Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

July 10, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:45 p.m.

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

PEB Board Counsel:
Michael Tunick, Assistant Attorney General

Call to Order
Sue Birch, Chair, called the meeting to order at 1:31 p.m. Sufficient members were present to allow a quorum. Audience and Board self-introductions followed.

Meeting Overview
Dave Iseminger, Director, Employees and Retires Benefits Division (ERB), provided an overview of today's agenda and noted the meeting schedule for 2020 is behind TAB 1.

June 19, 2019 Meeting Follow Up
Dave Iseminger: We answered most of the questions from the June meeting in real time. I do want to provide additional insight to one of the questions. When Tanya presented rates, Harry asked how long the plus $10 has been in existence. Any Tier that has a spouse, you take the rate factor and add $10. We checked our records and we have documentation back through 2000. It has been around at least 20 years. We'll continue to see if we find any documentation that goes into the last millennium. Every plan year in this millennium had the plus $10 factor.

2020 Premium Resolutions
Tanya Deuel, ERB Finance Manager, Financial Services Division. There are eight premium resolutions for action today. I've included the medical premiums in the Appendix.

HCA heard your concerns from the last meeting regarding the value formulary and the fact there is no adjustment included in the rates for 2020 for the impact of the value formulary. Our team had multiple discussions with executive leadership about the ability to make changes to the rates regarding the value formulary. At this point, the modeling is not at the level we deem necessary to put anything into a rate. Unfortunately, this year there will be no impacts on the rates for the value formulary. We do anticipate by this time next year when we do rate setting, we will be able to incorporate any necessary changes for the actual utilization as a result of the value formulary.

Dave Iseminger: I want to reassure the Board, since the last meeting, typically when we present the resolutions and then bring to you for action it's a much shorter time frame than when we presented them at the June meeting. We had a variety of conversations about the ability to include any piece of projections and we couldn't get to a point where we had enough quality checks within the projections necessary to wrap it up into the actual rate setting for this year.

Carol Dotlich: When we met last, letters were going out to people so they could start to apply for their exceptions if they desired one to the med changes. Have you had any response yet to those letters?

Dave Iseminger: The letters haven't gone out yet. The intent is to send those letters as we go into the open enrollment process. So, no, we haven't had any responses yet because we haven't sent those letters. That is part of that implementation plan over the next six months as we get into open enrollment and the plan year starting in January 2020.

Carol Dotlich: Thank you.

Tanya Deuel: By voting on the entire resolution by carrier, the Board is adopting the rates for all plans underneath that carrier. There is a set of resolutions for each carrier for Non-Medicare and a set for each carrier by Medicare.

Sue Birch: Thank you for the clarification.

Premium Resolution PEBB 2019-07 – KPNW Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-07 passes.

Premium Resolution PEBB 2019-08 – KPWA Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington employee and Non-Medicare retiree premiums.

Greg Devereux moved and Yvonne Tate seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-08 passes.

Premium Resolution PEBB 2019-09 – UMP Non-Medicare Premiums.

Resolved that, the PEB Board endorses the Uniform Medical Plan employee and Non-Medicare retiree premiums.

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

Dave Iseminger: Chair Birch, I want to acknowledge this resolution includes UMP Classic, which is dropping from the employee contribution at the subscriber level by $3. It's going down a bit. There have not been too many times where UMP Classic, the predominant enrolled plan in the portfolio, had a reduction in rates.

Carol Dotlich: I would like to request the $3 decrease be added to the retiree Medicare people, for UMP.

Sue Birch: I'm looking to my AAG about that discussion point. Carol, I'm not exactly sure what you're intending to do there.

Carol Dotlich: Well, if UMP is going down for the actives, I would like to see a $3 reduction for the retirees as well.

Sue Birch: Give us a second to determine our next procedure.

Dave Iseminger: Chair Birch, I would make a suggestion for everyone to think about the context of this. This resolution is about setting the Non-Medicare premium rates. It's not about setting the Medicare premium rates. At this point I think it's a question of if you want to make a motion to change the Medicare rates, I would suggest that would be more germane to the resolution on Medicare premiums, which is Premium Resolution PEBB 2019-13. We could certainly entertain discussion and debate and answer a question if that's possible.

Carol Dotlich: I would be amenable to discussion and debate.

Dave Iseminger: Without it being an actual motion on the table, let's just talk about this topic. Carol, I understand your question is related to if the non-Medicare rate is able to go down $3. Is it if the Medicare rate go down by $3 -- or $3 from the $7.45 that is proposed. I don't exactly understand your question. Is it to reduce the net change by $3

or have Medicare rates go down $3 -- which would be a $10.45 swing from the rates as presented.

Carol Dotlich: The latter.

Dave Iseminger: The latter, to have a $10.45 swing.

Tanya Deuel: Just a reminder the rate that went down is the single employee tier, not the overall plan rate, which is different than how we calculate retiree premiums on the Medicare rates. The overall rates are different than the premiums we're seeing here. It is not one-for-one.

Dave Iseminger: There are two things to talk about. One is the bid rate versus the employee contribution. The bid rate for UMP Classic actually went up $5, it didn't go down. But between the collective bargaining split, and the fact Non-Medicare retirees pay 100%, that changes what the member is paying. Carol, you're asking if we can apply what the member contribution is for Non-Medicare to the bid rate of Medicare. I think that's the actual question.

Sue Birch: I'm asking staff to slow down just a little bit to bring the Board along as we try to flush this out. Carol, I believe we're referring to Slide 18 where you see employee contributions. I do think this is an important point Dave is trying to drive. We're asking employees that are getting a $3 relief -- Carol's suggestion is to say to those employees, "your $3 savings now is going to cross-subsidize the carriers' bid rate on the retiree pool." I am really concerned that we don't have the authority to do that. I'm trying to understand how it is we would have that authority, Carol.

Again, I look to my legal team to say not just procedurally how are we handling this, but within our fund pools, Dave, and I'm reaching here. I don't believe within our fund pools we have that authority to cross-subsidize. We can recess if we need to take a break before we call for a vote. I think the simplest thing to do right now would be to finish up with the motion on the table, then take a break while we seek legal guidance and then resume before we vote on the Non-Medicare resolution.

Yvonne Tate: Procedurally, if Carol hasn't made an amendment to the current resolution, don't we go ahead and vote on that resolution? She would have to recommend an amendment, it would have to be seconded, and voted separately. She hasn't made an actual amendment recommendation.

Greg Devereux: I thought we were still in the discussion phase, though.

Yvonne Tate: But my point is we're discussing something that is not in the form of an amendment to the current resolution. Unless it's made in the form of an amendment it shouldn't affect the vote on the current resolution. That's my point.

