

# **Public Employees Benefits Board Retreat**

**January 31, 2018**

## Public Employees Benefits Board

January 31, 2018

9:00 a.m. – 4:00 p.m.

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

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**TAB 1**

**Public Employees Benefits Board Retreat**  
**January 31, 2018**  
**8:30 a.m. – 4:00 p.m.**

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

8:30 a.m.	<b>Coffee</b>		
9:00 a.m.	<b>Welcome Introductions and Purpose</b>		Sue Birch, Chair
9:15 a.m.	<b>Retreat Overview</b>		David Iseminger, Director Employees and Retirees Benefits Division (ERB)
9:20 a.m.	<b>Retiree Health Benefits</b>	TAB 3	Kim Wallace, Deputy Section Manager Financial Services Division Lauren Johnston, ERB Division
10:20 a.m.	<b>UMP Value Formulary</b>	TAB 4	Ryan Pistoressi, Assistant Chief Pharmacy Officer, Health Care Authority
11:30 p.m.	<b>Developing Premiums</b>	TAB 5	Tanya Deuel, Fiscal Information and Data Analyst, Financial Services Division
12:00 p.m.	<b>Working Lunch Set Up</b>		
12:15 p.m.	<b>UMP Utilization and Cost Review – Medical and Pharmacy</b>	TAB 6	Karin Freeman, Fiscal and Data Analyst Financial Services Division
1:15 p.m.	<b>Managed Care Plan Role in PEBB Benefits</b>	TAB 7	Fred Armstrong, Sr. Director of Strategic Accounts, Kaiser WA Bill Ely, VP, Actuarial Services, Kaiser WA
1:55 p.m.	<b>Break</b>		
2:10 p.m.	<b>Overview of Benefit Changes Proposed for 2019</b>	TAB 8	Beth Heston, Procurement Manager Employees and Retirees Benefits Division
2:35 p.m.	<b>Priorities for Benefit Design Changes – Plan Years 2020- 2021</b>	TAB 9	Marcia Peterson, Manager Benefits Strategy and Design Section
3:05 p.m.	<b>School Employees' Benefits Status</b>	TAB 10	John Bowden, Manager School Employees Benefits (SEB) Section
3:35 p.m.	<b>Legislative Update</b>	TAB 11	David Iseminger, Director, ERB Division
4:00 p.m.	<b>Adjourn</b>		

## PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8 <sup>th</sup> Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 <a href="mailto:sue.birch@hca.wa.gov">sue.birch@hca.wa.gov</a>	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 <a href="mailto:greg@wfse.org">greg@wfse.org</a>	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma WA 98408 V 253-583-5353 <a href="mailto:mljohnso@cloverpark.k12.wa.us">mljohnso@cloverpark.k12.wa.us</a>	K-12 Employees
Carol Dotlich 8312 198 <sup>th</sup> Street E Spanaway WA 98387 V <a href="mailto:wfsecarol@comcast.net">wfsecarol@comcast.net</a>	State Retirees
Vacant	K-12 Retirees

## PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170 <sup>th</sup> ST Kenmore WA 98028 V 206-819-5588 <a href="mailto:timbarclay51@gmail.com">timbarclay51@gmail.com</a>	Benefits Management/Cost Containment
Yvonne Tate 1407 169 <sup>th</sup> PL NE Bellevue WA 98008 V 425-417-4416 <a href="mailto:ytate@comcast.net">ytate@comcast.net</a>	Benefits Management/Cost Containment
Vacant	Benefits Management/Cost Containment
Harry Bossi* 19619 23 <sup>rd</sup> DR SE Bothell WA 98012 V 360-689-9275 <a href="mailto:udubfan93@yahoo.com">udubfan93@yahoo.com</a>	Benefits Management/Cost Containment
<b>Legal Counsel</b> Katy Hatfield, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6561 <a href="mailto:KatyK1@atg.wa.gov">KatyK1@atg.wa.gov</a>	

\*non-voting members

1/25/18



Washington State Health Care Authority  
*Public Employees Benefits Board*

P.O. Box 42713 • Olympia, Washington 98504-2713  
360-725-0856 • TTY 711 • FAX 360-586-9551 • [www.pebb.hca.wa.gov](http://www.pebb.hca.wa.gov)

**2018 Public Employees Benefits Board Meeting Schedule**

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8<sup>th</sup> Avenue SE, Olympia, WA 98501. The meetings begin at 1:30 p.m., unless otherwise noted below.

January 31, 2018 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 21, 2018

April 25, 2018

May 21, 2018

June 7, 2018

June 20, 2018

July 11, 2018

July 17, 2018

July 25, 2018

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

Updated 7/21/17

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: August 01, 2017**

**TIME: 1:51 PM**

**WSR 17-16-148**

**TAB 2**



## PEB BOARD BY-LAWS

### **ARTICLE I**

#### **The Board and its Members**

1. **Board Function**—The Public Employee Benefits Board (hereinafter “the PEBB” or “Board”) is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB’s function is to design and approve insurance benefit plans for State employees and school district employees.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Non-Voting Members**—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.
5. **Privileges of Non-Voting Members**—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.
6. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

### **ARTICLE II**

#### **Board Officers and Duties**

1. **Chair of the Board**—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board’s By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.
2. **Other Officers**—(reserved)

**ARTICLE III**  
**Board Committees**

**(RESERVED)**

**ARTICLE IV**  
**Board Meetings**

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.
6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

**ARTICLE V**  
**Meeting Procedures**

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.
4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .
6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.
8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.
9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.
10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

**ARTICLE VI**  
**Amendments to the By-Laws and Rules of Construction**

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

**TAB 3**



# Retiree Health Benefits

Lauren Johnston, Employees and Retirees Benefits Division

Kim Wallace, Financial Services Division

January 31, 2018



# Retiree Health Plan Coverage

There are a number of health plans available to retirees, and a number of ways to obtain/purchase them. A retiree can obtain/purchase health insurance through:

- Their employer (PEBB-Sponsored group coverage)
- Medicare
- Medicaid
- Commercial health plans
- An exchange (federal or private)

## Health plans available to PEBB Program retirees:

Non-Medicare Retirees	Medicare Retirees
PEBB-sponsored group coverage	PEBB-sponsored group coverage
Individual purchased health plan	Medicare Parts A and B
Medicaid	Medicare Advantage (Part C)
	Medicare Part D (prescription drug coverage)
	Medicare Supplement Insurance (aka Medigap) Plans (Plans A, B, C, D, F, G, K, L, M, N)
	Medicaid

# Plan Descriptions

Plan Type	Description	PEBB Offered Plans
PEBB-sponsored group coverage	Group health plans that are purchased and coordinated by the Public Employees Benefits Board (PEBB) Program for eligible public employees, retirees, and dependents. (Includes COBRA coverage)	4 Carriers 15 Plans
Original Medicare	Traditional fee-for-service program offered directly through the federal government. It includes Part A (inpatient/hospital coverage) and Part B (outpatient/medical coverage).	N/A
Medicare Advantage Plan	Also referred to as "Part C" or "MA Plans." Plans are offered by private companies approved by Medicare. If you have a Medicare Advantage Plan, you receive your Part A and B coverage through the MA Plan, not Original Medicare.	2 Carriers 2 Plans
Medicare Part D Plan	Also referred to as the Medicare prescription drug benefit, this plan is offered by the federal government to subsidize the cost of prescription drugs and prescription drug insurance premiums.	All PEBB plans (except Plan F) have <b>creditable drug coverage</b> . Not separately offered through PEBB.
Medicare Supplement Plans	Also referred to as Medigap plans, they are various private health plans sold by private companies that have been approved by Medicare. These plans are to supplement a retiree's Original Medicare (Medicare Part A and Part B).	1 Carrier 1 Plan
Medicaid	Health care program funded primarily by the federal government, but run at the state level. The program provides health care coverage for families or individuals who meet certain income criteria.	N/A



# PEBB Retiree Medical Benefit Offerings

## Non-Medicare Retiree Subscribers

Plan Name	Plan Type
Kaiser NW Consumer Directed Health Plan (CDHP)	PEBB–sponsored group coverage plans
Kaiser NW Classic	
Kaiser WA CDHP	
Kaiser WA Classic	
Kaiser WA SoundChoice	
Kaiser WA Value	
Uniform Medical Plan (UMP) CDHP	
UMP Classic	
UMP Plus – Puget Sound High Value Network	
UMP Plus – UW Medicine Accountable Care Network	

# PEBB Retiree Medical Benefit Offerings

## Medicare Retirees\*

All are PEBB-sponsored group coverage plans

Plan Name	Plan Type
Kaiser WA Medicare Advantage Plan	Medicare Advantage Plan (Part C)**
Kaiser WA Classic (Original Medicare Coordination of Benefits)	PEBB-sponsored group coverage plan**
Kaiser NW Senior Advantage Plan	Medicare Advantage Plan (Part C)**
UMP Classic Medicare	PEBB-sponsored group coverage plan**
Premiera Medicare Supplement Plan F	Medicare Supplement Plan

\*Subscribers, spouses, and dependents who are not Medicare eligible are enrolled in non-Medicare plans, therefore, creating split accounts.

\*\*Includes Part D creditable drug coverage.

