Washington State Health Care Authority

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 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 approximgely $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

<u>UMP Pharmacy Follow Up</u>
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 Pistoresi, 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 eviewed had similar results.

Ryan Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 OEBB and OPEBB, 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 Pistoresi: 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 OEBB 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 Pistoresi. Moda has been doing that for OEBB 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 Pistoresi: 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 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 Pistoresi: 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 PEB 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.