Tim Barclay: I just wanted to clarify, I think the way you made the comment about the $3, you made it sound like there's this savings, there's this bucket of money, this saving, which to Carol's point, I think in that context, makes sense of, "hey, let's spend that and give it to a different group of people." There is no $3 savings anywhere. According to the index rate and the way the index rate calculations work out, some people's

premiums go down, other people's premiums go up. It just so happens this one segment went down $3. There is no money here. There is no savings bucket of money to spend somewhere else. To lower the premiums for the Medicare people would be new money that we would be spending outside of anything else happening here. I think the way you said it led to some confusion and I don't know if I'm on the same slide as you or not, but there's no money here to reallocate and spend.

Tanya Deuel: There's more to it than just that, Tim. There's also switching assumptions, where we have to decide how many people are going to move out of a specific more expensive plan to a less expensive plan. There is no extra money just sitting there to reallocate to the Medicare pool.

Tom MacRobert: I had some questions, although I was going to wait until we got to the actual Medicare portion of this conversation. I would like to do that because I think it might get confusing. I would propose we finish the Non-Medicare conversation/votes first. What you're talking about, Carol, is definitely relevant to the Medicare resolutions and not to the Non-Medicare. If it's okay I'd like to finish the Non-Medicare. When we get to Medicare, I do have some comments and questions.

Sue Birch: I see heads shaking. And to Yvonne's point --

Yvonne Tate: If there's no actual amendment then we shouldn't be considering it.

Sue Birch: Any further comments on the resolution on the table? We will take a vote on Premium Resolution PEBB 2019-09.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-09 passes.

Premium Resolution PEBB 2019-10 - Medicare Subsidy.

Resolved that, the PEB Board endorses the monthly Medicare Explicit Subsidy of $183 or 50% of premium, whichever is less.

Tom MacRobert moved and Carol Dotlich seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-10 passes.

Premium Resolution PEBB 2019-11 - KPNW Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Yvonne Tate moved and Harry Bossi seconded a motion to adopt.

Dave Iseminger: Chair Birch, just for everyone's direction, we're talking about the rates that are in the Appendix on Slide 23.

Greg Devereux: Tom raised the point about discussing Carol's discussion in the Medicare area. We now are in the Medicare area. Are we going to have this discussion before we vote on any Medicare rates?

Yvonne Tate: Wouldn't it be under the context of Carol suggesting an amendment to a resolution, and then we discuss that amendment?

Sue Birch: I believe that's correct. Rather than a verbal amendment, I'd like to get that in writing as well. I want to be very clear about what is being suggested.

Tom MacRobert: The conversation I wanted to have is actually an attempt to make sure that I understand, and by doing so, hopefully everybody understands the proposal. I want to go back a little in history. In 2018, the Medicare Explicit Subsidy was $150. In 2019 it went from $150 to $168. For 2020, it went from $168 to $183.

When the Explicit Subsidy went from $150 to $168, we saw Medicare premiums across the Board either slightly decrease or remain flat. I think there was only one of the list that actually saw a tiny increase. In 2019, the subsidy went from $168 to $183, which is a $15 increase, yet most of the premiums saw modest increases. What accounts for that?

Tanya gave good mathematical explanations of how you come up with rates. But is that all that drives it, is simply plugging numbers in? Or is this something that is negotiated with, for example, Regence, Kaiser Permanente -- to establish those rates that you come up with.

Tanya Deuel: The overall bid rate is negotiated. We work with both Kaiser plans on their rates, just as we do on the Non-Medicare side. We have a few-month process where we're looking at their rates, what their administrative load is, all their trend assumptions that are built into those underlying rates. We go back and forth on rates. The simple math is once we've gotten to a final bid rate, it's that simple math of bid rate minus explicit subsidy -- which is the flat dollar amount or 50% of the premium, whichever is lesser, to equal the retiree premium. That's the simple math.

Tom MacRobert: The bid rate is what is negotiated, and that drives the final premium costs, okay.

Tanya Deuel: Yes. As that increases at a different rate than the explicit subsidy, you're going to see an increase on the member side because the increase on the subsidies may not be at the same rate.

Tom MacRobert: Since Regence is supposed to be a nonprofit and that subsidy increased by $15, what was their rationale for increasing?

Tanya Deuel: Regence doesn't actually negotiate with us, UMP being a self-insured plan. HCA does the rate development. Remember, we pay Regence a per subscriber per month fee to administer the plan. We do the rate development in-house with our contracted actuary Milliman. The rate development is HCA. We use our contracted actuaries to develop trend assumptions, as well as Moda, our pharmacy benefit manager, to develop the pharmacy side. On UMP Medicare, we pay secondary on medical but primary on pharmacy. 61% of this rate is pharmacy costs. We rely on Moda and their trend assumptions to inform the rates.

Tom MacRobert: Is it fair to say then that what has significantly driven those small increases is prescription drugs and what we've negotiated with Moda?

Tanya Deuel: Over half of it is pharmacy, yes.

Dave Iseminger: It's not what we've necessarily negotiated with Moda. When we say we're setting up a bid rate for UMP it is to be able to have the total cost on a per member basis, to be able to create a member premium. We're creating a number that, based on all the actuarial projections, will cover the total claims cost plus the small admin fee -- small in the relative picture of the entire cost of the entire plan, to make sure all claims are covered for the next plan year. There's no profit padding built in. That's why we're self-insuring, to make sure we are getting the amount of money that's the projected needed to cover the cost of the plan.

Sue Birch: Tom, I want to comment that the Board had information about delivering on a value-based formulary a year ago. We voted it down and it stalled our efforts to control pharmacy pricing. It's part of what has happened -- we weren't able to control that component of the cost that goes into the bid rate. We brought this on ourselves by not taking earlier action on a value-based pharmacy.

Greg Devereux: With all due respect, Chair Birch, I think the jury's still out on the formulary. What savings it will yield in the future we don't know yet.

Sue Birch: Fair enough -- although staff made recommendations to attempt cost containment strategies, and this is one other industries brought to bear to try to control costs. We're not seeing it yet, and it's why staff advised us that we aren't going to see it now because we need more run time to build that into next year's rates. I think that's part of the frustration, is we hear you saying, "we want these costs to come down," but we have to give our staff the tools to reign in some of this cost. Hopefully our value-based formulary strategies will bear fruit next cycle.

Dave Iseminger: Chair Birch, I do want to add more context. Tom, you were talking about the relationship when the explicit subsidy goes up and what happens on the member premium side. Slide 24 is a slide Tanya produced to show visually what's happening. The setting of the explicit subsidy and the bid rate are independent actions. They come together and are part of the formula as seen here. When you see that the explicit subsidy from plan year 2018 to 2019 went up $18, the reason that you saw plan decreases was the bid rate, reflected at the top of the bar, was flat. It actually went down a couple of bucks. When the bid rate went down and the subsidy went up, that directly offset dollars coming out of retirees' pockets.

