Public Employees Benefits Board
Meeting Minutes

July 27, 2017
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Louis McDermott
Yvonne Tate
Greg Devereux
Gwen Rench
Myra Johnson

Members on the Phone:
Tim Barclay
Harry Bossi
Marilyn Guthrie
Mary Lindquist (joined late)

PEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:39 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview
Dave Iseminger, PEB Division Acting Director, provided an overview of the agenda.

2018 Medicare Premium Resolutions
Greg Devereux: Is there the opportunity for testimony during the resolution process?

Lou McDermott: Yes, there is.

Greg Devereux: There are quite a few folks here today and I want to make sure there is the opportunity before we vote on anything that they have that.

Lou McDermott: Correct. We read the resolution, we do the motion to adopt, the second, public comment, and discussion from the Board. Each resolution has that opportunity.

Greg Devereux: Great, thank you Lou.

Kim Wallace, HCA and PEB Finance Section Manager, presented the 2018 Medicare Retiree Premium resolutions. The purpose of this segment is to have a vote on the resolutions for Medicare premiums that were presented on July 19, 2017.

Medicare Premium Resolution 1: Resolved, that the PEB Board endorses the monthly Medicare Explicit Subsidy of $150 or 50% of premium, whichever is less.

Dave Iseminger: For this resolution, I want to remind the Board that the statutory authority to set the explicit subsidy is with the Board within the parameters the Legislature gives the Board. This resolution represents the maximum authority within the legislative parameters that are given to the Board. If the Board were to set a different subsidy that is less than $150 or less than 50%, then that would result in larger member premium increases in the premium rates. The rates that were presented at the last meeting assumed that the maximum subsidy would be authorized by the Board as represented in this resolution.

Lou McDermott:

2018 Medicare Premium Resolution 1: Resolved, that the PEB Board endorses the monthly Medicare Explicit Subsidy of $150 or 50% of premium, whichever is less.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0
Mary Lindquist not available via phone for this vote.

Gwen Rench: I would like to take this opportunity to say thank you for having this resolution separate from the premium. It is an advancement over the recent years.

Kim Wallace: Medicare Premium Resolution 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Medicare Premiums.

Dave Iseminger: I'll just remind the Board that behind Tab 3 in your Briefing Book, behind the goldenrod sheet are the same slides from last week which show the premiums. This is the premium from the first row that has a 77 cents decrease per member per month.

Connie Bergener: Board Member Mary Lindquist is trying to call in and needs assistance.

Lou McDermott: Okay. We'll hold off on the Resolution 2 vote. Let's take a recess and wait for Mary to call in. Mary, is that you?

Mary Lindquist: Yes, it's me. I'm on the line.

Lou McDermott: We're going to go through Resolution Number 2.

Mary Lindquist: Thank you.

Lou McDermott:

2018 Medicare Premium Resolution 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Medicare Premiums.

Moved. Seconded.

Lou McDermott: Is there any comment from the audience? Any discussion from the Board?

Betty Anderson-Till: My name is Betty Anderson-Till. I didn't have a chance to look through all of this material. How did you arrive at the 20% change in subscriber rate for the UMP Classic Medicare?

Lou McDermott: Katy, I'm assuming it's okay to go a little bit out of order?

Katy Hatfield: Yes.

Kim Wallace: Thank you for your question. Regarding how the UMP Classic Medicare Premium rate is set, the HCA consults with an actuarial firm, and we review the claims' costs, all the medical costs, that include pharmacy and prescription drugs that the plan has experienced over the past year or two. We then project what we estimate the total costs are going to be in the upcoming year. There are many, many factors that are taken into account in making those projections or those estimates. While we do not ever purport to know exactly what will happen, we do monitor our estimates carefully and watch from month to month, quarter to quarter.

Our estimates for this upcoming year are based on expected cost increases that the members in the UMP Classic Medicare Plan will have. That's based on costs for a variety of medical services and prescription drugs. Specifically, for the UMP Classic Medicare Plan, over half of the expenses that are covered by that plan, and paid by that plan every year, are actually related to pharmacy, to prescription drugs. We are seeing double digit increases in the costs associated with prescription drugs from year to year. The prescription drugs that are being covered and paid for under the Classic Plan are the most powerful driver of the cost increase. Because the UMP Classic Plan is a coordination of benefits (COB) plan, that means, with Medicare, UMP Classic pays first, we're primary for prescription drugs. With medical, Medicare pays first and then UMP Classic covers largely what is left remaining to the member. That's one of the other factors that contributes to the importance, and in this case, the negative effect of the strong increases in prescription drugs costs.

Betty Anderson-Till: May I ask another question? Does the UMP Classic Plan negotiate with the drug companies over the prices or do they just accept what they are charged from the drug companies?

Kim Wallace: We have a rebate program in place through our pharmacy benefits manager. That is a separate company that specializes in acquiring and administering pharmacy benefits. We do have a very strong rebate program that we participate in that helps us off-set some of the costs. There are a number of other cost management mechanisms that we conduct, that we administer in partnership with them as well. We're constantly looking for ways to moderate the cost increases as best we can. But, clearly, we in Washington and many other states and employers across the country are experiencing this extreme pressure with cost increases. We are looking for even more and better ways to do this in the future. But, despite the myriad of efforts, initiatives, and special programs that we have in place to help with the cost containment, we are still seeing the 10, 11, 12, 13, even 16% to19 % cost increases in prescription drugs each year.

Betty Anderson-Till: More than that in some cases. And there's nothing that can be done about that? There's nothing that we can do to help?

Kim Wallace: Well there certainly are. Dave could probably weigh in about this. There are efforts that we are all aware of that are spreading across the country. Many people are being affected by this and we do what we can as a major purchaser of these services and benefits in Washington. But we do feel that we're caught up in what is essentially a national phenomenon and it's very concerning.

Betty Anderson-Till: Thank you for your answer. I appreciate it.

Kim Wallace: You're welcome.

Dave Iseminger: You know, I did want to give a couple more pieces of context for you and everyone. One of them being that we do leverage our purchasing power with a consortium of drug purchasers. We do purchasing in a consortium with the state of Oregon and we're working on bulk purchasing and leveraging even a larger population to get the best rates that we can on drugs. Another piece is it's the specialty drugs that are part of the phenomenon with drug trends right now. We hear in the news quite a bit about new drugs that are coming out that are very targeted to specific diseases, are very effective, but impact smaller populations. They tend to have a higher cost associated with them. So, that specialty drug trend, even though it is a small proportion of members who are accessing them, it's a larger driver of part of the increase.

The third thing I would add is related to Premium Resolution Number 1 that the Board just voted on. There is a state subsidy that comes to retirees and the Legislature sets parameters for that state subsidy. That state subsidy is something set within the state budget and the Legislature is constantly reviewing that framework. The Legislature sets a scaffold by which this Board then passes a resolution for setting a subsidy for the retiree premiums. That $150 retiree subsidy has been the same level for the last four or five years. That subsidy has remained at that level, but that is another piece when you ask, "What's something that we can do?" The framework for the explicit subsidy is established in the state budget and so that is a piece of this puzzle as well.