# Retiree Health Plan Enrollment

Medicare Retirees	Total Members
Kaiser Permanente NW Senior Advantage Plan	2,474
Kaiser WA Classic (Original Medicare COB)	444
Kaiser WA Medicare Advantage	22,677
Kaiser WA SoundChoice	21
Kaiser WA Value	392
Premera Blue Cross Medicare Supplement F	13,579
Uniform Medical Plan Classic	52,907
<b>Total</b>	<b>92,494</b>

Non-Medicare Retirees	Total Members
Kaiser Permanente NW CDHP	13
Kaiser Permanente NW Classic	199
Kaiser WA CDHP	45
Kaiser WA Classic	1,100
Kaiser WA Medicare Advantage	1
Kaiser WA Sound Choice	68
Kaiser WA Value	1,197
Premera Blue Cross Medicare Supplement F (includes disabled members)	362
UMP Plus-Puget Sound High Value Network	59
UMP Plus-UW Medicine Accountable Care Network	136
Uniform Medical Plan CDHP	243
Uniform Medical Plan Classic	6,576
<b>Total</b>	<b>9,999</b>

Total enrollment 102,493

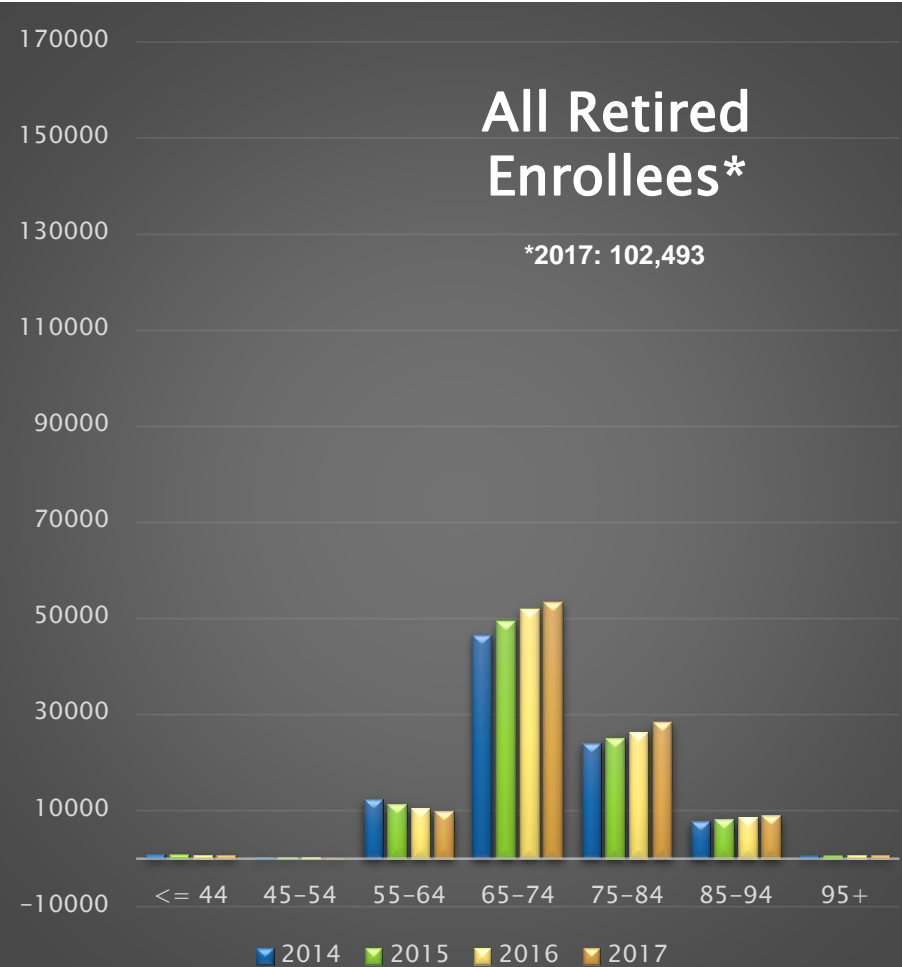
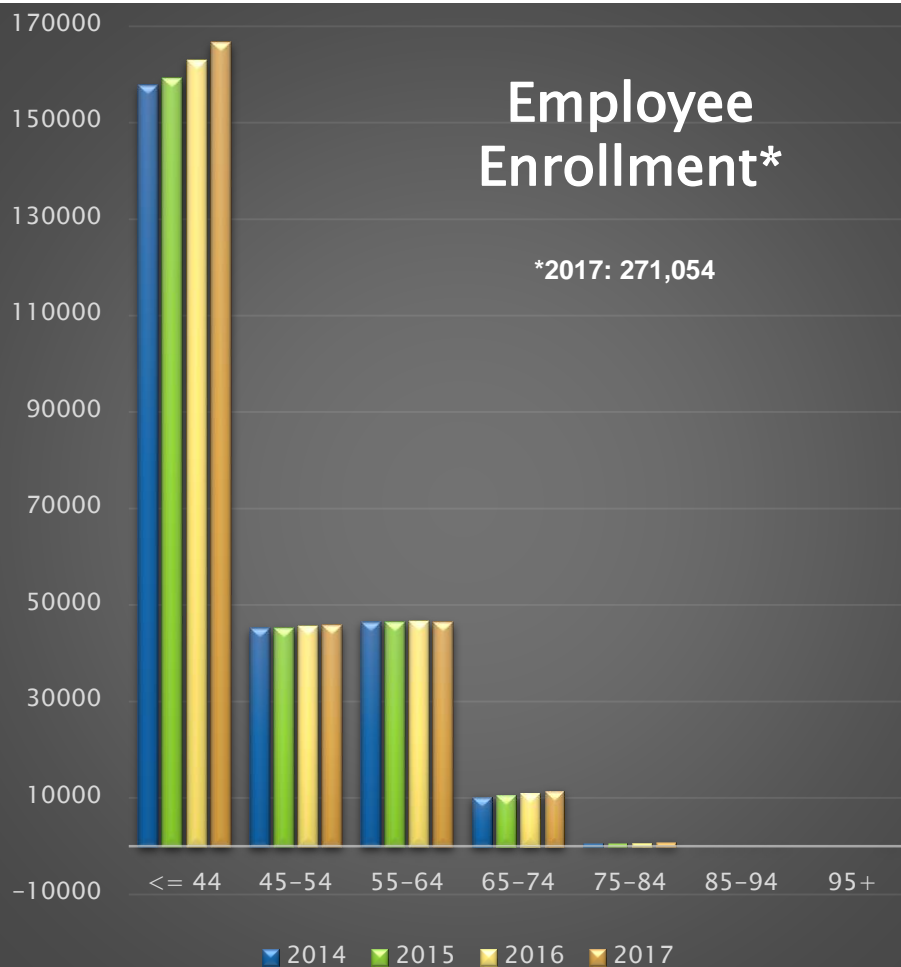
# Retiree Age Cohorts

## Non-Medicare and Medicare

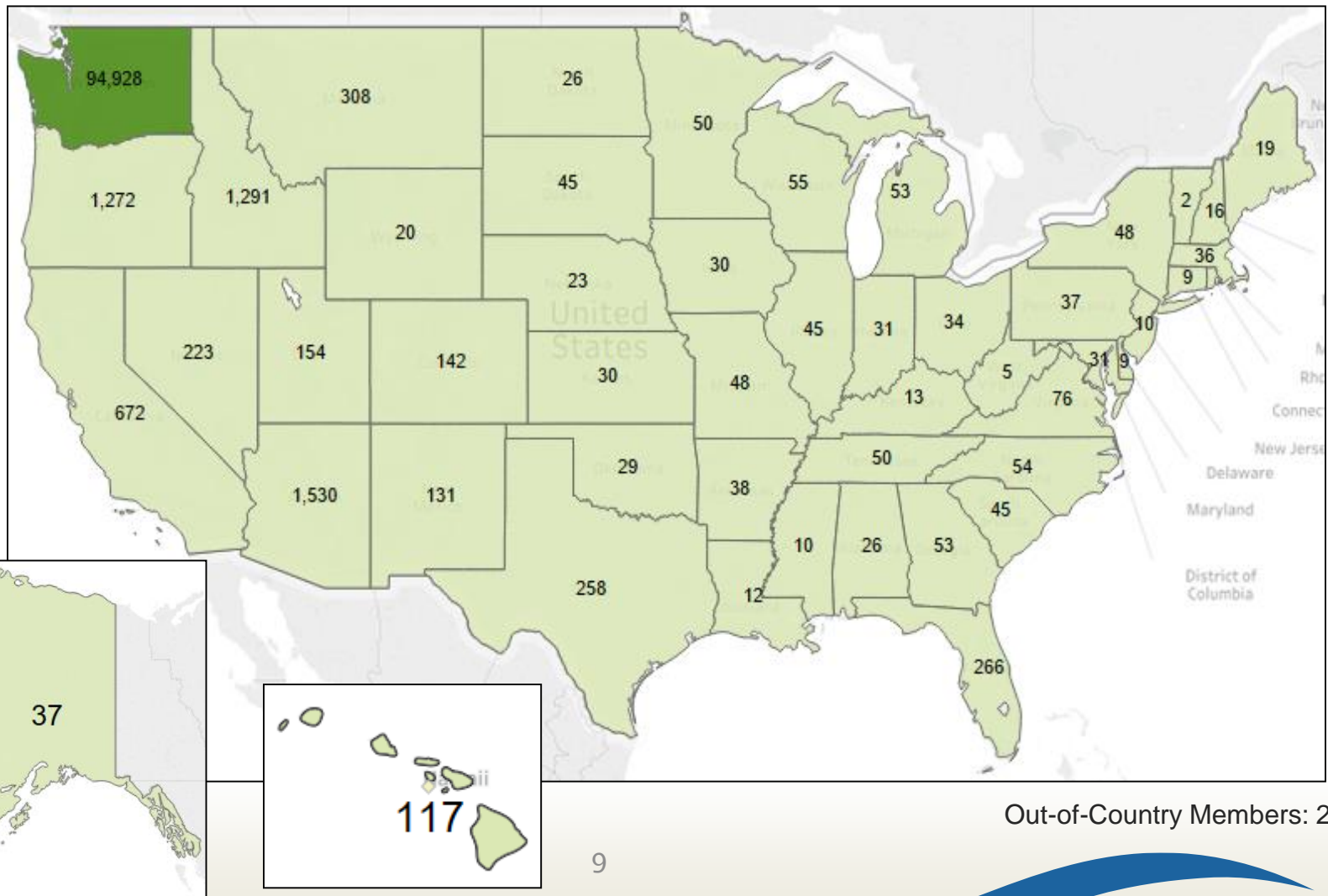
Age Cohort	Total Enrollees
54 and Under	1,090
55–64	10,061
65–74	53,431
75–84	28,273
85–94	8,931
95–104	704
105	3
<b>Total</b>	<b>102,493</b>