When you move from 2019 to 2020 and you see the bid rate went up about $22 when the explicit subsidy went up $15. That insulated retirees from the additional impacts of the bid rate going up, but didn't fully cover and subsidize the total cost of that incremental increase of the bid rate. There are completely different independent levers that come together in the final math formula. There isn't a direct relationship that when subsidy goes up and costs go down from members' out-of-pocket because you have to factor in what the bid rate was, and what direction the bid rate went. I thought you were trying to see if there was a way to tie those together when the explicit subsidy goes up, that means premiums go down. Those aren't directly related to each other.

Tom MacRobert: No, I wanted to make sure I understood how you arrive at the rates you do. That was what I needed to find out.

Michael Tunick: I want to add that the $183 was budgeted by the Legislature. That's part of the constraints of what you're working with here. Within the budget provided by the Legislature, you are not going to be able to increase that subsidy. I don't know if that's part of what you're thinking of here or where that $3 is coming from. Just make sure that the subsidy has that cap.

Carol Dotlich: It's my understanding that Kaiser people already have a formulary. Is that true? A value formulary sort of plan? That's my understanding. I have a friend who is a legislator who has this plan and he tells me they routinely have to get certain meds. Can't get other meds because of the Kaiser plan. If that's true, if there's a value formulary in this Kaiser plan and Kaiser's rates are going up, can you explain that?

Sue Birch: For clarification, Carol, are you asking what's the difference between the proposed value-based formulary through Moda versus Kaiser Permanente's formulary? I don't know if that is an apples to apples comparison. Staff, if you could speak to that or if we need to call in our pharmacy --

Dave Iseminger: I can speak to that. Kaiser plans are fundamentally HMO plans that have things in place like the value formulary. If I travel back in time to the January Retreat, the Board will remember that we had a panel of physicians -- two from Kaiser and two from components of the Uniform Medical Plan's networks. One of the themes during the physicians' presentation was that Kaiser already manages everything that way. Their internal formulary and systems are integrated together and when the patient is present and deciding between drug A and B, the doctor's talking with them about what is on the formulary. They physician knows what is covered under their plan because Kaiser is an integrated system. Then the physician talks about the side effects of the drug, not the cost of the drug. That's the bread and butter of what they've done and they've done that for years.

The impact on rates is embedded within their rate development and has been for decades. The Kaisers' are not implementing a value formulary today or tomorrow. They've integrated the principles of integrated care from the beginning of their model of building up a health plan. To answer your question, Carol, yes there are value formulary principles within their integrated care model. It's not something new and didn't have to be accounted for in these 2020 rates because it's baked into what they do as they build their rates every year.

Carol Dotlich: Before you go on, that's my point. If this formulary saves money and this method of integrating everything saves money, why are the Kaiser rates going up as well as the UMP rates?

Dave Iseminger: What I'm trying to say, Carol, is anything related to those formulary pieces are embedded within the rates from years ago. There's nothing that's changing from today to tomorrow. There is no incremental piece impacting this. What's impacting Kaiser's rates aren't necessarily formulary related. It's more the utilization within the plan on different services.

Tanya Deuel: Right. There's more than just pharmacy, obviously, in the Kaiser rates. The Medicare rates have different subsidies from the Centers for Medicare & Medicaid Services that are a whole different ballgame than our Uniform Medical Plan. It's a completely different story with Kaiser and the Uniform Medical Plan on the subsidies they receive in those rate-setting processes.

Dave Iseminger: The reasons individual plan's rates change aren't the same carrier to carrier, or within each plan. The reasons for an increase in one plan may be completely different in another plan. We see reports from our carriers where X drug is increasing in this plan and utilization is increasing in this plan, but it's decreasing in a different plan. There's a whole host of differences within how a plan is managed. What drives rates up or down in one plan is not indicative or comparable for other plans.

Sue Birch: Being a very pragmatic nurse, Carol, there could be plans that have a higher propensity of head injuries and associated medications and treatments that impact rates and rate build. There are many variables staff are sharing with you that tease that out. I think the KP model is different, since it's the HMO kind of construct. Again, I caution the value-based formulary we proposed, approved, and built is a little different than what KP's formulary is all about. They are not apples to apples comparisons with lots of variables at play.

Carol Dotlich: I have one more technical question. Yvonne suggested that the only way to change anything is to create an amendment to the resolution that's before us. That's my understanding.

Yvonne Tate: That's my understanding of Robert's Rules of Order.

Sue Birch: Yes, it's my understanding that we will take a vote on the current motion on the floor unless somebody moves to amend, and then we will take a vote on that amendment and see if it passes.

Carol Dotlich: So my question, it's just a question not a motion. My question is if I made an amendment to this resolution, I don't have the ability to go back and renegotiate rates. So what would be the technical point of making an amendment to change this resolution? What would be the purpose, since I have no ability to change the work that was done?

Sue Birch: It's my understanding that if this Board failed to approve these rates, staff would be redirected to go back and renegotiate. But I'm looking to Dave.

Dave Iseminger: Chair Birch, I'll remind the Board, and I think everyone was on the Board two years ago. I think that was the first cycle for both Tom and Carol and everyone else was on the Board. We had a point where we said if a resolution isn't passed, the plan wouldn't exist. Now that we are on July 10 and we've brought these to you a little early, I still think we're at a point where it would be very challenging to make any sort of modifications, especially when it comes to the UMP bid rate. We are not negotiating with anyone except ourselves. We're setting the rate based on what is necessary to cover the entire plan's expenses for the next year. There wouldn't fundamentally be something that could change on either the UMP bid rate or changing the retiree subsidy to a number that's higher than $183 because the Legislature's set that as the cap. There isn't a way to change those two fundamental numbers today, tomorrow, or at the end of the month. For impacting UMP, which I believe, Carol, is your question even though the resolution we're on is KP Northwest, your fundamental questions I think are about UMP. There wouldn't be a way to go back and change those rates.

Tanya Deuel: Over the last three weeks, since the last Board Meeting, we revisited the rates to see is there was a place to find even a dollar or two. We re-evaluated the total bid rate and found nothing we felt comfortable changing. The fact that the explicit subsidy is set in the operating budget bill by the Legislature, we essentially would be increasing the amount the state pays, which would be drawing the total PEBB Program fund into a deficit, which ultimately would trickle through an increase in funding rates in future years.

Sue Birch: I believe Carol's asking what would that do to the offerings on Slide 23? I hear staff saying if the Board voted down the Kaiser Northwest, Senior Advantage would be eliminated. It would be one less option or choice under the retiree selection. Is that correct?