Betty Anderson-Till: I know people have problems paying their co-pays and I see these little cards that come in the mail where you can go and get a discount on your prescriptions. But if you have insurance, even if you can't afford the co-pay, you can't use those cards. It's a Catch-22 situation for many people who are retired that they can't make their co-pays and so it makes it difficult for them to get their prescriptions and they can't make their co-pays to go see the doctor either. It's a sad situation and I just wondered how they came to that. That's the largest increase I've had with this particular plan since I entered state service in 1963; and it's the highest increase I've ever seen, especially with all the other taxes that are coming up and salaries are not raised similarly. But thank you. I appreciate your explanation.

Lou McDermott: I'd also like to note that we have many folks who indicated they want to testify and we do have an opportunity at the end to testify. We also have an opportunity during each of the resolutions to testify. So, if you wrote your name down and you would like to testify after the resolution is read, that's fine. You don't have to come up at the end. Or if you want to save it until the end, we can do that as well. I'm assuming you folks know who you are and who said, "Yes, I want to testify." Just know you can do it at different parts of the meeting.

Dave Iseminger: I'm assuming most people probably want to testify with regards to resolution number three. If you're trying to track which resolution relates to which premiums, resolution three is likely the reason that you are here to testify.

Connie Bergener: Actually, it's four.

Lou McDermott: Any other comment from the audience? Any discussion from the Board?

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Kim Wallace: Medicare Premium Resolution 3: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 3: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Kim Wallace: Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Moved. Seconded.

Lou McDermott: Is there any comment from the audience?

Carol Dotlich: Hi, my name is Carol Dotlich and I'm a retiree and a representative of Chapter 12 which is Pierce County Retired Public Employees Group and I have about 456 members. A lot of them can't come to these meetings because they have mobility issues and serious health concerns. They can't come to meetings and speak out about how this premium increase will affect them. But I want you to know that I have members, I called some of them on the phone and said, "What's the impact on you?" I have members who have PERS1. One gentleman retired in 1992 and has been with this UMP plan all this time and it's now 2017 and he tells me he now earns less money per month than he did in 1992, and it's 2017. They haven't gotten adequate increases in cost of living adjustments.

We lobbied very hard and you brought up the subsidy that the Legislature has some control over. We worked very hard, members came to Olympia, lobbied legislators, asked them to please restore the money that they took away in 2011. They took almost $40 away from us in 2011 when the budget was a mess. They were furloughing active people and they cut the subsidy for the retirees. Everyone else got restored; seniors never did. They took the money, they never gave it back. And this session they didn't gave it back either and it was only $30. I mean that doesn't sound like much, but it's huge when you're living on a fixed income and you have serious drug costs, and we do. The formularies change so some of the drugs that we had prescriptions for are no longer covered. They're telling people to go get it over the counter. The over the counter drugs are not the same as the drugs that they were using.

I just need you to know that this impact is very serious and very real. In my case, my husband and I will pay $110 more a month, every month for a year. I don't have that money. I don't know where I'm going to get it from and I'm probably better off than a lot of my members, and that's frightening. When I think about the service that state employees gave through all those years, I mean we never were paid a good salary, an adequate salary for the work that we did. We were always 25% or more below the private sector market for the same jobs. We accepted that because we had good health care, and we knew one day we'd have a pension, and we thought we could retire in dignity. We're finding that's not the case. The costs have gone up for everything from hamburgers to gasoline. A lot of us still have mortgage payments. Our homes are not paid off. We can't afford $55 extra dollars per month per person. It's not reachable for a lot of the members here. As you can see there are about fifteen people that came to say to you we don't have that money. We don't, and there must be some other way. There are a lot of people.

I got a lot of questions from the members I represent, and they wanted to know is there a disparity between the younger people's premiums and the older people's premiums? Is there an "age tax" at play in this premium increase? That's one question.

Another question is, there's been an effort to force people into Medicare Advantage Plans. There's been huge ads and there's been a big push to do that. Are you trying to get people out of the PEBB, out of Uniform? Is that sort of a goal that people have in mind to force people out of the PEBB system and into Medicare Advantage Plans where the Insurance Commissioner has no input or say about what happens with those plans? And so those are two questions I have.

I heard Betty talk about what can we do to reduce the cost? We're doing everything we can. We're trying to be as healthy as we can. We're trying to take the meds that the doctor's tell us to take, in the amounts we're supposed to, when we're supposed to; but I myself, a year ago, I was taking a med every other day that I was supposed to take every day because I didn't have $200 extra dollars a month to pay for that and it wasn't on the formulary so I had to pay out of pocket. Then they gave me another drug that was $300 a month and I just told my doctor that I'm not doing it. I can't do it. So, as you consider this resolution, I want you to know that it has a really severe impact on a lot of people. Thank you for giving me the opportunity to speak and if you could answer those questions about the disparity and about whether or not you are trying to force people into Medicare Advantage, I would appreciate it. Thank you.

Lou McDermott: Thank you for your testimony.

Kim Wallace: With respect to the question about a potential, possible age tax or differentiation in the way that the premiums are set and what goes into them for older members versus younger members in PEBB, there is no specific factor, or adjustment, or special extra amount of money that's added based on age. We do have, as Dave mentioned, a part of our financing approach is that we have what we call risk pools. There are two major groupings or risks, or pools of folks that we use when we look at setting our premiums and rates. There is separation for our Medicare, what we call the Medicare risk pool for those retirees who're eligible for Medicare versus the non-Medicare risk pool, which of course, is those who are not Medicare eligible. What we are doing by creating that separation is that we are measuring and tracking the costs that I mentioned earlier, the costs of all of the services, supplies, prescription drugs, etc. that these two groups of members are utilizing from year to year. We track the costs separately. As you can imagine, in the non-Medicare risk pool, the average age and the age range of the members is lower. They're a younger group.

Dave Iseminger: Kim, who is in the non-Medicare risk pool? That's state agency employees, higher education employees, and those retirees who are not yet eligible for Medicare?

Kim Wallace: Correct. Those folks under 65, who've retired but are not yet eligible for Medicare. If anyone in the room is in that group then you are included, from our financing standpoint, in the non-Medicare risk pool. There is an age differentiation, but we're very careful to assess and evaluate the costs of the care, the services, by pool; and then to do the projections and estimates that I mentioned earlier based on what we see historically happening, and also based on a number of actuarial factors; what we believe will happen for the next year, what those total costs will be over the next year. The premiums that you're seeing here for UMP Classic are the result of that calculation. It is an actuarial, mathematical - as I'm saying that, it feels like cold language and that's unfortunate. But, the calculations are very straight forward. They're complex, but it is an actuarially sound calculation of what we estimate the costs truly to be. There is no additional factor or surcharge that is added to the retiree premium.

Dave Iseminger: We manage those separate risk pools as that's the authority and framework that is set up within statute for this agency. That's why we manage those risk pools; that wasn't a discretionary decision.

Audience: Are dependents included in the non-Medicare pool? Like the youngsters and what not?

Dave Iseminger: And so the question, just so that it's officially on the record is, "How are dependents factored into the risk pools?"