# All PEBB Program enrollment from 2014-2017

## Total 2017 enrollment 373,547



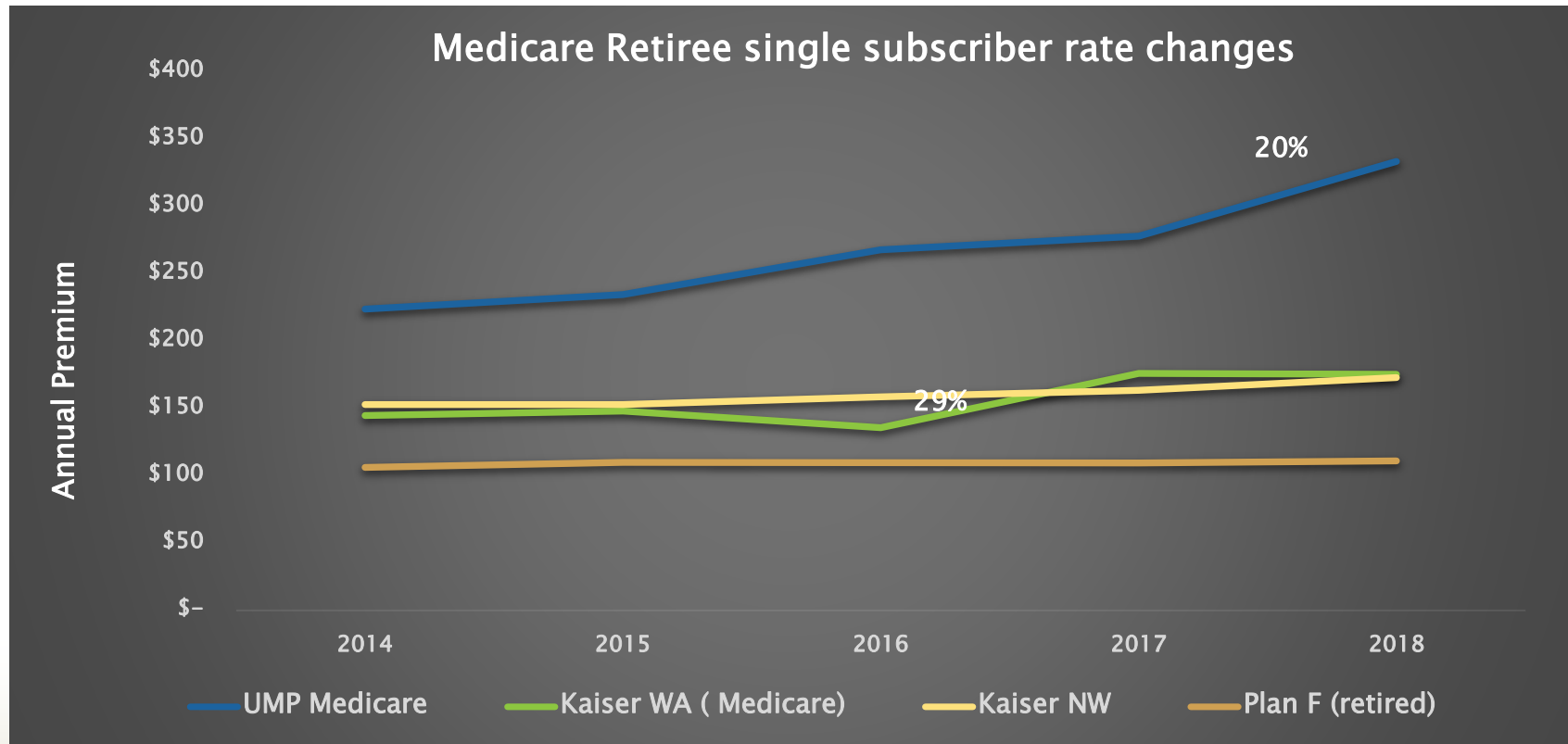
# Retiree members located in all 50 states



Out-of-Country Members: 24

# Issues our retirees are facing

**Rate Increases:** The Medicare retiree premium for Uniform Medical Plan went up due to specialty drug trend, as did a couple of the other premiums for non-Medicare retirees.



## Issues our retirees are facing (*cont.*)

**No Subsidy Increase:** The monthly subsidy, currently at \$150 or 50% of the premium (whichever is less), has not changed since 2012. This means that every year a Medicare retiree's premium increases, the retiree pays more out-of-pocket towards their insurance premium.



# Work in progress

## Retiree Analysis

The Governor's budget included funding for HCA to do a more in-depth analysis on what options are available, either through benefit design and or different plan offerings for retiree coverage.

## Retiree Risk Pool Analysis

By the passing of EHB 2242, HCA is required to consult with the SEB and PEB Boards and complete an analysis for the most appropriate risk pool for retired school employees.

## Plan F Replacement

- Effective 1/1/2020, Medicare supplemental plans that pay both the Medicare Part B deductible and co-pays are repealed by the federal government, except for any individual who does **not** attain age 65 or become newly disabled before 1/1/2020.
- Premera's Medicare Supplemental Plan F will need to be replaced with a new supplemental plan.
- Plan G is the closest to Plan F, covering all co-pays and co-insurance.
- Recommendation by program is to continue Plan F coverage as long as feasible, and offer a new Medicare supplemental Plan G effective 1/1/2019 or 1/1/2020.

# Premera Blue Cross Supplement Plan F

Plan F is currently the only Medicare Supplement Insurance (Medigap) plan offered by PEBB.

Plan F can help members pay for some health care costs that Medicare Part A and B don't cover, such as deductibles, copayments, and coinsurance.

There is no prescription drug coverage under Plan F. Members may need a Medicare Part D plan or have other creditable drug coverage. PEBB does not offer a Medicare Part D plan, so members must shop for a Part D plan from a private insurance company.

Like Plan F, the recommended Plan G does not have prescription drug coverage.

## Follow up to Board question

**Q:** What would it cost our Medicare retirees to purchase the Premiera Medicare Supplement Plan F and their own Part D plan?

**A:** Around **\$156**: \$111 + \$45 (2018 rates)

(Premera Plan F single sub premium + Part D average WA premium\*)

### Notes:

- Part D premiums range from around \$13-94\* in Washington
- Deductibles range from \$0-405
- According to the Kaiser Family Foundation there are:
  - 22 Part D stand-alone prescription drug plans available in Washington/Oregon; and
  - 782 Part D stand-alone prescription drug plans available in the United States

\*Part D premium source: [ehealthmedicareplans.com](http://ehealthmedicareplans.com)

# Potential Medicare benefit options

## **Procure a Private Medicare Retiree Exchange for PEBB**

- Active since 1980s.
- Accountable Care Act created spike in usage by employers and consumers.
- A number of private exchanges are available to Medicare retirees; with less available to pre-Medicare retirees. Pre-Medicare retirees are eligible for public exchanges as well.
- Since 2013, many employers have been moving retirees into private exchanges: IBM, CenturyLink, GE, Time Warner, AT&T, Starbucks (2016), and others.
- Some exchange offerings are: Towers Watson, Aon Hewitt, Mercer, and The Medicare Exchange.
- Potential for greater choice and lower premiums.
- Customized plan opportunities.
- Purchasing care based on the member's needs and location.
- Plan options include: Medicare Advantage Plans, Medigap Plans, also known as supplemental plans (Plans A, B, C, D, F, G, K, L, M, and N).
- Would like to offer through PEBB so retirees won't lose PEBB coverage.
- Includes evaluating subsidy offering.

# Benefit options (*cont.*)

## **UMP Classic Medicare changed to medical only plan**

- Members purchase Part D plan separately
- Includes evaluating subsidy role

# Discussion with the Board

- What concerns does the PEB Board have?
- What priorities does the PEB Board have regarding retirees and plan offerings?

# Questions?

Lauren Johnston, Benefit Analyst  
Employees and Retirees Benefits Division

[Lauren.Johnston@hca.wa.gov](mailto:Lauren.Johnston@hca.wa.gov)

360-725-1117

Kim Wallace, Deputy Section Manager  
Finance Services Division

[Kim.Wallace@hca.wa.gov](mailto:Kim.Wallace@hca.wa.gov)

360-725-9817

**TAB 4**





# UMP Value Formulary PEB Board Retreat

Ryan Pistoiresi, PharmD, MS  
Assistant Chief Pharmacy Officer  
Clinical Quality and Care Transformation  
January 31, 2018

# Overview

- Definitions
- Background
- Value Formulary Options
- Recommendation

# Definitions

- **Formulary (or Preferred Drug List):** A list of medications that is covered by a health plan.
  - **Open Formulary:** A formulary that includes all medications. Preferred drugs have lower cost-share than non-preferred drugs.
  - **Closed Formulary:** A formulary that only covers preferred drugs. Non-preferred drugs would only be covered if no preferred drug could treat that patient's condition.
  - **Hybrid Formulary:** A formulary where certain drugs are excluded. This can be done for clinical or financial reasons. Non-preferred drugs are either higher cost-share or excluded.

## Definitions (*cont.*)

- **Grandfathering:** A member will continue to receive the same benefit for a drug even after new policies are effective.
- **Multi-Source Brand (MSB):** An originator drug originally held by a drug patent, but the patent has expired and now has generic alternatives.
- **Copay Coupon:** A remuneration to patients for specific brand-name drugs. Applied after a drug has been billed to a health plan and used in place of member cost-share.