Dave Iseminger: It is correct. I'd make it a little broader. On each of the subsequent resolutions before the Board, if the Board chose not to adopt the rate, you would strike the applicable plans that fall under that resolution out of the retiree Medicare offerings. Right now, the resolution is about the top line on Slide 23. Fundamentally, I think the questions have all been around line three of Slide 23, which is a subsequent resolution that will come to the Board. By not passing a resolution, you essentially are saying we are not endorsing a premium; and therefore, not endorsing a plan to be in the portfolio.

Sue Birch: Eliminating choice.

Greg Devereux: I guess academically I have to disagree with that analysis. I'm not sure there's the votes to do anything here today anyway, but I think it could be voted down. There's not a lot of time. I understand it's a self-insured plan, but Milliman is extraordinarily cautious in their estimates. Something could be done to look at that estimate. I understand you have to move heaven and earth to go to the non-self-insured plans, timing wise. But something could be done, I believe, in a very short period of time. I'm not suggesting that, but I think something could be.

Harry Bossi: I'd like to comment that nothing can be done about past utilization. Nothing can be done about medical inflation that's associated with the future or the past. What could be done, which I don't think this Board wants to take on, is to look at the

principles within the plans, the coinsurance, the deductibles, the cost sharing, the limitations on the drug out-of-pockets. Those are things that would affect the premium. So if you want to drive premium back down, you're going to have to shift. It's fairly simple. It's a see saw. It's made up of two sides. To affect one side you have to offset it on the other side.

Yvonne Tate: I want to say two things. I still think this discussion is inappropriate without having an amendment on the table. But after having said that, we spent this entire first half of the year looking at these issues. We had many opportunities to raise questions like this. It seems like we're not paying attention if we wait until we get to the point of voting on the resolution to raise issues about the rates and how they were formulated. I think staff have done an excellent job of bringing us along every step of the way, tearing these whole plans down, piece by piece, and showing us what drives the costs. I think those were the appropriate times to have these kinds of discussions.

Carol Dotlich: I would like to say that I have raised these questions and these issues, I believe, every single meeting I've attended. I've been very clear about the stress and pressures placed upon people who have retired from public service and are struggling to put food on the table, pay their medical bills, and stay in their own homes. I know that people watch the news and you're well aware of what's happening with housing costs. And what's happening -- the PERS One people did not get a cost-of-living increase this session, again. People are seriously struggling financially. I think I have adequately explained my position and my desires on behalf of the participants in these plans. I've been very clear that I wanted to see the rates stay the same or go down. I did not want to see rates go up because if you can't afford this health care plan, then you've got to go somewhere else to get a health care plan. I don't think that serves this group or those consumers well. And so if there's a way to save a dollar, or $3 or $5, then I want to see that happen for these people. I really do. And my point that I was raising, for the record, is that no matter what we do as a Board, we don't have any choice. If we vote these things down, we have nothing to offer the consumers, right? And if we vote to support them then it appears that we're kind of obtuse to the struggle that some of the people that use these plans have, in survival. And so I would say that every single meeting I've been very clear about what I think is necessary to represent the retirees that are on Medicare, and even those that are not. That's my statement. Thank you.

Tom MacRobert: I just want to note that part of the reason we are having this conversation, though, is because we just saw those rates for the first time at our last meeting. Therefore, we haven't had a chance to really digest and talk about what we would like to see happen, which of course is what Carol's bringing up. Now I understand having had the conversation that we've had, a better understanding of how that came about. But I think that conversation needed to happen in order for us to move beyond it. So that's my point.

Sue Birch: I will take a roll call vote.

Voting to Approve: 5
Tim Barclay
Yvonne Tate
Tom MacRobert

Harry Bossi
Sue Birch

Voting No: 2
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-11 passes.

Premium Resolution PEBB 2019-12 – KPWA Medicare Premiums.

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington Medicare premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-12 passes.

Premium Resolution PEBB 2019-13 – UMP Medicare Premiums.

Resolved that, the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Yvonne Tate moved and Harry Bossi seconded a motion to adopt.

Fred Yancey: Thank you, Chair Birch and members of the committee. I'm not sure where this fits but it seems like the conversation is pretty broad. I would like Mr. Bossi's remarks to be planted in the committee's mind because the issue you're talking about is premiums. Carol is talking survival. And the issue really is how to make these plans less rich but more affordable. You need to look at the average income of what a pensioner, Non-Medicare gets in this state, and then realize the impact. If you're a single subscriber and spouse, 50% of the average pension a pensioner gets in this state goes for Medicare. How can you do that? I think I would like to see the committee spend some time to scale back maybe the luxury within some of these plans in order to drive down the costs because our members are faced with the decision of either something or nothing. Somewhere in between would be much preferred, given the economics. But the committee needs to look at the economics of who these pensioners, non-Medicare and Medicare-eligible people -- what their incomes are, and reflective of the insurance. Great insurance, that's not the problem. The problem is it's probably too great for the realities of the economy. So thank you very much.

Yvonne Tate: I somewhat felt offended by some of your comments, Carol. If you think that I don't care, you're missing the boat all together. I've been on this Board longer than anybody but Greg, and it's been over 20 years. And I care deeply about retirees and actives, and what they pay for health care.

The other thing I will say is, as a retiree myself -- but not a state retiree -- I pay far more for health care under Medicare than what the people you care about do. But my point is the reason we're on this Board is because we do care, not because we don't. That point I want to make strongly. I think staff have gone the extra mile, trying to get water out a rock, if you will, to come up with the best rate they can. The problem is in a word -- pharmacy. That's a problem. Pharmacy costs are what are driving these costs. I don't know how you deal with that. You can't tell people we're not going to let you have the medicine you need to stay alive. And that's my two cents.

Greg Devereux: I have to weigh in. I do appreciate Yvonne's comments very much. Over the years, she has voted for workers' interests and has an incredible heart for these issues. I have to take exception, though, with Mr. Yancey's earlier comment about a seesaw. It seemed like it was either the employee -- things are taken away from the employees or not. I don't think this is a zero sum game. I don't think these benefits are too luxurious. I think there are all kinds of other things. The formularies are one thing to do. There's bulk purchasing. There's all kinds of things. They're hard to do. That's why this country hasn't done them. But there are a lot of other things that can be done besides simply moving the costs back on employees. I think many of these benefits for years have been described as substandard. I guess I have to take exception to the characterization of them as luxurious benefits.

Voting to Approve: 4
Tim Barclay
Yvonne Tate
Harry Bossi
Sue Birch

Voting No: 3
Tom MacRobert
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-13 passes.