Kim Wallace: The subscriber is the person who defines which pool the person is in. You may have family members on your account, but that account is in the risk pool based on your assignment.

Dave Iseminger: I think the question, Kim, is the claims and risks costs of dependents in the calculation for setting the rates in both the non-Medicare and Medicare risk pools. So yes, the claims analysis in each risk pool takes into account all the experience for all subscribers and their enrolled dependents; separately in the non-Medicare pool and separately in the Medicare pool.

And then the second question from the prior testimony was about the relationship to Medicare Advantage. I think it's important to realize that in these premiums for Medicare there is no subsidization across the plans. Each plan's premium is set based on its own claims experience and so there is not a deliberate choice one way or the other to increase the premium. I think the suggestion was that perhaps there would be a raising of the premium to push people to select other plans. The premium is set based on the claims experience for that plan independent of the others and there's no deliberate mechanism to encourage, in the Medicare plans, enrollment for one or the other. There's no such lever in the Medicare rates setting process.

Kim Wallace: Correct. I agree.

Lou McDermott: Thank you Kim and David. Carol, do you feel like that gave you the answer?

Carol Dotlich: Yes, thank you.

Rudolpho Franko: Yeah, my name is Rudolph Franko, I was a state employee for 33½ years. I retired last August and I probably won't be as eloquent as Carol was, but I do want to tell you that this affects not only me, but a lot of other retirees. We have been giving and giving, in terms of takeaways from this and that and education and we gave $40 away a while back. We were supposed to get it back; we never did and now here we have you asking us to subsidize again the plan by paying another $40. I really resent the fact that you are being asked to fulfil the obligation of the legislators that can't come together and fund these things in a manner that doesn't affect the people at the bottom of the scale. This happens, not just here.

It's happening in city councils in Seattle. It's happening through taxes, whatever. I'm being driven out of my house in Seattle. When I first lived there I was paying around $1,300 in taxes; I'm paying over $5,700 and some cents a year. It's hard to remain calm and not angry and speak eloquently when you're feeling squeezed. But, in saying that, I know that I'm speaking for a lot of people; and for you people here, I don't know how it affects you. I don't know how it affects you at all and I hope it doesn't. But, I would expect that you, as a Board, would hear that this is unjust to ask us to pay for something that clearly the Legislature … you know, we need to prioritize where our money is going. I believe that the legislators need to do a better job of prioritizing where our money is going.

I'm not here to talk about Socialism, but I wish we'd stop that for corporate America and certainly for the state. You give them the money and they take it off to some other place. I didn't come here to say this to you. I didn't come here to berate you or anything like that. But I want you to understand where I'm coming from and I want you to understand that I'm paying $551 right now to keep my state insurance because I got beat up pretty bad at work. I've had a couple of accidents that required that I have neck surgery. I got caught between some trees and a backhoe. The operator wasn't very good and he caught me in there, tore my sternum and all that stuff. I was in the hospital. So, I'm still suffering from that. I've had 1, 2, 3, 4, 5 surgeries; and everytime I have one of those, because I can't prove that they were at work, and every time I try to do that I have to get an attorney and I just gave up on that. So, I have to pay for that, too. It doesn't only come out in terms of premiums, it comes out in terms of my pocket.

I'd like to believe that when I was working I was doing the best job I could and I'm not here to cry foul or anything like that. I'm just telling you that it affects us. It affects us financially. It affects us financially when you have a soda pop. I don't drink soda, but you know some people at the bottom of the scale, it's the people that…I'll leave it at that. But I would hope that you turn this one down.

T Hall: Hi, my name is T Hall. I am a retiree; I am not yet 65. I retired because I got injured off the job doing union business. The 20% increase is ridiculous. Last year when I did my taxes, I had paid out-of-pocket $7,000+ dollars. That's out-of-pocket. That didn't include my medication because, well it just didn't. I didn't have the stats there. That was just my costs for doctor visits. I opted out of the PEBB plans and went to a Medicare Advantage Plan. I saved just premium costs of over $200 a month. The benefits are about the same. They're paying about the same. We'll pay 80%, you pay 20%; we'll pay-you pay 12%, we'll pay the rest. I mean it kind of goes back and forth. There's just not enough money in retirement to pay these dramatic increases in bills from the health care providers. The plans, I mean I understand they're not non-profit, I understand that. But just how big of a profit do they need to make? I mean really? I worked 35 years for the state and when I can get my health care subsidy cheaper somewhere else there's a big problem. There's a very big problem. Thank you.

Lisa Randlette: Hello, my name is Lisa Randlette. I am not Medicare eligible. I do have a procedural question for you in your deliberations today. Seeing that this is a resolution before you, I would appreciate a little more information about what your timeline is for the types of decisions you're making today; and also I'm wondering, in your deliberations, if you choose to not pass this resolution today, what are the options for you and how can we support you in further considering whether or not this is an appropriate increase? Thank you.

Dave Iseminger: I suspected that question might come up today. So thank you for asking it because I did think it was an important one to get on the record. I do say this with the heaviest of hearts as to where we are in our development process for benefits for 2018, the reality is the runway for 2018 benefits is at its end. In order to operationalize any other types of possible changes, none of that would be available for 2018. The reality is if the UMP Medicare Premium is not passed by the Board for the 2018 plan year, there would not be a Uniform Medical Plan Classic offering to the retiree pool. These plans are independent of each other. Those plans that are approved with the premiums by the Board will be plans that are offered for 2018. So the roughly 60,000 members that are in UMP Classic Medicare right now would either have to select another plan offered by the PEB Board, which would be one of the other plans in the premium chart, or they would be able to select a non-PEBB plan. But, importantly, if they were to elect a non-PEBB coverage, they would have to seek deferral of their eligibility for PEBB benefits which would require submitting a form indicating they're going out into the outside PEBB market to be able to maintain their eligibility; and then if they wanted to come back into the risk pool, they would have to show that they met those eligibility requirements during deferral. One of those requirements is continuous coverage. There are certain types of coverage that have been authorized to be in the outside non-PEBB world and that's the unfortunate practicalities of where we are today. If the resolution for UMP Classic Medicare was not approved, that would effectively mean there is no UMP Classic for Medicare for 2018.

Lisa Randlette: Does that mean it has to be decided today?

Dave Iseminger: The question was, "Does this decision have to be made today?" There really aren't other levers that can be pulled to change the information in order to be operationalized for 2018. For example, some of the things that need to be evaluated by the Board for 2019 benefits I've foreshadowed at prior Board meetings, things like:

- Should the non-Medicare covered services that are covered by UMP Classic right now be reduced or eliminated?
- Should there be different requirements on the drug coverage within UMP Classic?
- Should there be elimination of the pharmacy benefit from UMP Classic or a reduction in some of the coverages and creation of a Part D Supplemental plan?

Those are all questions that are in the works for 2019 in response to this. But, the reality is those pieces can't be operationalized to change the world for 2018. There's no other information or circumstances that can be brought back to the Board with a different question. We do have to begin preparing for open enrollment and the materials to push out for retirees for open enrollment. We are at the end of that timeline.

Lou McDermott: Dave, can you talk a little bit about the RDS subsidy as it relates to the explicit subsidy and what we'll be going for next year?