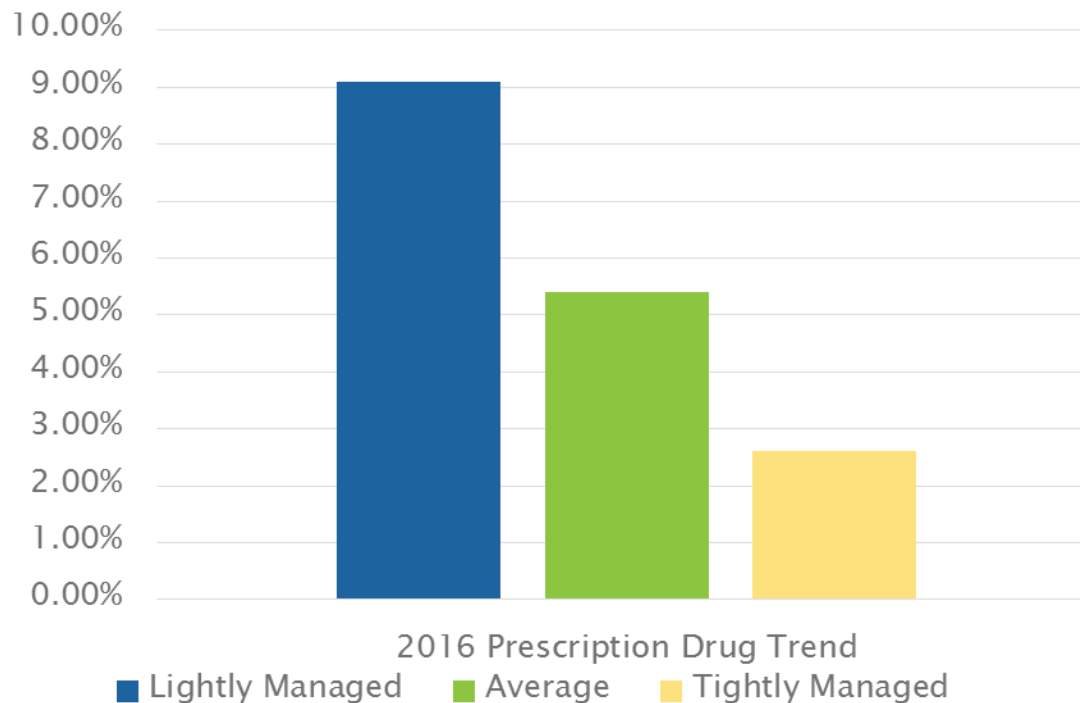
# Background

- Prior to the 1980s and 1990s, many commercial health plans operated closed formularies.
- During the late 1990s and 2000s, health plans transitioned to open formularies with cost-share tiers. This was done to promote member access and choice.
  - Patients are driven to preferred drugs through patient cost-share, but were able to access high cost drugs if needed.
  - Early tiers were often between brands and generics.
  - Later tiers were for preferred and non-preferred brands and specialty.

## Background (*cont.*)

- Manufacturer copay coupons, and other financial assistance direct to members, have reduced the ability of plans to drive members to preferred products by removing patient cost-share impacts.
  - Generic alternatives may have a higher patient cost-share than non-preferred brands after using a copay coupon.
  - Use of copay coupons for 23 of 85 multi-source brand name drugs accounted for \$700 million in drug expenditure nationally in 2007 and increased to \$2.3 billion in 2010<sup>1</sup>.
- Now, many pharmacy benefit managers (PBMs) use exclusion lists where select drugs are not covered for health plans.
  - Express Scripts excludes 45 drugs for its 2018 national formulary.
  - CVS/Caremark has 83 drug classes with exclusions in its national formulary.

## Background (*cont.*)



Total drug spend for tightly managed plans at Express Scripts had a significantly lower trend than lesser managed plans

# Information on Value Formulary Model

- The Value Formulary model examines what could occur when:
  - Certain drugs are excluded
  - Members are grandfathered
  - The number of appeal requests and approvals
  - What happens to grandfathered members and those with approved exceptions
- The Value Formulary model uses claims' data from 2015-2016 and projects member impact, cost avoidance, and administrative costs from 2019 through 2022.



# Overview of Value Formulary Options

- **Option 1:** Medicare members, Multi-Source Brand (MSB) only
- **Option 2:** Medicare members, Top 10 drug classes and MSB
  - **Option 2a:** Grandfather Top 10 classes, move to Tier 2
  - **Option 2b:** Grandfather Top 10 classes, keep at Tier 3
  - **Option 2c:** Do not grandfather users, exceptions move to Tier 2
- **Option 3:** Medicare members, All Tier 3 drug classes
  - **Option 3a:** Grandfather all classes, move to Tier 2
  - **Option 3b:** Grandfather all classes, keep at Tier 3
  - **Option 3c:** Do not grandfather users, exceptions move to Tier 2
- **Option 4:** All UMP members, MSB only

# **Option 1: Medicare Multi-Source Brand (MSB) Only**

# Option 1: Medicare MSB Only

<b>Who is affected?</b>	<b>Medicare Only</b> (Non-Medicare to have current formulary.)
<b>What changes?</b>	All Multi-Source Brands would be removed from formulary (all currently Tier 3).
<b>Current users?</b>	Current users would not be grandfathered and must appeal (generic alternatives are available).
<b>Is there Grandfathering?</b>	No grandfathering. Patients who have a medical necessity would pay Tier 2 cost share.

# Option 1: Medicare MSB Only (*cont.*)

2,039 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$1.31M	\$1.29M	\$1.20M	\$1.15M
% Change in Est. Trend	-6.1%	-6.7%	-5.4%	-5.4%
New Est. Trend	from 17.9% to 16.8%	from 14.9% to 13.9%	from 14.9% to 14.1%	from 14.9% to 14.1%

# **Option 2: Medicare Top 10+Multi-Source Brand (MSB)**

# Top 10 Drug Classes (by financial opportunity)

Drug Class Name	Examples
Antidiabetics	Victoza
	Trulicity
Vasopressors	Epipen
	Auvi-q
Blood Pressure Medications	Benicar
	Diovan
Antipsychotics/Antimanic Agents	Seroquel XR
	Abilify
Ophthalmic Agents	Lumigan
	Combigan
Antidepressants	Pristiq
	Trintellix
Cholesterol Medications	Crestor
	Lipitor
Endocrine and Metabolic Agents - Misc.	Forteo
	Somatuline depot
Antiparkinson Agents	Azilect
	Neupro
Urinary Antispasmodics	Vesicare
	Toviaz

# **Option 2a: Medicare Top 10+MSB Grandfather - Move to Tier 2**

## Option 2a: Medicare Top 10+MSB

<b>Who is affected?</b>	<b>Medicare Only</b> (Non-Medicare to have current formulary)
<b>What changes?</b>	All MSB plus all Tier 3 from Top 10 Drug Classes by estimated savings
<b>Current users?</b>	No grandfathering for MSB users; patients on Tier 3 for 1+ years would be grandfathered
<b>Is there Grandfathering?</b>	Grandfathered and exception users would be moved to a Tier 2 cost share



## Option 2a: Medicare Top 10+MSB (*cont.*)

4,076 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$4.59M	\$6.77M	\$8.52M	\$10.09M
% Change in Est. Trend	-18.4%	-30.9%	-38.9%	-47.0%
New Est. Trend	from 17.9% to 14.6%	from 14.9% to 10.3%	from 14.9% to 9.1%	from 14.9% to 7.9%

**Option 2b:  
Medicare Top 10+(MSB)  
Grandfather – Keep at Tier 3**

## Option 2b: Medicare Top 10+MSB

Who is affected?	<b>Medicare Only</b> (Non-Medicare to have current formulary)
What changes?	All MSB plus all Tier 3 from Top 10 Drug Classes by estimated savings
Current users?	No grandfathering for MSB users; patients on Tier 3 for 1+ years would be grandfathered
Is there Grandfathering?	Grandfathered and exception users would <b>remain on a Tier 3</b> cost share (no tier exception)

# Option 2b: Medicare Top 10+MSB (*cont.*)

4,076 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$5.80M	\$7.90M	\$9.66M	\$11.28M
% Change in Est. Trend	-23.5%	-36.2%	-45.0%	-52.3%
New Est. Trend	from 17.9% to 13.7%	from 14.9% to 9.5%	from 14.9% to 8.2%	from 14.9% to 7.1%

**Option 2c:  
Medicare Top 10+(MSB)  
Not Grandfathered – Move to Tier 2**

## Option 2c: Medicare Top 10+MSB

Who is affected?	<b>Medicare Only</b> (Non-Medicare to have current formulary)
What changes?	All MSB plus all Tier 3 from Top 10 Drug Classes by estimated savings
Current users?	No grandfathering for MSB users <b>or patients currently utilizing Tier 3 drugs</b>
Is there Grandfathering?	Grandfathered and exception users would be moved to a Tier 2 cost share (tier exception)

## Option 2c: Medicare Top 10+MSB (*cont.*)

4,076 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$7.31M	\$8.85M	\$10.23M	\$11.53M
% Change in Est. Trend	-28.5%	-40.9%	-47.7%	-53.0%
New Est. Trend	from 17.9% to 12.8%	from 14.9% to 8.8%	from 14.9% to 7.8%	from 14.9% to 7.0%

# **Option 3: Medicare All Tier 3 Classes**



**Option 3a:**  
**Medicare All Tier 3 Classes**  
**Grandfather All – Move to Tier 2**

## Option 3a: Medicare All Tier 3

<b>Who is affected?</b>	<b>Medicare Only</b> (Non-Medicare to have current formulary)
<b>What changes?</b>	All Tier 3 from all drug classes
<b>Current users?</b>	No grandfathering for MSB users; patients on Tier 3 for 1+ years would be grandfathered
<b>Is there Grandfathering?</b>	Grandfathered and exception users would be moved to a Tier 2 cost share

# Option 3a: Medicare Top 10+MSB (*cont.*)

27,454 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$0.41M	\$3.39M	\$5.46M	\$7.02M
% Change in Est. Trend	-1.7%	-14.1%	-23.5%	-30.9%
New Est. Trend	from 17.9% to 17.6%	from 14.9% to 12.8%	from 14.9% to 11.4%	from 14.9% to 10.3%