Premium Resolution PEBB 2019-14 - Premera Medicare Premiums.

Resolved that, the PEB Board endorses the Premera Medicare premiums.

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

Voting to Approve: 5
Tim Barclay
Yvonne Tate
Tom MacRobert
Harry Bossi
Sue Birch

Voting No: 2
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-14 passes.

Tobacco Surcharge Policy Resolution

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – PEB Board Policy Resolution. Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge is before you for action today. Slide 3 has the relevant language from the budget bill so you'll have it available as we talk about the policy resolution related to the tobacco use surcharge. Prior budget language expressly stated $25 is the amount of the monthly surcharge. This language changed in the current state operating budget, which started July 1. The Board can establish the amount of the surcharge, provided it is not less than $25 per month. Because of this change, HCA is bringing this policy resolution to you today.

Slide 4 – Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge. We made some changes since the last meeting. We added “thirteen years and older” before the word "enrolled" on the fourth line. The policy, as presented at the last Board Meeting, is included in the Appendix.

Why did we make this change? Our current practice is to only have a surcharge for members 13 years and older. We wanted that to be clear in this resolution.

Dave Iseminger: Rob, I believe part of the reason it's set at 13 years of age is because of the availability of cessation programs. There aren't specific cessation programs targeted to individuals under 13 years of age; and therefore, that's why the original policy was set up to say that we will start evaluating tobacco use as of 13 years of age. Under federal rules, you have to offer cessation programs when you offer a tobacco surcharge. There are no such things as tobacco cessation programs targeted to people younger than 13 years of age.

Harry Bossi: Is the current surcharge policy $25?

Dave Iseminger: Correct, Harry. That's because the Legislature previously said it shall be $25.

Harry Bossi: Okay, so why do we need this change now if we're keeping it at $25?

Dave Iseminger: We followed our prior practice. When surcharges were originally created legislatively in the budget back in the 2014 legislative session, the spousal surcharge had language that said the surcharge shall be *at least* $50. At that time we brought a resolution to the Board and said because you have discretion we want to make it clear whether you've exercised that discretion to go beyond what the minimum is that's set in the legislative budget. At that time in 2014, the Legislature didn't give this Board discretion on the tobacco surcharge, so there was no question to bring before the Board in that context. Now that language has changed in the operating budget. We brought something to show affirmatively that you did not exercise your discretion to set it at a higher level. We wanted to bring something to the Board to have that equally clear on the record -- the Board recognized they had discretion but did not take an extra step to go beyond and exercise that discretionary authority.

Tom MacRobert: Do I understand correctly that if we vote in favor of this resolution as is, we make no change to what currently exists.

Dave Iseminger: That is correct.

Yvonne Tate: We still have the option in the future to make a change if we so choose, by adopting this resolution.

Tom MacRobert: If we so chose, it would give us the option of adding more money to the surcharge. But the $25 is a minimum, no matter what.

Dave Iseminger: Yes, Tom.

Sue Birch: **Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge.**

Resolved that, beginning January 1, 2020, the tobacco use surcharge will be $25 per month for a subscriber with a member, thirteen years and older, enrolled on their medical plan that uses tobacco products.

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

Greg Devereux: I would say I'm voting against it just because, as I said at the last meeting, I believe it's a tax. I think the staff even indicated the tobacco use surcharge doesn't do what it's supposed to do. I simply think it's a tax. Yes, the money stays with HCA, but if it wasn't there, the Legislature would have to come up with the money. So that's why I'll vote against it.

Tom MacRobert: How do we know people are honestly answering the question? The assumption is you're a tobacco user, you're going to let people know you're a tobacco user. You have a member of your family who is a tobacco user and you're going to let them know that's happening. How do we know that ever occurs?

Dave Iseminger: Tom, we at HCA andERB Division, do not have an enforcement policy for tobacco users. This question came up during the initial implementation and it comes up periodically, that if an individual attests falsely and is brought to our attention, we refer that to the employer because the employer can decide whether it is a personnel issue they want to take action on for a false attestation. HCA defers to the employer.

Over the years, co-workers, neighbors, ex-spouses who are upset and know somebody didn't tell the truth, they tattled. We also have guilty consciences that come forward and write us a check. They said, "I lied in the past." I know of at least one specific instance of that. We do take people at their word. It is an attestation-based system and we defer to employers for anything that may be permissible or allowable under personnel policies at the employer level.

Carol Dotlich: I spent many years when I was an active state employee representing members who faced disciplinary action for things even less serious than this. I guess I would like to say, on behalf of those people that I represented in the past, most of them are very fearful of attesting or lying, making a false statement because the threat of losing your job when you have a family to care for is a huge, huge threat. I can't speak

for everybody, but I would like to stand up for the state employees who try to be very honest in their employment.

Voting to Approve: 4
Tim Barclay
Yvonne Tate
Harry Bossi
Sue Birch

Voting No: 3
Tom MacRobert
Carol Dotlich
Greg Devereux

Sue Birch: Policy Resolution PEBB 2019-06 passes.

Long-Term Disability (LTD) Insurance

Kimberly Gazard, Contract Manager, Employees and Retirees Benefits Division. Slide 2 – Agenda. Today we will discuss the updated March LTD open enrollment numbers and follow up on data questions.

Slide 3 – LTD One-Time Enrollment Opportunity is a recap of the March LTD open enrollment opportunity when changes took affect May 1. PEBB program members had the opportunity to enroll in supplemental LTD or to reduce their waiting period without evidence of insurability.

Slide 4 – Employee Supplemental LTD Enrollment Results. After open enrollment, we had 47,690 subscribers enrolled in the supplemental LTD, out of 138,555 eligible subscribers. The Standard typically sees between 8% and 15% increase in participation during open enrollment efforts. The PEBB Program surpassed the typical increase with 19%. Enrollment changes can be keyed up to 90 days after submitted by the employee. Keying for this LTD open enrollment concluded on June 29.

Dave Iseminger: It's really profound. When you step back and think 7,600 people have additional coverage because of an opportunity the carrier brought forward and the Board authorized, which was a result of the Board and the agency going out and doing a procurement on life insurance. That's where this journey began, as we started to revisit the development and the adequacy of the life insurance benefit. We had amazing results in that open enrollment that didn't have medical underwriting. The Standard approached us. We brought that to the Board at the end of last season, and in under a year we now have 7,600 people who otherwise may not have had coverage or would not have pursued getting coverage.

Kimberly Gazard: Slide 5 – March 2019 Open Enrollment Results. The results are as of July 1, broken down by group. State agencies had 4,203; higher education had 2,965; K-12 had 34; and other employer's group had 399, totaling 7,601. New enrollments keyed since the April presentation totaled 1,131. The total for April was 6,470. New enrollment during the March open enrollment for state agencies was about

20% of their total supplemental LTD enrollment. Higher education was about 13%, K-12 was about 9%, and other employers was about 13%.