Dave Iseminger: One of the other factors that's happening right now is that we do qualify, as the State, for an RDS refund (Retiree Drug Subsidy). Basically we get a refund because we have qualifying coverage in UMP Classic that is at least as good as, or better than, a Supplemental D plan at the federal level. Because we have that qualifying plan, we receive a refund that goes into the General Fund State account. With the explicit subsidy, we are reaching the pressure point where the state would be at risk for qualifying for that refund. There will be a broader discussion with the Legislature from the Health Care Authority about the implications of maintaining a $150 explicit subsidy going forward and the risk of not receiving that RDS refund in the future. There is that piece that's also in play. But, again, that is not for the 2018 plan year. That would be for 2019 plan year changes.

Gwen Rench: Can I have some clarifications regarding the deferral process? What would be the impact if a lot of people did choose to defer? Are there any grounds for denying a request for deferral?

Dave Iseminger: With the deferral option, the front end is the easier part. Gwen, somebody would fill out the appropriate form that we have on our website. We would be able to convey to our members as to what the proper form is to fill out. They indicate their intent to go out and get non-PEBB coverage and it outlines some of the criteria that they have to meet. Unfortunately, we won't know if they meet those criteria until they ask to come back into the PEBB pool. It's a notification as to what those requirements are to make sure the individual knows what criteria they have to meet and prove whenever they come back in. The denial isn't on the front end for going out for deferral,

it's on the back end coming back into the pool. Someone could be denied if they have a one month break in coverage, a multi-month break in coverage, or they enrolled in a Medicaid Plan; there's very limited options for enrolling in a Medicaid Plan that counts under the continuous coverage rule in the deferral setting. They might not have the right type of coverage; and if they didn't have that coverage, then they wouldn't be eligible to come back in. The whole deferral process fundamentally was set up to be able to anticipate and manage risk on the state's behalf because some people would opt to not be in that risk pool. It's a way for the state and the agency to be able to manage and have more predictive modelling around the risks that exists in that pool.

Gwen Rench: But if 20% of the current UMP Medicare enrollees deferred, would that have an impact on the rates for those continuing?

Lou McDermott: Basically it would not because the premiums are set using the risk pool and using the claims experience that we already have. If 20% would have deferred in the fall, there's no way to go in and adjust the rates to understand that these certain people left and they have a risk profile that looks like this. As a matter of fact, if some of the healthier people were to leave, it would have upward pressure on the rates. If the average person left, it would stay the same. If the sicker population left, then the rates, theoretically, could go down. But, there's no way to make that adjustment on the fly. It would be felt in the next rate setting.

Gwen Rench: Thank you.

Greg Devereux: So, I appreciate Carol and Rudolpho, T Hall, and Lisa's comments. I find it hard to believe that there isn't any leeway in the process. We're three months away from open enrollment and it just seems to me, and I'm not shooting the messenger, Dave, but almost everything you mentioned that we're looking at for next year are things that are taken away from employees. Maybe we, in a very expedited manner, look to see if there is a way to do additional consortium purchasing right now. You know, include more entities in the state, or include folks outside of the state; do something very quickly that could have an impact this year. I can't believe there isn't any time to step back and say, "Is there something that we can do that would alleviate this kind of increase?"

Dave Iseminger: We can go into a couple of different examples. I'll choose one of them. For example, one of the ideas that could be up for discussion with the Board for 2019 is, and I know that this is a takeaway example but its's just an illustrative one from an operational standpoint, if we were to look at changing cost shares of something or eliminating some of the non-Medicare services that are supplementary to Medicare, that would fundamentally be changing the UMP Classic product. We would have to launch a new plan. The question then would be before the Board as to whether that should be for all of UMP Classic or just on the retiree side? You would have to talk about bifurcating the plans between the two risk pools and either creating a new plan or reopening the rates for non-Medicare and establishing what would be the implications on those non-Medicare rates. That's with the underlying assumption that our vendors

are able to implement and bifurcate data streams in those pieces. It starts to get complicated quickly.

Greg Devereux: I understand that this is inconvenient and it would not be easy for the Health Care Authority staff. But as you've heard from the folks, this is a critical piece in peoples' lives; and at the bottom of this is just outright greed by the pharmaceutical companies. At some point, we collectively, and we're not going to get it from D.C., have to take it in the streets everywhere, city by city, and do something to stand up to them. I don't think we're going to get it somewhere else. We have to make a statement to them to say we're not, this is ridiculous; 19 - 16% increases…it's outrageous and surely there's something we can do here in a short period of time.

Lou McDermott: Greg, one of the problems we have is that anytime we want to reduce the premiums, it's going to have an impact in other ways. Either you're going to tell people they can't have this medication but they can have this other medication because it's more cost effective and equally effective, or you're telling people they have higher cost share. That's the only way to make the premium go down. We are leveraging the largest amount of purchasing we can. We've purchased for 360,000 people on the PEBB side; and we're going to be bringing in SEBB, which is approximately another 250,000 people. That might give us some additional leverage in the market. The real lever is that $150 subsidy from the Legislature. We have expressed to the Legislature the impact of not raising the $150. I believe an increase was slated in the House budget, but it did not make it through to the Conference budget.

Greg Devereux: So the bulk purchasing with Oregon is not a result of decreasing folks' premiums? I mean, it's not takeaways? That is, as far as I'm concerned.

Lou McDermott: Oregon bulk purchasing is already baked in.

Greg Devereux: What I'm saying is let's take the pie out of the oven and bake, put something else in quickly and see if there's something we can do. Maybe there's not, but for 24 years I've been on this Board and this is a continuing problem. At some point we have to do something extraordinary to deal with this problem.

Lou McDermott: One of our other constraints is that the manufacturers make the medications, the FDA approves the medications, and we cover the medications, and they get to set the price. That's all there is to it. We don't get to say we're not going to pay for that. As a matter of fact, if we were just to tell drug companies that we're going to pay them 50 cents on the dollar, they would refuse to sell them to us. We would have litigation, litigation would say you must cover that, and you must pay the appropriate price for it. We've already been forced in various litigation efforts to cover medications regardless of cost.

Greg Devereux: I just heard earlier that bulk purchasing has an impact on the cost.

Lou McDermott: We are purchasing in bulk and we're getting the benefit of it. I mean to say that it could be worse is kind of ridiculous. If we were trying to do our purchasing with just our pool it would be worse.

Greg Devereux: Right. That's my point. My point is could we quickly talk to Boeing, talk to the machinists, talk to others, Microsoft, talk to other folks in the state and say is there a way to do bulk purchasing together in this state? Is there a way to talk to other states quickly and say we want to, in addition to Oregon, do bulk purchasing with you? That doesn't take anything away from folks here and then Milliman can bake that into the formula for next year.

