 15, 2020 Board Meeting.

Questions?

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TAB 9



HCA Legislative Report on Consolidating PEBB & SEBB Programs

Marcia Peterson, Manager
Benefit Strategy and Design Section
Employees and Retirees Benefits Division
April 15, 2020

Legislative Charge

The health care authority must:

- study the **potential cost savings** and **improved efficiency** in providing insurance benefits to the employers and employees participating in the public employees' and school employees' benefits board systems **that could be gained by consolidating the systems.**

Legislative Charge (*cont.*)

The consolidation options studied must:

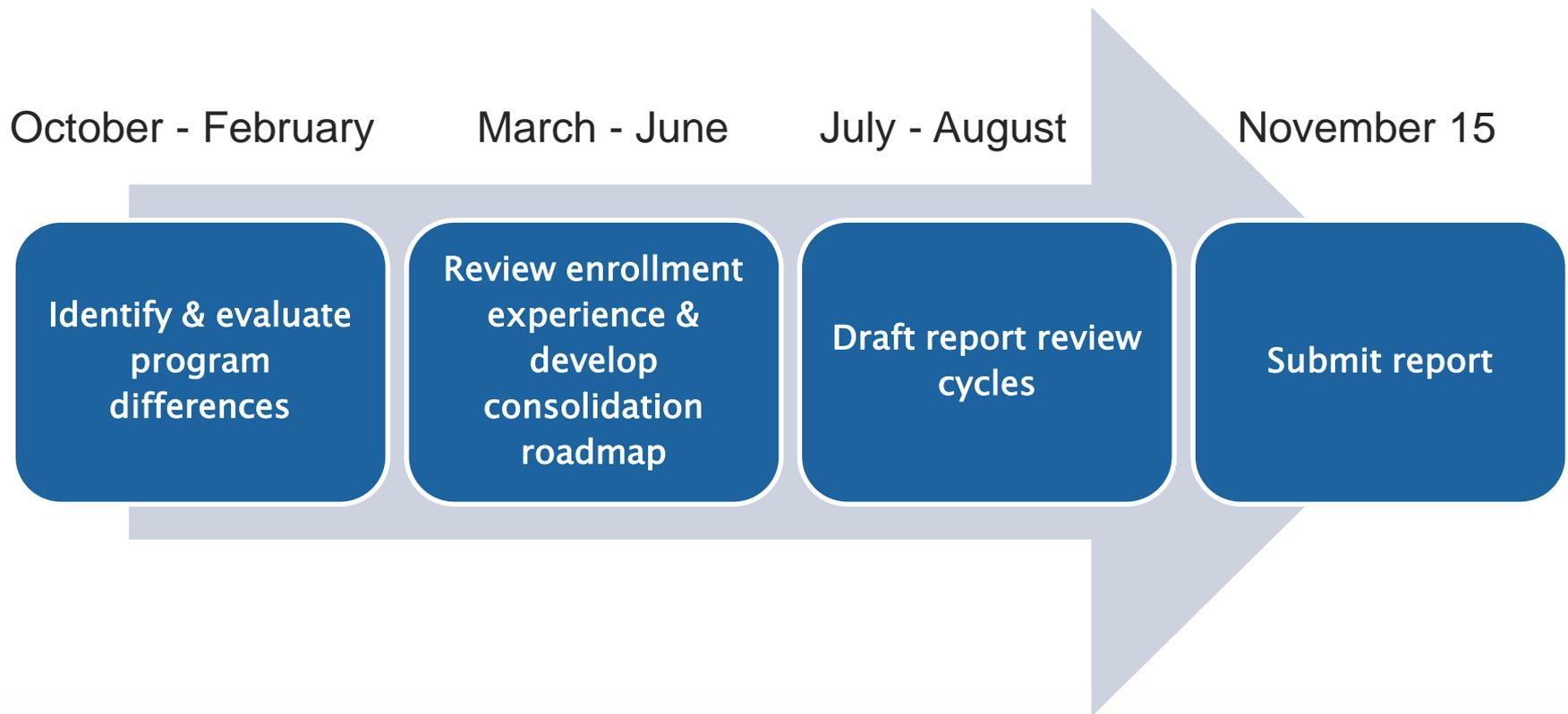
- **maintain separate risk pools** for Medicare-eligible and non-Medicare eligible employees and retirees,
- **assume a consolidation date of January 1, 2022,** and
- **incorporate the experiences** gained by the health care authority during the initial implementation and operation of the school employees' benefits board program.

Legislative Charge (*cont.*)

The study must:

- be submitted to the committees of the house of representatives and the senate overseeing health care and the omnibus operating budget by **November 15, 2020.**

2019 - 2020 Timeline



Milestones

2020

- Legislative Session (short) ends in March
- Collective Bargaining during Summer (impacts plan years 2022 and 2023)
- Report Due in November

2021

- Legislative Session (long)
- Budget biennium begins July 1

Elements to Consider

- Plan offerings
- Impacts of Collective Bargaining
- How premiums are calculated
- Tier structures
- Invoicing cycles
- Board Composition

Questions?

Marcia Peterson

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