Slide 6 – Benchmarking our LTD Participation. The Standard typically sees between 25% and 35% participation rates for similar public sector clients and plans. The PEBB Program, prior to open enrollment, had a 20% utilization rate. After open enrollment, the PEB Program enrollment had a 34.4% utilization rate.

Dave Iseminger: This was a paper-based enrollment. We didn't have the advantage in the LTD open enrollment that we had with life insurance. We doubled the amount of coverage in life insurance – $8 billion in additional elected coverage. That was when we transitioned from paper to online enrollment and had the advantage of syncing it with the annual November open enrollment. This LTD open enrollment was off-cycle, in March. There were reasons for that. Even with it being March and paper-based, we had additional increases in participation and coverage that people elected. It was a successful experience where the carrier, Board, and HCA were able to work together to bring to PEBB Program members.

Kimberly Gazard: Slide 7 – Follow up on Data Questions. Slide 8 – The Number of Approved LTD Claims. The Standard suggests looking at the last five years for a truer picture of utilization, because there is always a lag with claims' filing when you have multiple and extended benefit waiting periods. The PEBB Program has up to 360 days as a benefit-waiting period.

For the January 1, 2014 through December 31, 2018 five-year period, there were 9,509 claims. For the 2018 plan year, there were 403 claims. Included on this slide are the dollar amounts for claims for basic and supplemental for your reference.

Slice 9 – Approved LTD Claims Resulting in Being Permanently Disabled. The Standard considers members who have reached the end of their benefit period as permanently disabled. For the past five-year period, 41.5% of claims have closed due to the member reaching the end of their benefit period. This includes the mental health limitation claims as well. For reference, the mental health limitation is limited to 24 months per each period of disability caused or contributed by a mental disorder. In the past five-year period, 531 or 11.3% of claims have closed due to the member passing away.

Slide 10 – Income of Employees Enrolled in Supplemental LTD. HCA's LTD plan is a self-administered plan. The PEBB Program is the record keeper; therefore, The Standard is unable to provide the breakdown of member enrollment in the supplemental LTD plan. Despite PEBB Program system limitations, we were able to work around these limitations the past several weeks to gather salary information for the supplemental LTD. We are presenting this information using the same salary brackets used in the January, April, and June PEB Board presentations for consistency. The salary information in this chart is as of June 30 and does not include higher education salaries and the salary reported may not reflect the most up-to-date salary. This chart shows the large majority of PEBB Program members are in the 51K-80K salary bracket for the supplemental LTD. The salary chart for basic also reflects the majority of members also fall into the 51K-80K bracket.

Sue Birch: I'll just comment that this is a fabulous benefit to have in place for those that took advantage of it and participated. I thank staff and the Board for moving this forward because it really closed that loophole. Tim, I feel like it was under some of your leadership this was revisited. So thanks to staff and the Board for moving this forward on behalf of state employees.

Dave Iseminger: This was the first part of our journey together on improving the LTD benefit. When HCA brought this to the Board last year, we said this is an opportunity on the employee paid supplemental benefit, but at least this would be a way for people who want to opt into a benefit to have an opportunity without medical underwriting. We've had discussions at the past couple of Board Meetings about some strategies to be able to go back and evaluate improving the employer-paid basic benefit. That's phase two of our journey. I want to thank the Board for insight over this Board season as we work on decision packages and bringing other information forward during the next Board season, to see how we can further improve this benefit for plan year 2021.

Centers of Excellence Program Update

Marty Thies, Account Manager, Portfolio Management and Monitoring Section, ERB Division. I'm going to give you a quick update on the Centers of Excellence (COE) Program. The program now provides access to two bundled episodes of care to the Non-Medicare UMP Classic and CDHP membership. I'll first discuss the total joint replacement bundle followed by the spine care bundle.

Carol Dotlich: The Centers of Excellence is for whom?

Marty Thies: It's for the Classic and CDHP populations who do not have Medicare as their primary insurance.

Slide 3 – Background. I like to underscore how the Centers of Excellence Program has at its foundation a set of clinical standards developed by the Bree Collaborative, authorized by the Legislature in 2011. The Bree Collaborative established the appropriate fitness and clinical criteria pertaining to joint replacements and lumbar fusion, our two bundled procedures so far.

In 2014, the Legislature encouraged HCA to increase value-based purchasing. This Board approved a resolution for the Centers of Excellence Program in 2016. HCA went live with our first bundle January 1, 2017. The program is about 2½ years old.

Slide 4 – TJR: Benefit Design. The design of this benefit is of great value to PEBB Program members. HCA incentivizes members to use the COE Program by providing this surgery with zero to low out-of-pocket costs. CDHP members who take advantage of this program do need to pay their high deductible first, but then they pay no out-of-pocket. It includes the surgery, inpatient services, the implant, a walker if that's needed, and concierge case management from the first phone call to a post-discharge survey. They also get transportation, airfare, mileage, parking, and lodging. In addition, the Centers of Excellence Program provides HCA with a warranty for a specified set of complications over 7-90 days, post-discharge. The COE takes on that risk, if something goes awry with the surgery.

Slide 5 – The COE-TJR Team. For the total joint replacement bundle, the Centers of Excellence is Virginia Mason Medical Center in Seattle. They are also the COE for other organizations and employers like Walmart and Boeing. They have a lot of experience bundling joint replacements. Our Third Party Administrator (TPA) is Premera Blue Cross. They walk interested PEBB Program members through the process from start to finish. They all but literally hold hands with participants, making the journey as smooth and positive as possible.

Slide 6 – Member Volume. On this slide are numbers for completed surgeries. We are quickly reaching 200 surgeries for TJR. The second year saw a drop in our numbers. Time will tell what that means, exactly. But according to our data from Regence, we also dropped in the total joint replacements performed for this population not at the COE. Even though 95 surgeries in the first year and 71 surgeries in the next looks like a big drop, actually the market share for the total amount of surgeries was only about 2%. We'll see what happens this year. HCA asked Regence and Premera to run the COE surgical recipients through the Regence data to see if they experienced complications they didn't take back to Virginia Mason. To date, there are none. We've incurred no post discharge expenses at Virginia Mason in the last 30 months.

Slide 7 – 2018 Comments from UMP Members. These are new 2018 comments recently received from Premera drawn from the post-discharge surveys participants complete. The PEBB Program members who participate are largely very positive. Both years we received some comments about the quality of their hotel experience and sometimes participants think it takes too long to get their surgery. We take those comments seriously and address them whenever it's in our power to do so. The comments are extremely positive. Members are enthusiastic. They can't think of how their experience could have been better.