**Option 3b:  
Medicare All Tier 3  
Grandfather All – Keep at Tier 3**

## Option 3b: Medicare All Tier 3

Who is affected?	<b>Medicare Only</b> (Non-Medicare to have current formulary)
What changes?	All Tier 3 from all drug classes
Current users?	No grandfathering for MSB users; patients on Tier 3 for 1+ years would be grandfathered
Is there Grandfathering?	Grandfathered and exception users would <b>remain on a Tier 3</b> cost share

# Option 3b: Medicare Top 10+MSB (*cont.*)

27,454 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$4.77M	\$7.26M	\$9.19M	\$10.83M
% Change in Est. Trend	-18.4%	-32.9%	-40.9%	-48.3%
New Est. Trend	from 17.9% to 14.6%	from 14.9% to 10.0%	from 14.9% to 8.8%	from 14.9% to 7.7%

**Option 3c:  
Medicare All Tier 3  
Not Grandfathered –  
Exceptions Move to Tier 2**

## Option 3c: Medicare All Tier 3

Who is affected?	<b>Medicare Only</b> (Non-Medicare to have current formulary)
What changes?	All Tier 3 from all drug classes
Current users?	No grandfathering for MSB users <b>or patients currently utilizing Tier 3 drugs</b>
Is there Grandfathering?	Grandfathered and exception users would be moved to a Tier 2 cost share



# Option 3c: Medicare Top 10+MSB (*cont.*)

27,454 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$6.76M	\$7.71M	\$9.57M	\$10.50M
% Change in Est. Trend	-27.4%	-37.6%	-43.0%	-47.0%
New Est. Trend	from 17.9% to 13.0%	from 14.9% to 9.3%	from 14.9% to 8.5%	from 14.9% to 7.9%

# **Option 4: All Multi-Source Brands (MSB) for All UMP**

## Option 4: All MSB for UMP

<b>Who is affected?</b>	<b>All UMP</b>
<b>What changes?</b>	All Multi-Source Brands would be removed from formulary (all currently Tier 3)
<b>Current users?</b>	Current users would not be grandfathered and must appeal (generics exist)
<b>Is there Grandfathering?</b>	No grandfathering. Patients who have a medical necessity would pay Tier 2 cost share

# Option 4: All MSB for UMP (*cont.*)

9,952 members would be affected

Outcome	2019	2020	2021	2022
Est. Cost Avoidance	\$0.29M	\$0.65M	\$0.68M	\$0.72M
% Change in Est. Trend	-1.3%	-0.8%	-0.8%	-0.8%
New Est. Trend	from 15.3% to 15.1%	from 13.2% to 13.1%	from 13.2% to 13.1%	from 13.2% to 13.1%

# Recommendation

- We recommend exploring **Option 2** in more detail
  - Targets the highest cost avoidance while limiting impact to members
- Within **Option 2** are different ways to implement the Value Formulary:
  - **Option 2a:** Grandfather Top 10 classes, move to Tier 2
    - Members who used Top 10 drugs for over 1 year will continue to have access and see a reduced patient cost share. Newer users must switch to alternatives or appeal.
  - **Option 2b:** Grandfather Top 10 classes, keep at Tier 3
    - Grandfathered members will continue to have access and pay the same patient cost-share. Newer users must switch to alternatives or appeal.
  - **Option 2c:** Do not grandfather users, exceptions move to Tier 2
    - All users must switch to alternatives or appeal. Approvals would allow patients to pay a Tier 2 cost share.

## Member Example (Option 2a)

- Paula and Edward are UMP members who both use Trulicity (dulaglutide) for their Type 2 diabetes mellitus.
  - Each month, each member pays \$310.29 for Trulicity. UMP pays the remainder for each member, \$310.29. The total cost is \$620.58 per month for each member.
- Under Scenario 2a, Trulicity could be grandfathered for members who have used the medication for over 1 year.
  - Paula has used Trulicity for 2 years, so she would be grandfathered and pay a Tier 2 cost share. Now, Paula would pay \$75 and UMP would pay \$545.58 each month.
  - Edward has only used Trulicity for 3 months, so it would be excluded for him. Ed could switch to another diabetes medication or appeal the exclusion. If approved, Ed would pay \$75 each month for Trulicity.

# Member Example (Option 2b)

- Beatrice and Benny are UMP members who both use Vesicare (solifenacin) for their overactive bladder.
  - Each month, each member pays \$157.49 for Vesicare. UMP pays the remainder for each member, \$157.49. The total cost is \$314.98 per month for each member.
- Under Scenario 2b, Vesicare could be grandfathered for members who have used the medication for over 1 year.
  - Beatrice has used Vesicare for 3 years, so she would be grandfathered, but continue to pay the same Tier 3 cost share. Beatrice would continue to pay \$157.49 each month.
  - Benny has only used Vesicare for 2 months, so it would be excluded for him. Benny could switch to another overactive bladder medication or appeal the exclusion. If approved, Benny would pay \$157.49 each month for Vesicare.

# Member Example (Option 2c)

- Sarah is a UMP member who uses Azopt (brinzolamide) for her glaucoma.
  - Each month, Sarah pays \$131.07 for Azopt. UMP pays the remainder, \$131.07. The total cost is \$262.14 per month.
- Under Scenario 2c, Azopt would not be grandfathered for members.
  - Sarah could switch to another glaucoma medication or appeal the exclusion. If approved, Sarah would pay \$75 each month for Azopt.



# Questions?

Ryan Pistoiresi, PharmD, MS  
Assistant Chief Pharmacy Officer  
Clinical Quality and Care Transformation  
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**TAB 5**



# Developing Premiums

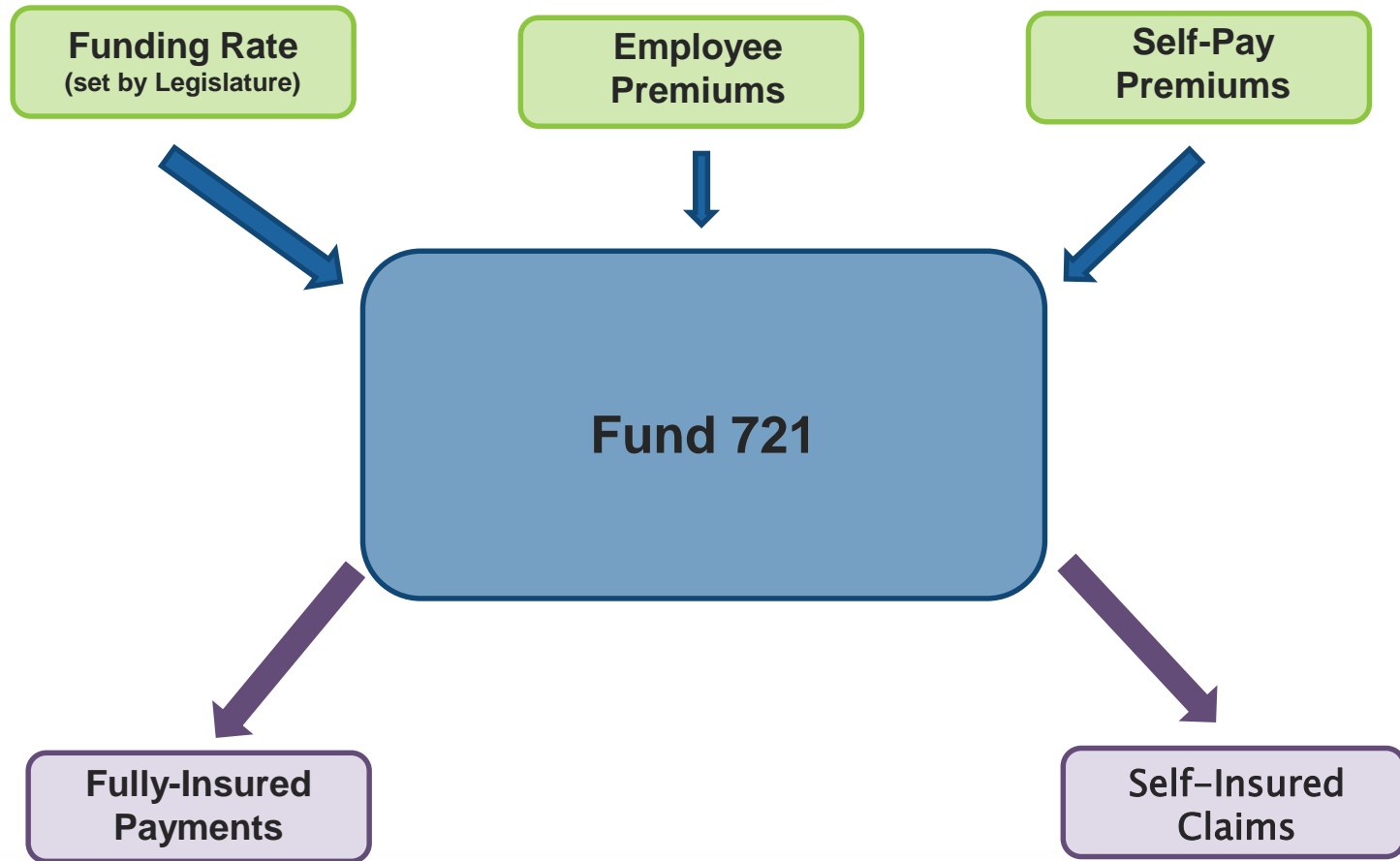
Tanya Deuel  
Fiscal Information and Data Analyst  
Financial Services Division  
January 31, 2018



# Medical Rate Development and Negotiations – Non-Medicare

- Fully insured
  - Carriers submit bid rates by plan to HCA, these rates are negotiated and proposed to the PEB Board in June/July of each year.
- UMP – Self-insured
  - HCA develops “bid rates” for the UMP Plans based on projected costs for the upcoming plan year.
  - The bid rate is developed strictly for the purpose of developing employee premiums.

# Premium Revenue and Expenditure Flow



# What is a “State Index Rate”

- The term “State Index Rate” is the amount the employer contributes to the employee’s medical insurance.

# Why a “State Index Rate”

- Per the Collective Bargaining Agreement (CBA), the Employer will contribute an amount equal to 85 percent of the total weighted average of the projected health care premium.