Lou McDermott: We do purchase with Oregon now. We are in the Consortium. I don't know what those opportunities would be in order to expand the Consortium's footprint. I would imagine it's a fairly lengthy process, it's complex. People are having to give up their Consortiums that they're in. Many people are in group purchasing already, and to be honest with you, I think the drug manufacturers move that money around the country and they leverage different discounts in different areas. I don't think it matters if you're with a group that purchases for 20 million people, or 25 million people, or 16 million people. At the end of the day, I think you wind up paying approximately the same. You may have a different mix and a ratio of rebates, you may get more of a rebate on drug X and less on drug Y, but when it comes out in the end, I honestly don't think it makes much difference. I hear your concern and I hear that we want to do something. Unfortunately, the one lever that isn't a takeaway lever is the subsidy. We pressed on the subsidy and indicated what would happen if the subsidy didn't increase; and it did not increase.

Yvonne Tate: You know, Greg, I've been complaining about pharmacy costs ever since I've been on this Board, probably 20 years. It bothers me so much that the people we've elected to represent us in Washington, D.C. aren't focused on the real issues when it comes to health care. Pharmacy has been the real issue for a long time. Now I know why they're not focused on that issue; it's because our system is structured in a way that our representatives have to raise so much money to stay in office and where do they get that money from? They get a lot of it from the drug companies. We have got to find a way to change our system. What troubles me the most about all of this is you could go to Mexico or Canada and get the same drugs for little or nothing. There is absolutely something wrong with this system and it's bigger than what this Board can fix, unfortunately. But, none of that really deals with the issue that we have retirees that cannot afford these increased costs. I, myself, am retired. I'm not a part of the PEBB medical system, but I pay more for health care now that I've retired than I ever did when I was working. It just doesn't make sense. I could go on and on, but none of that is going to resolve the issue we have before us today. But, we're seeing how this bigger problem, this national issue, affects all of us on a personal level.

Greg Devereux: Yvonne, you've probably been on longer than I. So I defer to your seniority. And I do appreciate your comments very much. I don't think either that this Board can solve this problem. I do not think that. But I think creative minds, really

sitting in a room, thinking "What can we do? What alternative might there be?" That kind of percolation of brain power, that's what will come up with something. This Board, over the Governor's opinion, voted for domestic partners. This Board pushed transgender coverage. Neither one were easy issues; and I for one am tired of each year saying it's a bigger problem, its big pharma, you know, we can't really deal with it. That's never going to end until some Boards and some people around the country take a stand and say, "Enough is enough." We have to do something else and I don't disagree with you. We should push hard on our elected officials in D.C. We should push on the Legislature here. But the explicit subsidy isn't an answer either. We can keep raising the subsidy forever and big pharma is still going to get their money. We, somehow, we have to deal with that bigger issue … it starts somewhere.

Tim Barclay: Lou, this is Tim, if I may jump in? I agree with Greg. I think as a Board we need to do something. I think it's unfortunate that we sit here today, so late in the process, looking at a 20% increase. I feel like our hands are tied at this point given Dave's comments and I appreciate Greg's desire to find solutions. It has been my experience with this market, those things don't happen quickly. What I would like to see us do as a Board is not just pass this, shrug our shoulders, and then wait until next year. I'd like to see us actively pursuing this, see the Health Care Authority actively pursuing this. And at a minimum, put this on our January agenda, as well as the topic we talked about at the last meeting, and really sit and ask the question as a Board, "What can we do to press this issue going forward," because I agree, increasing the subsidy is a good idea and it will be a helpful thing, but it's not the long-term solution either. So, I would just like to echo my support of Greg's comments. I think we need to, as a Board, find a way to take a stand and make some noise. Let's make sure we put that on our agenda and we do that.

Karen Mork: Hi, I'm Karen Mork, recent retiree and also not under this, however, it's going to be my future. In listening to your conversations I did hear you saying, "Well, oh, we'll have to say we can't cover that," and that you said that pharma is what's really driving this. The Epipen is a perfect example of how that cost has horrendously increased. When there is another one called the Adrenaclick, which you cannot get unless the pharmacist, your doctor prescribes it because it's a two click dispenser. The Epipen is a one click and it's significantly lower. Has the PEBB considered fighting back these pharms and saying, "No we're not going to even allow that?" Who picks the formulary? Can we say, no, we're not going to pay for an Epipen, but we will pay for the Adrenaclick, which is just as good, like you were saying, just as effective? It's just not that name. It would be significantly lower in cost. So, there's that question.

The other question I have is, having worked in the Community Services Office (CSO) with DSHS clients for 36 years, what we see is clients who will use the ER instead. With my seniors we have the spend-down program where you have to meet a specific… I don't know if you are familiar with spend-down? It's basically a deductible program. Some of these people its $5,000-$6,000 because it's a stupid program. No offense, I want to get rid of it. Let's just do like HWD where you pay a premium and what they're doing is going without their meds, going without that stuff until it becomes a catastrophic

event. Now, our medical is having to pay for a catastrophic event instead of paying $50 a month for some meds that would have kept them away from this catastrophic event. Has the PEBB considered that making a change like this is going to stop people from going until they have a catastrophic event and then it's going to be higher costs for PEBB? So, those are my two questions.

Dave Iseminger: One is formulary; the formulary creator. Where to start on the formulary creation? There's a couple different parts of this. The way that the UMP Classic is structured at this point is all drugs that are…it's an open formulary concept and so there are a couple of different players that set up the formulary. First, Board has some jurisdiction over setting up different parameters of the formulary. Earlier this session Donna Sullivan presented about the history of the formulary within the Uniform Medical Plan; and so there are some contours within which the Board can set different parameters around the formulary; and that's one of the things that was discussed a couple Board meetings ago. Several Board members asked some questions and indicated is there a way to pilot that for 2018? As we went through those pieces, that just isn't in the cards for 2018. That is, again, part of the 2019 discussion that we'll be bringing back to the Board. Yes, Tim, it's already on the agenda with regards to retiree plan options. The other parts of the formulary are with the state Pharmacy and Therapeutics (PNT) Committee. There are various committees that review the evidence-based basis and effectiveness of various drugs, and those decisions are recommendations for how drugs are paid for once they are approved in a plan. There's a couple of different pieces that come together for creating the formulary. Is there anything, Kim, that you think can be added to that?

Kim Wallace: No, but I do want to confirm and recognize that the Board did receive information, I believe it was in April; and so there is a commitment that the Board made and the HCA staff are well aware of and have started to put into motion to evaluate appropriate and helpful changes potentially to the formulary for 2019. Again, the spot we got stuck on was in whether any of those changes could be made for 2018. We learned by consulting with a number of different people and partners that would be required to cooperate and to be able to move quickly with us in order to enact changes to the formulary for 2018, that it was not possible. That's why it was immediately put on the priority list for 2019.

Lou McDermott: Karen's second question was related to extraordinary medical expenses incurred because pharmaceuticals weren't being utilized appropriately because of cost.

Karen Mork: That's something I see where $50 a month turns into a $300,000 hospital bill.