Slide 8 – 2018 Member Survey Results. This slide has quantitative results from the post-discharge surveys. There are more than a dozen questions, and these few are the most telling. I indicate whether they reflect on Premera or Virginia Mason. We had an 84% response rate, which is phenomenally high and can be an indication that those surveyed are either ecstatic or irate. Here, it's definitely the former.

The percentages are those who responded to these questions with an 8, 9, or 10 on a scale of 1-10. These are extremely important to our members: I understood my recovery plan. My case manager was courteous and helpful 100%. I think these are passing grades. PEBB Program members appreciate the service greatly after going through the program and receiving a significant surgical procedure.

Slide 9 – Age and Gender. The lion's share of those participating, predictably, is the 45-64 year old age group. Old enough to need a joint replacement and young enough to have Classic or CDHP as their primary health insurance. The upper left chart, the portion in blue, are those older than 64 who continue to work, which wouldn't be a huge cohort but would be the cohort with the oldest joints making up 25% of those utilizing the bundle. By gender, the chart at the lower right indicates females receive nearly three fifths of the joint replacements, which is in keeping with the national data, especially for knees, as women experience osteoarthritis more than men, as well as arthritis with worse symptoms and greater disability.

Slide 10 – 2017-2019 Member Savings. On the financial slide, using the 192 completed surgeries up to the middle of last month, multiplied by an approximate average of $1,000 out-of-pocket had they not gone through the program, we've saved members nearly $200,000.

Slide 11 – Cost Comparison with non-COE TJRs. Looking at 166 total joint replacement surgeries paid through the month of May and using the paid inpatient and professional costs for the equivalent non-COE surgeries performed, the plan continues to save more than 15% on each COE surgery. As far as what UMP is spending on Non-Medicare classic and CDHP joint replacements, it's important to consider both cost and utilization because a rise or fall in annual TJR costs may only reflect the rising or falling number of TJRs performed. The clearest way to take both cost and utilization into account is finding the average cost per surgery. From 2015 to 2018, looking at the utilization and total spend on joint replacements in the Non-Medicare Classic and CDHP population, and TJRs in COE and not COE, the per surgery cost across the board has dropped 8.6% in those five years. We'll see what happens as time goes on, but I think it's a good indication.

Harry Bossi: The population here is a mix of UMP Classic and UMP CDHP. They have a little difference in the out-of-pocket potential liability. I'm not sure how you come up with $1,000 as the average. You must have mixed it over time, because the CDHP, don't they have a $2,000 minimum they have to reach to start getting the benefit?

Marty Thies: They may have spent some before. They might wait until the end of the year to engage. I think the participation is 95%-97% Classic. I'll have to re-check that.

Harry Bossi: I do think it's a wonderful program. But I drill into the number because in Classic isn't the maximum out-of-pocket for a year, Dave, do you know what it is, off the top of your head?

Dave Iseminger: You're asking for out-of-pocket maximum or deductible?

Harry Bossi: Out-of-pocket. Isn't it like $2,000?

Dave Iseminger: I've looked at so many charts lately at so many programs that I'm afraid I'm going to answer wrong.

Harry Bossi: I've answered my own question. I was thinking it was well below $1,000. These are great numbers, thank you.

Sue Birch: Marty, what sort of data do we have on the ones referred to the program but then went away to do exercise therapy, weight loss, or were advised they weren't fit?

Do we have any cost avoidance, cost savings, or do we have any other qualitative, quantitative data on those that were diverted from unnecessary procedures?

Marty Thies: We are working on that. I think it's 91% of people referred by Premera to the Centers of Excellence follow through with their surgery. Sometimes people have to cancel because of family emergencies or they couldn't quit smoking.

Dave Iseminger: As we're talking about a small number here, we have to wait until the data gets to a number where we're able to report it. When you're only talking 10-15 people, it's not anonymized enough even in its aggregate form. We have to wait until the numbers are large enough to do that aggregate reporting.

Tom MacRobert: Let's say I get my health care at Bothell Memorial Clinic, which no longer exists, and my doctor refers me. He says you're going to need hip replacement surgery. He says now I can refer you either to Overlake or Evergreen Hospital for that surgery. How am I going to know about the Centers of Excellence as a Uniform Medical Plan participant?

Marty Thies: Every year it's in our Certificate of Coverage, which probably isn't an easy place to find it. When we first introduced the program, we highlighted it in our open enrollment materials. At all of our benefits fairs, Premera makes the effort to have a table. They get some traffic that way. When we introduced the spine care bundle, open enrollment nine months ago, it was a chance for us to highlight the successes of the joint replacement bundle as well. ERB Communications created a video in collaboration with Virginia Mason, posted on the Premera site. Other than that, all they have to do is call the Premera number.

Dave Iseminger: Marty, could you describe any proactive outreach Premera does? I know when we originally launched the program we were able to send letters to members based on diagnosis code of people who might be interested in learning about these types of things. We would do a claims and diagnosis code draw and send a generic letter asking if they know about this benefit.

Tom MacRobert: Would my doctor know about this program? Should my doctor know about this program?

Marty Thies: Well, I think everybody should know about it. But if your doctor performs surgeries like this, they might not want to refer outside of their own provider or hospital setting. Dave is right. I forgot that it's going on behind the scenes, finding likely candidates looking at data to identify services rendered that indicate a joint replacement may be considered by a member. They would receive something. Thank you.

Myra Johnson: I'm liking your 84% return rate on your surveys. Can I ask whether they were paper, online, or both?

Marty Thies: I think they send those out email, about 30 days post-discharge, with a follow-up call.

Dave Iseminger: When we presented this to the SEB Board, they appreciated the work this Board had done in authorizing the program. I believe the words were "no brainer" when it came to adding the Centers of Excellence Program to the new School Employees Benefits Board Program. There were direct comments appreciating the trailblazing this Board has done in creating the program that they were able to leverage.

Sue Birch: Just to echo that, this COE Program is one of the hallmark strategies Washington is known for around the country, and being a pacesetter. I find it interesting, the volume dipping down, but I also can tell you in talking to the providers,

there's been a move to raise the bar on the COE concept. In the spinal care bundle, you will hear how it brought other providers up in bringing the bar up to a new level of excellence. I'm wondering if that's cutting into the numbers, too, because other programs followed suit, and while they might not be deemed COE sites yet, we're seeing more interest in their ability to do these types of COE concepts.

Marty Thies: Time will tell but looking at the drop in 2018, it's a question of how many people are thinking they would love to get a joint replacement but the out-of-pocket is too great and put it off. This program came along, and it could have pushed a number of people through in 2017 that we're not going to see in 2018. We're at a quicker pace than last year so far this year. We'll see what the final numbers tell us.