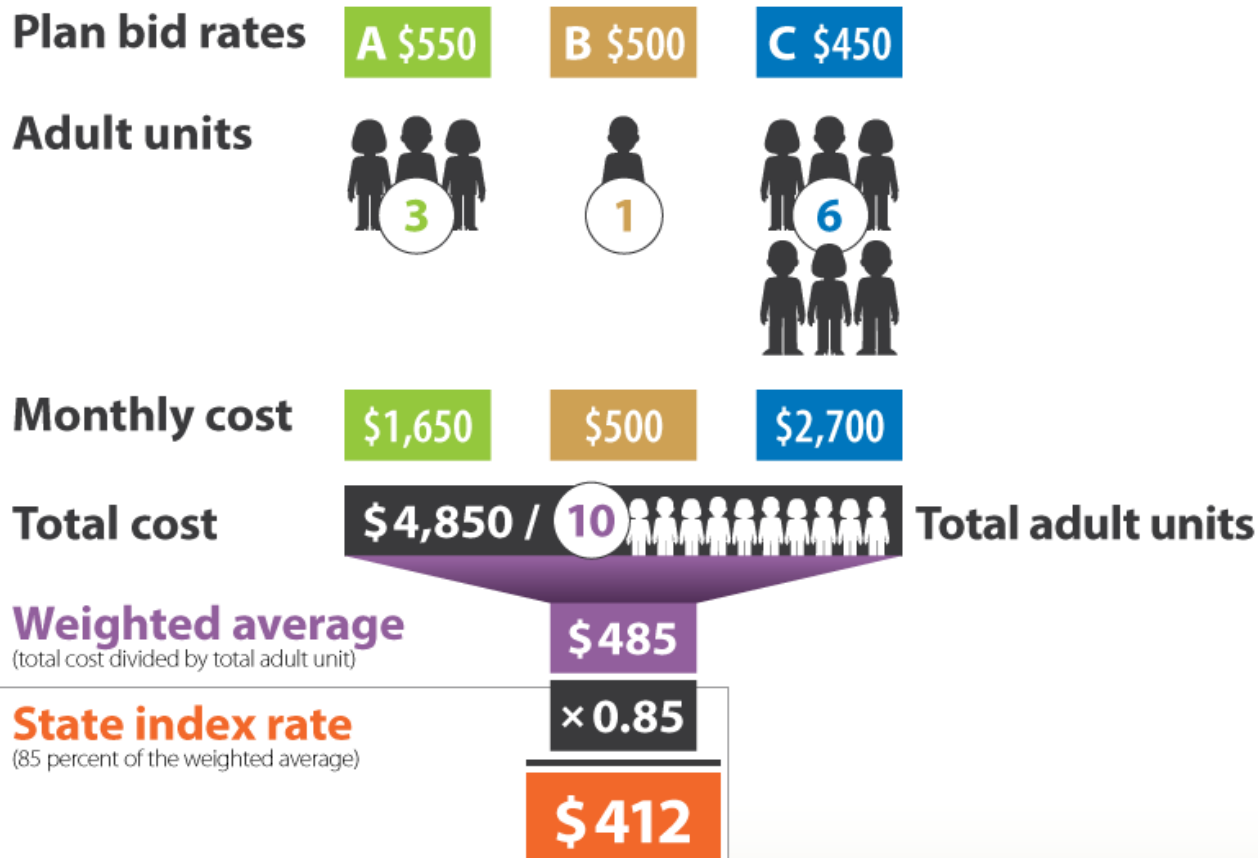
## ARTICLE 43

### HEALTH CARE BENEFITS AMOUNTS

- 43.1 A.** For the 2017-2019 biennium, the Employer will contribute an amount equal to eighty-five percent (85%) of the total weighted average of the projected health care premium for each bargaining unit employee eligible for insurance each month, as determined by the Public Employees Benefits Board (PEBB). The projected health care premium is the weighted average across all plans, across all tiers.

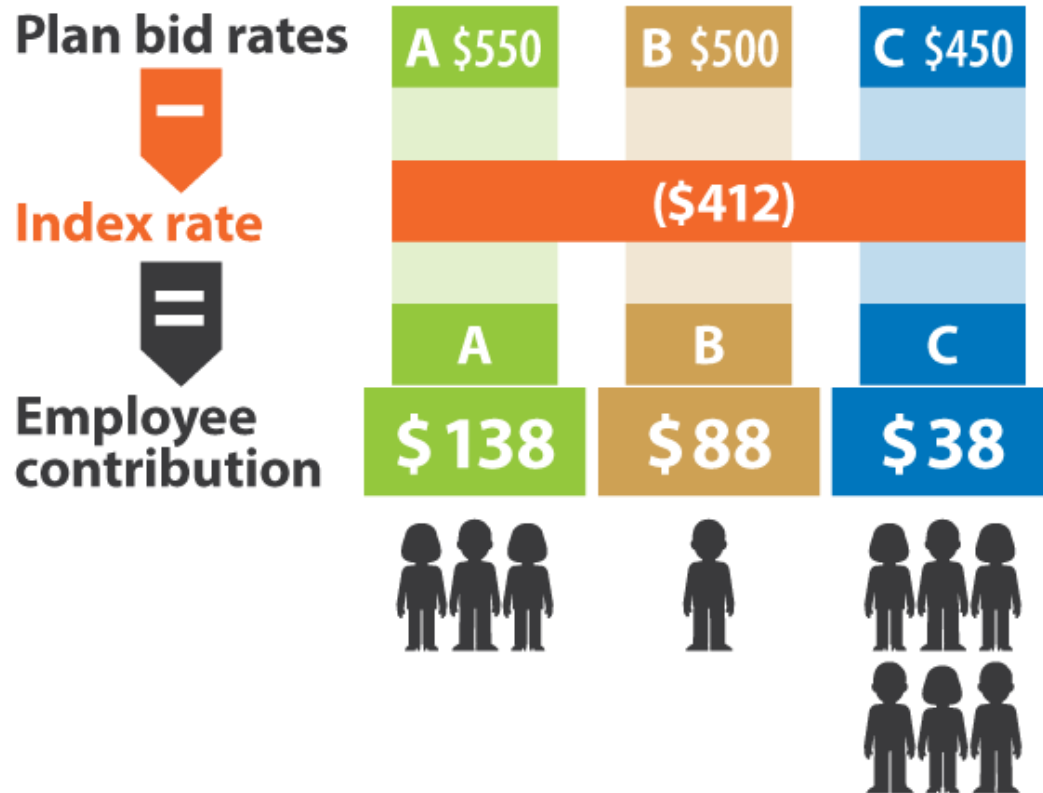
# Calculating the State Index Rate

## Sample Illustration










# Determining Employee Premiums



# Determining Employee Premium by Tier

Plan		A	B	C
Employee contribution		\$138	\$88	\$38
Tiers				
Tier 1	1 	\$138	\$88	\$38
Tier 2	2  +\$10	\$286	\$186	\$86
Tier 3	1.75 	\$242	\$154	\$67
Tier 4	2.75  +\$10	\$390	\$252	\$115

\*Tiers 3 and 4 do not change when you go from one child to more than one child.

# Employee / Employer Premium Contributions

	2018 Employee Contribution (Single Subscriber)	2018 Employer Contribution (State Index Rate)	2018 Composite (Bid Rate)
Kaiser NW Classic	\$137	\$551	\$688
Kaiser NW CDHP	\$27	\$551	\$578
Kaiser WA Classic	\$162	\$551	\$713
Kaiser WA Value	\$78	\$551	\$629
Kaiser WA SoundChoice	\$51	\$551	\$602
Kaiser WA CDHP	\$25	\$551	\$576
UMP Classic	\$102	\$551	\$653
UMP Plus	\$45	\$551	\$596
UMP CDHP	\$25	\$551	\$576

# Medical Rate Development and Negotiations – Medicare

- Fully insured
  - Carriers submit rates to HCA.
  - HCA reviews rates, negotiates final rate, and presents to the PEB Board in June/July of each year.
  - Retirees pay this rate less the Medicare Explicit Subsidy\*.
- UMP – Self-insured
  - HCA develops rates for the UMP Plans based on projected costs for the upcoming plan year.
  - Retirees pay this rate less the Medicare Explicit Subsidy\*.

\*Medicare Explicit Subsidy currently set at \$150 or 50% of the premium, whichever is less.

# Dental, Life, and LTD Premiums

- Dental Premiums
  - Fully-insured dental carriers submit rates to HCA.
  - Self-insured dental (UDP) rate is set by HCA based on projected claims costs.
  - Paid 100 percent by the state for employees.
  - Dental coverage is offered to retirees on a self-pay basis.
- Life and LTD Premiums
  - Rates are set based on experience.
  - Basic benefit paid 100 percent for employees.
  - Optional benefit paid by the employee.
  - Life coverage is offered to retirees on a self-pay basis.

# Questions?

Tanya Deuel, FIDA  
Financial Services Division

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**TAB 6**



# UMP Utilization and Cost Review Medical and Pharmacy

Karin Freeman  
Fiscal Information and Data Analyst  
PEBB and SEBB Programs  
January 31, 2018





# UMP Utilization and Cost Review

Today, we'll cover:

- Summary of Medical Costs
- ER Utilization
- Maternity Costs and Trends
- Pharmacy Costs and Trends
- Opportunities to Improve

# Summary of Medical Utilization and Costs

# Overview

- Data is from the November 2017 UMP/Regence Annual Performance Report
  - January through June 2016
  - January through June 2017
  - 3-month claims runout (September)
- Non-Medicare
- Two categories of year-over-year costs:
  - Overview of utilization and costs
  - Medical Practice Categories

## Medical Utilization and Cost

- Non-Medicare utilization decreased in all service categories.
- Cost per case increased in all categories.
  - 2.7% increase overall
- The increased cost per case resulted in an overall increase in the paid Per Member Per Month (PMPM).