Lou McDermott: The thing with this plan in particular is that it's weighted so heavily towards pharmacy and pharmacy changes have an impact. In some strange world, if everybody stopped taking their drugs and all of the costs were born on the medical side, these premiums would go way down because they are disconnected; because Medicare

is primary and they're taking care of hospital and the medical stuff. What you are talking about is a capitated world where you're saying we give the delivery system x-number of dollars and we say do good things, take care of these patients, take care of our members; and therefore, it's in their best interest to make sure they're maximizing their efficiency so that they're using pharmaceuticals appropriately, they're using the medical stuff appropriately, they're using hospital care appropriately, and they're trying to stay below a bottom line. We are trying to implement that through our accountable care product for active state employees. We went live January 1, 2016 and we're monitoring that program. We're trying to determine:

- How well is it working?
- What are the outcomes?
- Are people getting better care?
- And, if that's the case, how do we spread that through other products?

We have fully insured products and we have our self-insured product. Unfortunately, our self-insured product is a wide-open Preferred Provider Organization ((PPO) which allows people to do what they want to do; go to the ER when they want, whatever they want to do. We are going in that direction, but it takes time to evaluate these programs and to spread them to other products.

Greg Devereux: There have been a number of references to the earlier discussion with the Board regarding the formulary. As I remember it, that discussion started with talking about a closed formulary and that makes the hair on the back of my neck go up, to start with a closed formulary. I see takeaway right away. I don't have any problem talking about formulary, and I think I told you that at the time, Lou, and I will be very active in that process. I think we should look at these drugs and see if there are alternatives and other ways to do things; but I just want to note that I remember it as a discussion about a closed formulary and I think that's not the best way to start that discussion.

Lou McDermott: I think that closed formulary is a typical description that's used to say you're not going to cover certain things, but you're going to cover other things. I think at the end of the day we don't want to go to a system where we're just saying, "For these conditions it's one medication, and for another condition it's one medication." We have members on anti-seizure medication, we have cancer medications; we have a lot of different medications and therapeutic classes. What we do what to do is address the Epipen-type issues within. Now, are there enough of the Epipen issues within the total dollars to have a substantive impact on the rates? That analysis is complex, a heavy lift, and being undertaken by our pharmacists and our Pharmacy Benefits Manager (PBM). There are over 20,000 members who are taking medications.

When you have a certain condition, there are multiple medications. We have a lot of members who are taking the higher cost medications, so back to Greg's point, we don't want to just slam the door and say tomorrow you get a letter in the mail that says you're no longer allowed to take this. The trick is how do we implement something like that where it makes sense; where we say to the Epipen, we're not going to do that anymore

because that's crazy; paying $600 for an Epipen, we're going to do the alternative. If there's a medical reason why that alternative doesn't work, then you can use the primary medication. There's a lot of complexity there. I think closed formulary is not an accurate description of what we want to do. I think it's something for people to recognize that it's just not a wide open formulary anymore.

Kim Wallace: I want to confirm that when I mentioned the earlier presentation by Donna Sullivan, it absolutely included alternatives or different scenarios that are not a completely closed formulary. When I referenced the thinking, the work and the analysis that HCA staff are teeing up with respect to changes in the formulary, it is absolutely not limited to a closed formulary solution.

Greg Devereux: I understand that, but as I remember it, the words "closed formulary" were on the page**.**

Kim Wallace: Yes, it was, and hybrid formulas as well.

Greg Devereux: Yes, but words matter.

Kim Wallace: Yes, I acknowledge that.

Denny Johnston: My name is Denny Johnston. I'm a retired public employee living here in Olympia. I just wanted to say that the people's comments so far have been excellent. I think by now you are fully aware, if you weren't already, of the pain this is going to cause people. I particularly enjoyed Mr. Devereux's comments. I appreciate your distaste for the use of the word "can't" because I think we can always do things. I think we need to do more though. When we ask people for a rate increase such as this I believe we have a moral obligation to do everything possible to mitigate that increase; and to go a little bit further down the road than Greg went, I think we need to look long range at this. Years ago we declared war on the illegal drug trade and I think it is time that we declare war on the legal drug trade. Pablo Escobar, in his wildest dreams, could not imagine what the pharmaceutical industry has been able to do. If he were still with us he would look upon it with envy and say, "Why didn't I think of that?"

Other states are much more active, perhaps, than we are. California had an initiative last year that failed at the ballot, but it would rein in the pharmaceutical industry. The pharmacy industry had to spend $102,000,000 to defeat it compared to $19,000,000 for the proponents of that initiative. Ohio is considering something along the same lines. California is pending a Senate Bill 482 which would establish a state monitoring system for prescription drugs, take away the heavy-duty opiate drugs, prevent doctor shopping, and other things like that. Other states are involved here, including here in Washington, Everett and/or Snohomish County has filed suit against Purdue Pharmaceuticals for basically pushing hard-core pain drugs on its population. We can go anti-trust suits, legal pressure, bulk purchasing, and negotiating. I appreciate what we do in that regard already. There are four states that have caps on drug co-pays for those people who haven't exhausted what they are obligated to do for out-of-pocket expenses. I think

when I say we have a moral obligation, I think I do, I think the Health Care Authority, the PEBB, the Governor, the Legislature, the Attorney General's office, and many others need to work in this effort of perhaps not on this particular increase here, but on increases that we're going to experience down the road if we allow things to continue as they have gone. I could go on. Thank you.

Lou McDermott: I think we need to get you down to the Legislature to testify. I think that was excellent.

Tom Ripley: Hi, I am Tom Ripley, a retired public employee. Both my wife and I went into service of the state to, as with our own, because of social commitment. We've worked hard and she a retired teacher. I've retired from DSHS Children's Services and what I find at this point is that we're really heavily burdened with our own medical expenses for drugs and for other things, and this is another add on that makes it more difficult for us. When I retired from DSHS, at that point we had not had a raise for the better part of a decade and that affected my retirement amount, of course, and my wife had also not seen much in the way of increases. That also reduces our financial abilities to pay things. It's just a hard thing to swallow to see a 20% increase at this point. I don't know where the money will come from quite honestly. I appreciate what you do to work on that. I think that we, you know, as we've been committed to social justice, I know that you folks are too, and I hope that you will work your best to figure out a solution to this so that we're not faced with the same situation year after year, decade after decade. The one question I did have, is obviously the large increase here is with Uniform as opposed to Kaiser. I would like an explanation why we have such a large increase in Uniform and why is that much more than Kaiser? Thank you.

Kim Wallace: Thank you for your question. I can share that while we don't have all of the details on the rate development assumptions that go into the final proposed rates and negotiated resulting rates with Kaiser Permanente of Washington and Kaiser Foundation Health Plan of the Northwest, what we do know is that we negotiate hard to do everything we possibly can to maintain flat premiums every year. One factor that plays into their rates and premiums that is very different than with UMP Classic is that they receive, because of the type of Medicare plan that they are offering, Medicare Advantage Plans, they do receive a set amount of money directly from CMS, a subsidy from CMS that goes into their consideration and it's a sizable amount of money, several hundred dollars per month; and so that CMS subsidy and all the rules in the setting of that amount, together with $150 Medicare explicit subsidy, together with the amount that's paid by the retiree directly, is the amount of money that they are actually receiving to offer to run their plan and to offer their plan. It's a fundamentally different financial scenario than the Uniform Medical Plan Classic COB plan that's self-insured by the state.

Katy Hatfield: I heard someone asking quietly in the audience, "What is CMS?"