Slide 13 – Centers of Excellence Program: Spinal Care. 2018 was the year we pulled this bundle into shape, including the RFP, building and getting the contracts signed, and implementation. It went live January 1, 2019.

Slide 14 – Spine Care Centers of Excellence. The benefits design is very similar to the joint replacement. It's a voluntary program. You don't have to go to the Centers of Excellence. Members using the Centers of Excellence will have little to no out-of-pocket expense. There's a travel benefit for easy access to the services. It requires the participant to have a care companion to assist them while they're at the facility, and must meet fitness and appropriate standards, per Bree.

There are differences, too. Lumber fusion has a much lower utilization in the eligible populations, and the spine care bundle actually has two destinations, surgery and an evaluation only. We want members to come to the COE for spine care. We definitely do not want members to get a fusion if it's not an appropriate procedure for them, or they're not fit to be successful afterward. For those who entered the program but don't get a surgery, the evaluation provides them a full clinical assessment and care plan.

Slide 15 – Spine Care Centers of Excellence (cont.). For this bundle, there are two Centers of Excellence. Virginia Mason responded to the RFP and was successful. Capital Medical Center in Olympia was also successful as a COE. Through mid-June, there are nearly 20 people engaged in the program any given week. That's people engaged at some point in the process. Eighteen evaluation only bundles have been done so far, and only one surgery. Time will tell what it's all going to look like.

Slide 16 – Centers of Excellence: Future. There's a consideration to expand the spine care bundle to offer a second surgical destination, maybe laminectomy. This would make the bundle a little more versatile and meet the needs of more members. Implementation of a third bundle on the table could possibly be bariatric surgery and an oncology treatment planning bundle.

Carol Dotlich: I want to thank you for the update. I really appreciate it. I've been really interested in this program. I think it's wonderful that we're working on this.

Greg Devereux: Marty, when we're considering a bundle what attributes, it seems like they're pretty small numbers so far. Is that to focus on excellence initially and then maybe broaden it over time.

Marty Thies: I believe the impetus behind the total joint replacement bundle was high utilization and high variability. A lot of people are doing it and the price is from low to sky high. We have a prospective price on this. We are controlling our costs. With spinal fusion, the Bree criteria for lumbar fusion are essentially prefaced on the idea that spinal fusion is over utilized, perhaps it's performed two times the amount it should be. It's a real service to our membership to provide a Centers of Excellence to look at their spine before surgery. Cost and utilization are key factors.

What's interesting about the possibility of the oncology bundle for treatment planning, it's almost like a second opinion. You get diagnosed for something where there's not a lot of traffic, when it comes to oncology. At the Centers of Excellence, you get an evaluation, a treatment plan, and work for a time. The Centers of Excellence will work with local providers to implement the treatment plan. That's a very interesting concept. It has to do with an extremely expensive regimen of treatment. The average oncology treatment is approximately $157,000. We could certainly provide a valuable service to our members if we are sure of diagnoses and treatment plan.

Sue Birch: If I can add to what Marty's describing. For the quality alignment, not only do we see a huge variation in cost, we have seen huge variation in the quality. The warranty piece and the decision support tools, or the client engagement, really getting somebody to understand their role in this process and/or screening out unnecessary procedures, to me those are hallmarks of the COE Program.

Board Season Wrap UP

Dave Iseminger: We're essentially at the end of our Board season. I want to give you an update on the SEBB Program. I want to make sure the Board is aware we are releasing to the SEB Board, and publicly on Monday, Board materials with rates, plans, and service areas for all the medical plans in the SEBB Program portfolio. As we finish launching the program, it is one of the key areas we're going to talk with this Board about. There are more plan options from SEBB Program procurements. We crafted those procurements and contracts in a way that this Board could leverage opportunities to incorporate and bring additional plan choice into the Non-Medicare population of the PEBB Program portfolio.

We are at a very significant stage in the SEBB Program, where people will finally be able to know those answers of how much, where, and what plans. Once the SEB Board takes action, that information will be going out to school employees.

There are three major areas when I think about 2020, that this Board and the PEBB Program can learn from and have opportunities to leverage from the SEBB Program.

First is the additional plan options we'll be able to talk about with you. In the PEBB Program portfolio for 2020, there are 15 UMP only counties. While it's a great plan option, it's not robust choice. For the SEBB Program portfolio, I can't say the number publicly until we get the materials out, but it's much fewer than 15 counties. There may be an opportunity to bring significant amount of choice to PEBB Program members who live in different parts of the state where their only choice next year is UMP.

Secondly, we've spent a lot of time in the SEBB Program launch on IT development. In the PEBB Program, we're very paper based in initial enrollments. On the SEBB

Program side, we're not going to be paper based. There are opportunities for people to make plan changes and do enrollment through an online portal. We've gone through a lot of testing, and that program launches very soon. After we've worked through that in the initial enrollment for the SEBB Program for 2020, we'll talk about ways to incorporate that for PEBB Program members.

Finally, with school employees being more geographically diverse than PEBB Program employees, it creates new innovations and thought processes about how to communicate with such a geographical diverse population. We do have PEBB Program employees all over the state, but we have a high concentration in the Thurston/Pierce County area for many reasons. Most state agencies have major operations in the Olympia/Tumwater area. We'll have a lot of communication ideas we are testing within the SEBB Program population that we'll be able to learn from and incorporate as we move forward in the PEBB Program.

I want to acknowledge that when you reconvene in January, the structure of your Board will have changed because Myra's nonvoting K-12 active employee position is no longer statutorily part of this Board. When the SEBB legislation created a separate Board for active school employees, that legislation retired the position Myra currently holds on the Board. I want to acknowledge that our Board composition is changing. Myra has been with us for five full Board seasons and I've appreciated the insight she's provided and the questions she's raised along this process. I want to acknowledge Myra's service. Thank you, Myra, for serving on this Board.

Sue Birch: On behalf of the Board, we're going to give you this tiny little token of thank you for all you've done for our state. We have appreciated your perspective.

Myra Johnson: I learned a lot being on this Board. When I first found out about it five years ago, I was like, the what? The where? Who? As a school employee, it wasn't relayed to us at all. I have learned a lot. I really am inspired by what's going on in SEBB. I will be watching them, listening to them, appreciating, and I will have a different perspective than most in the audience. I do appreciate it and continue with all the hard work. I will be a retiree one day so keep pushing for us! I appreciate that. And again, thank you very much. I've enjoyed working on this Board and I will miss you.

Sue Birch: Thank you. [applause]

Next Meeting
January 30, 2020 Retreat
9:00 a.m. – 3:00 p.m.

Meeting adjourned at 3:20 p.m.