# Medical Practice Categories

## *(Includes Medicare)*

- In general, costs for individual medical practice categories decreased.
- Exceptions to the decrease are in three categories:
  - Orthopedics
    - Increases in spending for all episodes of care
  - Neurology
    - Increases in spending for all episodes of care
  - Endocrinology
    - Increases in spending for obesity and diabetes related episodes of care

# Emergency Room Utilization Maternity Utilization and Cost

# ER Utilization

- Non-Medicare.
- ER utilization decreased 1%.
- The combined rate for potentially avoidable ER visits was 8.9% for the first half of 2017.
- Potentially avoidable ER utilization decreased 3%.

# Maternity

- Overall decrease in births/1,000
- Vaginal births
  - Vaginal births/1,000 decreased by 12%
  - Vaginal birth PMPM cost decreased by 2%
- C-sections
  - C-section/1,000 increased by 13%
  - C-section PMPM cost increased 5%



# Pharmacy Utilization and Costs

## Pharmacy Year-Over-Year Trends

- Pharmacy cost overall is projected to rise 14% from 2016 to 2017.
- General trend drivers:
  - Unit Cost projected to rise almost 6%
    - Largest component for increase is specialty drugs
    - Largest traditional drug class increases are related to diabetes, asthma, and HIV

# Specialty Drugs

- Top 5 Specialty Therapeutic Classes by claims paid January through November 2017
  - Antineoplastics/Adjunctive Therapy \$33,068,769
  - Analgesics/Anti-Inflammatories \$28,641,280
  - Psychotherapeutic/Neurologic \$22,020,321
  - Antivirals (Hep B and Hep C) \$10,967,415
  - Dermatologicals \$ 7,605,470
- Trend (2017 over 2016)
  - Non-Medicare 21%
  - Medicare 21%

Gross of rebate

# Traditional Drugs

- Top 5 Traditional Therapeutic Classes by claims paid January through November 2017
 

– Antidiabetics	\$35,986,707
– Analgesics/Anti-Inflammatories	\$29,168,817
– Antivirals (non-Hep C only)	\$11,059,125
– Antiasthmatics/Bronchodilators	\$10,788,115
– Psychotherapeutics/Neurologicals	\$ 8,862,311
- Trend (2017 over 2016)
 

– Non-Medicare	2%
– Medicare	2%

Gross of rebate

# Opportunities for Improvement

- Medical
  - Virtual diabetes prevention program
    - Expected start date January 1, 2019
    - Online; easy accessibility and flexibility
  - Build on success of Centers of Excellence program for joint replacements
  - Build on ACP success and geographic expansion
- ER
  - Continue to reduce avoidable ER visits through promotion of alternative care
- Maternity
  - Focus on the Washington Bree Collaborative
- Pharmacy
  - Continue to improve drug purchasing
  - Consider changes to the UMP formulary

# Discussion

Karin Freeman  
Financial Information and Data Analyst  
PEBB and SEBB Programs  
Karin.Freeman@hca.wa.gov  
(360) 725-0944

**TAB 7**



# Public Employees Benefits Board Annual Retreat

January 2018



# Presenters:

- Bill Ely – Vice President, Actuarial Services
- Fred Armstrong – Senior Director, Strategic Accounts

# Kaiser Permanente Model

- Kaiser Permanente Washington is a mixed network model – owned/ operated & contracted providers
- 25 owned/operated medical centers, 1100+ Washington Permanente Medical Group (PMG) physicians
- PMG physicians are salaried and incented to achieve high quality, not high volume
- PMG recognized by the Washington Health Alliance as the highest quality medical group in Washington
- Focus on Right Care – Right Time
  - Integrated or collaborative care
  - Evidence-based
  - Shared decision making
  - Formulary management

# Kaiser Permanente Trend

- Trend – mix of price and utilization
- How we break down our model:
  1. Medical Trend
    - a) Owned/Operated
    - b) Contracted
    - c) Non-Contracted
  2. Pharmacy Trend
- Generally owned/operated trend is the lowest of the components

# Key Factors that Influence Annual Rate Change

- Trend
- Projected Claims Experience
  - Population changes, increase/decrease in risk burden/demographics
- Benefit changes

**TAB 8**



# Overview of Benefit Changes Proposed for 2019

Beth Heston  
PEBB Procurement Manager  
Employees and Retirees Benefits Division  
January 31, 2018



# Dental Restoration: Reducing 7-Year Limit to 5 Years for Uniform Dental Plan

## Class III Restorative Services

- Primarily restoration of crowns
- 96% of all placed crowns are still in place after 7 years
- The majority of exception requests made are for exceptions to this 7-year limit

## Reducing the Time Limit

- Removes the delay in treatment for members
- Offers a reasonable alternative to an extraction
- Reduces administrative burden on providers who initiate exception requests
- Aligns with other dental plans in portfolio

# Diabetes Prevention Program

- Executive Order 13-06 (2)(b) ordered the PEB Program to implement Diabetes Prevention Program (DPP).
- DPP is a Centers for Disease Control (CDC) recognized, evidence-based, in-person, or online program.
- Participants take part in a structured lifestyle change program, lose 5% to 7% of their body weight through healthier eating and 150 minutes of physical activity per week.
- DPP can cut the risk of developing Type 2 diabetes by 58% (71% for people over 60 years old).



# Diabetes Prevention Program (*cont.*)

- The current DPP program is not available for members who:
  - Live in areas that have low population density,
  - Work non-traditional shift hours,
  - Do not work at an agency that sponsors on-site DPP classes, or
  - Prefer to take the courses with more privacy.

# Virtual Diabetes Prevention Program

- Allows access to members in all regions of the state because it's available online.
- Provides more choice of when to participate and where because it's available 24/7.
- Offers more privacy for members to pursue the program.
- Allows members to proceed at their own pace.

# Questions?

Beth Heston, Procurement Manager  
Employees and Retirees Benefits  
Division (ERB)

[Beth.Heston@hca.wa.gov](mailto:Beth.Heston@hca.wa.gov)

Tel: 360-725-0865

TAB 9



# Priorities for Benefit Design Changes Plan Years 2020 - 2021

Marcia Peterson, Manager  
Benefit Strategy and Design  
Employees and Retirees Benefits Division  
1/31/2018

## RCW 41.05.065

### Public employees' benefits board— Duties—Eligibility—Definitions— Penalties.

(1) The board shall ***study all matters connected with the provision of health care coverage***, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, the enumerated types of insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state. However, liability insurance shall not be made available to dependents.

## RCW 41.05.065 (*cont.*)

(2) The board shall **develop employee benefit plans** that include comprehensive health care benefits for employees. In developing these plans, the board shall consider the following elements:

- (a) Methods of maximizing **cost containment while ensuring access to quality** health care;
- (b) Development **of provider arrangements that encourage cost containment and ensure access to quality care**, including but not limited to prepaid delivery systems and prospective payment methods;
- (c) **Wellness incentives that focus on proven strategies**, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education;

## RCW 41.05.065 (*cont.*)

(d) ***Utilization review procedures*** including, but not limited to a cost-efficient method for prior authorization of services, hospital inpatient length of stay review, requirements for use of outpatient surgeries and second opinions for surgeries, review of invoices or claims submitted by service providers, and performance audit of providers;

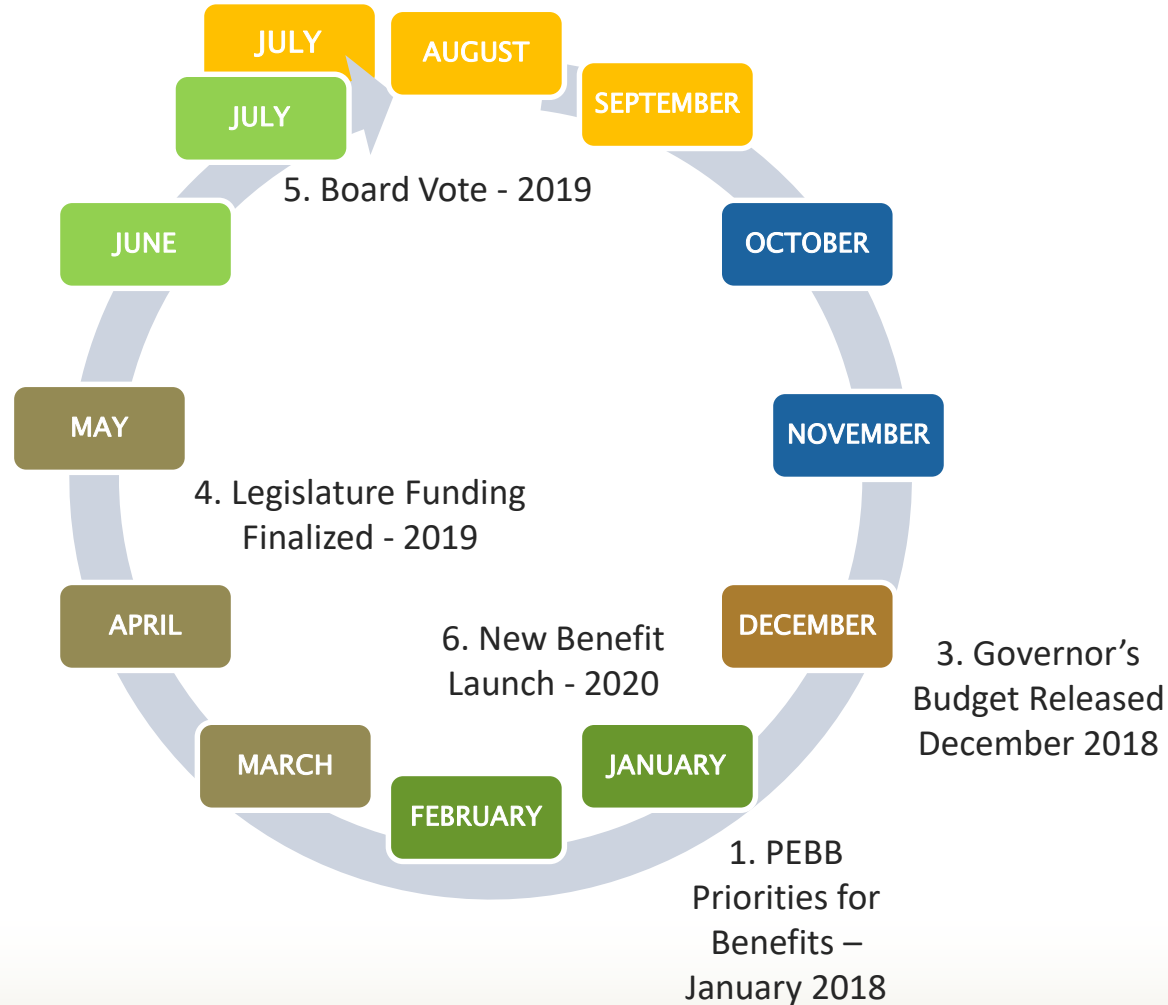
(e) Effective coordination of benefits; and

(f) Minimum standards for insuring entities.