Kim Wallace: The Centers for Medicare and Medicaid in the Department of Health and Human Services in the federal government. Basically, the headquarters, the

administration, administrative body that runs Medicare and Medicaid and it's shortened to CMS rather than CMMS.

T Hall: I just have one question. What happens if you don't endorse? You're basically hearing from us we don't want you to endorse it. So what happens if you don't endorse it?

Lou McDermott: Basically, the product would not available for 2018.

T Hall: The whole Uniform Medical Plan would go away?

Lou McDermott: That particular product goes away. Not the the Uniform Medical Plan as it relates to active employees, but this particular product for retirees would not be available for 2018.

Dave Iseminger: And for the record, the question was, "What would happen if this resolution were not passed by the Board?"

Lou McDermott: Other questions or comments from the public? From the Board?

Greg Devereux: I guess sometimes it seems to me that when there is a crisis answers are born from that crisis. I understand what it would mean to vote it down, but I wouldn't mind the opportunity to go to Governor Inslee and say let's really think about is there anything we can do quickly that would change this outcome and make it a real focus of the administration?

Lou McDermott: I guess my thought is it's not one or the other. It can be both. We can carry the resolution and we can still approach the Governor. All of the testimony that's been given today has been recorded and will be transcribed into a document which the Board will approve as minutes and we can bring that forward to the Governor and key legislators for review.

Yvonne Tate: I just wanted to say, speaking for the Board, I'm sure we really appreciate having you all here. Your public comment to us helps enrich our decision making. Our meetings are always open to the public and I would invite you to come any time you choose because we are deciding on your behalf. It is very, very helpful to hear from you. Thank you.

Gwen Rench: I will be voting no as this increase harms retirees with limited income and I feel like it enables the excessive profits of the pharmaceutical industry; and because of those two reasons, and the fact, of course, no cost of living increase for people of limited income for many years, I feel obligated to vote no.
(Applause)

Myra Johnson: As a non-voting member on this Board, I would like to piggy-back what Yvonne said and I thank all of you who've come in and testified today. I will be retired

one day soon, probably, and so I do appreciate where you're at because I will be there. I also know that as a member of this Board, while I may not vote, your words are definitely heard and I truly believe that everything will be done to make sure that hits like this aren't taken lightly. I think times are hard. I work in the school district, and so I understand not having a cost of living. I too bring home less than I used to. So, it's real and we do hear you. I'm not sure how this vote will come out, but please be assured that your words are not taken lightly and it will be negotiated and talked about with this Board and the work that the HCA does. So, thank you for your comments.

Dave Iseminger: Lou, I did just want to add for the record that it's not typical that we get a lot of correspondence to the Board that is directly lobbying the Board for one action or another. Usually it's questions that the staff can answer and then give a copy to the Board as to how the staff responded. I did want to note for the record that in the last 48 hours, there were four different emails sent to the Board Correspondence Mailbox that were more directive, please vote no. I wanted that to be noted for the record that there were a few that came in over the past couple of days in addition to the people that have come today.

Gail McGaffick: Thank you, Mr. Chair. Gail McGaffick. I'm a PEBB subscriber through my husband who is retired. Thankfully, I'm not retired because of these sorts of increases, but I want to say this. I think you're in a really tough place and I would not like to see the UMP Classic Medicare go away. I do not want to be a part of Kaiser. I do not want to be a part of a Medicare Advantage Plan. Having said that, I know you're in a tough place. What I would like from the group because you landed in this place because you started talking about it in April. I'm kind of curious about how your meetings go. Having said that, I'm super impressed with all of you; how well you listen, how you conduct your meetings. As a lobbyist myself, I sit in a lot of meetings and I'm just so impressed with how you do business.

I would like to suggest that this issue is so big and so important that you not put off until January talking about this. That you revisit how you schedule your meetings and perhaps look at what kinds of things you can tee up now to be sure you are well prepared to do the type of work that Greg, Yvonne, and Gwen, I mean all of you have, pardon me if I say your first names, that all of you have talked about. I mean it really is time, I think, to look at different solutions here. I mean this is not tenable; but having said that, at the end of the day, I still, I guess I'm speaking as someone who would still like this plan over the others as bad a choice as it is, and I mean for the large increase in premiums. So, that's what I wanted to say and I thank you very much for listening.

Greg Devereux: I agree with Gail. I would not want to see the Uniform Plan not available this year. I think voting it down today doesn't necessarily mean that it has to go away this year. I can't believe there isn't some leeway in the process that would give us some time to look at alternatives.

Carol Dotlich: I'm Carol Dotlich. I have a question. I don't know how the vote will end up among the Board members, and I don't know how far the testimony given today will

travel. So my question to you is, you've had quite a turnout to this meeting. Obviously people are very, very concerned about what is going on. Will somebody be relaying the objections to the insurance company? And let them know how very unhappy we are about a 20% increase? Will there be some message to UMP to let them know that this is damaging to us?

Lou McDermott: The strange thing in this case is that we are UMP. It's a self-insured plan.

Carol Dotlich: Oh. (laughing)

Lou McDermott: So we have told ourselves about this. (Laughter) We are not happy, and I think this gets back to the Board's schedule and the rates; and without going into excruciating complexity, some of the issues we have is that it takes a long time to implement a change. A change in our plan normally takes about 18 months. There's also rate setting activities which are done on an annual basis. There's a legislative process which occurs every January. It's all a delicate balance between the Governor's office, the Legislature, the claims experience, the rates setting, and the timing that those things happen in. Part of the problem is that we don't know there's a problem until we start getting into rate season, until the numbers start coming in and we start looking at that experience. You can't look at January 1 and say how did last year go? You have to wait until March, April, and May to wonder how last year went.

Carol Dotlich: If you called, my house, I'm happy to tell you how last year went.

Lou McDermott: I understand. On an aggregate basis with the population, a little more difficult, and so part of our issue has been that there is a delay in action occurring because of these cycles and when people do their thing. When the Legislature comes to town, when they produce the budget, when we begin to evaluate the rates, when we begin to evaluate new ideas for plan design changes; and so unfortunately, there is a lag in that whole process. This year when that experience came in and we discovered there was going to be a large increase, I can let folks know we didn't just say okay, well, I guess that's how it is. We worked all of the avenues we felt were available to us. We communicated clearly with the Legislature to indicate the impact of the change. We did a lot of activities to try and offset the increase and we were unsuccessful. It was a brutal legislative season and they almost didn't get out of town with a budget. They had the McCleary Decision over them. They had a lot a financial issues they were dealing with; and so unfortunately, they did not resolve this issue with one of the levers that is available.

Carol Dotlich: I would like to leave you with one word. I watched the news more than I used to since it's available to me and there's a program, I think it's "The Last Word of the Day," and I think the word you used is prefect for us to share with you and that word is "excruciating" because this is financially excruciating.

Lou McDermott: I understand.

Carol Dotlich: Thank you.

Lou McDermott: Thank you. Would anyone else like to say anything? We will do a roll-call vote on this resolution.