## PEBB BENEFIT PLANNING CALENDAR for 2020

### 2. New Benefits Analysis and Feasibility - 2018



# Board Discussion



# Questions?

Marcia Peterson, Manager  
Benefit Strategy and Design  
Employees and Retirees Benefits Division  
Phone: (360) 725-1327  
[Marcia.Peterson@hca.wa.gov](mailto:Marcia.Peterson@hca.wa.gov)

**TAB 10**



# School Employees' Benefits Status

John Bowden, Manager  
School Employees Benefits Section  
Employees and Retirees Benefits Division  
January 31, 2018

# SEBB Background

- Legislature created the School Employees Benefits Board and SEBB Program in 2017.
- HCA mandated to develop and administer SEBB Program as the single state agent for purchasing health care services.
- 250,000 to 300,000 school employees and their dependents in a new single community-rated risk pool.

## SEBB Background (*cont.*)

- SEBB Program employers includes:
  - 295 school districts
  - 9 Educational Service Districts (ESDs)
  - 10 charter schools
- 8,190 school employees and dependents in 5 ESDs and 71 school districts currently enrolled in PEBB Program will transition to SEBB Program.
- SEBB benefits begin January 1, 2020.

# Retired K-12 Employees in PEBB Program

- 52,171 retired and disabled K-12 employees and dependents remain in PEBB Program unless the Legislature directs a change.
- Report on the most appropriate risk pool due to Legislature by December 15, 2018.
  - HCA will conduct study
  - In consultation with SEB Board and PEB Board



# SEB Board Responsibilities

- The Board's role is to design and approve benefit plans and to establish eligibility criteria.
- In developing health care plans:
  - Maximize cost containment
  - Ensure access to quality health care
  - Offer wellness, preventive care, and chronic disease management services
  - Leverage purchasing by coordinating with PEB Board

# SEB Board Meetings

- SEB Board has met four times since October 2017
- In preparation for making decisions about benefits, the Board has been briefed on:
  - State processes for procuring benefits
  - Foundational insurance concepts
  - State's commitment to value-based purchasing
  - Bree Collaborative and Health Technology Assessment Program
  - Examples of benefit structures

## SEB Board Meetings (*cont.*)

- HCA gathered, analyzed, and presented data to the SEB Board about:
  - How school districts, ESDs, and charter schools procure employee benefits and what benefits are currently offered to school employees
  - Legal and historical information about school districts, ESDs, and charter schools
  - Demographic data about school employees and results of focus groups conducted around the state

## SEB Board Meetings (*cont.*)

- At the January 29, 2018 meeting, SEB Board was presented with resolutions regarding:
  - Procurement and leveraging options
  - Eligibility rules
- Voting on proposed resolutions is scheduled for the March 15, 2018 SEB Board meeting.

# Questions?

John Bowden, Manager  
School Employees Benefits Section  
Phone: 360-725-1113  
[john.bowden@hca.wa.gov](mailto:john.bowden@hca.wa.gov)

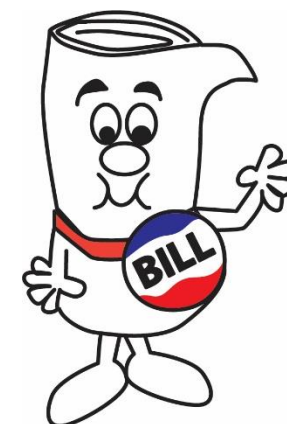
**TAB 11**



# Legislative Update

David Iseminger, Director  
Employees and Retirees Benefits Division  
January 31, 2018

# Number of Bills Analyzed by ERB Division



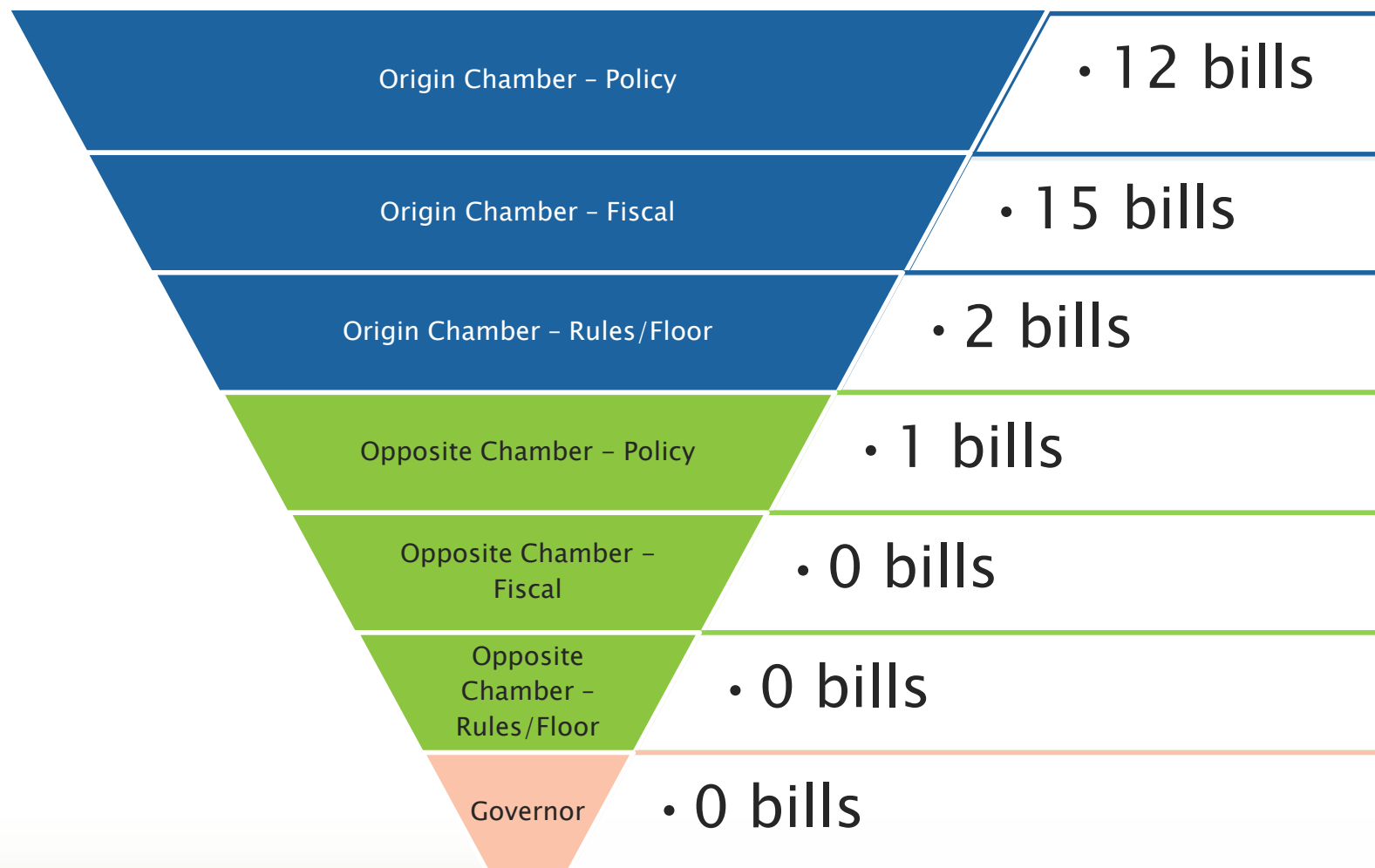
	ERB Lead	ERB Support	
High Impact	27	37	64
Low Impact	27	17	44
	54	54	108

*There are also 3 ERB Lead, High Impact bills from the 2017 session that have significant 2018 session activity*

*Information as of January 24, 2018*



# Legislative Update – ERB high lead bills



## Legislative Update – PEBB Program Impact bills

- HB 2869 - Addressing the maximum share of public employee health benefit premiums to be paid by employers participating in the public employees' benefits board
- HB 2452/SB 6305 - Addressing retiree benefits for participants in the public employees' retirement system, the teachers' retirement system, and the public employees' benefits board
- HB 2633/SB 6213 - Addressing the presumption of occupational disease for purposes of workers' compensation by adding medical conditions to the presumption and extending the presumption to certain publicly employed firefighters and investigators and law enforcement

# Legislative Update – SEBB Program Impact bills

- HB 2408/SB 6564 - Preserving access to individual market health care coverage throughout Washington State
- HB 2438/SB 6241 - Concerning the January 1, 2020 implementation of the school employees' benefits board program
- HB 2655/SB 6286 - Adding members to the school employees' benefits board
- HB 2657/SB 6288 - Regarding the school employees' benefits board
- HB 2755/SB 6461 - Addressing employee benefits provided by the school employees' benefits board

# Legislative Update

## Both Program Impact bills

- 2SSB 5179 – An act relating to requiring coverage for hearing instruments under public employees and medicaid programs
- ESHB 2114 - An act relating to protecting consumers from charges for out-of-network health services
- SHB 1421 - An act relating to the removal of payment credentials and other sensitive data from state data networks

# Questions?

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