2018 Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Moved. Seconded. Approved.
Voting to Approve: 5
Voting No: 2

Yes: Tim Barclay, Mary Lindquist, Yvonne Tate, Marilyn Guthrie, Lou McDermott
No: Gwen Rench, Greg Devereux

Lou McDermott: 2018 Medicare Premium Resolution 4 passes.

I voted yes, but I will commit to working with the Governor's office and our Legislature so that they fully understand the impact of their decision, the impact of the pharmaceutical increase, and the impact to our members. I will provide them with the testimony that was given today.

Kim Wallace: 2018 Medicare Premium Resolution 5: Resolved, that the PEB Board endorses the Premera Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 5: Resolved, that the PEB Board endorses the Premera Medicare premiums.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Lou McDermott: 2018 Medicare Premium Resolution 5 passes.

2018 PEB Board Meeting Schedule

Dave Iseminger: There is one slight change on this schedule from what I presented a week ago. A June 7, 2018 meeting was added to the list. As we've been talking about all the work before the Board and the delicate conversations that we need to have, we wanted to build in some extra flexibility, pre-planned, for having more discussions during the procurement season. So we added that date to the agenda. I will highlight because this question and the topic was breached during the testimony a little while ago. These are just the pre-planned regularly scheduled meetings. This does not mean that, if necessary, the Board can't be called for a special meeting. The Open Public Meeting Act does have a mechanism to have special meetings. It just requires additional

notifications and pieces to have additional meetings of the Board. These are just the pre-planned meetings of the Board that make us all aware of the dedicated times that we're already thinking we need to meet. But if there is the need, the desire, and issues pop up, we can have the Board meet additionally. I just wanted to highlight that in addition to these regularly scheduled meetings.

Lou McDermott: It's the time for public comment if. Is there anyone that feels like they would like to testify and didn't get an opportunity?

Gail McGaffick: Mr. Chair, I would like to testify.

Lou McDermott: Absolutely, come on up.

Gail McGaffick: Thanks again, Mr. Chair, committee members. Gail McGaffick. You may recall a year ago I called you up and wondered about the increase in this same plan and my question was around the fact that I didn't think there was very much information in the explanation that went out to members as to why there was an increase. I guess what I would like to suggest is two things: one is to increase the amount of information that goes out so that people understand exactly what's going on, what's driving the increase; and then the other piece is I'm really a big believer in maximum information out to people and education about what they can do. I think the Epipen example was a really good one. One that I didn't know about because thankfully, knock on wood, I don't need to buy one. But I wonder if there could be some sort of outreach by PEBB to people really educating them and informing them about medications, about different choices, maybe even about here are the questions you should ask your prescriber because I think we all need to be more empowered in this. I think you all play such a special role because of the HCA and all the staff you have and your pharmacy benefit manager, all your specialized expertise, so I would just like to encourage more information and more outreach to help teach all of us how we can be as responsible as possible, and to not take anything from all of the other suggestions about dealing with pharmacy costs but...

Lou McDermott: One of the initiatives that we're embarking on is the health literacy initiative.

Gail McGaffick: Wow, I love that.

Lou McDermott: We are trying to communicate with members. We're in a little bit of a predicament sometimes because we are the employer as well.

Gail McGaffick: Sure.

Lou McDermott: And we don't want members feeling like we're looking over their shoulder knowing what medication they're on, making suggestions to them; but we do want members to understand that there are other therapeutic options that could be far less financially burdensome. It's walking that fine line. For every call we get for

someone being thankful that an alternative was suggested, we get a similar call asking, "Why are you looking at what medications I'm taking and why are you contacting me?" So it is a fine line. I do think it's something that we may just have to take more of a risk and on the side of getting people upset. Informing people of these things, Epipen is a great example of that.

Gail McGaffick: Well, I hadn't even really thought about it from that kind of drill down level into one individual. I can certainly see the push-pull of that. I was thinking of it actually a little more globally because I was taken with the comment that one individual made on one type of pill. $200 a month and her physician wants to give her one at $300 per month. Well, what are the kinds of questions we could all be teed up to ask in those types of situations and how might we be able to do research or get more information. Just kind of more in that generic sense of places to go, maybe a web page, assuming there's so much online now. I appreciate you listening; and again, I had the privilege of sitting in about four of your meetings and have just very much enjoyed it and I'm so impressed with how you conduct your business. Again, I'm so grateful that my husband went to work for a community college and I got to be covered under this plan. Thank you so much.

Lou McDermott: Thank you for your comment.

Betty Anderson-Till: I would like to ask one more question. The Insurance Commissioner's Office has a program where the people come out and speak about the benefits, explain everything. Do you work in connection with those people so that you get stories along the way so that you can let the Governor's Office know about what's going on as far as health care and all the problems that they see every year? Because we certainly see a lot of them and decisions that are made that make absolutely no sense.

Lou McDermott: We do have numerous Benefit Fairs we run every year around open enrollment.

Dave Iseminger: We do between 20-25 Benefit Fairs throughout the state.

Lou McDermott: At Benefit Fairs we get an opportunity to interact with our members. We also, because we're all state employees, get the stories from our friends, family, and each other. We all talk to each other. We all work in the same building with folks who administer the Medicaid program so we hear from them. We get complaints that come in, the retirees who call in those complaints are logged and so we keep track of them and try to prioritize those issues. We know how many complaints we get and on what topics. Maybe our website isn't clear; maybe this information hasn't gone out? We do try and collect that information and do something productive with it.

Betty Anderson-Till: Do you collect it from the Insurance Commissioner's Office? I heard a presentation they gave and they have a rather unique approach to things.

Some of the problems they've run into and the things that they've dealt with is very impressive and I think they're a good group to work with.

Lou McDermott: We do have meetings occasionally with the OIC. Maybe we can bring that up with them and ask them to have some of those folks talk to us.

Betty Anderson Till: Thank you.

Greg Devereux: I just want to follow up to Gail McGaffick's earlier comment about how this is so important we shouldn't wait until January. I'm not a proponent of more meetings, but I really do think pharmacy is at a critical stage and we can't keep saying we can't do it by ourselves; we can't do anything. I think we really need to dig in and think about what we can do with other folks to make a difference and waiting until January might not be a good idea.

Dave Iseminger: I think it's fair to say as we're diving into different pieces and to be able to present to the Board, it's not, with all diligence, and if there's the ability to call a special meeting and we feel we have enough information to be able to begin that next stage, then we'll certainly consult the Board to convene a special meeting.

Lou McDermott: I think it's fair to say that we have already started work on 2019. As we finish up the vote for 2018, the work already begins on 2019. The work groups are formed, the analyses are being done, the legal impacts are being identified. So all that work is being done. It's sort of pre-packaged and ready to go for the January Board meeting. But, if we want to have an earlier Board meeting sort of mid-flight and talke about where we are on those things, we can definitely share that with the Board. I think we can make something happen in that arena.

Other comments from the Board? Last chance audience? This is our final Board meeting for this season and next year's schedule is in the notebooks. Our next planned meeting is at the retreat on January 31, 2018. The caveat is we may have some fall meetings prior to the Governor's budget going in that's where we put a lot of the cost implications for changes that we're going to make going to the Governor's budget and we'll see if we can have a meeting prior to that.

Meeting adjourned at 3:20 p.m.